
E001359

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF ANNIVERSARY REVIEW AND AWARD GRANT APPLICATION
(A Privileged Communication)

ALBANY REGIONAL MEDICAL PROGRAM
Albany Medical College of
Union University
47 New Scotland Avenue
Albany, New York 12208

RM 00004 8/71
July 1971 Review Committee

Program Coordinator: Frank M. Woolsey, Jr., M.D.

This Region presently is funded for its 04 operational year at a direct cost figure of $806,001 (a twelve percent reduction from its original 04 year award of $915,910). Although the precise indirect costs attached to the $806,001 award are not yet known, past experience with this Region indicates they will be in the neighborhood of $283,000, representing an overall indirect cost rate of approximately 35 percent. The current budget period ends September 30, 1971. This Triennial Application requests support for:

I. Renewal support for three additional years of core.
II. Continuation with committed support of four ongoing activities for the 05 year and renewal for three of these projects for two years thereafter (06 and 07 years).
III. Developmental component funding for three years.

The Region requests $1,104,790 direct costs for its fifth year of operation, $1,171,092 for the sixth, and $1,248,198 for the seventh. A breakout chart identifying the components for each of the three years is included as pages 3 through 5 of this summary.

A STAFF REVIEW OF THIS APPLICATION HAS IDENTIFIED CERTAIN AREAS OF CONCERN IN WHICH THE SITE VISITORS, COMMITTEE, AND COUNCIL REVIEWERS MAY BE INTERESTED. THESE CONCERNS WILL BE OUTLINED IN A MEMORANDUM ATTACHED TO THIS SUMMARY.

FUNDING HISTORY

Planning Phase

Grant Year	Period	Funded (direct costs)
01	7/66-6/67	$267,679

Operational Program

Grant Year	Period	Funded (direct Costs)	Future Commitment
01	4/67-6/68	$1,040,458	--
02	7/68-9/69	1,237,456	--
03	10/69-9/70	1,177,809	--
04	10/70-9/71	806,001*	--
05	10/71-9/72	--	$322,362

*Reduced from original award of $915,910 due to RMPS fiscal stringencies.

ALBANY REGIONAL MEDICAL PROGRAM

Comparision of 01-04 year
funding & 05-07 year request

PROJECT	FUNDED				REQUESTED		
	15 mo. 01	15 mo. 02	03	04	05	06	07
Core (including community info. coordinators)	$ 509,691	$ 783,933	$ 712,094	$ 687,159	$ 791,460	$ 850,610	$ 914,512
Developmental component	--	--	--	--	85,000	85,000	85,000
Two-way Radio	144,104	124,689	143,975	142,975	154,030	163,171	173,118
Postgraduate Instruction Development Panel	102,608	69,932	80,745	--	--	--	--
Community Hospital Learning Centers	75,833	76,665	111,082	--	--	--	--
CCU Training - Albany	125,240	103,850	71,746	71,746	60,270	62,981	65,912
CCU Training - Community Hospitals	55,410	39,576	36,930	--	--	--	--
Intensive Care Unit	25,472	33,455	7,207	--	--	--	--
Schenectady Cancer Coordinator	2,100	5,356	5,000	5,000	5,000	--	--
Develop Community Leadership	--	--	9,030	9,030	9,030	9,330	9,656
TOTAL DIRECT COSTS	1,040,458	1,237,456	1,177,809	915,910*	1,104,790	1,171,092	1,248,198

*original 04 year award has been reduced to $806,001 due to RMPS fiscal constraints. However, the new allocation among projects is not yet known.

REGION Albany RM 00004 8/71
CYCLE July/August 1971

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
#D00 - Developmental **				85,000	85,000	- 0 -	85,000
Core		791,460			791,460	322,185	1,113,645
#1A - Two-Way Radio Communication	* 12,370				12,370	4,902	17,272
#1B - Two-Way Radio Communication	*141,660				141,660	25,779	167,439
#6 - Coronary Care Trg. & Demonstration Pg.	* 60,270				60,270	14,441	74,711
#13 - Coordinator for Cancer	5,000				5,000	1,445	6,445
#16 - Development of Com. Leadership	9,030				9,030	723	9,753
TOTAL	228,330	791,460		85,000	1,104,790	369,475	1,474,265

* 06 and 07 Year Beyond Approved Period of Support
** Request amended to 3 years per telephone conversation by E. Faatz and the Region 5/7/71.

GRB-5/7/71

REGION Albany RM 00004
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
#D00-Developmental				85,000	85,000
Core -		850,610			850,610
#1A		13,339			13,339
#1B		149,832			149,832
#6		62,981			62,981
#13		- 0 -			- 0 -
#16	9,330				9,330
TOTAL	9,330	1,076,762		85,000	1,171,092

REGION Albany RM 00004

BREAKOUT OF REQUEST 07 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
#D00 - Developmental				85,000	85,000	255,000
Core -		914,512			914,512	2,556,582
#1A -		14,388			14,388	40,097
#1B -		158,730			158,730	450,222
#6		65,912			65,912	189,163
#13		--			--	5,000
#16	9,656				9,656	28,016
TOTAL	9,656	1,153,542		85,000	1,248,198	3,524,080

Geography and Demography

The Albany Regional Medical Program is composed of 24 counties in eastern and northeastern New York, southwestern Vermont, and western Massachusetts. Three of the counties in northern New York and the two in southern Vermont have been designated as an interface area for the Albany and Northern New England RMPs. The westernmost county of Massachusetts (Berkshire) has a traditional socioeconomic and medical relationship to Albany. (The ARMP & Tri-State RMP overlap in this county). The Region has been divided into six subunits. The two maps which follow on pp.4 and 5 show (1) a geographic delineation of the Albany Regional Medical Program and its subdivisions, and (2) the geographic relationship of the ARMP to the other five RMPs in New York State.

The approximate population served by this Region is two million, and the area contains one medical school (Albany Medical College of Union University), 26 schools of nursing, eight schools of technology, and 55 non-federal hospitals with 7,461 beds. In addition, the Region has approximately 2,302 active physicians and 8,806 active nurses.

History

The Albany Regional Medical Program - one of the first four operational Regions - received its initial planning grant in July 1966. The grantee organization, the Albany Medical College of Union University, had a particular strength in that it had one of the country's most extensive postgraduate education programs and had developed over a ten-year period the two-way radio as an education medium. For this reason, there was initial (and unresolved) discussion among Committee and Council reviewers relative to the degree to which RMPS should support ongoing programs. When the initial operational grant application was submitted less than a year later, the ARMP's heavy emphasis on continuing education was considered by the reviewers to serve as a test of the capacity of continuing education to provide the means for developing broader programs and expanding into other areas. The first operational award included funds for core activities, community information coordinators (since incorporated into core), two-way radio network expansion and program production, postgraduate instruction development panel, community hospital learning centers, coronary care training and demonstration at the Albany Medical Center and two community hospitals, an intensive cardiac care unit at a small community hospital, and the part-time services of a cancer coordinator in the Schenectady area.

In the Spring of 1969 when the entire program was up for renewal, a site team visited Albany because of Committee's and Council's qualms about: the ubiquity of the influence of Dr. Woolsey and the Department of Postgraduate Education in the regional planning, review, and decision-making process; the small number of new activities that had been developed outside of Albany itself; the continued program concentration on continuing education; and the apparent lack of receptivity to (or failure to stimulate) ideas from outside the Albany Medical Center. The site team found the concerns to be valid and delivered an appropriate message to the Region.

CENTRAL DIV.
1. Albany

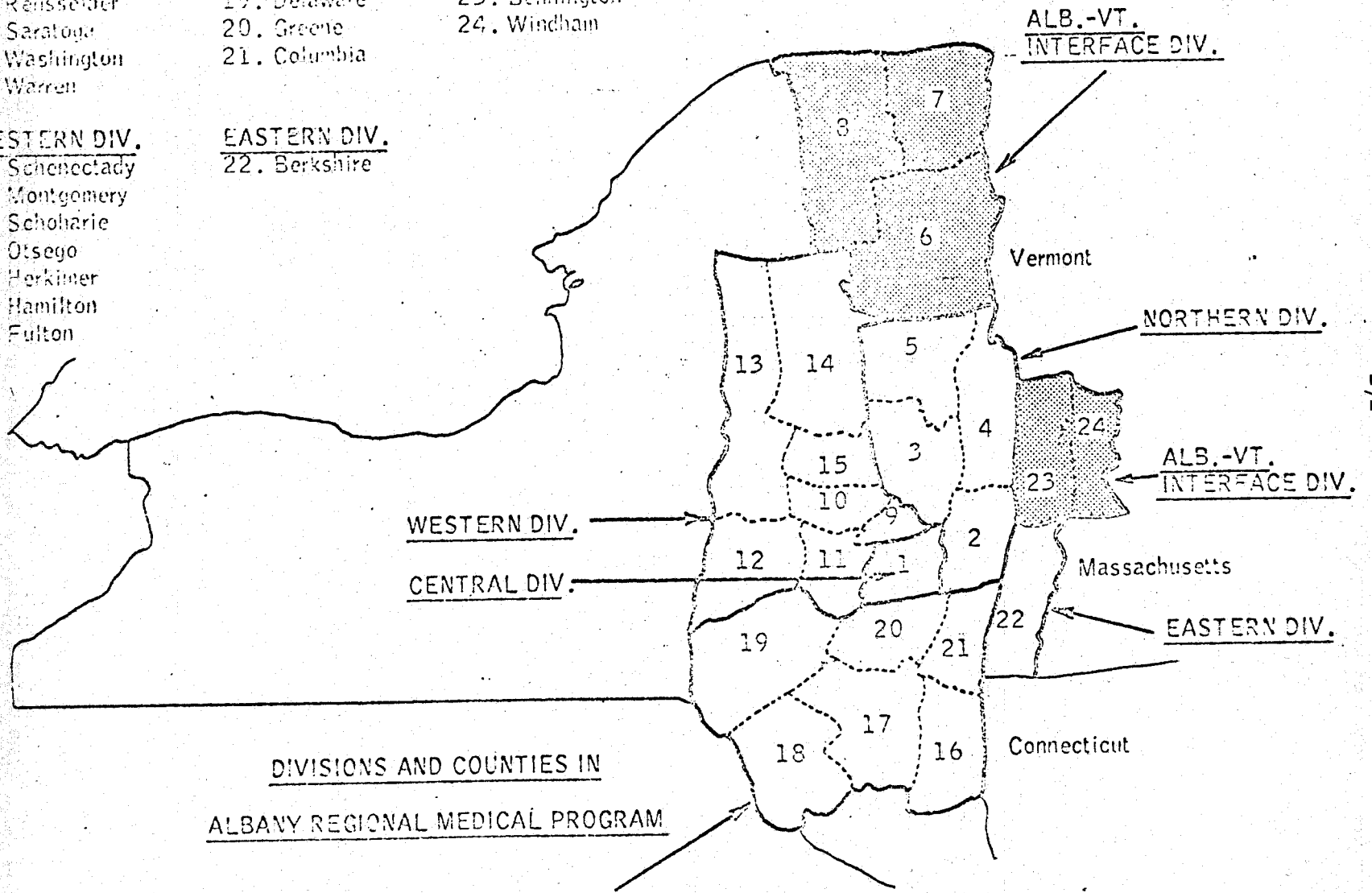
NORTHERN DIV.
2. Rensselaer
3. Saratoga
4. Washington
5. Warren

WESTERN DIV.
9. Schenectady
10. Montgomery
11. Schoharie
12. Otsego
13. Herkimer
14. Hamilton
15. Fulton

SOUTHERN DIV.
16. Dutchess
17. Ulster
18. Sullivan
19. Delaware
20. Greene
21. Columbia

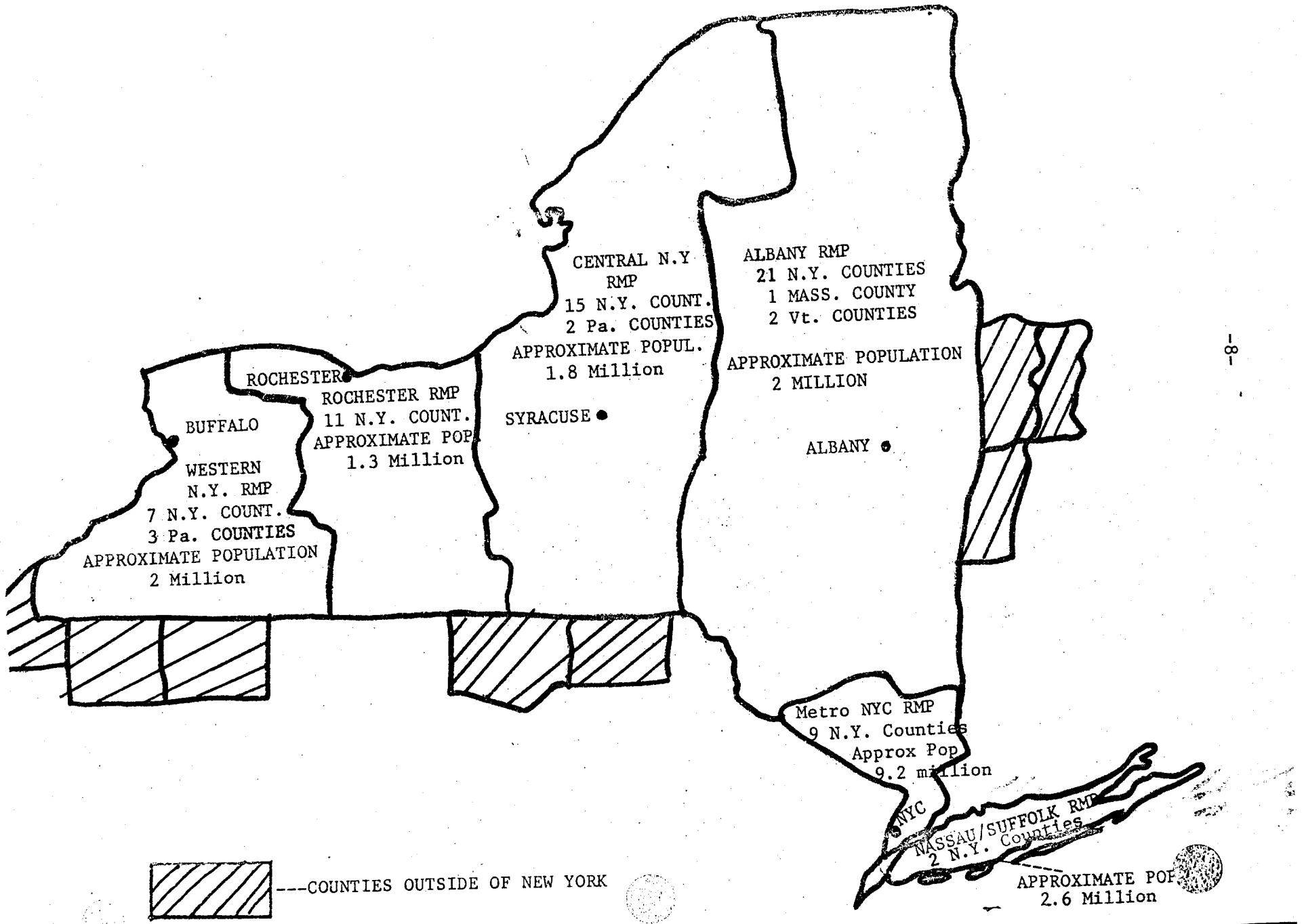
EASTERN DIV.
22. Berkshire

ALB.-VT. INTERFACE DIV.
6. Essex
7. Clinton
8. Franklin
23. Bennington
24. Windham



DIVISIONS AND COUNTIES IN
ALBANY REGIONAL MEDICAL PROGRAM

GEOGRAPHIC RELATIONSHIPS OF SIX REGIONAL [illegible]
IN NEW YORK



The subsequent Committee/Council, in view of the site report, recommended various periods of funding for the Albany activities. For instance, a new program for the development of community leadership looked very promising in terms of subregionalization and was recommended for five years' support. On the other hand, some activities, the advantages of which were doubtful, were approved for only one year's support. Two years of funding for core activities was provided.

In September 1970, when staff reviewed this Region's application for 04 year continuation, the following observations were made:

1. Although the ARMP did provide $60,000 during its 03 year toward the planning of the North End Community Health Center in a ghetto area of Albany, that was the only evident contribution to one of the Region's new stated goals of correcting quantitative deficiencies in the health manpower pool and providing health services in medically-deprived areas. The predominant emphasis of the program remained continuing education emanating from Albany. The large amounts of money that continued to support activities such as the two-way radio project, at the expense of the community development program, attested to the emphasis placed on continuing education. However, it was observed that the last three projects the Region had submitted were not exclusively in the Albany-based continuing education mold, but each had been rejected by Committee/Council. A proposal for the establishment of a regional cancer program received a recommendation of disapproval at the national level, while proposals for a community stroke program and a regional library service project were returned for revision.

2. The influence of Dr. Woolsey, the Albany Medical College, and the Department of Postgraduate Education on the planning, review, and decision-making process remained a problem. Eleven of the 27 RAG members were from the AMC, and of these eleven, seven were on the ARMP core staff. Although Dr. Woolsey, after the May 1969 site visit, relinquished the chairmanships of both the Preliminary Planning and Review Group and the Planning and Review Group (subcommittees of the RAG) he still was a member of both. Both groups, too, were almost exclusively Albany Medical College and core staff dominated.

3. Subsequent to the April 1969 site visit, the Review Committee and Council were furnished with an assurance by Dean Wiggers of attempts to increase consumer, and particularly minority, representation on the RAG. It had not increased. The continuation application stated that efforts to get minority and consumer representatives met with some difficulty because the "more talented individuals" from these groups were in great demand. The consumer membership on the RAG consisted of a civic leader, the Commissioner of Education, and a representative from the Department of Corrections.

4. ARMP seemed not yet to have addressed the necessity of the eventual phaseout of RMP support for ongoing activities and the concomitant turnover of projects. The project progress reports and continuation requests seemed to assume support in perpetuity.

The 04 operational year of this Region sees greatly diminished project activity from the time of the 1969 site visit-support for the intensive cardiac care unit has been terminated by the Region, coronary care training and demonstration activities at the two community hospitals received renewal approval from August 1970 Council but were not funded, and renewal requests for the community hospital learning centers and the postgraduate instruction development panels were reviewed by November 1970 Council which recommended no additional funding. The allocation of the current 04 year award of $806,001 is not yet known since the Region only recently received notice of its twelve percent reduction. To give an idea of the relative allocation among ongoing components, however, based on the original 04 year award the money was distributed as follows:

Activity	Percent of total award
Core	75.1%
#1 Two-way radio	15.6%
#6 CCU Training-Albany Medical College	7.8%
#13 Cancer Coordinator-Schenectady	.5%
#16 Community Leadership	1.0%

Regional Goals and Objectives:

The application states that until the present the main thrust of the ARMP program has been in the field of continuing education and training in order to keep physicians and allied health professionals abreast of the latest advances in diagnosis and treatment. There has been, in addition, a more limited effort in the development of health manpower. Although it is expected that education and manpower development will continue to receive emphasis, the program intends to become involved as well in efforts to improve health care delivery and to correct the maldistribution of health manpower. Reflective of the new program direction, the RAG has approved two overall and long-range program goals and seven shorter-range objectives, as follows:

Goals

I. To promote and influence regional cooperative arrangements for health services in a manner which will permit the best in modern health care to be available to all.

II. To assure the quality, quantity and effectiveness of professional and allied health manpower.

Objectives

1. To explore and encourage innovative methods of health care delivery with particular attention to improving delivery in medically-deprived urban and rural communities.

2. To mobilize consumer-provider participation in the identification and solution of local and regional health problems.

3. To recruit health manpower and improve its distribution and utilization.

4. To introduce methods to relieve overburdened health professionals.

5. To engage in the education and training of health personnel with particular attention to continuing education and to the training of personnel to fill recognized gaps in critical areas.

6. To promote public education in health matters.

7. To further the process of regional cooperative arrangements.

In addition, there has been formulated a list of ten items to be considered in determining priorities within the program. These appear on page 21 of the application.

Regional Advisory Group

The Regional Advisory Group presently is composed of 37 members--32 regular and five ex efficio. Of these 37 members, eleven are from the Albany Medical College and 24 are from the Albany vicinity. The Equal Employment Opportunity form in the application indicates that four of the RAG representatives are black. The current RAG composition reflects a greater diversification of membership from the time of the last staff review through the addition of minority members, the percentage reduction of Albany Medical Center and core staff members, and the increase in non-health-oriented representatives. The RAG meets quarterly.

The Planning and Review Group, which had been almost exclusively Albany Medical Center and core staff dominated, has been abolished and supplanted by a 13-member (ten regular and three ex officio) Executive Committee of the RAG. The regular Executive Committee membership includes two Albany Medical College representatives. Four of the ten are from outside Albany itself. The application does not indicate who the three ex officio members are. The Executive Committee meets monthly and reports to the full RAG quarterly.

Each project proposal submitted to the Albany Regional Medical Program is processed through the review mechanism of the Executive Committee which, with the advice of the appropriate Consulting Group (there are 13) assigns a priority rating. Apparently, there are certain specified limits within

which the Executive Committee can act without RAG concurrence, but the rest of its approvals must be referred to the full RAG. It is not made clear in the application whether projects rejected by the Executive Committee routinely are seen by the Regional Advisory Group.

An adjunct to the Regional Advisory Group is the subregional structure developed through the Community Leadership project in the three New York counties of the Northern Interface Division.. It is hoped that this 25-member local advisory group and its three task forces will provide the ARMP with the necessary experience for further subregionalization through the formation of local advisory groups in other areas.

APPLICATION COMPONENTS

I. Core Activities — 05 yr request $791,460

Three year renewal of core activities is requested. The application states that the strength of the ARMP resides in core staff. Core is involved in the operation of all ongoing activities and performs all project evaluation. In addition, the core payroll contains many persons who would usually be included in project budgets; for instance, many of the technical personnel associated with the two-way radio system, the personnel from the Community Leadership Program (project #16), and the project director for the CCU training program. There are 28 professional staff, although many (including the Coordinator) are listed at less than full-time. Of the 28, the Equal Employment Opportunity form shows that none are black and only one is a woman. The most significant accomplishments of core staff over the past two years are explained on pages 37-39 of the application, and the most important areas for future core activities are described on pages 40-41.

In terms of planning and feasibility studies, some of the major core-supported activities during the coming triennium will be in the area of:

Continuing education for dieticians, medical technologists, x-ray technicians, pharmacists, and medical librarians -- many of these studies involving the two-way radio network

Continuation of the physicians consulting panel (previously a project activity for which renewal support was not recommended by the National Advisory Council) without honoraria and at a fraction of its previous cost

Planning for a physicians assistant program.

Creation of a health maintenance system for physicians offices

Determination of need and practicability of a day rehabilitation center

Feasibility of health care information centers to serve needs of general public

Planning for a regional kidney program

Feasibility of a pap smear program in community hospitals

Studying for training of physician's office personnel--physician extenders

Study in Rh immunization

Traveling Rehabilitation teams for education and service

Training nurses for service in hospital emergency rooms

Treatment guidance for physicians based on tissue diagnosis

Study of two-way radio conference utilization

The approximate cost next year for planning and feasibility studies will be $133,000 as compared to the approximately $62,000 spent for such activities in the 04 year.

Core-supported and operated central regional services which will be continued or instituted during the next triennium are:

Continued

Continuing Education Registration - record keeping activity which provides a data base for planning and research in continuing education

Health Data Inventory and Resources

Postgraduate Program Service - assistance in planning, production, and evaluation of continuing education programs within the Region

Registry of Continuing Education Programs for Physical Therapists

Registry of Physical Therapists

Selective Mailing System

New

Educational Resource Service - development of a cooperative library network

Prescription Education Service - patient education aimed initially at medically-deprived persons

Public Information Resource Service

During the 04 year $33,400 was allocated to central regional services. During the 05 year approximately $87,000 is budgeted for these functions.

06 -- $850,610 07 -- $914,512

II. Ongoing Activities

Continuation with committed support of four ongoing activities is requested for the 05 year and renewal for three of these projects for two years thereafter (06 and 07 years). The application states that with regard to the question of phasing out RMPS support for ongoing activities, there is no other regional agency to absorb the essential activities of continuing education which have been performed by the ARMP. It is believed that current activities cannot be phased out without doing serious damage to ARMP's image as the regional agency most concerned with keeping health personnel abreast of modern developments. Since all projects have been under core staff supervision, consideration will be given to terminating them as individual projects and incorporating the expense in an enlarged core staff budget.

Project #1 - Two-Way Radio Communication System — 05 yr. request $154,030

This project initially was funded in April 1967. The two-way radio communication system will be of assistance in health manpower recruiting efforts, providing information to the public relative to health and welfare services available to them, helping in the training of new types of community health aides, and assisting in programs designed to upgrade various types of health personnel. The application states that:

> At this point in time, it is felt strongly that community hospitals would not accept total financial responsibility for the support of this project. During the proposed triennium, however, a calculated plan for gradual shifting of responsibility for funding will be implemented by ARMP core staff. It is felt that this process will take at least three more years.

Project #1 is separated in two parts:

#1A - This portion of the program is concerned with the expansion of the network and the installation and maintenance of the technical facilities used in the system. Sixty hospitals now are equipped for full two-way participation in the radio conferences. The plan is to continue activating and maintaining two-way as well as receive-only installations and initiate an adult education network.

#1B - This portion of the program deals with the actual production and presentation of radio conferences. Conferences are planned for nurses, physical therapists, medical technologists, x-ray technicians, dieticians, dentists and pharmacists, among others.

06 year - $163,171 07 year - $173,118

Project #6 - Albany Medical Center Coronary Care Training and Demonstration Programs — 05 yr. request $60,270

This project initially was funded in April 1967. Since February 1968, nineteen courses have been provided to 190 nurses from 29 hospitals, and during 1970 three advanced seminars in teaching coronary care were conducted for 28 nurses from 24 hospitals. These latter nurses have organized nine subregional training programs. In addition, a demonstration training program for practical nurses was completed. During the coming triennium, planned courses will accommodate 150 nurses, and subregional activities will involve the participation of 600 registered and practical nurses. Individualized courses will be designed for 36 to 54 physicians. It is stated that "alternative sources of support will be developed during this phasing out period." See the attached memo of staff review for a discussion of the policy implications for this project.

06 year - $62,981 07 year - $65,912

Project #13 - Cancer Coordinator for Schenectady Area — 05 yr. request $5,000

Only one additional year's support is requested for this project which was initiated in January 1968. RMP support has provided the part-time salary of a physician who has developed professional and lay cancer education programs, coordinated cancer care activities and implemented statistical evaluation procedures regarding cancer in the Schenectady area. It is planned that during the coming year the various activities will be stabilized, strengthened, and given sufficient impetus to assure their continued operation and success. It is expected that alternate sources of support will be developed to continue all the activites.

Project #16 - Development of Community Leadership — 05 yr. request $9,030

This activitiy was favorably received by the May 1969 site team and the subsequent Review Committee and Council. Although funds for this program have not been awarded, the Region has supported it through its rebudgeting authority for two years. The Director of the activity and the Community Information Coordinator assigned to it are on the core staff payroll. The purpose of the project is to stimulate community leaders to take the initiative in the development of RMP activities of significance to their community. Experience gained in this model program will be used to further subregionalize the activities of the ARMP. Since project activity was initiated, a local advisory group and three task forces have been formed, and there have been a number of continuing education programs and seminars. Support is requested for three additional years.

06 year - $9,330 07 year - $9,656

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III. Developmental Component 05 yr. request $85,000

Developmental component funding is requested for three years. The stated objectives for use of the developmental component are:

1. To design and conduct developmental activities which will further the objectives of ARMP and allow an exploration of the feasibility of specific and more extensive endeavors.

2. To give the RAG an opportunity to utilize its knowledge, experience, and perception without the delays and other disadvantages of additional review.

3. To originate an administrative process which will assure support of relevant activities without delay, allow rapid solution of unforeseen problems, take advantage of expertise and unforeseen opportunities as they appear, allow participation in governmental programs with similar or complementary objectives, and assure adequate safeguards without unnecessary encumbrances.

The Executive Committee of the RAG will determine the developmental feasibility and planning studies which will be used for developmental component funding and the studies recommended by this group will be presented to the RAG during July 1971 so that they will have been specifically identified prior to approval and funding of the developmental component. The Executive Committee may authorize the Coordinator to make expenditures for less than $1,000 and not involving the purchase of equipment without prior specific approval of the Executive Committee.

06 year - $85,000 07 year - $85,000

RMPS/GRB/5/12/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: May 24, 1971

Reply to Attn of: Eileen I. Faatz
Public Health Advisor, GRB

Subject: Staff Review of the Albany Regional Medical Program Triennial Application and Identification of Issues for Site Visitors.

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

Staff met on Tuesday, May 11, to review the Albany application. Discussion revolved around the following topics:

Decision-Making and Review Process

1. The composition of the Regional Advisory Group represents a greater diversification of membership from the time of the last staff review through the addition of four blacks, the percentage reduction of Albany Medical Center and core staff members, the increase in non-health-oriented representatives, and broader geographic representation.

2. The Planning and Review Group, which had been AMC and core staff dominated, has been abolished and replaced by an Executive Committee of the RAG.

   a. The application does not explain the responsibilities and functions of the Executive Committee nor the method of appointment. Copies of the amended By-Laws creating this group have been requested of the Coordinator.

   b. It appears that the Executive Committee rather than the entire RAG determines project priorities. According to the RMPS Technical Review Standards, the RAG as a full body should rank projects.

   c. Staff was unable to determine whether the Executive Committee membership includes a racial minority.

3. There are 13 categorical and disciplinary Consulting Groups which serve in advisory capacity to the Executive Committee. The involvement of these groups is questioned since most have had very few meetings during the past year. For instance, each of the three consulting groups in the major categorical areas of heart disease, cancer, and stroke held only one meeting last year. Where does the leadership come from?

4. Under the auspices of Project #16 (Development of Community Leadership) a subregional local advisory group has been formed to serve and represent the interests of the three New York counties in the Northern Interface Division. Staff would be interested to learn not only what ideas have been generated by this group and the fate of any such suggestions, but also its relationships with CHP.

5. The Equal Employment Opportunity Form indicates that of the 128 members of the ARMP committee structure other than the RAG, only one is black.

6. Both the RAG and the Executive Committee include ex-officio members. Do they have voting privileges?

Developmental Component

1. The application includes a request for $85,000 for each of three years for developmental component activities.

   a. The Executive Committee will determine what planning and feasibility studies will be supported through developmental funding. Decisions as to the activities to be supported apparently will be made in advance of the actual receipt of the award, thereby losing the important flexibility the developmental component was designed to afford.

   b. Staff was unable to distinguish between the uses to which developmental funds will be put and the planning and feasibility studies designated for core support.

Core

1. Staffing

   a. Staff was pleased to note that the numerous clinical specialists who previously had been included on the core roster at extremely small percentages of time are no longer listed.

   b. There are no blacks on the core staff, and of the 29 professional and technical personnel only one is a woman.

   c. With the exception of a physical therapist, there are no allied health personnel on the core staff, although there is a vacancy for a nurse. The previous nurse coordinator died last year.

d. Last year ARMP listed five vacancies on the core staff, and this year eight vacancies are noted. Staff wondered whether some of these vacancies might not be built into the budget to provide extra undesignated money for core activities.

2. Activities

a. A plethora of planning and feasibility studies is proposed for support from the core budget, which apparently is viewed as an umbrella under which many studies relating to ongoing operational activities (two-way radio, specifically) and to activities not approved for funding at the national level (e.g. physicians consulting panel) can be supported.

b. It was noted that last year only ten percent of the core budget was expended for "program direction and administration," and staff wondered what activities were included in this calculation.

c. Project and program evaluation is performed by core staff, although it is unclear exactly what is done in this regard. Some specific questions that have emerged are:

1. How have the health data inventories and similar activities been used to define total program as well as continuing education needs?

2. How has information retrieved through registry activities been transmitted and data interpreted to health professionals, and what use has been made of the data by the recipients?

3. Have evaluative activities for continuing education programs been instituted to determine whether changes in the practices of health team members have resulted?

4. Has the Region been able to document that educational activities have been effective in the improvement of patient care, health service delivery, diagnosis and management of patient care problems, and/or the management aspects of health care organizational problems?

Goals and Objectives

1. The new goals and objectives of the ARMP are stated to be reflective of the Region's desire to expand its program from a concentration on continuing education activities to include efforts in health manpower development, improvement of health care delivery, and correction of the maldistribution of health manpower. However, since this triennial application proposes the initiation of no new operational activities and three-year continuation of the present program, staff reviewers were unable to find evidence of efforts to expand the program in the new directions described in the goals. This application presents no indication that the new regional objectives have become operational.

Phase Out

1. Although the application mentions the question of phasing out RMP support for ongoing activities, the assumption appears to be that some activities (specifically, the CCU training and two-way radio) must be funded by RMP in perpetuity.

2. The RMPS National Advisory Council at its November 1970 meeting enunciated the following policy with regard to coronary care unit training:

   > Coronary care unit training projects are to disengage Regional Medical Program funding at the end of their current project periods or within a reasonable time thereafter (no more than 18-24 months is considered a reasonable period of time).

The following staff members participated in the review of the Albany Regional Medical Program:

A. Burt Kline - Regional Development Branch
Frank Zizlavsky - Regional Development Branch
Larry Witte - Program Planning and Evaluation
Elsa Nelson - Continuing Education and Training Branch
Jerry Stolov - Kidney Disease Control Program
Paul Boone - Systems Development Branch
Eileen Faatz - Grants Review Branch

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

ALBANY RM 00005-8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

Year	Request (d.c.)	Recommendation (d.c.)
05	$1,104,790	$900,000
06	1,171,092	-0-
07	1,248,198	-0-

Recommendation: The Committee agreed with the site team that the Albany Regional Medical Program be funded at $900,000 for one additional year, with a follow-up site visit in a year to check the Region's progress with regard to numerous and specific recommended changes. The only specific disapproval is for developmental component funding. Although the award is to be allocated at the Region's discretion, the Review Committee joined the site team in urging that the amounts set aside by the Region for the two-way radio and coronary care training activities be of a magnitude that will not hinder the Program as it strives to redirect and reorganize its activities during the coming year. At the time of the site visit a year from now, the ARMP will be accountable to the team for the allocation of all its resources. The Committee agreed with the categorization by the site team of the changes to be accomplished during the next year: (1) Those changes which must be demonstrated to have occurred at the time of the site visit in a year, and (2) Those areas to which the Region should give consideration, although the adoption of these recommendations will not be a requisite for continued funding.

1. Necessary Changes

   A. Mechanisms for the phase-out of RMP support should be developed for the two-way radio and coronary care training activities, with the understanding that:

      1. RMP funds for the two-way radio will not be forthcoming for longer than twelve months. ARMP financial input for this operation must cease by September 1972.

      2. No more than one year's terminal support for the coronary care unit training can be borne by RMP. Other sources of support must be found by September 1972.

B. The RAG and its Executive Committee must become policy-making bodies which actively review and evaluate on-going and proposed activities, allocate funds among them, and set goals, objectives, and priorities. The functions of these groups should include periodic reviews of the Program's effort allocation including personnel efforts.

1. In this regard, the RAG and Executive Committee must be educated as to their responsibilities. A conference/seminar might be one way of doing this.

2. The Planning and Review Subcommittee of the Executive Committee as it is presently constituted (one RAG member, two Executive Committee members, and three core staff members -- plus plans for inclusion of outside members) appears unnecessary if the Executive Committee is a strong group. If, however, the Executive Committee feels the need for such a working group it should be a true subcommittee: i.e., include only Executive Committee members.

3. All deliberations of the Executive Committee must be reviewed and considered by the full Regional Advisory Group.

C. A functional review procedure must be established for all ARMP efforts: proposed and operational projects as well as core-supported studies and activities. This process must provide for a non-core technical evaluation.

1. The present consulting groups have been established to serve both technical review and program development functions. A means must be found to separate these functions so the techncial review is not performed by the same group which developed the activitiy.

2. Efforts should be made to include in the technical review process qualified people from outside the Albany and Albany Medical College area.

3. All technical review bodies should have specific review criterial and guidelines.

D. The excellent data base which has been assembled by ARMP core staff must be distributed and applied to establish new activities and priorities of action.

E. Strenuous efforts must be made to fill the core position of Nurse Coordinator which has been vacant for more than a year.

F. The Albany RMP needs a set of operating objectives which are quantified and measurable, time-dependent, and ranked in priority order.

G. All individual projects must be evaluated not only with regard to their intrinsic success but considering their contribution to program goals and objectives.

H. There must be a clear delineation between the activities of the Albany Regional Medical Program and those of the Department of Postgraduate Education of the Albany Medical College.

2. Suggested Considerations

A. The Albany Regional Medical Program should consider the desirability of establishing itself as a separate corporation with retention of fiscal management functions by the Albany Medical College.

B. Consideration should be given to creating a position of Deputy Coordinator.

C. An outside management consultant might be called in for a formal review of goals and objectives and assistance in sharpening them.

Critique: The Triennial application under consideration requests, essentially, a three-year renewal of the ongoing program for the 05, 06, and 07 years. The current program consists primarily of core activities, the two-way radio project, coronary care training project, and an experimental project in local leadership and subregionalization. No new projects are proposed for funding, the Region having incorporated most of its request for new activities as planning and feasibility studies in the core budget. It was noted that approximately 75 percent of last year's expenditures and next year's request fall within the core budget.

In reviewing Albany's Triennial application, the Committee harkened back to its recommendation after the site visit two years ago that unless the Region demonstrated it had come to grips with its chronic problems, no further funding could be recommended. And the question confronting the Review Committee, then, was whether the progress which the Region has made can be said to represent a coming to grips with its problems. It was agreed that they probably represent a step in the right direction at any rate. Numerous changes have been made in the Region, but many of these are of such recent origin that new processes are untested and new ideas have not had a chance to reach fruition.

Perhaps the most dramatic revisions have been made in the review process, through: the enlargement and considerable diversification of the RAG; the creation of a representative Executive Committee of the RAG to replace a previous core and medical school dominated group; and the reduction of core, Coordinator, and medical school input in the review process. The Executive Committee was seen as a group with considerable potential (although presently confused as to its role) which could be educated to become a true policy-making body. And although the present review process is cumbersome, it was thought that as it is tested the problem areas will surface and be refined. The core staff represents a pool of many talents and is tentatively moving away from the traditional ARMP focus on only continuing education. An excellent data base has been established, local ideas are being gathered through the consulting physicians panel and the local leadership project, the community information coordinators are doing a good job of publicizing ARMP activities, staff is providing assistance in the hopeful development of CHP b agencies, and core is moving into the areas of neighborhood health center and rural medical care development, as well as physicians' assistants and nurse practitioners. Nevertheless, core activity in the newer areas is characterized by an unbecoming hesitancy to upset the medical community.

Although many concerns were voiced, and these are reflected in the specific recommendations of the Review Committee and the site visitors (lack of leadership of RAG, inadequate technical review, lack of realistic, time-limited operational objectives, inadequate evaluation, etc.), perhaps the aspect of the Albany RMP which provoked the most discussion and provided the most cause for concern, centered around the Region's inability to phase out support for activities which have been going on since the inception of the Program (in the case of coronary care training) and for at least ten years before that (in the case of the two-way radio). The Region had been warned two years ago that it must withdraw its support from these activities. It has not. The Committee reiterated that the Program cannot hope to have any impact in new areas as long as money is frozen in the support of these old-line activities. The Review Committee agreed with the site team's recommendation that only one year's terminal support be provided for coronary care training activities, but disagreed with the team's 18-month suggestion for the two-way radio activities and recommended that it be limited to a year as well.

In discussing funding recommendations, a range of $825,000 to $900,000 was offered for consideration, and the Review Committee again concurred with the site team in recommending $900,000. It was thought that this sum could provide, through judicious allocation, adequate support for program maintenance and termination activities, with sufficient funds remaining to implement the numerous recommendations of the site team and the Review Committee. The current year's level is $806,001 (reduced from $915,910 by the recent cut) and the request for next year is $1,104,790. The Review Committee agreed that a funding level

smaller than the $900,000 recommended would not permit the Region to accomplish the things that it must if the site team next year is to see the changes that have been recommended. It was stressed that the $900,000 recommended grant is to allow the Region some discretionary money to turn the organization in new directions, and at the time of the next site visit a year from now the ARMP will be accountable to the team for the allocation of all its resources.

Regional Medical Programs in Northern New York

One point that arose repeatedly during the two-day meeting was that three of the four RMPs in northern New York had submitted Triennial applications for this review cycle, had been site visited, and all found to have basic problems in terms of the quality and direction of the programs. The three RMPs are Albany, Central New York (Syracuse), and Rochester. The fourth RMP, Western New York (Buffalo), was reviewed by October/November 1970 Committee and Council. There was some sentiment on the Review Committee that serious thought should be given to combining these three, or possibly four, Regions and that this would represent a better use of limited dollars and perhaps combine the strengths of the various programs. It was recognized at the same time that, politically, any combination of these Regions would be quite difficult. Also, since each of the three Regions being reviewed this cycle was seen as being at a turning point in its development, with some hope for resolution of its problems during the coming year, the reigning attitude was that now would be an inopportune time to suggest any combined superstructure without giving the programs another year to iron out their own difficulties. The Committee also saw the need for more data before considering any possible merger.

RMPS/GRB/7/14/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 18, 1971

Reply to Attn of:

Subject: Quick Report on the Albany Regional Medical Program Site Visit June 2-3, 1971 (Albany, New York)

To: Director, RMPS
Through: Acting Deputy Director
Regional Medical Programs Service

I. Site Visit Team

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Robert Shaw
DHEW Region II
Regional Office Representative

II. BACKGROUND: The Albany Regional Medical Program has been an issue of concern to staff, Committee, and Council reviewers for a long time, primarily because of: the ubiquity of the influence of the Coordinator and the Department of Post-graduate Education in the Regional planning, review, and decision-making process; the small number of activities developed outside of Albany itself and the small number of RAG members, etc. from peripheral areas; the continued program concentration on continuing education; and the apparent lack of receptivity to (or failure to stimulate) ideas from outside the Albany Medical College. A site visit two years ago counseled the Region that it must examine the processes that contributed to the above problems and change them. Subsequent staff, Committee, and Council reviews uncovered no particular revisions in the way the Region was operating, and this, combined with attendant RMP fiscal stringencies, has served to diminish project activity in ARMP (through renewal disapprovals and approvals without funds) from eight projects two years ago to the current four ongoing activities. The Region has submitted a Triennial application requesting three years support (05,06,07 years) including a developmental component. A sum of $1,104,790 was requested for the first year of the Triennium (05 program year).

III. GENERAL IMPRESSIONS: The general conclusion of the site team was that the ARMP is neither here nor there: it's not where it should be but, on the other hand, it's not where it had been. It is just now (and certainly belatedly) entering a transition phase. The site team had the definite feeling that the ARMP core office had been the scene of feverish activity for the last couple of months or so, as document after document, hot off the press and describing numerous organizational and procedural changes of recent origin, were presented for inspection. Some major changes have been made, but since they have just been made the site team had no way of judging their effectiveness. Many have not yet been put into operation. There is always the possibility that these represent a restructuring of form without any real change in leadership. The visitors hoped not.

Perhaps the potentially most drastic revisions have been made in the review process, through: the enlargement and considerable diversification of the RAG; the creation of a representative Executive Committee of the RAG to replace a previous core and medical school dominated group; and the reduction of core, Coordinator, and medical school input in the review process. Although the RAG and the new Executive Committee have potential, they either are unaware of, or loath to assume, their considerable responsibilities. The Executive Committee is newly appointed and appears confused as to its role, and the RAG seems not to exercise judgment of its own - merely accepting what is presented to it. This must change

during the coming year. Technical review of activities was found to be definitely inadequate and restructuring was recommended.

Although the Region has developed a recent set of objectives they are: too comprehensive to be meaningful, not ranked in any priority order, and unfamiliar to many - expecially since they were established by the planning group which recently has been abolished. Further, although there is much talk of new directions and activities and expansion into fields other than education, considerable sums of money still are frozen through the continued support of the two-way radio and coronary care training activities. The Region must demonstrate its willingness to actually do things it talks about. The present application, for instance, essentially requests three years of continued funding for the existing program. No new projects are proposed. The only areas through which program change can be accomplished are through proposed core and developmental component activities.

The core staff is a talented group and must work to divert its interests from the radio into newer activities. A lot of this is happening already through many core studies which are being carried out or planned. With proper direction, the core staff can accomplish interesting things.

Because the Region has not demonstrated especial maturity in terms of the review criteria, a developmental component award could not be recommended. And since the ARMP is just entering a transition stage, and has not yet tested the workability of its new procedures, the site team thought a reasonable solution to its dilemma would be to allow the Region one year to turn itself around. The following recommendation was unanimous among the visitors. The dollar recommendation of the site team is an amount sufficient to provide for a core allocation adequate to support the studies and activities necessary to accomplish the Region's change in direction and emphasis.

RECOMMENDATION: One additional year's funding for $900,000 with a follow-up site visit in a year to check the Region's progress with regard to the site visitors' recommendations. The only specific disapproval is for developmental component funding. The award is to be allocated at the Region's discretion. However, the team strongly urges that the amounts set aside for the two-way radio and coronary care training activities be of a magnitude that will not hinder the Program as it strives to redirect and reorganize its activities during the coming year. The suggestions of the site team as to specific changes to be accomplished during the next year are presented in two categories: (1) those changes which must be demonstrated to have occurred at the time of the next site visit -- approximately June 1972, and (2) those areas to which the team thinks the Region should give consideration, although the adoption of the recommendations will not be a requisite for continued funding.

1. Necessary Changes

A. Mechanisms for the phase-out of RMP support should be developed for the two-way radio and coronary care training activities, with the understanding that:

1. RMP funds for the two-way radio will not be forthcoming for longer than eighteen months. ARMP financial input for this operation must cease by March 1973.

2. No more than one year's terminal support for the coronary care unit training can be borne by RMP. Other sources of support must be found by September 1972.

B. The RAG and its Executive Committee must become policy-making bodies which actively review and evaluate on-going and proposed activities, allocate funds among them, and set goals, objectives, and priorities. The functions of these groups should include periodic reviews of the Program's effort allocation including personnel efforts.

1. In this regard, the RAG and Executive Committee must be educated as to their responsibilities. A conference/seminar might be one way of doing this.

2. The Planning and Review Subcommittee of the Executive Committee as it is presently constituted (one RAG member, two Executive Committee members, and three core staff members -- plus plans for inclusion of outside members) appears unnecessary if the Executive Committee is a strong group. If, however, the Executive Committee feels the need for such a working group it should be a true subcommittee: i.e., include only Executive Committee members.

3. All deliberations of the Executive Committee must be reviewed and considered by the full Regional Advisory Group.

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F. The Albany RMP needs a set of operating objectives which are quantified and measurable, time-dependent, and ranked in priority order.

G. There must be a clear delineation between the activities of the Albany Regional Medical Program and those of the Department of Postgraduate Education of the Albany Medical College.

2. Suggested Considerations

A. The Albany Regional Medical Program should consider the desirability of establishing itself as a separate corporation with retention of fiscal management functions by the Albany Medical College.

B. Consideration should be given to creating a position of Deputy Coordinator.

C. An outside management consultant might be called in for a formal review of goals and objectives and assistance in sharpening them.

RATIONALE FOR FUNDING RECOMMENDATION

The one year $900,000 recommendation was thought to represent a sum which could provide, through judicious allocation, adequate support for

program maintenance and termination activities, with sufficient funds remaining to implement the numerous recommendations and suggestions of the site team. The current year's level is $806,001 (reduced from $915,910) and the request for next year was $1,104,790. The site team felt a smaller funding level would not permit the Region to accomplish the things that it must if the site team next year is to see the changes that have been recommended in this report and which must be accomplished if the program is to be continued.

Eileen I. Faatz
Public Health Advisor
Grants Review Branch
Regional Medical Programs Service

(A Privileged Communication)

SITE VISIT REPORT
ALBANY REGIONAL MEDICAL PROGRAM
June 2-3, 1971

Table of Contents

RMPS/GRB
RM 04-8/71

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B. Regional Participants

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Dr. W.T. Strauss, Associate Coordinator
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Dr. E.B. Howe, Associate Coordinator
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Mr. R.W. O'Neill, Director of Public Relations
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Mr. A.A. DeLuca, Director, Community Information Coordinator
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Miss. Majory Kennan, R.N., Associate Professor, Department Nursing, Russell Sage College
Mr. F. Donald Lewis, Prudential Insurance Company of America
Mr. John Murphy, Administrator, Saranac Lake General Hospital
Mr. Paul R. Robinson, Associate Executive Director, NYS Health Planning Commission

Other RAG Members:

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Mr. Bernard Siegal, Vice President, Business and Finance, Albany Medical College
Mr. James J. Warren, Warren & Son Plumbing and Heating
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Dr. Robert Gilston, Practicing Physician
Miss Helen Middleworth, Director, Albany Medical Center School of Nursing

Other Representatives:

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Mr. James B. Clemens, Administrator, Potsdam Hospital, Potsdam
Mr. William A. Clermont, Administrator, Alice Hyde Memorial Hospital, Malone
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Dr. G. Peter Cook, Ticonderoga, Medical Society
Dr. Symour Horwitz, Schenectady, Medical Society
Dr. Arthur Howard, Johnstown, Medical Society
Dr. Franklyn Hayford, Chairman, Upper Hudson Regional Comprehensive Health Planning Organization.
Dr. Peter Birk, Northend Community Health Center and Department Community Medicine
Mrs. Katherine Bradley, Medical Technologist
Dr. James Cullen, Consulting Group for Pulmonary Disease
Dr. Joseph T. Doyle, Consulting Group for Heart Disease
Mrs. Lynne W. Ferrari, Physical Therapist
Dr. John Horton, Consulting Group for Cancer
Mrs. John Murphy, Saranac Lake, New York
Dr. Boris J. Paul, Consulting Group for Stroke
Mrs. Dorothy Paul, Community Medical Care Program
Mrs. Ann Ruggerio, Dietician
Mr. Frederic G. Stefan, X-ray Technician

II. BACKGROUND INFORMATION

The Albany Regional Medical Program has been an issue of concern to staff, Committee, and Council reviewers for a long time, primarily because of: the ubiquity of the influence of the Coordinator and the Department of Postgraduate Education in the Regional planning, review and decision-making process; the small number of activities developed outside of Albany itself and the small number of RAG members, etc. from peripheral areas; the continued program concentration on continuing education; and the apparent lack of receptivity to (or failure to stimulate) ideas from outside the Albany Medical College. A site visit two years ago counseled the Region that it must examine the processes that contributed to the above problems and change them. Subsequent staff, Committee, and Council reviews uncovered no particular revisions in the way the Region was operating, and this combined with attendant RMP fiscal stringencies, has served to diminish project activity in ARMP (through renewal disapprovals and approvals without funds) from eight projects two years ago to the current four ongoing activities.

The Region has submitted a Triennial application requesting three-years' support (05, 06, 07 years) including a developmental component. (A comparison of the Triennial request and the Region's previous funding is shown on page 2.) The task of the site team, then, was to discover the Albany Regional Medical Program's conformance to new RMPS review criteria and to determine whether the previously-identified deficiencies still existed. The agenda developed by the Coordinator, in conjunction with the site team chairman, was found to be particularly facilitative by providing for both large and small group discussions, a well-attended feedback session, and provision for site visit examination of numerous documents of interest.

III. CONCLUSIONS AND GENERAL IMPRESSIONS

The general impression of the site team was that the ARMP has made progress during the past year although it still lacks the maturity desirable for local autonomy. It is just now (and certainly belatedly) entering a transition phase. The site team had the definite feeling that the ARMP core office had been the scene of feverish activity for the last couple of months or so, as document after document, hot off the press and describing numerous organizational and procedural changes of recent origin, were presented for inspection. Some major changes have been made, but since they have just been made, the site team had no way of judging their effectiveness. Many have not yet been put into operation. The visitors were concerned that they may represent more of a paper operation than the actual implementation of process.

Perhaps the potentially most drastic revisions have been made in the review process through: the enlargement and considerable

ALBANY REGIONAL MEDICAL PROGRAM

Comparision of 01-04 year
funding & 05-07 year request

PROJECT	FUNDED				REQUESTED		
	15 mo. 01	15 mo. 02	03	04	05	06	07
re (including community info. ordinators)	$ 509,691	$ 783,933	$ 712,094	$ 687,159	$ 791,460	$ 850,610	$ 914,512
evelopmental component	--	--	--	--	85,000	85,000	85,000
wo-way Radio	144,104	124,689	143,975	142,975	154,030	163,171	173,118
ostgraduate Instruction Development Panel	102,608	69,932	80,745	--	--	--	--
ommunity Hospital Learning Centers	75,833	76,665	111,082	--	--	--	--
CU Training - Albany	125,240	103,850	71,746	71,746	60,270	62,981	65,912
CU Training - Community Hospitals	55,410	39,576	36,930	--	--	--	--
ntensive Care Unit	25,472	33,455	7,207	--	--	--	--
chenectady Cancer Coordinator	2,100	5,356	5,000	5,000	5,000	--	--
evelop Community Leadership	--	--	9,030	9,030	9,030	9,330	9,656
TOTAL DIRECT COSTS	1,040,458	1,237,456	1,177,809	915,910*	1,104,790	1,171,092	1,248,198

*original 04 year award has been reduced to $806,001 due to RMPS fiscal constraints. However, the new allocation among projects is not yet known.

diversification of the RAG; the creation of a representative Executive Committee of the RAG to replace a previous core and medical school dominated group; and the reduction of core, Coordinator, and medical school input in the review process. Although the RAG and the Executive Committee have potential, they are somewhat unaware of their authority and responsibility and- as a result, are not functioning at desired levels. The Executive Committee is newly appointed and appears confused as to its role, and the RAG seems not to exercise judgment of its own - merely accepting what is presented to it. Technical review of activities was found to be definitely inadequate and restructuring was recommended. Although the Region has developed a recent set of objectives they are: too comprehensive to be meaningful, not ranked in any priority order, and unfamiliar to many - especially since they were established by the planning group which recently has been abolished. Further, although there is much talk of new directions and activities and expansion into fields other than education, considerable summs of money still are frozen through the continued support of the two-way radio and coronary care training activities. The Region has some good ideas and is involved in some interesting things through core activities, yet this has not generated any projects which indicate an expansion or differentiation. The present application, for instance, essentially requests three years of continued funding for the existing program. No new projects are proposed. The only areas through which program change can be accomplished are proposed core and developmental component activities.

The site team was impressed with the talent of the core staff and its diverse interests, but was disappointed that core has not directed its efforts away from old-line activities. With proper direction, the core staff can accomplish interesting things.

Because the Region has not demonstrated especial maturity in terms of the review criteria, a developmental component award could not be recommended. And since the ARMP is just entering a transition stage, and has not yet tested the workability of its new procedures, the site team thought a reasonable solution to its dilemma would be to allow the Region one year to turn itself around. The dollar recommendation of the site team is an amount sufficient to provide for a core allocation adequate to support the studies and activities necessary to accomplish the Region's change in direction and emphasis. The following recommendation was unanimous among the visitors.

Recommendation: One additional year's funding for $900,000 with a follow-up site visit in a year to check the Region's progress with regard to the site visitors' recommendations. The only specific disapproval is for developmental component funding. The award is to be allocated at the Region's discretion. However, the team strongly urges that the amounts set aside for the two-way radio and coronary care training activities be of a magnitude that will not hinder the Program as it strives to redirect and reorganize its activities during the coming year. At the time of the site visit a year from now the ARMP will be accountable to the team for the allocation of all its resources. The suggestions of the

site team as to specific changes to be accomplished during the next year are presented in two categories: (1) Those changes which must be demonstrated to have occurred at the time of the next site visit--approximately June 1972, and (2) those areas to which the team thinks the Region should give consideration, although the adoption of the recommendations will not be a requisite for continued funding.

1. Necessary Changes:

   A. Mechanisms for the phase-out of RMP support should be developed for the two-way radio and coronary care training activities, with the understanding that:

      1. RMP funds for the two-way radio will not be forthcoming for longer than eighteen months. ARMP financial input for this operation must cease by March 1973.

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   B. The RAG and its Executive Committee must become policy-making bodies which actively review and evaluate ongoing and proposed activities, allocate funds among them, and set goals, objectives, and priorities. The functions of these groups should include periodic reviews of the Program's effort allocation, including personnel efforts.

      1. In this regard, the RAG and Executive Committee must be educated as to their responsibilities. A conference/seminar might be one way of doing this.

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      3. All deliberations of the Executive Committee must be reviewed and considered by the full Regional Advisory Group.

   C. A functional review procedure must be established for all ARMP efforts: proposed and operational projects as well as core-supported studies and activities. This process must provide for a non-core technical evaluation.

1. The present consulting groups have been established to serve both technical review and program development functions. A means must be found to separate these functions so the technical review is not performed by the same group which developed the activity.

2. Efforts should be made to include in the technical review process qualified people from outside the Albany and Albany Medical College area.

3. All technical review bodies should have specific review Criteria and guidelines.

D. The excellent data base which has been assembled by ARMP core staff must be distributed and applied to establish new activities and priorities of action.

E. Strenuous efforts must be made to fill the core position of Nurse Coordinator which has been vacant for more than a year.

F. The Albany RMP needs a set of operating objectives which are quantified and measurable, time-dependent, and ranked in priority order.

G. All individual projects must be evaluated not only with regard to their intrinsic success but considering their contribution to program goals and objectives.

H. There must be a clear delineation between the activities of the Albany Regional Medical Program and those of the Department of Post-graduate Education of the Albany Medical College.

I. The purpose of the $900,000 recommended grant is to allow the Region some discretionary money to turn the organization in new directions, and at the time of the next site visit the ARMP will be accountable to the team for the allocation of all its resources.

2. Suggested Considerations:

A. The Albany Regional Medical Program should consider the desirability of establishing itself as a separate corporation with retention of fiscal management functions by the Albany Medical College.

B. Consideration should be given to creating a position of Deputy Coordinator.

C. An outside management consultant might be called in for a formal review of goals and objectives and assistance in sharpening them.

IV. REVIEW DETAILS

A. Goals, Objectives and Priorities

Findings: The Albany Regional Medical Program has developed two long-range program goals and seven shorter-range objectives as follows:

Goals

I. To promote and influence regional cooperative arrangements for health services in a manner which will permit the best in modern health care to be available to all.

II. To assure the quality, quantity, and effectiveness of professional and allied health manpower.

Objectives

1. To explore and encourage innovative methods of health care delivery with particular attention to improving delivery in medically-deprived urban and rural communities.

2. To mobilize consumer-provider participation in the identification and solution of local and regional health problems.

3. To recruit health manpower and improve its distribution and utilization.

4. To introduce methods to relieve overburdened health professionals.

5. To engage in the education and training of health personnel with particular attention to continuing education and to the training of personnel to fill recognized gaps in critical areas.

6. To promote public education in health matters.

7. To further the process of regional cooperative arrangements.

Since the objectives were promulgated by the predecessor of the newly-created Executive Committee of the RAG (the Planning and Review Group which was almost exclusively Medical College and core staff membership), they were unfamiliar to the members of the Executive Committee with whom the site team talked. The objectives are not prioritized and are considered by the Program to be comprehensive enough to cover just about any contingency and, if they are not, new objectives will be added.

Although the program objectives are not ranked in order of importance or need, an instrument recently has been developed by the core educational psychologist and sociologist which will permit a numerical rating of project proposals. This ten-page rating device has just emerged from the testing stage (on core staff) and has not yet been put into operation. It is anticipated that a composite numerical rating for each project will be calculated on the individual evaluations of twelve to fourteen core staff, five to ten consulting group members, and the ten members of the Executive Committee of the RAG--a total of approximately 30 separate evaluations. The priority rating of each project will be presented to the RAG, and this score will be one of several considerations in determining approval, funding allocation, etc. The new Executive Committee had not been exposed to this complicated rating scale prior to the site visit.

Comments: The site team thought that recent efforts in the development of objectives to emphasize the Region's participation in more than continuing education were indicative of Albany's desire to expand its programmatic interests. However, it was explained to the Region that non-prioritized objectives, which were broad enough to include everything, lost their value potential for determining program direction within certain limitations. It was suggested that the Region develop measurable operating objectives which are time-limited and ranked in priority order. The recently updated data base should be considered by the Executive Committee and the RAG in establishing these objectives. The visitors also were apprehensive about the relative benefits of such a complicated activity rating scale, particularly in light of the limited use to which the final composite numerical rating will be put, and with the heavy core staff input.

B. Organizational Effectiveness

Core Staff Composition:

Findings: Of the 28 professional and technical core staff, ten are physicians who devote between 40% and 95% of their time to ARMP and the remainder to Albany Medical College pursuits. All core staff have AMC appointments and operate under the College's personnel policies. Nine of the physicians are designated as Associate Coordinators and have responsibilities for overseeing the implementation of ARMP activities in the subregional geographic areas. Except for Dr. Spear, who directs an experiment in subregionalization and local planning in three northern counties, all the Associate Coordinators are located in Albany. The site team had difficulty understanding the precise nature of the Associate Coordinators' operating spheres, as well as their division of effort between RMP and AMC. In fact the team was concerned about the allocation of time between RMP and AMC and asked the Dean to investigate. His reply is attached to this report.

In addition to the Associate Coordinators' work in the field, ARMP employs four Community Information Coordinators who carry information of the RMP to the practicing physicians and hospitals and generally serve

as good-will ambassadors. They are involved peripherally in assisting with the establishment of CHP "b" agencies. Although these field people maintain daily logs of their contacts, they report to no one on the core staff.

Other core staff positions include fiscal specialist, educational psychologist, sociologist, public relations, administrative assistant, and physical therapist. The position of Nurse Coordinator has been vacant for a year since the previous nurse died, and Dr. Woolsey has been under some pressure from the Nurses Consulting Group and others to fill it. The site team reinforced that suggestion. Six other positions on core staff deal exclusively with the two-way radio activities, and almost all staff are involved with the radio to some degree. There are, in addition, three physician vacancies for which the site visitors could find no rationale (beyond that of probably creating a slush fund) and which the team considered unnecessary.

Comments: With regard to the composition of the core staff, then, it is obvious that physicians are predominant and allied health interests are represented by only the physical therapist. There is very little administrative talent--the administrative assistant is not involved in running the program. Also, an overwhelming amount of core effort is channeled into the two-way radio. The visitors, therefore, recommend that a search begin immediately for a qualified Nurse Coordinator, that the Region consider the possibility of creating a position for Deputy Coordinator to assist Dr. Woolsey in the management of the program, and that ARMP involvement in two-way radio activities cease in at least eighteen months.

Core Staff - Internal Management:

Findings: The ARMP staff appears to operate primarily through consensus management via the core staff assembly (all professional staff) which meets weekly for the purpose of discussing progress and problems and providing a continuous feedback on core activities. Fourteen core members report directly to the Coordinator, and some report to no one, except through the mechanism of the core staff assembly.

Thorough and up-to-date fiscal services are provided by the grantee organization, and the personnel policies of the Albany Medical College guide core staffing.

Comments: Overall, with regard to the organizational aspects of the program, the site team thought that although consensus management is a functional mode of operation, it is rendered rather cumbersome by the large size of the group. And the primary problem of the core staff in this respect is that there are a lot of good, competent people working under the general direction of the Coordinator but with no specific guidance.

Regional Advisory Group--Planning and Review Structure

Findings: The composition of the Regional Advisory Group has diversified and greatly improved since the site visit two years ago: there are two black members (compared to none a year ago), fewer Albany Medical College and core representatives and more non-health-oriented members. The present membership is 32, which the Region intends gradually to increase to 40, primarily through the addition of more consumer representatives and non-physicians from various geographic areas. There are, as well, five ex-officio members (the VA Hospital Director, the Director of the AMC Hospital, the ARMP Coordinator and two Associate Coordinators) and it was emphasized that these are non-voting representatives who act in an advisory capacity only. The Regional Advisory Group meets quarterly.

Harold Wiggers, Dean of the Albany Medical College, has been the RAG Chairman since the inception of the program. He is concerned over his role in the organization and wonders whether he should step down as Chairman. The team replied that this was not a decision they could make, that the situations varied with the individuals and institutions involved, but that generally speaking the loyalties of a dean would lie first with his school.

Until a couple months ago, the primary force in the planning and review process had been the Planning and Review Group--heavily dominated by core staff and Medical College membership. However, the ARMP's recent moves to shift the focus of power included the abolition of this group and the transfer of its functions to a ten-member Executive Committee of the RAG. The Executive Committee is composed of five physicians (two with the AMC), a nurse educator, the Director of the CHP "A" agency, a hospital administrator, a black consumer, and the Chairman--the President of the Regional Hospital Review and Planning Council. There are also three non-voting ex-officio members. Four of the ten representatives are from outside the Albany area. Unfortunately, this group is so new, and knows so little about its responsibilities, that it could not provide the site team with much information about its functions. In fact, four of the members were just added to the RAG and have little or no knowledge of the ARMP. The Executive Committee meets monthly and reports to the full RAG quarterly.

The Planning and Review Subcommittee of the Executive Committee is still in the formation stage. It presently consists of one RAG member, two Executive Committee members, and three core staff members, and there are plans for inclusion of outside members. Plans are that this group will be the real working arm of the Executive Committee and will meet weekly. The site team could not quite grasp the need for this subcommittee.

Technical review is supposed to be in the province of the thirteen consulting groups, which also are responsi-le for program development. The question arose as to how active these groups have been in performing either function. The number of meetings during the past year ranged from six for the dieticians' group to one apiece for the groups

on heart disease, cancer, and stroke. Those groups that are relatively active seem to be concerned mainly with two-way radio pursuits. It appeared that most consulting groups (which contain primarily Medical College people) were desultory in their approach, and a random look at the minutes of meetings revealed a tendency toward discussion of AMC as well as RMP business. For instance, from a perusal of the minutes, one would gather that the cancer consulting group was a medical school committee, on the basis of the topics discussed. The consulting groups have no specific technical review criteria other than the general RMP guidelines.

Although a visual presented to the site visitors depicts the review process as beginning with "community origination" of an idea, the team gathered the impression that community originated ideas are few and far between--most activities being initiated by core, and to a lesser extent, the consulting groups. Each project, after appropriate core staff assistance, is assessed by the Planning and Review Subcommittee, with a concomitant technical review by the proper consulting group (each member of which completes a ten-page rating scale) and an administrative review by approximately 12 to 14 core staff (each of whom completes a rating scale). The recommendations of these three reviews are forwarded to the Executive Committee (each member of which completes a rating scale). The Executive Committee, on the basis of these three assessments, its own judgment, and program guidelines, develops a specific recommendation for the project and sends it (along with a composite rating) on to the full Regional Advisory Group for consideration. There is no requirement that disapprovals be sent to the RAG for review, and the evidence was that they generally are not. What happens when project proposals reach the RAG is questionable. A review of recent minutes indicates that little discussion takes place or, if dissenting opinions arise, they are not reflected in the minutes.

The use of the full review process appears to be sporadic. All new activitie have been included as planning and feasibility studies or central regional services under core auspices, and it was unclear how many of these went through the full (or any) review process. Some received technical review. Some did not. One feasibility study was discovered to have resulted from at least two consulting groups' suggesting that an operational proposal was inappropriate because it duplicated existing resources and was not feasible. A feasibility study of training nurses for service in hospital emergency rooms was reviewed by the physicians' but not the nurses' consulting group. The Regional Advisory Group does not receive the minutes of the consulting groups.

Comments: The site team found the broadened RAG representation and the demise of the old Planning and Review Group very encouraging first steps away from AMC and core domination and toward a program more responsive to the Region's needs. The Region was encouraged, in its search for the eight additional RAG members, to concentrate on genuine consumer representatives, and it was suggested that church groups, labor unions, etc. might be good sources. The

main and overwhelming difficulty with the RAG and with its Executive Committee is that they apparently do not understand their responsibilities. They must be educated to the necessity of their beoming policy-making bodies which review ongoing and proposed activities, allocate funds among them, and set goals, objectives, and priorities. The RAG appears, in the past, to have forfeited these functions to others -- mainly the core staff. However, with the infusion of new blood, the diversification of the RAG and the creation of an Executive Committee, the site team thought the potential and ingredients existed for the assumption of a directing and decision-making role by these groups. Furthermore, immediate steps must be taken to ensure that all deliberations of the Executive Committee are reviewed and considered by the full RAG. It was explained by the site team that a complacent RAG is not the hallmark of a strong Region.

As mentioned before, the site visitors could discover no particular rationale for the existence of the Planning and Review Subcommittee of the Executive Committee. A strong Executive Committee should obviate the necessity for the Planning and Review group. If, however, the Executive Committee feels the need for an information-gathering and preliminary work group, it should be a true subcommittee and include in its membership only Executive Committee representatives.

The Region must revise its review procedure to provide a review of all ARMP efforts: proposed and operational projects as well as core-supported studies and activities. These procedures must include non-core technical assessment by groups other than those who developed the activity, and technical review bodies should be furnished specific review criteria and guidelines. Further efforts should be made to include in the technical review process qualified people from outside the Albany and AMC area.

Subregionalization

Findings: The primary subregional effort has been through Project #16 - Development of Community Leadership - in three northern New York counties. The purpose of the project is to stimulate community leaders to take the initiative in the development of RMP activities of significance to their community. This experiment is in its second year, but the Region feels the results are not yet all in. The local advisory group was rather slow-starting. So far it has submitted no ideas to the RAG but has developed some local continuing education activities. It also is involved in local efforts to form a CHP "b" agency. The experiences of this group will identify the do's and don'ts for similar efforts in other subregions -- although the Region has not established a timetable as to when the problems of other geographic subregions will be tackled.

Another emerging approach to community organization involves the use of approximately 30 practicing physicians from throughout the Region to design programs to meet local needs relative to health care delivery, health manpower, and public education. These physicians are from the Consulting Physicians Panel, a project

activity which operated for three years before the November 1970 Council recommended no additional funding. The physicians now are serving as ARMP consultants without honoraria and will be used as community leaders and organizers. The group now is working with the idea of establishing medical outposts using primary care nurses -- something that the core staff or the medical school group could not accomplish. The idea is that emergency outposts would be established in rural areas and that highly trained nurses would be able to take care of the emergency needs of patients until a physician became available. It is hoped to expand the panel to include consumer groups and use it to educate consumers and producers about the need for changes in health care systems.

Comments: The site team was pleased to see the number of physicians from the consulting panel whose services have been retained without financial remuneration. They can be valuable community resources for subregional organization and local ideas and should be used in conjunction with techniques developed in the experimental community leadership project. If the Albany Regional Medical Program is to move in new directions, the support and participation of local areas are imperative.

C. Involvement of Regional Resources

Findings: The involvement of health agencies and providers of health services in the Albany RMP activities has occurred mainly through RAG membership and programs sponsored by multidisciplinary groups. The RAG has representation from the State Health Department, Medical Society, Hospital Association, Model Cities program, Russell Sage School of Nursing, University, Hospital Facility Planning Council, and the State Comprehensive Health Planning Agency. Joint RAG membership has been developed with bordering RMPs. It appears that these groups have not been overly active in ARMP activities in the past, but the reorganization of RAG and the formation of the Executive Committee provide the framework for active participation.

The ARMP also brings agencies and providers into cooperative programs through its operating activities. The two-way radio, for example, has successfully brought drugstore pharmacists into the hospital setting for radio programs and has brought doctors, nurses, dentists and many allied health groups into similar contact with the hospital and with each other. Also, the Neighborhood Health Program is an example of a joint activity among ARMP, OEO, the University, and, to a degree, the Health Department. With regard to OEO, the ARMP has provided data for the Model Cities planning effort, has incorporated Model Cities representation on the RAG, and has developed, through OEO, an education program for consumers. The physicians consulting panel (discussed in this report under the section on subregionalization) is still another tie with the Region's physician community.

The program has acted as a catalyst to get CHP "b" agencies off the ground, and this no doubt will serve to further the relationships of

the various providers of health services through the Region in the future and furnish more opportunities for RMP field representatives to act in an integrative manner. These field agents (Divisional Coordinators and community information coordinators) have developed a strong network throughout the Region and have established good contacts with local communities. For instance, one of the subregions lost its last practicing physician through an automobile accident, and RMP was extremely helpful to the community in re-thinking its needs for health services before attempting to solve the problem. Some of the more positive benefits of this process included the discussion of why doctors settle in rural areas, the positive and negative aspects of building a hospital to attract another doctor, and recruiting techniques that are most effective in bringing physicians to these areas.

Comment: The site team noted the increased activity in terms of involvement with other agencies, particularly with regard to health care for the poor, planning for rural areas, and assisting rural areas in developing medical care programs.

D. Assessment of Needs, Problems, and Resources

Findings: The ARMP has a very good and comprehensive three-volume data base which recently has been completely updated from its original preparation in 1966. It deals with the demographic characteristics of the Region and the resources available to meet health care needs, and appears to surpass that developed by most of the Regional Medical Programs. Not much seems to have been done with it, however, in terms of analysis, distribution, and as a base for the development of activities. The needs, problems and resources exhibited in the data base are reflected in the Region's objectives only to the extent that the objectives were designed to be nearly all-encompassing. The old planning and review group apparently did not work with this information in establishing Regional objectives, nor did core staff in devising its activity rating scale for priority determination.

Comments: The site team was impressed with the data base which has been developed and thought it could become a real planning resource. The Region was encouraged to widely publicize the existence of this information; to make it available to many groups such as CHP, medical society, hospital association, health departments, communities; and to encourage the RAG and its Executive Committee to use it as a reference for planning and decision-making functions.

E. PROGRAM IMPLEMENTATION AND ACCOMPLISHMENTS

CORE

Findings: The bulk of activity (outside of the two-way radio) is conducted under core auspices and so a lot of what they do is discussed in other parts of this report. As mentioned before,

the Region has submitted no proposals for new projects -- all new endeavors are included as planning and feasibility studies or central services to be funded from the core budget. Not only is this practice suspicious from a fiscal standpoint, the review process is by-passed for many activities, and it vests the control of projects in core staff. The plethora of studies appears to be random bits and pieces that do not add up to a coordinated whole. The various activities which are carried out seem to dictate what the program will be rather than the other way around.

A great deal of core time has been consumed by two-way radio activities. However, it appears that perhaps the core staff is looking hesitantly in other directions.

One of the primary illustrations of this is ARMP's support of the Community Medical Care Program. In its development of the North End Community Health Center in a black ghetto area of Albany, this program encountered a funding hiatus which probably would have spelled its demise had not ARMP provided interim holding support until OEO grant money was approved. Consequently, in 1970, $60,000 of core money was diverted to the planning for this ghetto health center. Dr. Woolsey now is chairman of the policy council of the Community Medical Care Program and the ARMP core staff is working with the program to identify two rural sites for which OEO has agreed to provide funds.

The core staff in addition is planning a physicians' assistant training program and studying the feasibility of nurse practitioners as assistants to the physician.

Core also is assigned the responsibility of monitoring ongoing projects, although none of these appears to have much in the way of specific evaluation methodology. Presumably, progress and problems are discussed at the weekly core staff assembly.

Comments: The site team saw the core staff as a potentially powerful force in this coming transition phase to a more community-oriented program and hope that some of the studies which are to be conducted will come to fruition in the development of project proposals. The Coordinator and the core staff are particularly (and perhaps overly) sensitive to the feelings of the physicians in the area. The program people characterize these physicians as "conservative" and go out of their way to do nothing to destroy the physicians' faith in ARMP - maybe to the point of undesirable inactivity in the face of opportunity. Dr. Woolsey, for instance, appears rather cautious about core involvement in the development of rural health centers beyond assistance in identifying sites. The visitors thought it likely that the core staff has not kept pace with the changes that are occurring among physicians' attitudes throughout the country, and that Albany physicians might not, on re-examination, be as "conservative" as they were some five or ten years ago. At any rate, the core staff should be encouraged to be adventuresome in its activities. And, as mentioned earlier, all core activities, other than routine, should be submitted through the review process.

Operational Projects

Findings: There presently are four ongoing operational projects. The two major activities in terms of time, money, and effort are the two-way radio and the coronary care nurse training, neither of which represents any new directions for the Region. Both have been operational since the 01 year and are now requesting renewal support for three more years -- through the 07 year. And there are ominous signs that the projects might be expecting RMP support in perpetuity.

The two-way radio was the base on which the ARMP was built and is the activity through which the program became known throughout the Region. In fact, many physicians and hospitals seem to think of ARMP and the two-way radio as synonymous. Many ARMP staff appear to have the same problem. The radio really has gained a large degree of acceptance for the ARMP and apparently is tremendously successful. The site visitors were practically inundated by obviously sincere testimonials to the radio's effectiveness. The site team two years ago urged the Region to seek ways to phase out RMP support of this activity through the increase in hospital contributions or some other means. The rationale behind this suggestion was that the two-way radio had served its purpose as a launching vehicle and had been demonstrated an effective means of education. It was time for someone else to pick up the bill. RMP could not continue to tie up its resources in this activity. In the intervening two years, RMP support has not diminished and, in fact, the annual requests for each of the next three years represent increases over previous years' allocations for the radio. It was explained to the site team that there was no other organization in the Region which could support it. The close and continued involvement of the ARMP, too, further muddies distinctions between ARMP and the Department of Postgraduate Education which sponsors the overall radio system, to the extent that key ARMP core (including the Coordinator) are identified in publications as full-time staff of the Department of Postgraduate Education.

The project for coronary care nurse training, likewise, is requesting fifth, sixth, and seventh years of support. Dr. Woolsey said that he has a plan for ARMP withdrawal from this project, although he disclosed neither his timetable nor the precise nature of his plan.

The only other two project activities, which are miniscule in the overall scheme of things, are the program for the development of community leadership (described in this report in the section describing subregionalization efforts) and a project which provides the part-time salary of a cancer coordinator in the Schenectady area. This latter activity is requesting support for only a year longer, and then it is hoped that alternate sources of support will be found to finance the cancer coordinator's activities.

Comments: The site team agreed that the ARMP absolutely must phase-out its contributions to the two-way radio and the coronary care training projects. A Region which is trying to turn itself around

cannot afford to have so large a chunk of its resources tied up in the same activities year after year. Consequently, it is recommended that no more than 18 months support be provided for the two-way radio and that only a year's termination funds be provided for coronary care training. Of course, out of its total funds for next year the Region must make the decision as to the amounts to be allocated to these two activities. The site visitors hope, however, that the money diverted to these projects will not be of sufficient size to belie the Region's avowed aim of traveling the new road of health care delivery, etc. Furthermore, there is definite need to more clearly distinguish between RMP and the Department of Postgraduate Education involvement in the radio activities. The efforts of the RMP staff must be clearly identified with the program and not with the Medical College.

F. Evaluation

Findings: Each project is assigned a core staff monitor. And in the two-way radio project each subspecialty series of programs is assigned a separate staff person. There appears to be no particular mechanism for relating project evaluation to program planning, beyond the feedback and exchange in the core staff assembly. Since there is really no cohesive program as yet, there is nothing that legitimately can be termed program evaluation.

Comments: There are on core two educational psychologists and sociologists who likely are capable of spearheading evaluation efforts. From what the site team could see, however, they have been bogged down in the past by refining too much on exceptionally complicated techniques of comparative rating and the use of sociometric devices to chart group dynamics, which all seems somewhat beside the point. The Region should develop more formal evaluation methods, establish links between results of effectiveness and future planning, and provide the RAG and its Executive Committee with understandable results for planning and decision-making purposes.

V. RATIONALE FOR FUNDING RECOMMENDATION

The one year $900,000 recommendation was thought to represent a sum which could provide, through judicious allocation, adequate support for program maintenance and termination activities, with sufficient funds remaining to implement the numerous recommendations and suggestions of the site team. The current year's level is $806,001 (reduced from $915,910) and the request for next year was $1,104,790. The site team felt a funding level smaller than that recommended would not permit the Region to accomplish the things that it must if the site team next year is to see the changes that have been recommended in this report which must be accomplished if the program is to be continued.

VI. RECAPITULATION IN TERMS OF RMPS MISSION STATEMENT REVIEW CRITERIA

A. Performance Criteria

1. Goals, Objectives and Priorities. The Region has established goals and objectives which are so comprehensive as to cover any potential activity. Priorities have not been set among the various objectives. The site team recommended to the Region that it develop measurable operating objectives which are time-limited and ranked in priority order. Refer to the section on Goals, Objectives, and Priorities, page 10.

2. Accomplishments and Implementation. The activities undertaken to date appear to have been reasonably successful in terms of the specific ends sought. The problem lies with the fact that these specific ends have been, in the past at least, in the area of continuing education almost exclusively. The Region just now is branching out into other areas.

3. Continued Support. Activities stimulated and initially supported by ARMP are, for the most part, still being supported by ARMP rather than being absorbed within the regular health care financing system. It was suggested to the Region that it phase out RMP support of these long-term projects so it can invest its money in innovative activities designed to assist the Region in its proposed change in direction. Refer to the section on Operational Projects, page 19.

B. Process Criteria

1. Organizational Viability and Effectiveness. With regard to the organizational effectiveness of the ARMP, the primary problem appears to lie with the advisory, review, and decision-making structure -- which is new and untested. During the coming year the Region must concentrate on seeing that the RAG assumes a program directing role. See section on Organizational Effectiveness, page 11.

2. Participation. The involvement of the health-related interests of the Region is provided for primarily through RAG membership -- and this involvement should be strengthened as the role of the RAG is strengthened. In addition, two-way radio programs and the activities of the core field representatives garner considerable local interest and support. See section on Involvement of Regional Resources, page 16.

3. Local Planning. CHP "b" agencies are non-existent in the Albany area, although ARMP staff have provided assistance in initial efforts to establish such agencies. The experiment in sub-regionalization in three northern New York counties, plus the services of the physicians on the consulting panel, have potential for providing for excellent local planning and input

But this is not yet a reality. See section on Subregionalization, page 15.

4. Assessment of Needs and Resources. The ARMP has an excellent and current data base, but has not yet used it in the most productive manner possible, and there is evidence that it was given scant attention in the development of objectives. Refer to the section on Assessment of Needs, Problems, and Resources, page 17.

5. Management and Evaluation. The Region's evaluation process still is nascent. See section on Evaluation, page 20.

C. Program Criteria

1. Action Plan. Past activities have centered around continuing education programs which reflect a provider-action plan of needs to the extent that they were developed in response to (a) needs expressed by an 80-man physician panel representing the general geographic area, and (b) the health professionals in and around the 56 hospitals tied to the two-way radio network. Current activities indicate involvement (in terms of dollars and planning assistance) in health care delivery problems through the means of a University-sponsored neighborhood health program health planning through two Model Cities programs, and the investigation of medical care changes through the physician panel. It is expected that during the coming year, as the RAG and its Executive Committee assume more of a program directing role, the ARMP's developing activities will be reflective of providers' high-priority needs and in congruence with RMP mission and objectives.

2. Dissemination of Knowledge. The two-way radio continuing education program appears to be a very effective means of disseminating knowledge of new and improved techniques to a large number of professional practitioners, including doctors, dentists, pharmacists, nurses and other allied health personnel.

3. Utilization of Manpower and Facilities. With respect to increased utilization and effectiveness of community health facilities and manpower, although there had not been as much progress as the site visitors had hoped to find the program has nonetheless made a contribution through the following efforts: (a) the neighborhood health effort (to which ARMP is contributing dollars and planning assistance) is providing health care to a medically deprived urban area, is experimenting with new types of manpower, and plans to expand to rural areas; (b) the physician panel is exploring the possibility of group practices and the use of allied health manpower in their practices in the various subregions within the regional area; (c) the RMP is studying the feasibility of nurse practitioners as assistants to the physician.

4. Prevention. The areas of health maintenance, disease prevention, and early detection are addressed in the continuing education program and through the neighborhood health program. Proposed core activities in this area include a Pap smear program and the creation of a health maintenance system for physicians' offices. Overall, the program has not demonstrated a strong effort in health maintenance to date, but this probably will develop as the program progresses.

5. Ambulatory Care. Activities involving ambulatory care and out-patient treatment are covered in the above discussion. However, the primary push in this direction probably will result from ARMP involvement with neighborhood health center and Model Cities planning efforts.

6-8. Continuity of Care, Short-Term Payoff, and Regionalization. With regard to the relationship between primary and secondary care, accessibility, quality, and cost moderation and the linking of multiple health institutions, the program has not demonstrated a strong integrative function nor has it affected to any large degree the improvement of the health care delivery system. The program fields a strong team of information coordinators and geographic area coordinators, but unfortunately they have few tangible results in terms of how their efforts have actually resulted in improvements in health services in these various regions. The neighborhood health program and the plans to expand this program into the rural areas is one exception and stands out as the highlight of their activities. They believe their field representatives have been successful in changing attitudes in the region and believe that eventually this will lead to changes and improvements in the organization of health services. This is, at the moment, still speculative. However, the site visit team was impressed with the fact that they have established working relationships with the community.

9. Other Funding. The ARMP is supportive of other Federal efforts to the extent of their support of CHP, OEO, and Model Cities planning activities. However, in terms of tapping local, state, and other funds, the program appears not to have tried this, at least with respect to current long-term RMP funding of ongoing projects.

The Albany Medical College of Union University

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FOUNDED IN 1839

Office of the
Executive Vice President and Dean

June 11, 1971

Dr. John E. Kralewski
Assistant Professor and Director
Division of Health Administration
University of Colorado Medical Center
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Denver, Colorado 80220

Dear Dr. Kralewski:

As suggested by you, I have completed a very careful study of the requested salary budget on pages 33 and 34 of the ARMP application. The major purpose was to ascertain whether the percentages of salaries of the core staff charged against ARMP were truly realistic. In this review, I fully anticipated that I might find significant changes to recommend on the basis that some of the time charged to ARMP activity might be clearly chargeable to non-ARMP performance--i.e., perhaps Medical College programs per se.

After extremely careful review and discussion of the activities of the core staff, including secretaries, I am truly convinced that the percentage of effort designated for each employee to ARMP functions is as close as it is possible to estimate.

There is no question that those assigned 100 percent to ARMP activities are fully justified. Although the formal College work week is 35 hours (non-administrative and non-faculty personnel are paid overtime for work in excess of 40 hours), the key administrative personnel of ARMP are expected and do usually work a longer week in order to fulfill satisfactorily their assigned tasks and obligations. A number of these 100 percent ARMP salaried individuals do hold Medical School faculty appointments--and like other (voluntary) "clinical" faculty--do make minor contributions to various Medical College programs--in physical diagnosis or in O.P.D. programs. This might amount to as much in some cases as 36 hours per year--but usually less than 24 hours. We could not have recruited these very competent physicians for the core staff without offering faculty appointments--and the latter require this minimal degree of teaching.

In evaluating the proposed ARMP funding of the "less than 100 percentees", the percentage estimate of effort toward ARMP as compared to other activities seems justifiable.

Dr. John E. Kralewski June 11, 1971

If it seems to the uninitiated that too much time is charged to ARMP activities and not enough to other sources for other responsibilities, I would point out that the College has provided free to ARMP innumerable hours of effort on the part of many department chairmen and other faculty. It has done so willingly because the College very much wants to see the ARMP fulfill its catalytic obligations to the region and the ARMP needed the expertise and judgment of professionals such as these who are only available at the Medical College. Doctors Bondurant, Eckert, Horton, Paul, Hawkins, Doyle, Barron, as well as Mr. Siegel and I, have spent an inordinate amount of time and effort in trying to strengthen the planning and implementation of ARMP activities and will continue to do so.

I might add--thanks to suggestions from the site-visit team--that the RAG and its Executive Committee will strive for clear visibility, identification and greater control of all activities of the core staff. We have a better idea than we were able to convey at the time of the site visit but will exert much effort to strengthening this particular aspect. Other suggestions made by the site-visit team were excellent and will be worked upon and implemented as rapidly as possible.

In conclusion, I believe the budget as outlined on pages 33 and 34 represents a realistic assignment of staff activities to ARMP functions. I see no place where a glaring error has been included. In my view, it is by no means padded in favor of Medical College functions--including specific operations of the Department of Postgraduate Medicine. Thank you for inviting these comments. They are sincere and I hope helpful.

Sincerely,

Harold C. Wiggers

Harold C. Wiggers, Ph.D., Sc.D.
Executive Vice President and Dean

HCW:jw

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

Bi-State Regional Medical Program
607 N. Grand Boulevard
St. Louis, Missouri 63103

RM 00056-03 8/71
July 1971 Review
Committee

Program Coordinator: William Stoneman, III, M.D.

The Region is currently funded at $875,083 (Direct Costs) for its second operational year which ends September 30, 1971. The Region currently receives indirect costs of $272,231 which is 31 percent of the direct cost award. It submits a triennial application that proposes:

I A developmental component

II The third year continuation of core

III The renewal of core for two additional years

IV Continuation of five ongoing activities

V Three-year renewal of one ongoing activity

VI The implementation of four new approved unfunded activities

VII Funds for one approved unfunded activity to be initiated on 9/1/73 with the sixth and seventh years to follow in the next triennial application.

The Region requests $1,449,269 (D.C.) for its third year, $1,247,099 (D.C.) for the fourth and $1,587,983 (D.C.) for the fifth year of operation. A breakout chart identifying the components for each of the three years follows on Pages 3, 4 and 5.

The Region is not scheduled for a site visit during this review cycle.

On May 27, 1971 staff conducted its preliminary review of this application. (A memorandum to the Director, RMPS, covering staff's findings and recommendations is attached.) Briefly, staff recommended that the application be approved for one additional year of support instead of the three-year program requested. Dollar support was recommended at the following level:

Total direct cost support at $924,113. This total represents the projected 1972 fiscal year level of $689,113 plus new funding of $235,000. Since this Region is potentially faced with a 28% reduction for its third year of operation, staff believed that the increase recommended would provide a more realistic funding base and could

be used for: 1) maintaining essential core staff needed for the development of program activities which will specifically implement pertinent national health priorities, 2) provide the Region with some additional funds so that they may become more actively involved in the provision of catalytic functions, 3) for implementing Project #16 - To Develop a Model for Testing Effectiveness of Physician Continuing Education Programs in Terms of Patient Management and for providing a portion of the renewal request for Project #9 - Health Surveillance, Health Education and Health Care Accessibility for a Low Rent Urban Housing Project which is, of course, contingent upon satisfactory review by the August 1971 Council. In addition, staff recommended that a management assessment visit be conducted.

FUNDING HISTORY

Planning Stage

Grant Year	Period	Funded (Direct Costs)
01	4/1/67 - 10/31/68 (19 Mo.)	$495,395
02	11/1/68 - 10/31/69	443,625

OPERATIONAL PROGRAM

01	7/1/69 - 10/31/70 (16 Mo.)	1,094,077
02	11/1/70 - 9/31/71 (11 Mo.)	875,083 *

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* Reflects 12% reduction imposed on all Regions

REGION Bi-State
CYCLE RM 00056 8/71

BREAKOUT OF REQUEST 03 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
Core -	589,742*				589,742	253,146	842,288
DOO - Developmental				131,752	131,752	———	131,752
#2-Coop.Reg. Rad.Therapy Develop. & Support	124,885				124,885	25,143	150,028
#4-Compreh. Diagnostic Demon. Unit for Stroke	47,684				47,684	20,132	67,816
#5-Nursing Demon. Unit in Early Inten. Care(Stroke)	63,831				63,831	11,959	75,790
#8-Coop. Regional Inf. System-Health Prof.	13,881				13,881	2,179	16,060
#7-Establish a Radiation Therapy Facility			——**		———	———	———
#12-Coronary Care Trg. for Nurses	58,902				58,902	28,793	87,695
#13-Rehabilitation for Myocard. Infarc. Pats			73,800		73,800	28,083	101,883
#14-Clinical & Cyto. Det. of Cancer-Indig.Females			60,000		60,000	———	60,000
#9-Health Surveillance Urban Housing Project		232,652			232,652	21,170	253,822
#15-Education on Harmful Effects of Smoking			35,390		35,390	———	35,390
#16-Effectiveness of Physician Cont. Educ.			16,750		16,750	———	16,750
TOTAL	898,925	232,652	185,940	131,752	1,449,269	390,605	1,839,874

* 04 &05 Beyond Approved Period of Support
** Funds requested for 05 year only with 06 & 07 to follow in next triennium

REGION Bi-State RM 00056 8/71
BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
Core		627,740			627,740
DOO - Developmental				137,468	137,468
#2 -					—
#4 -					—
#5 -					—
#8 -	7,621				7,621
#7 -			—**		—
#12 -	61,471				61,471
#13 -			64,140		64,140
#14 -			60,000		60,000
#9 -		251,821			251,821
#15 -			20,988		20,988
#16			15,850		15,850
TOTAL	69,092	879,561	160,978	137,468	1,247,099

**Funds requested for 05 year only with 06 & 07 to follow in next triennium

REGION Bi-State RM 00056 8/71
BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
Core		663,992			663,992	1,881,474
DOO - Developmental				141,764	141,764	410,984
#2					—	124,885
#4					—	47,684
#5					—	63,831
#8						21,502
#7			365,681		365,681	365,681
#12					—	120,373
#13			67,167		67,167	205,107
#14			60,000		60,000	180,000
#9		258,529			258,529	743,002
#15			15,000		15,000	71,378
#16			15,850		15,850	48,450
TOTAL		922,521	523,698	141,764	1,587,983	4,284,351

GEOGRAPHY AND DEMOGRAPHY

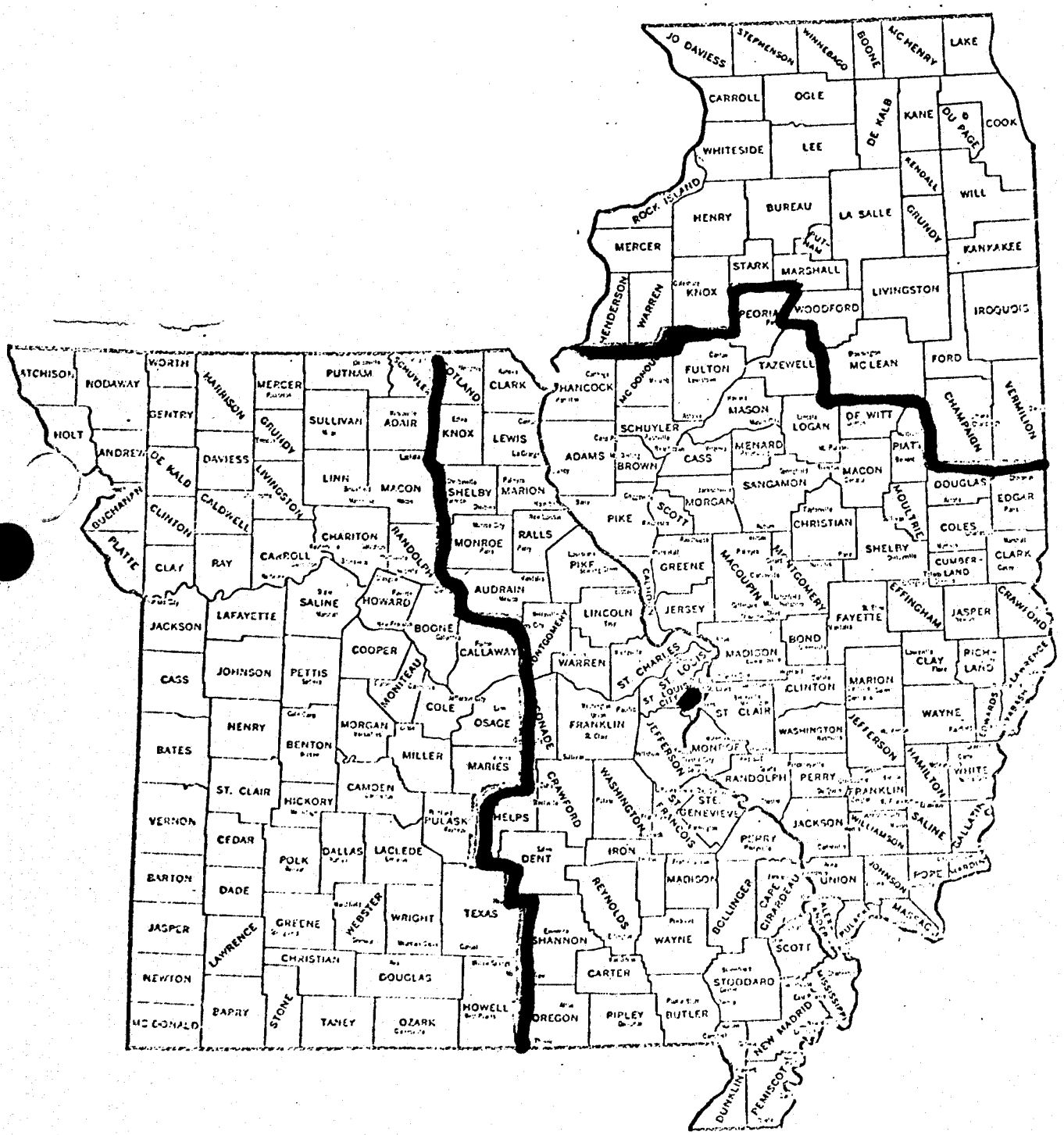
The Bi-State Regional Medical Program centers around the St. Louis metropolitan area.

The Region served by the Bi-State Regional Medical Program is complex in that it (1) is based on patterns of medical service rather than on geographic state-defined boundaries and (2) is bi-state as the name of the Program implies, bridging the Mississippi River to cover parts of Missouri and Illinois. The medical service area is that surrounding the institutions whose joint action brought the Program into being on April 1, 1967: St. Louis University School of Medicine and Washington University School of Medicine in St. Louis and Southern Illinois University, with major campuses in Edwardsville and Carbondale, Illinois, then planning and now initiating a medical school in Springfield, Illinois. The area is roughly described as southern Illinois, covering 66 counties, and eastern Missouri, covering 43 counties. (See map, page 7)

In this area live more than 4,500,000 persons who look, or whose physicians look, in varying degree to these medical centers for medical advice, consultation, treatment and health--related education.

The metropolitan St. Louis area has a population of 2.5 million at least 10 percent of which are estimated to be the urban poor. Only four other communities in the region have a population of more than 30,000. About 260,000 persons live in these communities; the remaining 1,740,000 of the region's population live in smaller towns and rural areas.

In the metropolitan St. Louis area (comprising eight Missouri and Illinois counties), there are, as might be expected, the most numerous and most sophisticated health resources: two medical schools, 52 hospitals with a total of 20,000 beds, 17 educational institutions, including junior and senior colleges and universities, and more than 3,000 physicians. Clusters of resources of varying levels of sophistication dot the rest of the region.


JO DAVIESS
STEPHENSON
WINNEBAGO
BOONE
MC HENRY
LAKE
CARROLL
OGLE
DE KALB
KANE
DU PAGE
COOK
WHITESIDE
LEE
KENDALL
WILL
ROCK ISLAND
HENRY
BUREAU
LA SALLE
GRUNDY
KANKAKEE
MERCER
PUTNAM
STARK
MARSHALL
HENDERSON
WARREN
KNOX
PEORIA
WOODFORD
LIVINGSTON
IROQUOIS
ATCHISON
NODAWAY
WORTH
HARRISON
SCHUYLER
SCOTLAND
CLARK
HANCOCK
MC DONOUGH
FULTON
TAZEWELL
MC LEAN
FORD
GENTRY
GRUNDY
SULLIVAN
ADAIR
KNOX
LEWIS
ADAMS
SCHUYLER
MASON
LOGAN
DE WITT
CHAMPAIGN
VERMILION
HOLT
ANDREW
DAVIESS
DE KALB
LIVINGSTON
LINN
MACON
SHELBY
MARION
BROWN
CASS
MENARD
PIATT
BUCHANAN
CALDWELL
CLINTON
CHARITON
RANDOLPH
MONROE
RALLS
PIKE
SCOTT
MORGAN
SANGAMON
MACON
DOUGLAS
EDGAR
PLATTE
CLAY
RAY
CARROLL
AUDRAIN
GREENE
MACOUPIN
MONTGOMERY
CHRISTIAN
MOULTRIE
COLES
SHELBY
CUMBERLAND
CLARK
JACKSON
LAFAYETTE
SALINE
HOWARD
BOONE
CALLAWAY
LINCOLN
JERSEY
FAYETTE
EFFINGHAM
JASPER
CRAWFORD
CASS
JOHNSON
PETTIS
COOPER
MONTGOMERY
WARREN
ST CHARLES
ST LOUIS
MADISON
BOND
CLAY
RICHLAND
LAWRENCE
BATES
HENRY
BENTON
MORGAN
MONITEAU
COLE
OSAGE
FRANKLIN
ST LOUIS CITY
ST CLAIR
CLINTON
MARION
WAYNE
JEFFERSON
WASHINGTON
VERNON
ST CLAIR
HICKORY
CAMDEN
MILLER
MARIES
CRAWFORD
JEFFERSON
MONROE
RANDOLPH
PERRY
FRANKLIN
HAMILTON
WHITE
CEDAR
POLK
DALLAS
LACLEDE
PULASKI
PHELPS
DENT
WASHINGTON
ST FRANCOIS
STE GENEVIEVE
JACKSON
WILLIAMSON
SALINE
GALLATIN
BARTON
DADE
GREENE
WEBSTER
WRIGHT
TEXAS
IRON
MADISON
REYNOLDS
BOLLINGER
CAPE GIRARDEAU
UNION
JOHNSON
POPE
HARDIN
JASPER
LAWRENCE
SHANNON
WAYNE
ALEXANDER
PULASKI
MASSAC
CHRISTIAN
DOUGLAS
CARTER
SCOTT
NEWTON
BARRY
STONE
TANEY
OZARK
HOWELL
OREGON
PIPLEY
BUTLER
STODDARD
MISSISSIPPI
MC DONALD
NEW MADRID
DUNKLIN
PEMISCOT

Regional Development

During December 1966, the St. Louis University School of Medicine, Southern Illinois University and Washington University School of Medicine submitted an initial planning grant application. Following several meetings, the first planning award was made during April 1967. Washington University was approved as the applicant agency. Deans Danforth and Felix (St. Louis and Wash. Univ.) were named as co-program coordinators.

During February 1968, the Region submitted an application for 02 year planning support. Because progress in the Region had been extremely slow due to a number of factors and events, the 01 year was extended from 3/31/68 to 10/31/68. Dr. William Stoneman was appointed planning director during August 1968. At this time the Region began to gain momentum. During November 1968, a second-year planning award was made. Dr. Stoneman was promoted to program coordinator. The pre-operation site visit was conducted during April 1969. The Region's original operational application contained six proposals. The May 1969 Council concurred with the site visitors and the Review Committee and recommended three of the six projects for approval; three were to be returned for revision. On July 1, 1969 the Region became operational with three activities: Project #2-Cooperative Regional Radiation Therapy Development and Support Program; #4-Comprehensive Diagnostic Demonstration Unit for Stroke and #5-A Nursing Demonstration Unit in Early Intensive Care of Acute Stroke. Third year continued support is requested in this application for these activities. During the Region's first operational year three additional proposals were submitted. The August 1969 Council approved the projects with conditions:

Project #7 - Establish a Major Radiation Therapy Facility as Part of a Center for Comprehensive Care - (Hold RMP Dollars for equipment pending further justification); Project #8 - Establish a cooperative Regional Information System. (Fund for 3-years at 1/2 the requested level.)

Project #9 - Health Surveillance, Education and Care Accessibility for Residents of Low Rent Urban Housing Project (fund for one-year to allow time for further planning). This application requests continued support for #8, deferral of funding until the 5th triennial year for #7 and Renewal of project #9 which has been supported for one year.

The July 1970 Council recommended approval of Project #12 - C.C.U. Training for Nurses. Carryover funds were authorized to initiate the activity for the period 11/1/70 - 9/30/71. Two years of continued support are requested in this application. From various review cycles the Region currently has four projects which are approved/unfunded.

The present application reflects the Region's decision to submit a triennial application on its anniversary rather than an application geared only to its plans for the next year. With the exception of the developmental component, no new activities are proposed. The following chart displays the Region's funding status at the time this application was developed; the level of funding for the continuing life of ongoing projects and specific new/approved-but-not-initiated activities plus the developmental component:

	Present Funding	Projected for Triennium 1st Year	2nd Year	3rd Year
	(11/1/70-9/30/71)			
Core	$447,116	$589,742	$627,740*	$663,992
Developmental Component	None	131,752	137,468	141,764
Ongoing Projects, Continuation or Renewal	427,967	541,835	320,913	258,529
New Projects and their continuation	None	195,940	160,978	523,698
Totals	$875,083	$1,449,269	$1,247,099	$1,587,983

* Core Renewal

ORGANIZATIONAL STRUCTURE AND PROCESSES

Regional Advisory Group: On August 15, 1970, the Bi-State Regional Group was reorganized. The total membership was increased from 55 to 77 members. While the original group contained 2 minority representatives and 3 consumers, the reorganized RAG contains 12 minority representatives and 14 consumers or public representatives. The number of representatives of medical schools was reduced and geographic representation was broadened. Although the actual total membership in the Greater St. Louis area was increased from 38 members to 44 members, the increased membership is caused by more inner-city and non-provider community representation. In arriving at the total membership of 77, 21 former members were dropped. According to the application, the reorganization has created a RAG which has greater potential for broad Regional in-put and decisionmaking and a potential from more effective advocacy of the RMP aims from the varied interests and geographic areas represented.

The Regional Advisory Group meets approximately every three months and has approximately 75% attendance.

Executive Committee: The function of the Executive Committee is to study the program in depth, develop and make recommendations to the Regional Advisory Group on basic planning, direction of development and other policy matters. The committee meets between RAG meetings approximately six times a year. The original committee was composed of 12 members (1 Black). The committee was recently reorganized and the membership increased from 12 to 15 (3 Blacks). The new membership includes: three University Medical Center representatives; three representatives of the public; three practicing physicians; two allied health representatives; and four representatives from the public and private health administrative interests.

Committee Structure: The Region has eight standing committees on heart disease, health manpower, cancer, continuing education, communications and public education, stroke, demography and statistics and a committee on health care delivery.

There is also a Scientific and Education Review Committee which is composed of the chairmen of the eight program committees listed above and members of the Administrative Liaison Committee. The responsibility of the Scientific and Education Committee is to review all proposals submitted by the several program committees beforesubmission to the RAG. Approved proposals are ranked according to priorities.

The Administrative Liaison Committee, appointed by the Deans of the Medical Schools has responsibility for overseeing the administrative aspects of the Region's program, including review of salaries and expenditure of funds.

Review Process: At the first indication of interest, a prospective applicant is put in contact with an appropriate associate director (in the medical school) or an associate director on core staff (example - Allied Health) who will assist him in the development of the proposal, if the idea appears feasible. The completed proposal is first reviewed by the appropriate program committee. If the review is positive, it goes to the second level of review, the Scientific and Educational Review Committee. If the proposal is successful at this level, it then goes to the Regional Advisory Committee.

Evaluation: During the past year the Region has made some progress in trying to develop a more adequate evaluation process. A full-time planning director has been employed who is to have primary responsibility for both planning and evaluation. Also, the Region has designed a standard form evaluation type questionnaire which is to be used in all activities. RMPS Staff, in its review of the application, believed that some method should be developed whereby information derived on the progress of the ongoing program can be reviewed (and used) by the appropriate committees and by the RAG.

Data Collection and Analysis

Data collection is the third highest priority set by the Regional advisory Committee and is one of the areas in which developmental funds would be used. Currently the Region is cooperating in a consortium of Federal agencies and other interested groups in the six-county area comprising the Metropolitan St. Louis community to develop summary census data center.

Program Priorities: On page 23 appears a listing of program objectives with priorities assigned by Bi-State Regional Advisory Committee on March 22, 1971. Objective Priority #1 relates to physician manpower and "to develop programs aimed at correcting the lack of physician manpower services in parts of the region." Objective #2 relates to allied health manpower and is "to develop programs to make appropriate health manpower available throughout the region."

Objective priority ranking has been assigned to 21 activities identified under nine problem areas.

Staff noted in its review of the application that on September 1, 1970, the Bi-State RMP Region Advisory Committee adopted the following statement of general program priorities:

I. Improvement of health care delivery

   a. Improve systems for delivery of health care services to the medically disadvantaged.

   b. Extend and increase availability of improved scientific and technical modalities in health care.

   c. Delivery of service-systems by development of center-sub-center cooperative relationships.

II. Education, including continuing education of the medical, nursing and allied health professions, especially in support of aims expressed above.

III. Prevention of disease and its complications.

Present Application

The Developmental Component

The Region requests developmental funds of $131,752 for the first triennial year; $137,468 for the second and $141,764 for the third year.

The ability to move expeditiously to solve problems and gain cooperation, using small amounts of funds, has been cited by the Region as one factor in its program growth. The application lists, by order of priority, how the proposed developmental funds will be utilized in the areas of manpower, health care systems, data base, continuing education for primary care personnel, comprehensive strategy for primary care, medical information (patient management), availability of medical resources, and strategy for utilization of secondary and tertiary sources. In general, the approaches are described as planning studies, specific investigations, demonstrations, and "seed" money.

Developmental requests of $10,000 or less will be allocated by the program coordinator with approval of the Executive Committee of the Regional Advisory Committee. Requests for larger sums will be reviewed and allocation made upon approval by the R.A.C. following recommendations from the program coordinator. RMPS Staff noted the the proposed use of Developmental funds appeared to be in line with the region's problem-priority rankings.

Requested (D.C.)

Core

Third Year
$589,742

Core is presently supported at the $447,116 (d.c.) level for the (02 year) eleven-month period, 11/1/70 - 9/30/71. Support for the Region's 4th and 5th years are requested which is beyond the approved period of support for this activity.

The current staff consists of 26 full and part-time personnel. The Program Coordinator is supported for 97% time or effort. One full-time field coordinator position is vacant along with four half-time associate director positions. Three of the latter positions are budgeted for the new Southern Illinois University School of Medicine. Uncertainty as to the wisdom of retaining categorical emphasis along with budget cuts have delayed recruitment. The core budget escalates due to the limited staff additions, salary increases and normal inflation of equipment costs, travel, etc. The application describes a busy core staff operation which moves in the areas of planning, support in identifying needs, assistance with project development, evaluation in operational effectiveness, data collection, developing cooperative relationships, and public relations. The application describes several core-supported feasibility and planning studies which are in progress or are being developed. Several of the projects which are currently awaiting funds stemmed from feasibility studies using core funds or by using core staff capabilities. RMPS Staff believed that Council may favor an increase for core during the (03) year provided the funds would be utilized by the region to develop program (project) activities leading to a new three-year look for next year's application.

Fourth Year
$627,740

Fifth Year
$663,992

Continuation of Projects within approved Periods of Support

Staff, in its review of the triennial application, found it difficult to relate these activities to the newly evolving national health priorities. However, it was realized that as this application was being developed, the national health strategy was changing. Staff concluded this would require a fair "turn-around or re-direction period."

Third Year
$124,885

Project #2 - Radiation Therapy Development and Support Program - Washington University Mallinckrodt Institute of Radiology

This project was initially supported during August 1969. Currently it is supported at the 11-month, through 9/30/71 $108,064 (d.c.) level.

Requested (D.C.)

One year of support is requested to further pursue the original objectives of: 1) extending a dosimetry communication system (telecopiers); 2) developing a cooperative radiation physics center; and 3) providing radiation-therapy technology enrichment and training to advance skills in technology.

The project plans to continue and expand its telecommunication network (presently 23 hospitals) through which hospitals and medical groups are connected to the Mallinckrodt Institute for consultation on treatment plans. Plans are to continue both physician and technician refresher courses (30 physicians - 30 technicians participated during September-October 1970). Training components for professional and paramedical personnel are to continue.

Phase out to institutional, local or other grant mechanisms support is expected.

Fourth Year	Fifth Year
-0-	-0-

Project #4 - Comprehensive Diagnostic Demonstration Unit for Stroke - St. Louis University — Third Year $47,684

This project was initially funded during August 1969. It is currently being supported for the eleven-month year, 11/1/70 - 9/30/71 at the $42,037 (d.c.) level. One year of continued support is requested to pursue the orginal objectives which were to demonstrate the best techniques for stroke diagnosis to physicians, nurses and technicians and to encourage establishment of similar units throughout the region. Lectures and demonstrations have been presented to 1,275 physicians and medical personnel either at the home base or in "circuit-riding" units. This total represents 128 hospitals - 78 medical societies. Regional units are now being planned for several towns and cities in both Missouri and Illinois. Phase out is planned in terms of medical center and community hospital support following withdrawal of RMP funds.

Fourth Year	Fifth Year
-0-	-0-

Requested (D.C.)

Project #5 - Nursing Demonstration Unit in Early Intensive Care of Acute Stroke - St. Louis City Hospital

Third Year
$63,831

This project was initially supported during April 1970. It is currently supported for an 11-month year (ending 9/30/71) at the $55,690 level. One year of continued support is requested to help solve three basic problems which were identified during the projects planning period. These are: 1) lack of intensive care facilities for the indigent stroke patient; 2) a lack of nurses trained in the necessary specialized techniques; and 3) a need to determine the effect of early intensive nursing care of the kind a modest-sized hospital can provide. A six-bed unit was proposed. Due to the usual alterations and renovation problems, opening of the unit was delayed until 12/70. Since that time and through April 1971, 71 patients have been admitted. (94% occupancy rate, 21 deaths.) To date, 15 nurses have received special training. The project is receiving regional as well as national inquiries. Phase out plans are not firm at this time.

Fourth Year
-0-

Fifth Year
-0-

Project #8 - Cooperative Regional Information System for Health Professions - St. Louis University - Medical Center Library

Third Year
$13,881

This project was initiated during June 1970. It is currently supported for the 11-month period, 11/1/70 - 9/30/71 at the $30,278 level. Two years of continuing support are requested. The primary objective is to make available up-to-date medical information to hospital libraries. Since the program was initiated 87 hospitals have joined the network, one workshop has been conducted (attendance 40), a field librarian has been added to core staff to coordinate the activity, evaluation techniques are to be developed. Phase out is planned in terms of charges, on an ascending scale, for subscriptions, photocopy service and tuition for workshops.

Fourth Year
$7,621

Project #12 - Coronary Care Training Program for Nurses - St. Louis University — Requested Second Yr. $58,902

This activity was initiated during December 1970 utilizing $64,293 of carryover funds. This amount has since been reduced to $60,293.

The Region now requests two continuing years of support.

Since December, and through the time this application was prepared, the program has been staffed, equipment installed and a classroom has been renovated to simulate a mock C.C.U. Three courses which are to train a total of 30 nurses are scheduled for April, June and August 1971. This activity is related to the Region's second priority - to develop programs to make appropriate allied health manpower available throughout the Region.

The November 1970 Council policy as it relates to CCU's and training for CCU's is quoted:

"Coronary Care units: Council affirmed that although coronary care units are now established community resources, Regional Medical Program funding units may be desirable when such units make important contributions to regionalized improvement in medical care, including overall efficiency and cost and when projects are planned to disengage from Regional Medical Program support promptly. To qualify for Regional Medical Program assistance, coronary care unit projects must also meet the following conditions: (a) An organizational structure and staff capable of implementing a high quality system must be present; (b) the mechanisms for entry into the system require development; and (c) RMP funding does not finance established technology, equipment, or patient service operations.

Training for coronary care units: Council requested RMPS to instruct all Regional Medical Programs having coronary care unit training projects to disengage Regional Medical Program funding at the end of their current project periods or within a reasonable period thereafter as noted above."

Third year - $61,471

Continuation of Projects Beyond Approved Periods of Support (Renewals) — Requested Second Year $232,652

Project #9 - Health Surveillance, Health Education and Health-Care Accessibility for a Low-Rent Urban Housing Project - Pruitt - ICOE
Men's Progressive Medical Action Program Inc.

This activity is currently funded for one year (11/1/70-9/30/71 - 11 months) at the $131,605 (D.C.) level. This application requests renewal for three years.

The proposal was originally reviewed by the July 1969 Review Committee who believed that while the project represented an area of great health needs, more planning was needed. The Review Committee recommended disapproval, with encouragement to revise and resubmit the application. However, the August 1970 Council, while recognizing the validity of the Committee's questions and reservations, felt approval of one-year funding equal to that requested ($143,492), would enable the Region to pursue the planning necessary for the submission of another proposal for its operational support.

Also, staff in its review of this application as a part of their total recommendation to the Director, RMPS partial funding contingent upon the August 1971 Council's review and approval of the renewal request. This recommendation would provide Council with the opportunity to again review the activity with reference to the Region's total program. The activity has the approval of the Executive Board of the Model Cities Agency. The original objectives of the program were to make better medical care available to the residents of a low-income housing development and to raise their health education and awareness levels. Also, the activity is to be an attempt to introduce the population into the existing health care system. Pages 97 and 98 contain both a progress report and triennial plans for the project. The budget escalates approximately $100,000 second year over first. Personnel accounts for $179,726 of the total second-year request of $232,652. The project is included in the Region's second highest priority ranking to develop a comprehensive strategy for the delivery of health care, etc.

third year - $251,821 fourth year - $258,529

N.A.C. Approved Projects Which Have Not Previously Been Funded

Project #13 - Rehabilitation for Patients Who Have Had a Myocardial Infarction - Washington University School of Medicine — First year $73,800

This activity was approved during the July 1970 Council. Three Years of support are requested. The objectives are to: (1) Provide patients (in the St. Louis area) who have had a myocardial infarction, with rehabilitation services which will help them return to an active productive life; (2) Educate members of medical and lay communities regarding the benefits patients can derive from coronary rehabilitation procedures. Approximately 250 patients (physician referrals) are expected during the first year, 300 for each of the following two years. The program is to provide initial patient evaluation, diet therapy. First-year costs include $55,659 for personnel: cardiologist - director, exercise physiologist, medical technician, physical therapist and secretary.

second year - $64,140 third year - $67,167

Project #14 - Clinical and Cytological Detection of Cancer in an Indigent Female Population
St. Louis University — First Year $60,000

The Region was notified by letter on January 20, 1971, that Council's original policy to not fund cancer programs which had formerly been funded under 314(e) had been reconsidered. Therefore, this program is now being held as approved/unfunded. Three years of support are requested. The proposal merges two discontinued projects and provides not only screening for cervical cancer but also for breast and rectal cancer. Screening clinics are to be held three times per week in St. Louis University Hospital and in St. Louis city and Homer G. Phillips Hospitals four times a week. Additionally, the DePaul, St. Louis Chronic, St. Louis State Hospitals and St. Mary's Health Center Mobile Unit will provide screening for indigent neighborhoods in St. Louis and East St. Louis. As estimated 60,000 are to be screened over a three-year period.

The three-year direct cost total is $380,000. Negotiations are in progress to split the costs among several agencies (model cities) with Bi-State RMP's share projected at $180,000 over the 3-year period.

second year _ $60,000 third year - $60,000

Project #15 - Coordination for Public Education Programs on the Harmful Effects of Cigarette Smoking
Bi-State Inter-Agency Council on Smoking and Health — First Year $35,390

This project was reviewed, and not disapproved but considered of low priority, by the May 1971 Council. Three years of support are requested. The project has a single objective which is to improve coordination of the Bi-State Metropolitan Area (a total of six Missouri and Illinois Counties) efforts in public education on the harmful effects of smoking. The 3-year descending scale budget includes initial full support for a coordinator and secretary plus the usual expenses. During the 3rd year, support is requested only for the salary of the coordinator.

Basically evaluation will be in terms of local support received.

second year - $20,988 third year - $15,000

Project #16 - Develop a Model for Testing Effectiveness of Physician Continuing Education Programs in Terms of Patient Management - Bi-State RMP — First Year $16,750

This project was reviewed and approved by the May 1971 Council as an especially interesting proposal. Three years of support are requested. The program has two objectives which are to: (1) determine the feasibility and acceptability to practicing physicians of an experimental system for ascertaining patterns of patient management from hospital record analysis and (2) test the usefulness of such patient management analysis to faculty and local physicians in planning education programs.

The RAG regards this project as possibly one of the Region's important achievements. In addition to having a low dollar cost, this activity represents to the local review body acceptance of the RMP as competent to exert leadership among professionals, in this instance, the physician staff of three hospital areas.

The project was voted the highest priority of any Bi-State proposal to date. The state medical societies of Missouri and Illinois have approved and/or commended the innovative character of the activity. The project has a good potential of becoming a complete regionalized activity.

second year - $15,850 third year - $15,850

Project #7 - Establish a Major Radiation Therapy Facility as Part of a Center for Comprehensive Cancer Care — First Year $365,681

Included in the application is a request for support ($365,681) during the fifth year (third year of triennium) for this project. The August 1969 Council approved this project with the following conditions and recommendations. "The Council was concerned about the use of large amounts of RMP funds for the purchase of expensive equipment and other costs of establishing patient service facilities. Especially because of the large amount of radiation equipment known to exist in the St. Louis area the Council would like to be reassured concerning the need for this new installation in serving the poor residents of the immediate area and in teaching and demonstrating good radiation therapy practices. Expenditure of RMP dollars in the equipment category is to be held until some further details and assurances can be submitted and reviewed by the Council." St. Louis University is to construct a $6 million building to house the facility and the expanded cancer treatment program. It is anticipated this will be completed in 1973. Therefore, the Region requests approval to defer funding of the program until October 1973 which will come during the third triennial year or the 5th year. The total request is $365,681. Of this total, $254,135 is for equipment. (Principal items are linear accelerator, X-Ray therapy simulator, tomograph and programmed console).

The request is further complicated by support requested for a second and third year which would occur in the Region's next Triennium.

In its review of this application members of staff believed that the Region should re-apply for this project at or near the time the facility is completed. This would provide Council with an opportunity to reconsider the program and satisfy its concerns regarding the original submission (equipment, etc.).

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 17, 1971

Reply to Attn of:

Subject: Staff Review and Action on May 27, 1971 of Triennial Application submitted by Bi-State Regional Medical Program, RM 00056 8/71

To: Director
Regional Medical Programs Service

THROUGH: Acting Deputy Director
Regional Medical Programs Service

Chairman of the Month

Chief, Grants Review Branch

Chief, Grants Management Branch

Acting Chief, Regional Development Branch

Recommendation: Staff recommends that the Bi-State Triennial Application dated 5/7/71 be approved for one additional year of support instead of the three-year program requested. Dollar support is recommended at the following level: total direct cost support at $924,113. This total represents the projected 1972 fiscal year level of $689,113 plus new funding of $235,000. Since this Region is potentially faced with a 28% reduction for its third year of operation, staff believed that the increase recommended would provide a more realistic funding base and could be used for: 1) maintaining essential core staff needed for the development of program activities which will specifically implement pertinent national health priorities, 2) provide the Region with some additional funds so that they may become more actively involved in the provision of catalytic functions, 3) implementing Project #16 - To Develop a Model for Testing Effectiveness of Physician Continuing Education Programs in Terms of Patient Management and for providing a portion of the renewal request for Project #9 - Health Surveillance, Health Education and Health Care Accessibility for a Low Rent Urban Housing Project which is, of course, contingent upon satisfactory review by the August, 1971 Council. In addition, staff recommended that a management assessment visit be conducted.

Staff Participating in Review

1) Mr. Robert Chambliss
2) Mr. George Hinkle
3) Mr. Joseph Jewell
4) Dr. Marian Leach
5) Mr. Spero Moutsatsos
6) Mr. Michael Posta

Current Funding

The Bi-State RMP is currently funded at $1,147,314 (total costs) for its 02 year which terminates September 30, 1971. This total includes the 12% reduction which was imposed on all Regions during April 1971. This amount, for an eleven-month period 11/1/70-9/30/71, represents new funding of $681,858 and an unobligated balance of $465,456 from the first year of the operational grant. Indirect costs of $272,231 are included in these figures.

Much to the surprise of the majority of staff attending the meeting, the Region has submitted an application requesting three-year support. Members of staff had been expecting a one-year application which would cover only the 03 year of the Region's initial three-year operational program. Based on this belief, no site visit had been planned.

The current application requests $1,449,269 (d.c.) for the Region's next year operating level. There are no new project activities included with the exception of the request for a developmental component. A $100,000 increase in core is essentially to provide for the present staff in addition to filling part-time associate director positions in the medical schools. (1/2 time-stroke-Washington University, 3-1/2 time associate directors in the fields of continuing education, health care systems, and community health, at the new Southern Illinois University School of Medicine) and a full-time Regional Field Coordinator.

On October 20, 1970, staff conducted its review of the Region's application for the (02) year. During the Review, a list of ten general concerns regarding the Bi-State RMP developed. These were:

1) The "turf" problem between the Bi-State, the Missouri and the Illinois Regional Medical Programs.
2) The assignment of a Bi-State field coordinator to the Springfield, Illinois area in view of the jurisdictional and geographic problems.
3) At what levels in the local review process, vetoes may be imposed-appealed.
4) The number (and types) of proposals which have been disapproved in the local review process.
5) The Region's evaluation methodology and the uses which are being made of the information.
6) How the proposed data collection system would actually strengthen the planning efforts of the Region.
7) The actual contribution toward the goals and objectives which was being made by the disease categorically assigned associate directors in the two medical schools.
8) A lack of reported impact that the currently funded operational projects have (or may have) on the improvement of the delivery of health care.

9) How (and why) some of the minimal requests for carryover ($200-$350) were processed through the local review system.
10) The Region's stipend level was not in line with Council's July, 1970 policy as it relates to stipends, travel, etc., for short-term traineeship.

During its review of the current application, staff believed that the Region had satisfied some of the above concerns. For example, the Region has employed a full-time planning director who is to be responsible for program evaluation. While it is obvious that this individual has made a beginning, staff believes the Region will need additional time to develop a method of self determination and seek answers to the following questions:

1) How is evaluation used by the RAG in decision making?
2) Have projects (or studies) been terminated or returned as a result of the evaluation process?
3) At what point does evaluation come into plan in the operation of the program?
4) What is the relationship of the core staff responsible for evaluation to the Regional Advisory Group?

Also, the Region has made an effort to "solve" the Illinois-Bi-State RMP turf problem by describing a seven-county area surrounding Springfield, Illinois (site of part of new S.I.U. Medical School) as a local determination area. The Region reasons this should leave reasonable flexibility to communities which are uncertain of their position and still provide sufficient definition to allow each RMP to plan for allocation of limited resources.

Staff was aware of the fact that during the time the anniversary application was being prepared redirected National Health goals and priorities were emerging. This was one of the factors upon which staff recommended (03) year continuation rather than consideration of the three-year program requested.

On September 1, 1970 the Bi-State RAG adopted four general program priorities. The highest priority, at that time, was "Improvement of Health Care Delivery" which included improved systems for delivery of health care services to the medically disadvantaged. On March 22, 1971 the program objectives and priorities were modified (or changed), and objective priority Rank #1 was assigned to Physician Manpower with the regional objective "to develop programs aimed at correcting the lack of physician manpower services in parts of the Region." Similarly, #2 was assigned to allied health manpower with a regional objective "to develop programs to make appropriate allied health manpower available throughout the Region." While the Regional Advisory Group now has designated health manpower as the main thrust for the RMP, this application does not reflect this priority. It appeared to staff that

the RAG has failed to operationalize its priorities. This then raised a question of on what basis does the RAG establish priorities? In this connection the recently reviewed supplemental proposals (May, 1971 Council #15 - Smoking and Health and #16 - Physician Continuing Education Program) do not appear to concern themselves with meeting manpower shortages or improving the accessibility and availability of health services within the Region. It appeared to staff that the Region has not had sufficient time to translate priorities into project proposals concerning explicit criteria against which project proposals are reviewed.

Staff, again realizing this application was prepared during a period of transition, noted the heavy categorical emphasis of the associate directors who are supported (all 1/2 time) as a part of Core in the Washington University and St. Louis University Medical Schools. Three associate directors in heart, cancer and stroke are currently supported at the St. Louis University School of Medicine while Washington University has two associate coordinators in heart and cancer. The stroke position at Washington University is vacant. Continued support is requested for all these positions.

In arriving at its recommendation, staff believed that the Region might wish to utilize the one-year period to realign and recast some of its personnel to more accurately reflect the current mission of RMP.

While there was some confusion as to how one would relate the Bi-State goals and objectives to the "1971 Philosophy", there was a general agreement that the budget request had "missed the mark." A categorical approach appears to remain evident in the numbers of core staff requested for the three medical schools. The projects which have been approved but not funded and those programs for which continuation is requested appear to lack innovation and to be more of the "same old thing." While it is known that the Region has strived for and gained consumer participation in its program, evidentally more time is needed for this group to have an influence on the program. Most of the funds requested are destined for institutional rather than community ventures where a large majority of health services gaps appear to exist.

After a long contentious period of review, the majority of staff believes that the Bi-State RMP is not yet ready to "pass the test" for triennial status. Rather, staff recommends continuation of one more year at an increased level from the present book commitment forecast for this Region which now stands at 28% below the current (02) year funding level.

Staff further recommends that Project #9 - Health Surveillance, Health Education and Health-Care Accessibility for a low-rent urban housing project be considered for renewal during the August, 1971 meeting of the National Advisory Council. This project was recommended for approval for one-year by the August, 1970 Council. The one-year period was to enable the Region to pursue the planning of such a program preparatory to the submission of another proposal for its operational support. The Region

has supported the project through 9/30/71 ($131,605 d.c.) with Model Cities earmarked funds which were obtained from the (01) year unobligated balance. Staff singled out this project for special consideration for the following reasons:

1) It is based in a community rather than institutional setting.
2) It is in line with the current mission of increasing availability of care, enhancing its quality and moderating its costs--making the organization of services and delivery of care more efficient.

In summary, Staff believed that the one-year continuation period will provide the Region with the opportunity to objectively reconsider and restructure itself more in line with the national health goals. Staff believes that its recommendation follows an honest and thoroughly thought-out appraisal and is based on a belief that the Region contains the necessary strengths and talents to make a visible impact in improving the health care system. The continuation in time, coupled with the new funds recommended, may provide the necessary catalyst to enable the Region to present a "new Look" triennial application in May, 1972.

Joseph T. Jewell
Public Health Advisor
Grants Review Branch

Action by Director Approval

Initials TJM

Date 6/22/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

BI-STATE REGIONAL MEDICAL PROGRAM
RM 00056 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: The Review Committee concurred with staff's recommendation that this triennial application be approved for one additional year instead of the three years requested, and that additional dollars be provided to the Region. The request for Developmental Component Funds was not approved.

OPERATIONAL YEAR	REQUEST (D.C.)	RECOMMENDED FUNDING (D.C.)
03	$ 1,449,269	$ 924,113
04	1,247,099	-0-
05	1,587,983	-0-
TOTAL	$ 4,284,351	$ 924,113

CRITIQUE: The Review Committee noted that the Region has one additional year of committed support remaining from its initial operational program period. It was agreed that the submission of this triennial application was premature; a one-year continuation application would have been more appropriate. In arriving at its recommendation, the Committee considered and agreed with the review and recommendations of staff in its review of the triennial application. "Staff believed that the one-year continuation period may provide the Region with the opportunity to objectively reconsider and restructure itself more in line with the national health goals. Staff further believed that the continuation in time, coupled with the new dollars recommended, may provide the necessary catalyst to enable the region to present a 'new look' Triennial Application next year."

The reviewers believed that the Bi-State RMP has many strengths such as a good committee structure (although their real involvement in RMP is vague), an apparently well balanced rather strong Regional Advisory Group and qualified leadership. However, they suggested

that the Region be advised of their concerns in relation to the following problem areas and deficiencies:

1) The fragmentation of the Region in relation to the Illinois and Missouri RMP's. A perfect example of this is the Springfield, Illinois area which is torn between the Illinois and the Bi-State RMP.

2) The continued categorical emphasis of the program in view of its newly established program priorities.

3) The Committee suggests that the Region's operational projects need a very close review. The heavy emphasis placed on the provision of expensive radiology equipment was particularly cited.

4) The Committee was concerned about the actual contributions to the RMP effort being made by the three categorically (Heart, Cancer, Stroke) assigned associate directors who are currently supported for 50% of their time or effort in both Washington University and St. Louis University Schools of Medicine. This is particularly important since the Region has requested support of three additional half-time associate directors in Continuing Education, Health Care Systems and Community Health in the new Southern Illinois University School of Medicine. It was suggested that the Region establish RMP related job descriptions for all of these individuals.

5) While not unique to this Region, the reviewers believe that its evaluation could be strengthened if more emphasis were placed on "outcome" methods and procedures.

6) The reviewers noted the vagueness and lack of detailed planning for the future of the program. For example, the triennial application contained no new proposals with the exception of a request for a developmental component.

7) The Committee strongly suggests that the Region immediately take whatever steps are necessary to insure local (or other support) for the continuation of its operational projects.

Rationale for Funding Recommendation

The Review Committee concurred with staff's funding recommendation and recommends one additional year of support instead of the three-year funding requested. Dollar support is recommended at the following level: Total Direct Cost support at $924,113. This total represents the projected 1972 Fiscal Year level of $689,113 plus new funding of $235,000. Since the Region is potentially faced with a 28% reduction for its third year of operation, it was believed that the $235,000 increase recommended would provide a more realistic funding base and could be used for: 1) Maintaining essential core staff needed for the Development of Program activities which will specifically implement pertinent national health priorities; 2) provision of sufficient funding to permit more active involvement

in their catalytic functions; 3) Implementation of Project #16 - To Develop a Model for Testing Effectiveness of Physician Continuing Education Programs in Terms of Patient Management and for partial support of the renewal request for Project #9 - Health Surveillance, Health Education and Health Care Accessibility for a Low Rent Urban Housing Project. The Review Committee singled out these two projects for special consideration. The innovative and unique qualities, at a modest cost of the continuing education program were cited. Project #9 is based in a community rather than in an institutional setting and, more important, is in line with the current mission of increasing availability of care, enhancing its quality and moderating its cost--to make the organization of services and delivery of care more efficient.

One member of the Committee had questions about the physical fate of the Pruitt-Igoe Housing Project in St. Louis, the site for Project #9. On a recent television program (First Tuesday) it was indicated that the housing project might be torn down because of extreme vandalism. Staff has contacted both the H.U.D. offices in Washington and the St. Louis F.H.A. area office. It was learned that although the City of St. Louis has requested that the housing project be demolished, the request has been denied. "Plans are currently being developed to restore the units." Approximately 500-600 families are still housed in the project.

RMPS/GRB
7/14/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

CALIFORNIA MEDICAL EDUCATION AND
RESEARCH FOUNDATION
693 Sutter Street
San Francisco, California 94102

RM 00019 8/71
July 1971 Review Committee

PROGRAM COORDINATOR: Mr. Paul D. Ward

Award Statement figure

This Region is currently funded at ~~$6,995,574~~ 6,992,247 direct costs. Of this amount, 99,083 ~~$703,509 is~~ reauthorized unspent funds from prior years. Its current level of support is $6,292,065 and this level is expected to prevail as a maximum for the upcoming fourth operational year unless additional RMPS funds become available. At the time overall fiscal constraints required budget retrenchment by all regions, this Region was operating at ~~$7,548,457~~ 7,767,372 direct costs.

This application is the "second chapter" of the Region's triennial application. It focuses primarily on the matrix the operational activities form in the Region's total program. The first chapter of the triennial application was submitted to the January/February review cycle. It presented primarily a request for an expanded Core activity (for staff to coordinate with CHP and Model Cities) and a Developmental Component. Although increases were approved, RMPS budget constraints prohibited their funding. Therefore, the Region has had to redesign both the Core activity portion of the triennial plan and its former design for an operational activity matrix in order to retrench to a $6.2 million level. The refashioned Core activities are included in this application to show their redesigned, complementary functions under California's retrenched funding.

The application includes:

I. Progress reports on 10 terminating projects. (These are not terminal reports covering the entire life of these activities--they will be ongoing until August 1971.)

II. A redesigned plan and budget for continued funding of the nine Area Cores and the Central Office.

III. Requests for continuation within the approved period of support for 12 operational activities.

IV. Requests for continuation beyond the approved period of support for two operational activities.

V. A request to activate 17 previously approved but unfunded operational activities.

VI. A request for the approval of ten new operational proposals.

VII. A new Central Office activity for a Regional Kidney Disease plan.

FUNDING HISTORY (Direct Costs Only)

Planning Stage

Grant Year	Period	Funded (d.c.o.)
01	11/1/66 - 12/31/67 (14 mos.)	$1,368,137
02	1/1/68 - 2/28/69 (14 mos.)	$2,613,500

Operational Program
(Overlaps with planning stage)

Grant Year	Period	Funded (d.c.o.)
01	7/1/68 - 6/30/69	$2,917,144
02	7/1/69 - 8/31/70 (14 mos.)	$8,012,055
03	9/1/70 - 8/31/71	$7,548,457*

*An award statement reducing this amount to $6,292,065 plus $703,509 reauthorized unspent funds will be issued shortly.

GEOGRAPHY AND DEMOGRAPHY: The Region is coterminous with the state, except for the Reno and Las Vegas, Nevada areas which are "shared" jurisdictionally with the Mountain States and Intermountain RMP.

The Region is divided into nine Areas, each centered around a medical school. The total land area is 156,573 square miles, with a population of 19,953,100 (1970). The population spread is 80% urban, with a median age of 30. The racial distribution is 89% White, 7% Negro and Other 4%.

The Region has nine medical schools, and one of the most recently established was a result of joint efforts of the Drew Medical Society (the NMA affiliate in this area of Los Angeles) and the UCLA and USC Schools of Medicine (Areas IV and V). There are 62 nursing programs, including 42 that are collegiate. There are 20 medical technology programs and 615 hospitals with a total of 138,722 beds. The majority of these are non-federal, short-term hospitals.

There are approximately 35,224 physicians in the Region, including all but about 100 Osteopaths, and about 91,961 nurses, of whom 57,700 are active.

HISTORY OF REGIONAL DEVELOPMENT: With the passage of PL 89-239, committees were appointed at UCSF, UCLA, Stanford and USC to study the legislation.

The California State Department of Health organized the "California Coordination Agency for Training, Research, Education, and Demonstration in the Field of Heart Disease, Cancer, Stroke and Related Diseases." This agency included representatives from the California Medical Association, the California Hospital Association, and the Deans of the eight schools of medicine. The Agency was organized with the purpose of developing an "overall plan" for cooperative medical arrangements throughout the State. Planning

for developing regional medical programs was to proceed at each of the participating medical centers. The Coordination Agency would "develop suggestions" to delineate geographic areas of responsibility for each of the medical centers, and would coordinate and mediate other questions. The proposed method of operation relied heavily on systems analysis techniques.

The Agency submitted an application outlining its structure and goals, as described above. At this time, the Agency Chairman was Dean Robert Glaser of Stanford, and the Project Director was to be Dr. Nemat Borhani of the State Department of Public Health.

Reviewers criticized the proposal, feeling that it was "poorly tied together", had a vague chronological plan for development, and overemphasized systems analysis.

The major question raised by the application was the creation of a "mega-region" -- a question not discussed in PL 89-239.

The Office of Legal Counsel advised against RMP creating a central agency unless it were to coordinate a group of "subregions". The Region decided on this kind of structure and UCLA withdrew the planning application it had independently submitted. The various medical centers agreed to reconsider at a later date whether to break up into several regions--perhaps before receiving operational grants.

A revised application, incorporating the recommendations of the site visit team and the National Advisory Council, was submitted. The coordinating agency became a nonprofit corporation and changed its name to California Committee on Regional Medical Programs (CCRMP). The grantee became the California Medical Education and Research Foundation (CMERF), a second nonprofit corporation, the fiscal arm of CCRMP, with its own staff.

The Region's first Planning grant in the amount of $223,400 was made in November 1966 and Mr. Paul Ward was appointed Program Coordinator in February 1967.

Another site team visited the Region in February 1967 and expressed concern about the apparent lack of cooperation among the sub-regions and little evidence of overall planning.

The Region organized along the lines of its original plan and a site visit team went out in March 1967 to review progress and the "revised application". The full year award for planning included the Areas of UCSF, UCLA, USC, CMA and CHA. Three supplemental planning grants during the first year added the Areas of Davis, San Diego and Stanford.

The first operational application indicated that each Area had begun to forge meaningful cooperative relationships within the community it served. There seemed to remain a lack of interaction between Areas, and total regional planning and direction were had to discern.

The Region's first operational grant was made effective July 1, 1968, including nine projects out of a total of 21 submitted. The same award included a new planning area for the Northeast San Fernando Valley.

In April 1969, a special site visit to each of the Areas, for a total of five days, was organized for the purpose of evaluating progress of the overall program and to review in depth the individual Core staff requests. The site team was impressed with most of the Areas, particularly Areas I, III, IV, V, VII, and VIII. Most impresive was the evidence of true peripheral involvement. During the visit Area IV (UCLA) raised the question of the possibility of making each Area a separate Region; there was little support for this position outside of Area IV.

Subsequent review cycles have included supplemental project requests from this Region, resulting in several program and technical site visits.

With the award of the continuation for the third operational year, on September 1, 1970, the Region is supported at the direct cost level of $7,548,457, which includes a carryover from previous years unexpended balance of $480,168. The current base level is $7,068,289.

THE REVIEW & DECISION-MAKING PROCESS: The CCRMP review process has three stages: (1) determination of Area need (by the Area); (2) technical review (conducted by a panel responsible to CCRMP; and (3) regional consideration and priority setting.

The review system has been operative for sometime and evolved from a great deal of study by the Committee on Organization and Procedures. The process begins when the Area Core Office notifies CCRMP that a proposal is in its final stages of development. A Staff Consultants Committee then recommends the precise categories from which an ad hoc review committee is established for the proposal. The latter is drawn from the Regional Technical Review Panel, composed of individuals from each Area in various categories -- heart disease, cancer, stroke, etc.

The ad hoc Review Committee meets with the Coordinator, his staff and the author of the proposal. The proposal is examined from the standpoint of overall appropriateness in terms of personnel, facilities, relationships, etc., and if found to be technically sound, it goes to the Area Advisory Group for approval, then to CCRMP, with a summary of the technical review. Only if there is conflict between the Area Advisory Committee and the Technical Review Committee will the CCRMP be expected to bring additional considerations into its decision to approve or reject. Normally, CCRMP will only examine how the proposal fits into the regional design, and what priority it should be given.

The Evaluation procedures were developed through the joint efforts of CCRMP central staff, headed by Dr. Jack Thompson, and an Evaluation Committee of the RAG. This committee has been responsible for pointing out ways in which evaluation can take place, including how program objectives can be crystallized by utilizing evaluation techniques. Evaluation is now an integral part of planning from the inception of a project, with assistance and guidance provided by the CCRMP central staff.

INTER-AREA PLANNING ACTIVITIES: Stimulated by Review Committee and Council concerns and questions about this element of communication between Areas, region-wide committees are appointed as required to assure coordination between Areas and projects. Monthly meetings of Area Coordinators are held and serve as forums for planning. In addition, there is planning between given groups--i.e., nurses, stroke activities, etc. Another example, the Coronary Care Unit Committee meets about every six weeks to assure non-duplication of effort, sharing of educational programs, priority systems for participation and cost-sharing a common registry, etc. There is increasing evidence that sincere, coordinated, statewide efforts are addressing common problems throughout the Region, with a resultant lessening of Area autonomy.

REGIONAL ADVISORY GROUP: This Group is called the California Committee on Regional Medical Programs (CCRMP). It is a heterogeous body including the Deans of the nine medical schools and two schools of publich health, the Director of the State Department of Health, and representatives of the California Medical Association, the California Hospital Association, the California Heart Association, the California Division of the Cancer Society, TB and Respiratory Disease Association and representatives of the public.

Dean Clifford Grobstein of the University of California San Diego Medical School, serves as Chairman of the Committee on Organization and Procedures. As an outgrowth of this committee's studies, the CCRMP, through the Coordinator's staff, has assumed a more active role in assisting the Areas in developing local objectives and priorities.

The question of whether California should be one Region or several has been discussed many times by CCRMP, and agreement continues that a confederacy of Areas creates a statewide cohesiveness and coordination not easily obtainable otherwise. This position has always been supported by spokesmen from the Heart Association, Hospital Association and other public representatives on CCRMP. It is also generally agreed that any administrative difficulties can be adjudicated.

The CCRMP has turned greater attention during the past year to activities organized to help provide a service function for the public. Manpower development and means of developing services where they do not exist are concerns receiving more concentrated attention. Health provider interests give strong support to CCRMP, but RMP activities have been increasingly influenced by representatives of the general public.

BACKGROUND: The anniversary date of the California RMP is September 1. Under the RMPS anniversary review system, this Region's single, annual application is scheduled for the July/August review cycle. However, during the year of transition to the anniversary system, regions with anniversary dates of September, October, November, December and January were permitted to submit an additional application to one of the earlier review cycles. The California Region opted to submit an application to the January/February 1971 review cycle.

The main feature of the optional application was that it constituted the Region's triennial plan for the Core portion of the entire program. Californias Core support was in its final year of commitment, and the Region's rationale for its early proposal for Core renewal basically was two-fold:

1. Under its option, California was requesting a Developmental Component and an expanded core funding. If approved, it hopefully could be funded for the last half of the ongoing year as well as the succeeding triennium. And, because the expanded Core requests were for funds to increase staffs for coordination with local CHP agencies and Model Cities programs, the Region presented a 3½ year design.

2. As the Region stood at the time it submitted the optional application, its level of funding was $7.5 million and its commitment for the next year dropped to $1.7. It had amassed such a large pool of approved but unfunded activities (and had 21 additional proposals in its own review process) that advice from national headquarters on a total program level was needed.

Staff responded with the decision that the Region should be site visited for the following purposes:

1. to determine the Region's readiness for triennial review
2. to examine the proposal for a Developmental Component
3. to assess the request for renewal of the nine Area Core staffs and the Regional headquarters.
4. to develop a recommended level of total program support for the next 3½ years.

The visit took place December 7-9, 1970 and the site visitors' recommendations were:

03 - $8,363,994*
04 - $9,044,526
05 - $9,451,752
06 - $9,879,340

The Review Committee was not comfortable with the site visitors' recommendation. Some members were reluctant to set a program level for future years that included committed funds for operational projects not to be submitted until the following review cycle. However, some Committee members pointed out that the program level would set a maximum and not a minimum and that the Region already had approved but unfunded activities that nearly matched the figure proposed by the site team. Finally the Committee recommended that the Developmental Component be approved at an annual rate of $400,000, that Core be renewed at the increased level recommended by the site visitors

*The team recommended this for the annualized amount realizing that the increase would operate only for the last half of the year.

($3,878,346), that the level for operational activities be continued at the then current amount of $4,085,648; and that this total program level ($8,363,994) be continued for 18 months which would allow for review of the second portion of the Region's program (the operational activities) at the July/August review cycle.

Council's action differed from Review Committee's recommendations in the number of years of funding recommended. Council concurred with the site visit team that this Region needed guidance from Council regarding overall level of funding to be anticipated before submitting an application for three-year funding to the July/August cycle. Council approved the $8,363,994 level for the Region's 04, 05, and 06 years.

In April 1971 all regions were notifed that retrenched funding was required due to overall fiscal constraints. This Region was advised that its current level of funding must be reduced to $6,220,094 for its ongoing third operational year and that the retrenched funding would continue into its upcoming fourth operational year if fiscal 1972 RMPS budget allotments are not increased.

This Application

The California Region has responded by submitting two designs--one presenting their plan for operating on a $6,220,094 budget, and another requesting approval of a $10,043,175 plan from which the Region would select activities to be funded within the Council approved $8,363,994 level should additional RMPS funds become available.

The $6.2 proposal shows decreasing budgets for the future years of the triennium. It is presumed that portions of the $10 million plan would be activated in future years to maintain the $6.2 level. This is a point the site visitors might want clarified.

The Region's goals, objectives and priorities, as well as its Area and regional review processes, were studied during the December visit. Also considered in December was the Region's concept of expanding its nine Area Core staffs for coordination with local CHP and Model Cities offices and the proposed use of Developmental Component funds.

The portion of the program to be reviewed at this time basically is the operational activities proposed and the resulting program matrix these activities form. However, Core activities are again included in this application for two basic reasons; many of the operational activities the Region had planned to undertake requiring funding in excess of $6.2 million must now be redesigned and shifted to the Cores; conversely, many of the activities described in the former optional application based on expanded Core staffs must be either redesigned or abandoned.

In arriving at its decisions on the selection of activities both for the $6.2 million and the $10 million plan, the Region made choices for funding both from its pool of approved and unfunded activities and from proposals approved by the RAG at its last meeting.

Generally, the decisions may be grouped as follows:

1. Continuation of ongoing activities:

In order to retrench to the $6.2 level, the 12 continuing projects have been selected for funding at a direct cost level of $1,456,549 rather than the $1,739,000 level for which the Region has a commitment. The reduction was not achieved through an across the board cut; selective reductions were invoked.

Under the $10 million plan, the 12 continuing activities have been partially restored to a $1,515,657 direct cost level.

2. Renewal of terminating activities:

Of the 12 terminating activities, two have been selected for renewed support requests at a combined direct cost level of $456,000 under the $6.2 plan. the $10 million design requests a $475,000 level for these two projects.

3. Activation of previously approved but unfunded projects:

The $6.2 plan proposes the activation of six such projects at a total direct cost level of $264,000. These six projects were selected from a pool of approximately 25. All of these projects are being proposed for activation at levels below Council approved amounts. One is an alternate to a renewing project (#25) which is also being considered for funding by OEO.

The $10 million design proposes the activation of 17 approved but unfunded projects at a total direct cost level of $1,888,098.

4. New proposals submitted for approval:

Three new proposals are submitted under the $6.2 plan requesting a combined direct cost level of $229,440. They were selected from a group of 12 activities approved by the last RAG.

Ten new proposals seek a combined direct cost funding of $1,094,091 under the $10 million plan.

5. Core support:

No previously approved increases for the nine Area Core staff expansions or to the Central Office are allocated under the $6.2 million plan. All cores, the Central Office and the CMERF Office are to be supported at a combined direct cost level of $3,380,185.

The $10 million design provides increases for all Cores, the Central Office and a small increase for the CMERF Office. The combined level of direct cost support under the $10 million plan is $4,548,409.

6. The Developmental Component:

The $6.2 plan reduces the Developmental Component to $384,000 while the $10 million plan restores it to $400,000.

7. The Regional Kidney Disease Program:

Both plans propose a direct cost budget of $121,920 for the support of this activity. The original renal proposal was based on a $760,880 total plan and only portions of it will be possible under both designs. The kidney proposal will be reviewed by an ad hoc panel at the national level prior to the July/August Committee/Council meeting.

The following chart compares the total Regional proposal under the two plans and groups the activities by type of request. The remainder of this summary will attempt to describe the application via an Area by Area approach in order to place the operational activities in a local setting with the individual Core staffs. The agenda for the June 10-11 site visit has been structured in a Southern California/Northern California fashion with a portion of both the first and the final day scheduled for total regional discussions.

Beginning on page 36, there is a fiscal breakout chart showing the Region's $10 million plan for their 04, 05 and 06 years.

The total Regional Proposals (under both the $6.2 and $10 million plans,) are charted below grouped by type of request:

	$6.2 Plan	$10.0 Plan
Continuation within approved period of support		
Central Office	$ 391,090	$ 457,426
Regional Kidney Plan	121,920	121,920
CMERF Office	49,003	53,596
Developmental Component	384,000	400,000
Area Cores		
Area I	538,404	666,712
Area II	214,435	334,288
Area III	264,893	433,450
Area IV	705,149	888,497
Area V	575,481	743,771
Area VI	157,456	244,526
Area VII	149,536	256,818
Area VIII	181,344	284,767
Area IX	153,394	184,558
All Cores, Central Office, CMERF & Dev. Comp.	$3,886,105	$5,070,329
Continuation within approved period of support		
Operational Activities		
#15 - Area I Cancer	$ 234,864	$ 244,650
#23 - Area V Chronic Respiratory	78,112	81,367
#25 - Area I Rehab & Continuity	143,246	149,215
#27 - Area I Rural Hospitals	66,562	69,335
#28 - Area VIII Comprehensive Stroke	230,874	240,494
#30 - Area VII CCU	75,982	79,148
#37 - Area III Stroke	100,794	105,000
#43 - Area I Stroke	172,598	179,790
#45 - Area II Stroke	72,000	75,000
#46 - Area III San Joaquin	153,655	160,000
#50 - Area V Pacemaker	56,390	57,208
#52 - Area VI Perinatal	71,472	74,450
All continuation projects	$1,456,549	$1,515,657
Continuation beyond approved period of support		
#6 - Area IX Drew School	$384,000	$400,000
#24 - Area IV N.E. Valley	72,000	75,000
All renewing projects	$456,000	$475,000

	$6.2 Plan	$10.0 Plan
Approved but Unfunded Projects		
#27S - Area I Family Practice	-0-	$ 55,740
#41R - Area I Regional Monitoring	-0-	35,446
#44R - Area I Oncology C.E.	-0-	184,091
#54 - Area VIII Rapid Hospitalization	$ 48,000	50,000
#56 - Area VIII CRIS	19,200	20,000
#60 - Area VI Medical Information Service	-0-	39,388
#62 - Area VII CE for MD's	-0-	120,416
** #63 - Area IV Perinatal	72,000	96,232
#64 - Area IV MD's CE	-0-	68,892
#66 - Area VII REACH	-0-	231,014
#67 - Area I Respiratory Disease	-0-	266,240
#68 - Area II Compendium	52,800	55,000
#69 - Area VII Respiratory Disease	62,400	65,000
#70 - Area II Allied Health	-0-	50,400
#71 - Area IV Respiratory Disease	-0-	177,159
#72 - Area VIII Radiology	-0-	71,957
#73 - Area III Oncology	9,600	301,123
All Approved/Unfunded activities	$264,000	$1,888,098
New Proposals:		
#75 - Area I Indian Health	$120,000	$127,409
#76 - Area I Hypertension	-0-	190,133
#77 - Area I Intensive Care	-0-	190,000
#78 - Area III Oral Health	-0-	105,210
#79 - Area IV ECF	60,480	62,321
#80 - Area V Computerized ECG	-0-	95,334
#81 - Area V Indian Health	48,960	51,000
#82 - Area V & IX Intensive Care	-0-	81,000
#83 - Area V Free Clinic Coordination	-0-	80,000
#84 - Area VIII Neonatal IC	-0-	111,684
All new proposals	$229,440	$1,094,091
Sub Total	$6,292,094	
	- 72,000**	
Grand Total	$6,220,094	$10,043,175

**This project is an alternate to project #24.

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

Central Office

Executive Director: Mr. Paul D. Ward

Deputy Director: John A. Mitchell, M.D.

Total Population - 19,953,100

Present Funding (includes CMERF) $492,956 (includes $69,945 carryover)

Requested Funding	Plan A	Plan B
Central Office	$391,090	$457,426
Regional Kidney Plan	121,920	121,920
CMERF Office	49,003	53,596
Developmental Component	384,000	400,000
Total	$946,013	$1,032,942

The Regional Advisory Group in this Region is known as CCRMP (California Committee on Regional Medical Programs). It is composed of 35 members. CMERF (California Medical Education & Research Foundation) a subsidiary of the California Medical Association, is the grantee organization. There is also a very active Committee of Staff Consultants, which in many ways operates as a Steering or Executive Committee. It is composed of a Chairman (Mr. Ward), each of the Area Coordinators, and a representative from each of the member groups on the RAG. This committee has 24 members and met eleven times last year. The Region operates 23 standing committees or sub committees.

The Central Core staff operates with 14 full-time employees. In addition to the Director and Deputy Director, it includes three Associate Directors and Coordinators for Evaluation, Planning and Review, and Administration.

The development of integrated staff relationships and effort with CHP and Model Cities, the contribution of RMP staff to the development of a California State Plan For Health, the strengthening of its regionalized staffs and advisory groups, and the development of the role of an impartial facilitator are highlighted as significant accomplishments of this staff. The activities of the Central Office are described on page 14 of this application.

The Regional Kidney Plan will be reviewed by an ad hoc technical panel prior to the July Review Committee meeting. A copy of the panel review will be available at the Review Committee meeting.

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

University of California - San Francisco -- Area I

Acting Coordinator: Elliot Rapaport, M.D.

Geographic coverage - 11 counties

Population - approximately 3,029,800

Present Funding

Core	$ 491,337
Projects	1,239,502 (including $54,985 carryover)
Total	$1,730,839

Requested Funding	Plan A	Plan B
Core Staff	$538,404	$666,712
Continuation		
#15 - Cancer - Phase I	234,864	244,650
#25 - Rehab and Continuity of Care	143,246	149,215
#27 - Rural Community Hospitals	66,562	69,335
#43 - Stroke - Area I	172,598	179,790
	$617,270	$642,990
Renewals	-0-	-0-
Approved/Unfunded		
#27S - Family Practice Program	-0-	$ 55,740
#41R - Regional Monitoring	-0-	35,446
#44R - Medical Oncology	-0-	184,091
#67 - Respiratory Disease	-0-	266,240
		$541,517
New Activities		
#75 - Indian Health	$120,000	$127,409
#76 - Hypertension	-0-	190,133
#77 - Intensive Care	-0-	190,000
	$120,000	$507,542
All totals including Core	$1,275,674	$2,358,761

The Area has a local Advisory Group composed of 36 members and approximately 70 Committees and Boards involving 1,000 persons. The Area Core staff numbers 41 full-time employees and 21 full-time equivalents. A summary of the significant Core staff's accomplishments begins on page 215 of the application. 41 employees, 21 professionals + 20 secretarial/clerical. Of the 21 professionals, 15.75 are full-time equivalents.

The Terminating Projects:

Progress Reports on four terminating projects are submitted.

Project #1 - Coronary Care Training - This project is completing its third year of support. Its objective is to improve skills in management of myocardial infarction in Coronary Care Units. It is a multi-faceted project with eight separate activities and is a federation of approximately 100 community hospitals. Progress on each activity is covered in the Region's standard reporting format which begins on page 246. No alternative continuation funding has been developed for this project. However, the experience gained through this operation has moulded the design of several new proposals.

Project #18R - Intensive Care Training - This project is completing its third year of support. It is presently funded at $50,000 direct costs. This project has been funded by "carryover funds held in escrow" and is not reflected in the total estimated expenditures reported. Progress on this activity is covered in the Region's standard reporting format which begins on page 297. This activity trains physicians in skills of cardiopulmonary intensive care.

Project #20 - Regional Hypertension Program - This project is completing its third year of support. Two of the participating institutions have agreed to take over the demonstration activities of the project. Progress on this activity is covered in the Region's standard reporting format which begins on page 302. The project provides education, consultation referral and follow-up, planning and registries.

Project #26 - Emergency CPR - This project is completing its second and final year. Funds from other than RMPS sources have been contributed to the project this year, and it is anticipated that the same sources will continue the activity after RMPS support terminates. Progress on this activity is covered in the Region's standard reporting format which begins on page 348.

The Continuing Projects:

Project #15 - Regional Cancer Program - This activity has been ongoing for two years and continues for one more. It includes four activity components and its progress is described beginning on page 279. It builds on a cooperative arrangement between the University of California, San Francisco, and Mt. Zion Hospital and Medical Center, building on the base of cancer teams. It includes Consultation Service, radiological physics service, data retrieval and an educational program.

Project #25 - Rehabilitation and Continuity of Care - This activity has been ongoing for two years and continues for one more. It includes three activity components identified as the Alameda-Contra Costa Project, the Sonoma-Mendocino-Lake Project and the Humboldt-Del Norte Project. Its progress is described beginning on page 327. The activity is directed toward the development of discharge planning systems, education programs for staffs of extended care facilities and hospital staffs.

Project #27 - Rural Community Hospital Demonstration - This activity has been ongoing for two years and continues for one more. It is a cooperative effort between the Community Hospital of Sonoma County, in Santa Rosa and the University of California San Francisco Medical Center. Its progress is described beginning on page 353. The project is beamed at the medical student, the resident, and the practicing physician to enhance Family Practice.

Project #43 - Stroke Program - This activity is just completing its first year of operation and continues for two more. It is composed of six sub-project activities and was activated in June 1970. Its progress is reported beginning on page 370. Its purpose is to provide the community with the means to develop a more effective health care delivery system for persons with symptomatic cerebrovascular disease.

Approved/Unfunded Activities:

No approved but unfunded activities are proposed for activation by Area I under Plan A. Four are proposed under Plan B. They are:

Project #27S - Family Practice Program - This activity builds on Project #27 and was originally submitted to the November 1970 Council. The Council deferred action to the site visit team (December 7-9). On-site inquiry disclosed that the proposal was a logical Phase II of the parent activity and that its extension to the indigent population of Sonoma County augured well for addressing the Region's priorities. The site visitors recommended its approval and the February 1971 Council agreed. This activity is proposed for activation only under Plan B. Form 15 covering this proposal is on page 239.

Project #41R - Patient Monitoring System - This activity was first submitted by the Region in August 1969, was returned for revision and has been submitted through three review cycles since, each time with a deferral action. Implementation of the changes required by the deferral actions was delayed by the illness of the proposer and necessary negotiations with the Lockheed Corporation on the circuitry aspects of the project. The Area proposers appear to have met the revision requirements and May 1971 Council deferred action to this site visit team for a recommendation as to whether this activity should be an approved component of the Region's program. It is proposed for activation only under Plan B. Form 15 covering this proposal is on page 240. The proposal here is to test a patient monitoring system and a program of education and training of hospital staff to use the system. RMP support is in the area of the educational benefits.

Project #44R - Medical Oncology Program - This is Phase II of the ongoing Area Cancer Program (project #15) with a primary emphasis on continuing education and communication for health professionals as they relate to the total care of cancer patients. The proposal was approved by Council in December 1969 and is proposed for activation only under Plan B. Form 15 covering this proposal is on page 241.

Project #67 - Respiratory Care - This proposal concerns respiratory teaching teams from communities throughout the Area to be trained in the Bay Area by a faculty of specialists. It was approved by the February 1971 Council and is planned for activation only under Plan B. Form 15 covering this proposal is on page 242. San Francisco General, Presbyterian, Moffit, St. Mary's, Mt. Zion and Children's hospitals are the primary action bases.

The New Proposals:

Project #75 - Indian Health Program - This activity is proposed for funding under both plans - $120,000 under Plan A and $127,409 under Plan B. It constitutes a plan to identify those resources already available in the community (Northwestern California) and provides for their maximum utilization. The proposal is an outgrowth of a feasibility study begun in April 1970. A brief description of the proposal is on page 243. Expanded information begins on page 401.

Project #76 - Hypertension and Preventive Cardiology - This activity is proposed for funding only under Plan B at a level of $190,133. It aims to establish a web of patient care demonstration programs in local community hospitals inter-tied to Area-wide educational and planning activities. A brief description of the proposal is on page 244 and expanded information is on page 444.

Project #77 - Intensive Care Program - This activity is proposed for funding only under Plan B at a level of $190,000. It will integrate into a new approach the resources of two projects currently ongoing in this Area, but terminating this year (projects #1 Coronary Care and 18R Intensive Care Training). A brief description is on page 245 and expanded information begins on page 461.

Area II

The $6.2 million plan will hereinafter be designated as Plan A and the $10 million plan will be Plan B.

Davis - Sacramento -- Area II

Coordinator: Neil C. Andrews, M.D.

Geographic Scope - 20 counties

Population - approximately 1,448,200

Present Funding

Core	$ 210,670 (including 11,800 carryover)
Projects	273,813
Total	$ 484,483

Requested Funding	Plan A	Plan B
Core Staff	$214,435	$334,288
Continuation		
#45 - Stroke	72,000	75,000
Renewals	-0-	-0-
Approved/Unfunded		
#68 - Compendium of Extended Learning	52,800	55,000
#70 - Continuing Education for Allied Health Personnel and Health Careers Counselling	-0-	50,400
New	-0-	-0-
Total including Core	$339,235	$514,688

Area II

This Area submits progress reports on two ongoing activities (#2 and #45). One project (#2) terminates this year and the other (#45) continues for two more years.

It has an Area Advisory Group composed of 45 members and five Committees or Boards involving approximately 75 persons. Its core staff is composed of eleven full-time members and 9-1/2 full-time equivalents. A report of the significant core activities begins on page 496 of the application.
11 employees, 7 professionals + 4 secretarial/clerical. Of the 7 professionals, 5.53 are full-time equivalents

The Terminating Project:

Project #2 - Roseville Pilot Project - This activity is in its third and final year of RMP support. It is a multi-faceted activity that includes community surveys, multiphasic screening, tumor conferences, continuing education for physicians and dentists, clinical conferences and seminars and intensive coronary care training. Its progress report is included on Form 15 (page 506) and expanded information on its progress begins on page 510.

The Continuing Project:

Project #45 - Stroke - This activity is proposed for funding at a $72,000 level under Plan A and a $75,000 level under Plan B and will continue for two more years. It was activated late in 1970. It is a dual activity project composed of patient evaluation efforts and continuing education/training. It is briefly described on Form 15 (page 507) and in more detail in the Region's standard reporting beginning on page 535.

No renewing activities are proposed for this area under either plan.

Approved/Unfunded Activities:

Project #68 - Compendium of Extended Learning - This activity was approved by the February 1971 Council and is proposed for activation under both Plans ($52,800 under Plan A and $55,000 under Plan B). It proposes to establish a mechanism for the planning, development and implementation of a cohesive program of educational activities for the Area's health professions. It is briefly described on Form 15 page 508.

Project #70 - Continuing Education for Allied Health Personnel and Health Careers Counselling - This project was approved by the February 1971 Council and is proposed for activation only under Plan B at a level of $50,400. The proposed multidisciplinary continuing education programs will be carried out in three phases: (1) planning and development; (2) operational in several selected sites with evaluation; and (3) extension of phase 2 with modified programs (based on evaluation) in new sites. Form 15 describing the activity is on page 509.

No new proposals are included for this Area under either plan.

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

Area III

Stanford School of Medicine - Area III

Coordinator: John L. Wilson, M.D. (Acting Dean, Stanford School of Medicine)
William Fowkes, Heart Coordinator (Acting Coordinator of Area III)

Geographic Scope: 11 counties

Population - approximately 2,644,100

Present Funding

Core	$260,654 (including $40,000 carryover)
Projects	153,417
Total	$414,071

Requested Funding	Plan A	Plan B
Core Staff	$ 264,893	$ 433,450
Continuation		
#37 - Stroke Program	100,794	105,000
#46 - San Joaquin Multiphasic Screening	153,655	160,000
Renewals	-0-	-0-
Approved/Unfunded		
#73 - Cancer Program	9,600	301,123
New Activities		
#78 - Oral Health Care Program	-0-	105,210
All totals including Core	$ 528,942	$1,104,783

This Area submits progress reports on three ongoing activities (#37, #38 and #46). One project (#38) terminates this year. Each of the remaining two will continue for two more years.

It has an area Advisory Group composed of 23 members and 16 other District Committees, Subcommittees or categorical committees. Its core staff is composed of 18 full-time people. A report of the significant core activities begins on page 557 of the application.

The Terminating Project: 2 professionals + 6 secretarial/clerical

Project #38 - East Palo Alto Multiphasic Screening - Its purpose is to introduce citizens of a Black urban ghetto (East Palo Alto - Menlo Park) to the existing health care system. It established a Screening Center in

the Neighborhood Health Center (an OEO project). Although the project was funded in 1970 for a two-year life, its activation was delayed due to a number of reasons revolving primarily around strife in the community and changes of staff at the Center. Form 15 describing the project briefly is on page 582.

The Continuing Projects:

Project #37 - Stroke Program - This activity continues for two more years and is proposed for funding at $100,794 level under Plan A and $105,000 under Plan B. It is a project with six sub activities: (1) Organization; (2) Physical Therapy; (3) Prevention and Assessment; (4) Management Demonstration; (5) District programs; and (6) Teaching and Consultation. Its progress is briefly described on Form 15 (page 581) and in more detail in the Region's standard reporting format beginning on page 586.

Project #46 - San Joaquin Multiphasic Screening - This activity continues for two more years and is proposed for funding at a $153,655 level under Plan A and $160,000 under Plan B. The element of a mobile screening unit with referral and follow-up is in this project and it is aimed at urban poor and migrant agricultural workers. Its progress is briefly described on Form 15 page 583, and expanded information is included in the Region's standard reporting format beginning on page 613.

No renewing activities are proposed for this Area under either plan.

Approved/Unfunded Activities:

Project #73 - Cancer Program - This activity was approved by the February 1971 Council and is proposed for funding under both plans. $9,600 has been allocated to this project under Plan A; $301,123 under Plan B. It is a four-part program; (1) dosimetry; (2) consultation; (3) education in community hospitals in San Jose; and (4) a staff person for the Stockton Tumor Board. Plan A activates only part 4 of the project. Plan B activates all parts. The project is briefly described on Form 15 on page 584.

New Activities:

Project #78 - Oral Health Care Program - This activity is proposed for funding only under Plan B at a level of $105,210. It proposes the establishment of a "board of consultants" to review complex oral pathological problems needing multidisciplinary care. The cases will be referred to the board. The activity is briefly described on Form 15 on page 585 and in more detail beginning on page 623.

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

University of California - Los Angeles -- Area IV

Coordinator: Donald Brayton, M.D.

Geographic Scope: 7 counties

Population: approximately ~~1,406,700~~ 4,206,700

Present Funding

Core	677,647
Projects	496,421
Total	$1,174,068

Requested Funding	Plan A	Plan B
Core Staff	$705,149	$888,497
Continuation beyond approval period		
#24 - The Northeast Valley Project	72,000	75,000
Approved/Unfunded		
#63 - Perinatal Crisis Training	72,000	96,232
#64 - Continuing Education for Physicians in South Bay	-0-	68,892
#71 - Respiratory Care Training	-0-	177,159
New Activity		
#79 - Extended Care Facilities	60,480	62,321
All totals including Core	$909,629	$1,368,094

This Area submits progress reports on three ongoing activities (#24, #7 and #4). Support for all three terminates this year. Renewed support project #24 is requested under both plans.

This Area has a local Advisory Group composed of 71 members and approximately 5 Committees and Boards. The Area core staff numbers 41, 27 of whom are full time. A summary of the significant core staff's accomplishments begins on page 658.

The Terminating Projects:

Project #7 - Medical TV Network - This activity is in its third and final year of support. It produced, distributed and evaluated audiovisual media programs for the continuing education of health professionals. The network is planning for sources other than RMP to continue its activities but they are not specified. Form 15, briefly describing the project is on page 690.

Project #4 - Physicians Training in Coronary Care - This activity is in its third and final year of support. It has trained physicians who will occupy positions as directors or associate directors in coronary care units in community hospitals. Progress on this activity is reported on Form 15 on page 691.

Renewing Activity:

Project #24 - The Northeast Valley Project - This activity has been ongoing for three years and the Area requests its continued support for an additional three years. It is one of the two projects selected by the Region from a pool of 12 terminating activities that request renewal. The Region planned for its renewed support at a $72,000 level under Plan A and $75,000 under Plan B. The research activity of this project has generated interest in the plight of the community by Los Angeles County (which has qualified the area for a Neighborhood Health Center) and other groups such as Kellogg Foundation. The project also is being considered for funding by OEO and should such funds materialize the Area proposes project #63 as an alternate. The progress of Project #24 is briefly described on Form 15 (page 689) and in more detail in the Region's standard reporting format beginning on page 718. The activities to be pursued in the next three years are described beginning on page 723.

Approved/Unfunded Activities:

One project (#63) is proposed for activation under Plan A, this being the alternate to project #24. Three projects are proposed for activation under Plan B (#63, #64 and #71).

Project #63 - Perinatal Crisis Training - This activity was considered by November 1970 Council and deferred to the December site visitors. Based on the site visitors' recommendations the February 1971 Council approved it. The project proposes to develop physician and nursing manpower and to stimulate services for the treatment of severe medical and surgical ailments in newborns. It is scheduled for activation at $72,000 under Plan A (as an alternate to Project #24) and $96,232 under Plan B. Form 15 describing the project is on page 692.

Project #64 - Continuing education for Physicians in South Bay - This activity was also deferred by November 1970 Council to the site visitors and February 1971 Council approved it. Its protocol enables physicians to to participate in half-day clinical experiences each week on a two-month basis. It is planned for activation only under Plan B at a $68,892 level. Form 15 describes the project on page 693.

Project #71 - Respiratory Care Training - This activity was submitted to and approved by February 1971 Council. It proposes to train key personnel in respiratory care in hospitals where specialized units are not appropriate. It involves a nine-county area. Funding is proposed only under Plan B at a $177,159 level. Form 15 covering the activity is on page 694.

New Proposal:

Project #79 - Extended Care Facilities - This activity is proposed for funding under both plans - $60,480 under Plan A and $62,321 under Plan B. It provides for a coordinated continuing education program for nursing home and extended care facility administrators and directors of nursing. Form 15 briefly describing the proposal is on page 695. Expanded information begins on page 745.

The $6.2 million plan will hereinafter be designated as Plan A, the $10 million will be Plan B.

University of Southern California (Los Angeles) -- Area V

Coordinator: Donald Petit, M.D.

Geographic Scope: 1 county

Population - approximately ~~6,882,000~~ 4,082,000

Present Funding

Core	$551,399
Projects	443,453
Total	$994,852

Requested Funding	Plan A	Plan B
Core Staff	$575,481	$743,771
Continuation		
#23 - Physician Education in Early Chronic Respiratory Disease	78,112	81,367
#50 - Pacemaker Registry	56,390	57,208
No Renewing Activities		
No Approved/Unfunded Activities		
New Activities:		
#80 - Computerized ECG for Community Hospitals	-0-	95,334
#81 - Urban American Indian Health Needs	48,960	51,000
#82 - Intensive Care of the Critically Ill	-0-	81,000 *
#83 - Free Clinic Coordination	-0-	80,000
All totals including Core	$758,943	$ 1,189,680

* Also includes resources of Area IV and IX and involves populations of Areas IV and IX.

Progress reports on three ongoing activities are submitted (#11, #23, and #50). One project (#11) terminates this year. Project #23 continues for one more year and Project #50 continues for two.

The Area has a local Advisory Group composed of 34 members and approximately 13 other Committees or Boards are listed. The Area core staff numbers (40) full-time employees and 29 full-time equivalents. A summary of the significant core staff's accomplishments begins on page 776.

40 employees, 28 professionals and 12 secretarial/clerical. Of the 28 professionals, 17 are full-time equivalents

The Terminating Project:

Project 11 - Coronary Care Unit Training Program = This activity is in its third and final year of support. No alternative funding has been developed. Its progress is covered briefly on Form 15 on page 806.

The Continuing Projects:

Project #23 - Physician Education in Early Chronic Respiratory Disease - This project is in its second year of a three-year support period. Its support is planned at a $78,112 level under Plan A and $81,367 under Plan B. The Los Angeles TB Association Breathmobile refers individuals with abnormal respiratory symptoms to this project. Its progress is briefly reported on Form 15 (page 807) and in more detail in the Region's standard reporting format beginning on page 822.

Project #50 - Pacemaker Registry - This project was activated in September 1970 through funds rebudgeted from project #11. Although it was approved by December 1969 Council for a period of three years, funds have not been awarded for its support. The Region activated the project for its first year as described above, and allocated funds to support it under both Plan A ($56,390) and Plan B ($57,208). The project aims to determine the extent to which mortality and morbidity in patients with pacemakers may be due to pacemaker malfunction. It is briefly described on Form 15 (page 808) and in more detail beginning on page 828.

No new renewing activities are proposed for the Area under either Plan.

No approved/unfunded projects are proposed for activations under either plan.

The New Proposals:

Project #80 - Computerized ECG For Community Hospitals - This activity is proposed for funding only under Plan B at a $95,334 level. The project will undertake: (1) taking ECG's for computer interpretation; (2) assuring accuracy of the computerized interpretation; (3) setting up computerized ECG interpretation for private offices; (4) obtaining appraisals from physicians for improvement of services; and (5) determining optimal cost benefits. The activity is briefly described on Form 15 (page 809) and in more detail beginning on page 832.

Project #81 - Urban American Indian Health Needs - This activity is proposed for funding under both Plans - $48,960 under Plan A and $51,000 under Plan B. This proposal is an outgrowth of activities sponsored by the Area's investment last year of seed money and technical assistance. A church in Compton was made available for a health center and an incorporated group, The American Indian Free Clinic, Inc. serves as the clinic's administration. Volunteers average about 12 professionals and 8 non-professionals. With funding available as a result of this application and a similar application to the Economic Youth Opportunities Agency of Los Angeles, the clinic will expand its services and referrals, both in scope and hours offered. The proposal is briefly described on Form 15, page 810 and in more detail beginning on page 842.

Project #82 - Intensive Care of the Critically Ill - This activity is proposed for funding only under Plan B at a level of $81,000. The project will cover some of the population and resources of Areas IV and IX. Two hundred thirty seven general acute care hospitals in these areas with specialized intensive care units are noted as the resources and the project aims to train approximately one half of the 600 nurses currently in direct care positions in the specialized care of the critically ill. The project is an outgrowth of the Regional experience gained through its coronary training efforts. It is briefly described on Form 15 (page 811) and in more detail beginning on page 861.

Project #83 - Free Clinic Coordination - This activity is proposed for funding only under Plan B at a level of $80,000. It aims to enhance the functions of the Southern California Council of Free Clinics by providing professional and supportive staff to help organize new clinics and assist existing ones. It is briefly described on page 812 and in more detail on page 879

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

Loma Linda School of Medicine -- Area VI

Coordinator: Richard T. Walden, M.D.

Geographic Scope: 4 counties

Population: 1,162,800

Present Funding

Core	$144,335
Projects	65,516
Total	$209,851

Requested Funding	Plan A	Plan B
Core Staff	$157,457	$244,526
Continuing Activities		
#52 - Perinatal Monitoring	71,472	74,450
Approved/Unfunded Activities		
#60 - Medical Information Services	-0-	39,388
Total including Core	$228,929	$358,364

This Area submits a progress report on one activity, project #52, which will continue for two more years.

The Area has a local Advisory Group composed of 34 members and lists 13 additional committees or task forces. Its Core staff numbers 10 full-time employees. A summary of the Core staff's significant accomplishments begins on page 904.

This Area has no terminating projects.

The Continuing Project:

Project #52 - Perinatal Monitoring - This project is completing its first year of activity. It is proposed for continuation under both Plans - Plan A at a $71,472 level and Plan B at a $74,450 level. Its objectives are to lower perinatal mortality, to reduce the number of defective infants and to reduce the number of caesarian sections required by fetal distress. Its progress is briefly described on Form 15 (page 925) and in more detail beginning on page 928.

Approved/Unfunded Activities:

Project #60 - Medical Information Services - This project is proposed for activation only under Plan B at a $39,388 level. It was approved by the July 1970 Council and it proposes to expand and improve literature search and services to practicing physicians and other health professionals. It builds on a pilot study underway for 14 months. It is briefly described on Form 15 (page 926).

No new proposals are submitted for this Area.

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

San Diego - Area VII

Coordinator: Michael B. Shimkin, M.D.

Geographic coverage - 2 counties

Population: approximately 1,432,400

Present Funding

Core	$177,324 (including $37,200 carryover)
Projects	69,201
Total	$246,725

Requested Funding	Plan A	Plan B
Core Staff	$149,536	$256,818
Continuation		
#30 - Coronary Care Unit Training	75,982	79,148
No renewals are proposed		
Approved/Unfunded Activities		
#62 - Continuing Education for Physicians	-0-	120,416
#66 - R.E.A.C.H.	-0-	231,014
#69 - Respiratory Care	62,400	65,000
No new activities are proposed		
Total including Core	$287,918	$752,396

This Area submits a progress report on one activity which continues for two more years.

The Area has a local Advisory Group composed of 29 members and 15 committees or task forces. The Core staff number 10 full-time employees and 7.85 full-time equivalents. A summary of the significant Core staff accomplishments begins on page 945.

10 employees, 6 professionals + 4 secretarial/clerical. Of the 6 professionals, 3.85 are full-time equivalents

The Continuing Activity:

Project #30 - Coronary Care Unit Training - This project is completing its first year of activity. Its continuation is proposed at a $75,982 level

under Plan A and $79,148 under Plan B. It proposes to train 360 RN's for CCU duty, provide consultation on CCU design and equipment and to train rescue personnel in emergency cardiopulmonary resuscitation. Its progress is briefly described on Form 15 (page 964) and in more detail beginning on page 968.

No renewals are proposed.

Approved/Unfunded Activities:

One approved/unfunded activity (#69) is proposed under both Plans. In addition, two previously approved projects (#62 and #66) are proposed for activation under Plan B.

Project #69 - Respiratory Care - This project was approved by February 1971 Council and is proposed at a level of $62,400 under Plan A and $65,000 under Plan B. Both levels are requesting budgets significantly less than the original proposal. Through educational programs in respiratory care for physicians, nurses and other allied health personnel the project aims to upgrade and expand the diagnostic and therapeutic capabilities of the Area. It is briefly described on Form 15 (page 967).

Project #62 - Continuing Education for Physicians - This activity was approved by the November 1970 Council and is proposed for activation only under Plan B at a $120,416 level. It aims to provide coordinated continuing education programs for physicians in San Diego and Imperial Counties. It is briefly described on Form 15 (page 965).

Project #66 - R.E.A.C.H. - This proposal was approved by the February 1971 Council and is proposed for activation only under Plan B at a $231,014 level. It proposes supplementary staff in six general hospitals in San Diego County to establish multidisciplinary teams in each; a slightly modified team in two Imperial County Hospitals; methods for MD's to assume active leadership roles for follow-up care under their direction; and advice for allied health professionals. It is briefly described on Form 15 (page 966).

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

Irvine -- Area VIII

Coordinator: Robert C. Combs, M.D.

Geographic coverage: 1 county

Population: approximately 1,420,400

Present Funding

Core	$178,600
Projects	439,178 (including $35,000 carryover)
Total	$617,778

Requested Funding	Plan A	Plan B
Core Staff	$181,344	$284,767
Continuation		
#28 - Comprehensive Community Stroke Program	230,874	240,494
Approved/Unfunded Activities		
#54 - Rapid Hospitalization for Acute Myocardial Infarction	48,000	50,000
#56 - C.R.I.S. (Community Referral & Information Service)	19,200	20,000
#72 - Radiation Therapy	-0-	71,957
New Activity		
#84 - Neonatal Intensive Care	-0-	111,684
Total including Core	$479,418	$778,902

This Area submits progress reports on two ongoing activities (#21 and #28). Project #21 terminates this year; project #28 continues for one additional year.

The Area has a local Advisory Committee composed of 31 members, five standing committees and two ad hoc committees. The Area Core staff numbers 11 full-time employees and 9.12 full-time equivalents. A summary of Core staff's significant accomplishments begins on page 993.

12 employees, 9 professionals + 3 secretarial/clerical. Of the 9 professionals, 6.12 are full-time equivalents

The Terminating Project:

Project #21 - Pediatric Pulmonary Center - This activity is in its final year of a three-year period of support. Its aims are to increase the health professional's knowledge and skills in pediatric inpatient and outpatient care. The progress made is briefly described on Form 15 (page 1004).

The Continuing Project:

Project #28 - Comprehensive Community Stroke Program - This proposal was a part of the California RMP's original operational application. However, due to Regional funding limitations, this proposal was not activated until the Region's second operational year. It proposes to increase the quality of care of stroke patients by integrating all aspects of such care. Its continuation for one more year is proposed at a $230,874 level under Plan A and a $240,494 level under Plan B. Form 15, briefly describing the project is on page 1005.

No renewing activities are proposed

Approved/Unfunded Activities:

Two such projects (#54 and #56) are proposed for activation under Plan A and an additional one (#72) under Plan B.

Project #54 - Rapid Hospitalization for Acute Myocardial Infarction - This proposal was submitted to the March 1970 Council. It was essentially a two-component proposal dealing with public education and modes of transportation of victims of myocardial infarction. The original project proposed two study areas and included the involvement of a mobile unit. The proposal here confines the activity to a study of the value of public education in one controlled population segment (Leisure World, Laguna Beach) and the mobile unit aspects have been deleted. This project is proposed for activation under both plans - Plan A at $48,000 and Plan B at $50,000. Both levels are considerably below the Council approved level of $200,000. Form 15 is on page 1006.

Project #56 - C.R.I.S. (Community Referral & Information Service) - This proposal was originally submitted to the March 1970 Council and received a deferral action primarily because an earlier, similar proposal (CHAIRS) from California's Area V had been funded by HSR&D for a five-year period at approximately $700,000 and Council wanted a more indepth consideration of the relative merits of both proposals. The project was again submitted to July 1970 Council and received approval. Interim investigation by a staff member of Comprehensive Health Services established that the methodologies of CHAIRS and CRIS are different, the former being concerned with the application of computer technologies whereas the latter will employ standard techniques in developing a new service. CRIS is a seed activity for an essential component of a comprehensive health program in one of the fastest growing counties in the U.S. The project was approved at a $77,307 level. It is proposed for activation under Plan A at $19,200 and Plan B at $20,000. It is briefly described on Form 15 on page 1007.

Project #72 - Radiation Therapy - This proposal was approved by February 1971 Council and is planned for activation only under Plan B at $71,957. It is aimed at improving through continuing education for physicians, nurses, and technicians, the quality of radiotherapy. It is briefly described on Form 15 on page 1008.

The New Proposal:

Project #84 - Neonatal Intensive Care - This project is proposed only under Plan B at a $111,684 level. It is a four-faceted proposal -- (1) training of nurses for intensive care of newborn infants; (2) training of physicians (and teams of MD's and RN's); (3) mobile intensive care for critically ill infants; (4) a consultation program. It is briefly described on Form 15 (page 1009) and expanded information begins on page 1076.)

The $6.2 million plan will hereinafter be designated Plan A and the $10 million plan will be Plan B.

Watts-Willowbrook - Area IX

Coordinator: M. Alfred Haynes, M.D.

Geographic Scope: 1 county

Population: 526,700

Present Funding

Core	$159,785
Projects	470,366 (includes carryover)
Total	$630,151

Requested Funding	Plan A	Plan B
Core Staff	$153,394	$184,558
Continuation	-0-	-0-
Continuation Beyond Approval Period of Support		
#6 - Charles R. Drew Postgraduate Medical School	384,000	400,000
Total	$537,394	$584,558

This newly created Area grew from the Watts-Willowbrook District jointly sponsored by Areas IV and V. Drs. Brayton and Petit had developed a combination planning-operational proposal to coordinate the development of a Watts-Willowbrook District of RMP with the development of the Charles R. Drew Postgraduate Medical School. Its genesis was a $220,000 RMP grant to assist in the planning for and development of the faculty of the School. This activity has emerged from the overall Watts-Willowbrook District activity as project #6.

The current funding of Project #6 is $470,366. It is a four-faceted activity described by the Region as falling into the following categories: 1) Department of Community Medicine Activities; 2) Institutional Program Planning and Development; 3) Institutional Resources Development; and 4) Faculty Recruitment and Retention.

May 1969 Council approved a site visit team recommendation that the Watts-Willowbrook District be declared Area IX. The new status of the District was the subject of correspondence between the California RMP Coordinator and Dr. Mitchell Spellman, Dean of Drew Postgraduate Medical School. Dean Spellman named M. Alfred Haynes, M.D. the Coordinator for Area IX in October 1970. Dr. Haynes is Chairman of the Department of Community Medicine, Drew School.

The Drew School is the academic arm of the Martin Luther King, Jr. General Hospital (under construction). Department heads at the school accrue appointments as chiefs of service at the hospital and the credibility of the school to attract and retain able, motivated faculty--lacking a facility--has been an obstacle.

When the King Hospital becomes operational, a contract with the Los Angeles County Department of Hospitals is scheduled for activation, thereby providing the school with additional financial assistance.

This proposal from Area IX requests the continuation of support for the Area Core staff and renewed support for Project #6. From the information submitted, it is difficult to determine where one leaves off and the other begins.

Apparently, similar areas of question arose during the Region's own review process. In an effort to develop a clearer picture, this portion of the application includes the proposal originally submitted by Area IX to CCRMP as well as the responses of the proposers to requests for clarification stemming from the Region's review process.

The materials concerning the Area IX Core activities are included on pages 1096-1117 in Volume II. The materials concerning Project #6 begin on page 1119 in Volume II. Each requests support for three years.

The personnel budget lists 8 positions, 6 professionals + 2 secretarial/clerical. All are listed as full-time. At this time, 1 professional slot is filled.

REGION California
CYCLE RM 00019 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
(Central Offices)	(457,426)				(457,426)	---	(457,426)
(Regional Kidney Plan)	(121,920)				(121,920)	---	(121,920)
(CMERF Office)	(53,596)				(53,596)	(4,767)	(58,363)
(Area I)	(666,712)				(666,712)	(269,278)	(935,990)
(Area II)	(334,288)				(334,288)	(123,050)	(457,338)
(Area III)	(433,450)				(433,450)	(182,049)	(615,499)
(Area IV)	(888,497)				(888,497)	(272,082)	(1,160,579)
(Area V)	(743,771)				(743,771)	(121,995)	(865,766)
(Area VI)	(244,526)				(244,526)	(69,109)	(313,635)
(Area VII)	(256,818)				(256,818)	(69,090)	(325,908)
(Area VIII)	(284,767)				(284,767)	(112,498)	(397,265)
(Area IX)	(184,558)				(184,558)	(63,575)	(248,133)
TOTAL CORE	4,670,329				4,670,329	1,287,493	5,957,822
D00 - Developmental	400,000				400,000	---	400,000
#15 - (I)Cancer - Phase I	244,650				244,650	75,829	320,479
#23 - (V)Chronic Resp. Dis	81,367				81,367	16,188	97,555
#25 - (I) Rehab. & Cont. of Care	149,215				149,215	28,997	178,212
#27 - (I) Rural Comm. Hosp	69,335				69,335	15,595	84,930
#28 - (VIII)Comp. Stroke	240,494				240,494	72,545	313,039
#30 - (VII)CCU Nurse Tr'ng	79,148				79,148	4,167	83,315
#37 - (III)Stroke	105,000				105,000	44,100	149,100
#43 - (I)Stroke	179,790				179,790	47,829	227,619
#45 - (II)Stroke	75,000				75,000	17,869	92,869
#46 - (III)Multiphasic	160,000				160,000	21,000	181,000
#50 - (V)Pacemaker	57,208				57,208	11,451	68,659
#52 - (VI)Perinatal Monit.	74,450				74,450	29,446	103,896
#6 - (IX) Drew Postgrad.		400,000			400,000	145,859	545,859
#24 - (IV)N.E. Valley		75,000			75,000	18,000	93,000
#27S - (I)Family Practice			55,740		55,740	13,286	69,026
#41 - (I)Reg. Monitoring			35,446		35,446	5,670	41,116
#44 - (I)Med. Oncology			184,091		184,091	48,925	233,016
#54 - (VIII)Rapid Hosp. - Myocardial Infarction			50,000		50,000	7,895	57,895

REGION California
CYCLE RM 00019 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
#56 - (VIII)CRIS			20,000		20,000	326	20,326
#60 - (VI)Med. Info. Serv.			39,388		39,388	10,550	49,938
#62 - (VII)CE for M.D.'s			120,416		120,416	25,836	146,252
#63 - (IV)Perinatal Crisis			96,232		96,232	15,412	111,644
#64 - (IV)Phys. C.E.			68,892		68,892	13,113	82,005
#66 - (VII)REACH			231,014		231,014	16,924	247,938
#67 - (I)Resp. Disease			266,240		266,240	108,224	374,464
#68 - (II)Compendium of Learn.			55,000		55,000	3,691	58,691
#69 - (VII)Resp. Disease			65,000		65,000	29,235	94,235
#70 - (II)Allied Health			50,400		50,400	17,920	68,320
#71 - (IV)Resp. Care Training			177,159		177,159	50,386	227,545
#72 - (VIII)Rad. Therapy			71,957		71,957	30,492	102,449
#73 - (III)Oncology			301,123		301,123	118,100	419,223
#75 - (I)Indian Health				127,409	127,409	27,423	154,832
#76 - (I)Hypertension				190,133	190,133	80,726	270,859
#77 - (I)Intensive Care				190,000	190,000	55,239	245,239
#78 - (III)Oral Health Care				105,210	105,210	21,000	126,210
#79 - (IV)Ext. Care Fac.				62,321	62,321	18,134	80,455
#80 - (V) Computerized ECG				95,334	95,334	10,418	105,752
#81 - (V)Urban Indian				51,000	51,000	7,647	58,647
#82 - (V & IX) Care of the Critically Ill				81,000	81,000	2,778	83,778
#83 - (V)Free Clinic Coordination				80,000	80,000	18,260	98,260
#84 - (VIII)Neonatal Intensive Care				111,684	111,684	51,556	163,240
TOTAL	6,585,986	475,000	1,888,098	1,094,091	10,043,175	2,645,534	12,688,709

REGION California

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
(Central Offices)	(480,287)				(480,287)
(Regional Kidney Plan)	(122,000)				(122,000)
(CMERF Office)	(56,276)				(56,276)
(Area I)	(700,048)				(700,048)
(Area II)	(351,002)				(351,002)
(Area III)	(455,122)				(455,122)
(Area IV)	(932,785)				(932,785)
(Area V)	(780,960)				(780,960)
(Area VI)	(260,188)				(260,188)
(Area VII)	(269,658)				(269,658)
(Area VIII)	(286,191)				(286,191)
(Area IX)	(193,777)				(193,777)
TOTAL CORE	4,888,294				4,888,294
D00 - Developmental	400,000				400,000
#15					---
#23					---
#25					---
#27					---
#28					---
#30	63,318				63,318
#37	87,500				87,500
#43	149,825				149,825
#45	60,000				60,000
#46	133,333				133,333
#50	47,793				47,793
#52	62,042				62,042
#6		304,057			304,057
#24		75,000			75,000
#27S			55,740		55,740
#41			35,446		35,446
#44			184,091		184,091
#54			50,000		50,000

REGION California
BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
#56			20,000		20,000
#60			39,388		39,388
#62			120,416		120,416
#63			96,232		96,232
#64			68,892		68,892
#66			231,014		231,014
#67			266,240		266,240
#68			55,000		55,000
#69			65,000		65,000
#70			50,400		50,400
#71			177,159		177,159
#72			71,957		71,957
#73			301,123		301,123
#75				127,409	127,409
#76				190,133	190,133
#77				180,000	180,000
#78				105,210	105,210
#79				63,000	63,000
#80				95,334	95,334
#81				51,000	51,000
#82				50,000	50,000
#83				---	---
#84				111,684	111,684
TOTAL		$379,057	1,888,098	973,770	9,133,030

REGION California

BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
(Central Offices)	(504,312)				(504,312)	(1,442,025)
(Reg. Kidney Plan)	(122,000)				(122,000)	(365,920)
(CMERF)	(59,090)				(59,090)	(168,962)
(Area I)	(735,050)				(735,050)	(2,101,810)
(Area II)	(368,552)				(368,552)	(1,053,842)
(Area III)	(477,878)				(477,878)	(1,366,450)
(Area IV)	(976,424)				(976,424)	(2,797,706)
(Area V)	(820,008)				(820,008)	(2,344,739)
(Area VI)	(273,197)				(273,197)	(777,911)
(Area VII)	(283,141)				(283,141)	(809,617)
(Area VIII)	(287,622)				(287,622)	(858,580)
(Area IX)	(203,466)				(203,466)	(581,801)
TOTAL CORE	5,110,740				5,110,740	14,669,363
D00 - Devel.	400,000				400,000	1,200,000
#15					---	244,650
#23					---	81,367
#25					---	149,215
#27					---	69,335
#28					---	240,494
#30					---	142,466
#37					---	192,500
#43					---	329,615
#45					---	135,000
#46					---	293,333
#50					---	105,001
#52					---	136,492
#6		313,784			313,784	1,017,841
#24		75,000			75,000	225,000
#27S					---	111,480
#41					---	70,892
#44			184,091		184,091	552,273
#54			50,000		50,000	150,000

REGION California
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
#56			20,000		20,000	60,000
#60			39,388		39,388	118,164
#62			120,416		120,416	361,248
#63			96,232		96,232	288,696
#64			68,892		68,892	206,676
#66			231,014		231,014	693,042
#67			266,240		266,240	798,720
#68			55,000		55,000	165,000
#69			65,000		65,000	195,000
#70			50,400		50,400	151,200
#71			177,159		177,159	531,477
#72			71,957		71,957	215,871
#73			301,123		301,123	903,369
#75				127,409	127,409	382,227
#76				190,133	190,133	570,399
#77					---	370,000
#78				105,210	105,210	315,630
#79				63,000	63,000	188,321
#80				95,334	95,334	286,002
#81				51,000	51,000	153,000
#82					---	131,000
#83					---	80,000
#84				111,684	111,684	335,052
TOTAL	5,510,740	388,784	1,796,912	743,770	8,440,206	27,616,411

GRB 6/4/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

CALIFORNIA REGIONAL MEDICAL PROGRAM
RM 00019 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

Recommendation: (1) The $6.2 Million plan the Region has developed in order to reach its retrenched funding level is viable and represents good decision-making. (2) The $10 million plan the Region has developed should funds become available proposes the activation of some previously approved activities which the site visitors do not view as being wise to initiate at this time in view of the Region's new directions. (3) With much the same selectivity that characterized the development of the $6.2 plan, the Region certainly could mount an effective program at the previously Council approved level of $8.3 million which would be consistent with national priorities and the Region's new directions. (4) The site visitors concerns regarding the relatively ineffective program administered by Area VII should be relayed to the Region with the advice that CCRMP must address itself to these deficiencies. Also Areas VI and VIII are in need of intensive assistance with planning for the future. They are below the Regional RMP effort and might profit by assistance from Areas I, IV and V. (5) The issues and questions identified by Committee and Council during the January/February review cycle concerning the Area I proposal (project #85) for a cooperative effort with the Bay Area Model Cities Agencies (San Francisco) were satisfactory clarified. (6)The regional Kidney plan to be deleted pending its submission to and approval by the ad hoc Kidney Disease Panel prior to Council Meeting ($8,364,000 minus $121,920); (7) the region must include more realistic evaluation data in its Progress Reports for assessment by RMPS staff and the confidentiality impediment must be overcome.

Year	Component	REQUEST Plan A	REQUEST Plan B	Recommended Funding
04	Core	$3,380,185	$4,548,409	
	Kidney	121,920	121,920	
	Developmental Component	384,000	400,000	Allocations to be made by the region.
	Operational Activity	1,456,549	1,515,657	
	Renewal	456,000	475,000	
	Approved/unfunded	264,000	1,888,098	
	New Projects	229,440	1,094,091	
		$6,292,094*	$10,043,175	$8,364,000
				-121,920 Kidney
				$8,242,080 (d.c.)

Year	Recommended Funding	
05	$9,500,000	Allocations to be made by the region.
06	$10,000,000	" " " " " " "

The Review Committee member who participated in the site visit introduced the discussion of the second part of the two-part request. Also present and participating in the review was one of the consultants to the site team of June 10-11, 1971. A secondary reviewer also shared in the review of the application.

As background, the Committee was reminded that the purpose of the recent site visit was to assess the operational matrix of the region. Part I of the application covering the region's goals, objectives, Developmental Component request and an expanded Core renewal, were reviewed by the December 1970 site visit team, the Review Committee in January, and the National Advisory Council in February. The region's new objectives were discussed at that time. These objectives, established primarily to guide the use of developmental funds, also reflected the direction in which the region is beginning to move-that of stimulating changes in the organization and delivery of health services.

CCRMP's administrative management is considered to be outstanding, especially in terms of the development of objectives, first published in 1970 with the most recent updating including the Developmental Component. The opinion of the reviewers was that the Program Evaluation Committee, headed by Judge Landreen is impressive with a good grasp of the concept of Regional Medical Programs. It has developed sound procedures which are well defined.

It is also believed that CCRMP reflects small but strong Core staff expertise with specific strength of coordination and political know-how. There is a good feel for the national scope of RMP and this is reflected in the various program activities.

The evaluation component of the Core staff activities leaves room for improvement. Thus far, the region's efforts at evaluation seem to be limited to the task of digesting a mass of information that its reporting system generates. Based upon data collected by project directors and channelled through the Areas to the central office, the California RMP is maintaining information that gives a good overview of the emphasis of its activities.

It was reported that CCRMP evaluation staff believe it will have to rely on a self-reporting system because of the confidential nature of the data. The reviewers agreed with the site visitors that this position is unacceptable.

The Review Committee is of the opinion that more evaluation data should be included in progress reports, and further, that it will require continuing contacts between project and CCRMP staffs. Committee also feels that much good data is available, but it is admittedly hard to extract. Notably missing from the California approach is the "output" and "outcome" assessment. As an example of evaluating a stroke program, some very basic questions could be asked, such as: Has the stroke program been able to reduce length of hospital stay? What is the significant input

on the productivity in the care of stroke patients? And so forth. Addressing such questions should give some indication of the effectiveness of a program, in the opinion of the reviewers. Certainly it would afford an excellent example of what to use as a bench mark.

In continuing an extensive discussion of California's evaluation methods, the reviewers felt that it is commendable to refer to both 'good'and 'bad' projects. At the same time, they feel that the region should be reminded that CCRMP has spent a lot of money in some hard areas, and such an investment should yield some hard results. It was the feeling of some of the reviewers that perhaps RMPS could develop a parallel effort to the review process that would, in some way, produce a cross-cut of project activities. How well a region has performed, in the long run, should be another valuable criterion of the total review process.

All in all, it appears that California has developed a good technique for collection of data on which to make regional decisions, along "epidemiological" lines. However, it would seem that the present evaluative process does not provide the necessary assistance to Area or project personnel in appropriate techniques for determining the critical elements that contribute to the project's "success" or "failure."

There was discussion of the various Core staff activities in each Area, with consensus that the three strongest continue to be Areas I, IV and V, based in UCSF, UCLA and USC, respectively. Areas II and III (Davis and Stanford) are believed to be "Good" Areas VI and VIII (Loma Linda and Irvine) are "Poor", and Area VI in need of a thorough "overhaul".

Core activities for Area IX at Watts-Willowbrook are heavily involved in the Drew School, which is a unique departure from the traditional use of RMP funds. The Review Committee heard from the site visitors about the critical need for assistance in this area, particularly in terms of the expectations of the Watts community in that it continues to look to the King Hospital as a source of employment. Many factors have presented monumental problems to Doctors Spellman and Haynes: the financial condition of L.A. County (reported to be over $50 million in debt), the reduction of the 3,200 positions originally announced for the King Hospital to 1,800 by L.A. County, the recent earthquake, which has produced 3 - 4,000 unemployed, trained hospital workers. Also, the Department of Community Medicine has been eliminated from the County budget, notwithstanding a previous agreement with the County that when the King Hospital opened, support would emanate from that source.

Despite the foregoing, six of the ten Department Chairmen for Drew School have been recruited. The Medex program and a $250,000 grant from the Bureau of Health Manpower and Markel Foundation funds are positive forces, as are Model Cities funds, reported as $35 million. However, the Watts Area has not, as yet, been able to totally utilize such local resources to their best advantage. The Committee agreed with the site team that the operations of Area IX, the Drew School, the King Hospital are so irrevocably inter-related, that it is

most logical at this time to channel available financial resources from RMPS for Area IX and the Drew School (Project #6) in the same general directions. In addition, other forms of assistance were discussed in the form of professional consultants. This appears to be a very realistic means of an interim alleviation of an urgent manpower need.

The Reviewers were interested to hear about the newly established CCRMP Program Review Committee under the Chairmanship of Judge Kenneth Andreen. This body is charged with the function of program overview authority, reporting directly to the RAC, and may, at its option, perform regional site visits. This group is a potent performance evaluation mechanism.

The California RMP, in arriving at a $6.2 retrenched level of funding request, had many hard decisions to make in terms of its developing new directions. It was able to salvage its $400,000 Developmental Component, which was approved during the January/February cycle. This, in the opinion of the region, represents the best available means for change to new directions. The only two projects requesting renewal--the Drew School and the Northeast San Fernando Valley project--from twelve terminating programs, were selected as being commensurate with current objectives. Also, three new proposals, two addressing crucial needs in Indian health problems and one with extended care facilities, were selected in lieu of many approved but unfunded projects. The choices were made in an attempt to retain visibility in each of the Areas, and to maintain a capability to shift to objectives more in line with the new mission. The plan B proposed under the $10 million request does not evidence this selectivity and the reviewers failed to approve it. The reviewers concurred in the recommendation of the site visit team that the proposal to activate some previously approved activities up to $10 million would be unwise at this time in view of the region's new directions. However, there was consensus that the California RMP could effectively mount a program at the previously Council approved level of $8.3 million, consistent with national priorities and in line with the stated objectives of CCRMP.

It should be noted that the issues and questions identified by Committee and Council during the January/February 1971 cycle concerning the Area I proposal (project #85) for a cooperative effort with the Bay Area Model Cities Agencies (San Francisco) were satisfactorily clarified. There was positive evidence of a legitimate need and there was agreement that this program can fulfill the needs in a manner not possible from an other source of health planning. The reviewers agreed also that the Richmond program is more than adequately planned and is ready for implementation.

In discussing the Kidney Disease request, Committee was reluctant to approve the planning proposal without its review and concurrence by the ad hoc Kidney Disease Review Panel. The requested amount (approximately $121,000) was therefore deleted from the recommended amount, pending such a review with direct reference to the National Advisory Council. The plan is an outgrowth of a conference to organize a program that will realistically provide planning for kidney disease problems for the entire region. An attachment to this critique is a short version of the Panel's evaluation of the Kidney Disease Planning program.

SUMMARY OF REVIEW AND CONCLUSIONS
of the July 16, 1971
AD HOC PANEL ON RENAL DISEASE

Project: CCRMP Regional Plan for Kidney Disease in California

The CCRMP submitted a Region-wide plan as a guide for the developing renal disease activities in California. The plan addresses four areas or components for action:

1. Information System Component
2. Clinical Nephrology and Dialysis Training Component
3. Renal Transplantation and Organ Procurement Component
4. Pediatric Nephrology Component

The Panel was pleased with the organizational structure which was viewed as a reasonable and workable provision of direction toward satisfaction of renal disease problems in the Region. The Panel encountered difficulty, however, with a lack of definition in each of the described components.

Information System Component

The Panel felt that the need for a computer data system was not set forth, particularly with respect to how such a system would advance care for patients. It was expressed that neither the goals or objectives of this Component were explained with respect to the need to be met and the employment which would be made of the proposed data output. The Panel noted that a number of the stated objectives were already being accomplished. Comparatively, the Panel noted the absence of a coordinating point, such as a "Funding Desk" concept (developing in the Tri-State RMP) which could apply patient needs as a guide for data accumulation and processing. It is doubted, however, that an automated program is needed to relate available facilities to patients.

A positive leaning was discerned in an implication to continue the transplantation-related tissue typing and referral activities now being provided by UCLA through activities directed by Dr. Paul Teresaki. The Panel doubted, however, the practicability of incorporating dialysis data into Dr. Teresaki's program. The Panel felt that the need for the component had not been established, and urged that additional efforts be made to obtain more specific definition and purpose for this Component. The plan is conceptually appealing but too ambiguously described as a course of immediate action.

Clinical Nephrology and Dialysis Training Component

The Panel viewed the description of this component as too grandiose. The Panel was not sure that the Region has clearly determined what it should do. The Panel was unable to identify the needs to which this Component is addressed, or the goals to be achieved. The concept

of a nephrology program may have merit when clearly charted.

The Region's interest in training is not buttressed by recognition of training now being accomplished, nor the specific unmet needs to which programs should be addressed. The Component advises as to the desirability of training, but stops short of clarifying what training, for and by whom, and how it might be instituted to resolve named shortcomings. With respect to the scope of proposed formal courses, the Panel felt that the proposal was ambiguous. While it was agreed an implementation schedule might not yet be stated, the Panel believed that the results to be achieved should be definable.

The Panel felt that the sophisticated state of the art in California negates the need for training in dialysis beyond that which normally proceeds within existing dialysis programs. A concept of teams of consultants meeting with private physicians poses particular problems regarding the consent of private physicians, and the per-patient cost of such activities. The Panel believes that there is both waste and potential danger in bringing innovative diagnostic techniques outside of research centers where their application and interpretation is practised as a highly skilled and developing art. There is also, at the present time, little direct benefit to patients from such sophisticated procedures.

Rural Transplantation and Organ Procurement Component

This section reflects a desire to improve transplantation, improve immunosuppression through a program for ALG and improve organ procurement. The Panel could not identify what the Region proposed to do. It could not assure itself from the plan of the need for additional renal transplantation units in view of the 14 which presently exist in California. Dissatisfaction was expressed with the budget for this Component as reflecting a money-sharing outlook among California institutions, rather than support of programs to satisfy precise needs. The budget also fails to reflect the unusually good third party payment opportunities which exist in California.

Pediatric Nephrology Component

This Component is addressed to two salient problems: poor communications and followup; and non-systematic treatment, and evaluation of treatment. Current pediatric nephrology facilities, of which there are two, are stated to be adequate for the relatively small number of patients in need. The Panel was puzzled by this portion of the proposal as the sense switches from general pediatric renal disease to chronic uremia in children; implications of community-level care in the plan seem to contradict a statement that no further facilities are necessary, and the Panel was left unsatisfied in terms of specific details.

Project: CCRMP Regional Plan for Kidney Disease in California - 3-

This proposal requests largely computer facilities and staff, and does not seem to bear upon the specific delviery of care to children.

Dr. Kountz was absent from the room during the consideration and voting on recommendations.

Recommendations - The Panel recommends that the CCRMP kidney disease plan be accepted with advice to the Region. The organization established appears reasonable and workable, and capable of defining and responding to the particular needs of the Region. Recognizing the stricture of time and the scope of areas to be considered by the planners, the Panel felt that it could endorse the concepts of some parts of the initial plan, and that the proposed allocation of $121,920 can be utilized effectively in the development of those parts.

The Panel noted that the plan does not reflect the operational status of several kidney disease activities in California as well as the Panel knows that it exists. In this context, the Panel recognizes the present incompleteness of the plan with respect to lack of methods, procedures and timing. The Panel urges that California be instructed to continue with clarification of goals and objectives for which future applications should clearly provide an orderly approach to achievement.

At its present stage of development, the plan seems less directed to patient needs than it is to the various interests of institutions and investigators. The Panel felt that this was most apparent in the Renal Transplantation and Organ Procurement Component, but that this facet was observable throughout the plan.

The Panel recommends approval of the allocation of $121,920 in the first year, as a necessary vehicle for continued planning, and as a means to effect some non-insignificant operating progress within the scope of the plan. It is proposed that $26,500 be approved for continued work of the planning committee as requested. It is proposed that the balance of $95,420 be flexibly employed in areas which, in the opinion of the Panel, promise early results given the advanced state of renal disease activities in California. These are:

1. Increase the Region's capacity to procure and distribute cadaver organs toward increasing graft surgery.

2. Investigate the development of one or more central supply sources for the provision of ALG to transplanters.

3. Consider continued support of the UCLA tissue typing and donor-recipient record and referral service directed by Dr. Paul Teresaki.

The Panel suggests that these areas be dealt with flexibly in that continued pursuit of any area presenting significant problems be deferred, with increased effort extended in those more amenable to quick resolution.

The Panel did not find in the plan either immediate need, nor adequate procedures for patient oriented activities with respect to broad information programs, pediatric nephrology, or training.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 30, 1971

Reply to Attn of:

Subject: Quick Report on the California Regional Medical Program Site Visit June 10-11, 1971

To:

Director, RMPS
THROUGH: Acting Deputy Director
Regional Medical Programs Service

SITE VISIT TEAM

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Marian E. Leach, Ph.D., Continuing Education and Training Branch
Ronald S. Currie, ROR, DHEW Region IX

BACKGROUND

This site visit was arranged for the purpose of assessing the operational activity matrix of the Region. It was the second part of a two-part application. Part one, covering the Region's goals, objectives, a developmental component request and expanded Core renewal, were assessed by a December 1970 site visit team. At that time, the Region's new objectives were discussed. These objectives, established primarily to guide the use of developmental funds, also reflected the direction in which the Region is beginning to move---that of stimulating changes in the organization and delivery of health services.

As the agenda for the June 1971 visit unfolded, the team found itself again engulfed by Core activities as well as the operational project matrix. Probably, this was inescapable because retrenched funding, announced in the interim between the two applications required redesign of the Region's total program. The net result was a highly compressed presentation by each Area Coordinator of his total program activity.

The visit was conducted in two geographic locations. The first day in Los Angeles, we met with Dr. Spellman and some of his staff in Watts at the OEO Multipurpose Health Center. Area IX activity and the status of Project #6, the Charles R. Drew Postgraduate Medical School, were presented. The remaining southern California Regions (IV UCLA; V USC; VII San Diego; and VIII Irvine) were discussed in the afternoon. The second day, in San Francisco, the northern California Areas (I UCSF; II Davis; III Stanford; and VI Loma Linda) were presented. Portions of both days also were devoted to total Regional matters.

In an attempt to keep this mini report brief, I have selected only the following items for highlighting which I believe are the most crucial.

GENERAL IMPRESSIONS

(1) Watts needs help--of several kinds. The King Hospital, already about 14 months behind schedule, has suffered additional setbacks. These probably are attributable to several things, one of which is certainly the financial condition of Los Angeles County (reportedly over $50 million in debt). The recent earthquakes, the complication of the State Civil Service System, and community ferment, all contribute to monumental problems with which Drs. Spellman and Haynes are trying to cope. Approximately 50 area residents attended the three-hour morning

session hosted by Dr. Spellman in the OEO Center and the proceedings became somewhat vocal. The team requested that Mr. Ward make arrangements for a meeting with Drs. Spellman and Haynes the next day in San Francisco. A previous commitment precluded Dr. Spellman's participation, but the team had an opportunity to explore in depth the problems with Dr. Haynes. The following alarms were sounded. A commitment has been made to the community that King Hospital would be not only an outreach by the County to provide health needs, but an employer as well. However, the 3,200 positions originally announced for the hospital have been cut to 1,800 by the County as part of a drastic attempt to reduce its overall health budget. Also, as part of a health budget redesign, Dr. Haynes' Department of Community Medicine has been eliminated from the County budget (and there goes a previous understanding that when the King Hospital opened, support for this Department would begin.) This is a complicated set of circumstances which seem to turn on the ultimate point that Los Angeles County has decided it will not break a precedent by providing salary support for physicians not directly engaged in the provision of services.

It is estimated that between 3,000 to 4,000 trained hospital workers (mostly State civil servants with reemployment rights) are on the employment market as a result of the recent earthquakes. Knowledge of this makes the community in Watts suspicious of the inactivity to begin the hoped for programs to train area residents for positions in the hospital.

Dr. Spellman has recruited six of the ten Departmental Chairmen for the Drew School. To attract Chairmen in the absence of a facility and in the face of obvious financial difficulties has been a tremendous obstacle. The Medex program and a $250,000 grant from the Bureau of Health Manpower are visible stimulants as well as Markle Foundation funds. The team believes that the success of Area IX, the Drew School, and the King Hospital are so entwined that it is logical at this point in time to channel the financial resources provided by RMPS for Area IX and project #6 in the same general directions.

However, the team feels that assistance, over and above financial resources could be provided here in an effort to help Drs. Spellman and Haynes at what we belive is a critical time. Area IX and the Drew School must be able to do more than hold the line until the King Hospital opens (tentatively scheduled for February 1972).

Help in the form of professional assistance to move in new ways during the interim is indicated and I believe Mr. Chambliss has covered some recommendations along these lines with you.

(2) The team was unanimous in its concerns about Area VII San Diego, both its leadership and the operational program it displays. Although it is based in a very conservative area of the State, nevertheless it must be viewed as a part of a Region embarking on new directions

and probably requires a "slippered foot" kind of innovative leadership that the team feels is not present. If Area VII were not covered by the protective umbrella of the California total Region and had to compare and compete nationally, it would not do well at all. Area VIII, Irvine, left the visitors with bland impressions of its operational matrix that is disappointing. Area VI, Loma Linda, was also viewed somewhat negatively by most of the team. The vastness and remoteness of its geography were considered as well as the fact that the Medical School does not represent a resource primarily dedicated to local activities. It considers itself a national resource for the Seventh Day Adventist Church. However, because the Area base has a close proximity to Los Angeles, the team concluded that its leadership could have developed innovative inter-Area approaches to problem solving. Some of the site visitors felt that a second look at the boundaries of this Area might be wise. The next raking of concerns were Areas II Davis, and III Stanford. Total impressions recorded by visitors on these Areas were ambivalent--they probably are the gray areas. Areas I, UCSF, IV, UCLA and V USC again come through as making the greatest favorable impressions in terms of both organizational effectiveness and operational achievements. Area I presented an excellent Core developed guideline for activities covering the next two years. The leadership of these Areas has good vision and even though Dr. Rapaport made his usual statement of concern regarding quality versus quantity, he is moving in real ways to reach out to the six Model Cities Agencies in his Area as well as the United Indian Health Service, Inc. These Areas could compare quite favorably in national competition and the Region will continue to benefit from the directions these Areas pursue.

(3) The newly established 11-member Program Review Committee, chaired by Judge Kenneth Andreen and vested with program overview authority in the area of Regional strengths and weaknesses has the potential of a potent internal mechanism to assess performance. It reports directly to the RAG and may at its option site visit. If it does what it says it will do, it should prove interesting

(4) The visitors attempted to record their impressions in a fashion compatible with the new "mission statement" review criteria. Some of the consultants had not before participated in a site visit for RMPS, while for others it was a first visit to the California RMP. The reaction of your staff on the team was that given this diversity of team membership and in the face of a deluge of highlighted presentations in the Region, the basic compatibility of most of the ratings of new team members with those of the "old California watchers" was significant.

(5) Finally, a word about the decisions this Region had to make in order to retrench to a new level and at the same time salvage something for the development of its new directions. In arriving at a $6.2 level, the Region has almost entirely salvaged its approved $400,000

Developmental Component which is seen by them as "representing the best available avenue for change in new directions." Only two requests for renewals (the Drew School and the Northeast Valley project) out of twelve terminating projects were selected, both clearly in line with current objectives. The three new proposals, two in the area of Indian Health and one concerning extended care facilities, were selected at the cost of many approved/unfunded projects. A delicate balance was struck in an effort to retain visibility in each of the Areas and to maintain a capability to shift to objectives more in line with the new mission. The $10 million plan does not evidence this selectivity; hence the reviewers' failure to approve it.

RECOMMENDATIONS

(1) The $6.2 million plan the Region has developed in order to reach its retrenched funding level is viable and represents good decision-making.

(2) The $10 million plan the Region has developed should funds become available proposes the activation of some previously approved activities which the site visitors do not view as being wise to initiate at this time in view of the Region's new directions.

(3) With much the same selectivity that characterized the development of the $6.2 plan, the Region certainly could mount an effective program at the previously Council approved level of $8.3 million which would be consistent with national priorities and the Region's new directions.

(4) The site visitors concerns regarding the relatively ineffective program administered by Area VII should be relayed to the Region with the advice that CCRMP must address itself to these deficiencies. Also Areas VI and VIII are in need of intensive assistance with planning for the future. They are below the Regional RMP effort and might profit by assistance from Areas I, IV and V.

(5) The issues and questions identified by Committee and Council during the January/February review cycle concerning the Area I proposal (project #85) for a cooperative effort with the Bay Area Model Cities Agencies (San Francisco) were satisfactorily clarified.

Lorraine Kyttle

Lorraine M. Kyttle
Program Analyst
Grants Review Branch

(A Privileged Communication)

D R A F T

SITE VISIT REPORT
CALIFORNIA REGIONAL MEDICAL PROGRAM
JUNE 10-11, 1971

I. SITE VISITORS

Clark H. Millikan, M.D., Chairman, Member, National Advisory Council, Consultant in Neurology, Mayo Clinic

Joseph W. Hess, M.D., Member, Review Committee, Director, Office of Research in Medical Education, Wayne State University

Henry M. Wood, Director of Urban Health Planning, New Jersey Regional Medical Program

James A. Rock, M.D., Chairman, RAG Western Pennsylvania Regional Medical Program

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William Markey, Area IV-UCLA

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Richard Walden, M.D., Coordinator, Area VI - Loma Linda University
Mr. Derek Price, Associate Coordinator, Area III - UC San Diego
Robert Combs, Coordinator, Area VIII - UC Irvine

Mitchell Spellman, M.D., Coordinator, Area IX - Dean, Charles R. Drew Postgraduate Medical School, Watts-Willowbrook
Alfred Haynes, M.D., Chairman, Community Medicine Area IX - Watts-Willowbrook

OTHER REGIONAL REPRESENTATIVES

Mr. Cliff Cole, Project Director, South Central Multi-Purpose Health Service Center
Mr. Ray Eden, Executive Director, Los Angeles County Heart Association and Chairman, CCRMP Objectives Committee
Judge Kenneth Andreen, Member, CCRMP and Chairman, Program Review Committee

BACKGROUND

This site visit was arranged to respond to the second part of a two part application. Part one of the application (covering renewal of Core at an expanded level to coordinate programs with CHP and Model Cities; a Developmental Component; and new projects) was considered in the January/February review cycle. Part two of the application, covering essentially the project activity matrix, was scheduled for review in the July/August 1971 cycle. The recommendation of the site visitors in response to the first application was that a total program level should be established at that time to guide the Region with funding limits for the second part of the application. The Council of February 1971 approved a total program level of $8,363,994 for the Regiona's 04, 05 and 06 years.

In April all regions were notified of retrenched funding require by overall budgetary constraints. At that time, the California RMP was operating at $7.5 million with a commitment for the next year that dropped to $1.7. Council approved a level of $8.3 and the region had been notified that its reduced level would be $6.2. It also had amassed a large backlog of Council approved but unfunded projects. California responded by submitting two plans (A and B). Plan A reduced the programs to the $6.2 level and Plan B was presented at a $10 million level in the hope that additional funds might become available.

At the pre-site visit conference, the team agreed that the decisions the Region had made to retrench to a $6.2 level were well-grounded. The Developmental Componet request was not reduced appreciably. This is important to a region beginning significant moves in a new concept with the Developmental Component offering an early opportunity to implement timely programs in line with their new directions. The selectivity process that restricted requests for renewal to the NE Valley Project (#24) and the Drew School (#6) from a total of 12 terminating activities led the team to the conclusion that some thorny decisions had been made. The team also agreed that the assessment of the Region's operational activities must take into account that a part of the program is still devoted to the originally established objectives, while some of it is molded along the lines of national priorities. At this point, the CCRMP operational activity is described by Mr. Ward as "going in a least two different directions, at different levels, and different speeds."

The team devoted most of its pre-visit meeting in Los Angeles in discussing Area IX and the Drew School. A general framework of questioning was developed but it was agreed that the strategy for the morning session in Watts would be one of listening.

The disparate degrees of organizational effectiveness and program accomplishment among the Areas reflected in the application also discussed. There was agreement that the review criteria would be applied Area by Area.

GENERAL IMPRESSIONS

The California RMP in anticipation of changes in RMPS program directions began to develop a new emphasis some time ago. This Region, a federation of nine areas, some of which are larger in population and geography than other single Regional Medical Programs has required an alliance of leaderships was not easily accomplished. The 35-member California Committee on RMP (RAG) on which each of the nine Area Coordinators serve, approved a new set of objectives preparatory to submitting a triennial application. It was inevitable that new funding decisions emerged in directions quite different from the objectives that attracted so many members to the program initially. These new objectives also had to receive the approval of nine Area Advisory Groups as well.

Having adopted the new concepts, California found itself with a program evolving into two thrusts -- a portion of it committed to ongoing projects developed under categorical objectives and another portion molded in the new concept. Parts of the early categorically based program are in agreement with the new objectives. While a de-emphasis of the earlier concepts is obviously increasing the newly adopted thrusts are accelerating. Some representatives of the Region resisted this change. During this evolution, the Region was required to reduce its budget. The current site visitors agreed that the decisions that evolved struck a delicate balance in the $6.2 Plan A. The $10 million Plan B does not evidence this degree of selectivity. The team noted that it proposes the activation of some projects, which have been approved at the national level within the last 18 months. These are probably not as relevant now to regional or national priorities, and it might be unwise to begin them now.

As past site visit teams have noted, the current team agreed that the on-site visit mechanism offers an opportunity for understanding the real essence of the region's activities. California, in its attempt to reduce paper quantity, does not always present its case well. This is a perennial problem, and is probably due to the mass of data it attempts to synthesize for each submission. For example, this application reported on 86 ongoing activities and Core activities of nine Areas! Also contributing to the problem, in the opinion of the visitors, is the fact that the best available evaluation data is not usually included in the summaries. Each of the last three applications submitted were on the revised form. This has undoubtedly mitigated against the region's ability to "tell its story" to best advantage. Also, it has been noted that the region appears to have difficulty in developing an application which reflects consistency of preparation from all Areas.

The matrix formed by the operational activities when viewed regionally reflects a bifurcated program and Mr. Ward made no attempt to sidestep this issue. Rather, he spoke to it, both in Los Angeles and San Francisco in terms of total regional matters. The visitors believed that the spread of the operational activities in this Region is the logical extension of ongoing changes and, in all probability, reflects the status (or future status) of most regions, attempting such shifts in program thrusts.

The Region's review process which includes outside consultants and intra-regional site visits, is excellent and activities initiated since its promulgation are sound.

When viewed Area by Area the matrix loses some of its appeal and the balance becomes distorted. These concerns will be spoken to under Section IV, Program Accomplishments.

REVIEW DETAILS

A. Goals, Objectives and Priorities:

The assessment of the Region's goals, objectives and priorities was one of the missions of the December 1970 visit and the February Council accepted the team's recommendation of approval. The new objectives, which will apply to all developmental component funds and ultimately pattern the program, are clearly stated and are entirely consistent with national priorities.

B. Organizational Effectiveness

Although this portion of the program also was the subject of the December 1970 site visit, it was again reviewed for the following reason: The December team was assessing an application that proposed increases to Area Core staffs in order to coordinate with CHP activities and to provide the "underfunded" Areas (II, III, VII, and VIII) an opportunity to increase their staffs. There is a correlation between the productivity of Areas and their funding levels. However, the December visitors were not convinced that this was the only valid determinant and because the approved, overall increases were never funded, the December team believed the problem of disparate levels of core support had to be re-examined. The team's conclusions are as follows:

Central Staff

California's Central Office has a role that is singular. It is small (8 full time professionals and 6 secretarial/clerical employees) and it guides nine much larger bodies that in some ways are replicas of itself. It must be the introducer, the modifier, or the transformer, influencing the directions of the Areas who themselves have governing bodies vested with local decision-making. The Central Office has demonstrated its capability to fill this role. For example, it has created an atmosphere fostering collective leaderships; yet the Regional Advisory Group is strong. It has developed an internal review system that provides for local determination; yet those determinations are subject to expert consultant review. It has developed the tenets necessary for the formation of a federation of nine Areas; yet it has established a Program Review Committee to monitor the effectiveness of the Area's programs.

Much of the Central Office effectiveness is a reflection of the leadership of Mr. Paul Ward. The Central Office staff appears to be well balanced in terms of professional training and skills.

They appear to function in a cohesive manner. The Executive Director enjoys a very positive relationship with the Area Coordinators in an unusual capacity of being a gentle, but firm, administrator.

CRMP is faced with the problem that some Areas are below regional standards of performance. Areas I, IV and V have established excellence that could favorably compete nationally. The "below standard" Areas are receiving much the same kind of message from the central governing body that the national review process employs--rejection of proposals or such low priority rating as to compress funding. On the other hand, decisions have been made to "earmark" one-fourth of the developmental component for some of these Areas IF they produce quality proposals designed to meet the new objectives. Some reevaluation of the various Areas leadership must be employed if these remedial measures are not effective, and feedback from this site visit will speak to that point.

Area I - San Francisco

This group has performed effectively consistently. It has developed an excellent guideline for its Core activities for the next two years. The basic premise is that efforts should be directed not only where community need is greatest, but also where there is significant potential for change. They have addressed themselves to the self sufficiency of activities so that changes made will have continuing impact and RMP resources can be shifted elsewhere. Work plans to achieve the Area's objectives have been developed and two-year goals have been specifically identified. They are aware of the need to continuously inspect their own activities, to be aware of changing priorities, and to continue to update their own reaction and interaction to RMPS objectives. A redistribution of Regional funds which would constrict the Area I budget is a matter of serious concern. Area I was the only one with concrete evidence of in-depth continuing planning activity, including planning concerning the semantics of the changing RMPS objectives.

An extraordinary number of cooperative arrangements have taken place, such as: an extensive network of RMP advisory committees covering all 12 counties in Area I and involving hundreds of health professionals and consumers. Also, interrelationships have been established between major functioning groups, such as CHP, County and State organizations, social agencies, etc.

The excellence of the staff and the programs developed by the staff under aggressive leadership is unquestioned. Further, the team believed that Area I is probably one of the two or three most outstanding RMPs in the nation. There is great emphasis by Dr. Rapaport and his staff of "planning as the community sees it." Significant community participation has been achieved through its 800 volunteers on various committees, including seven District committees, each of which meets monthly.

Area II - Davis

From the information presented, this Area did not demonstrate the significant planning found in some Areas. Activities generally labelled "continuing education" and "bridging or consultation" were presented as the planning base. The latter represents the Area's attempt to supply personnel to create liaisons with the CHP and other agencies. The development of health manpower and the organization and delivery of health services are seen by this Area's leadership as being a future expansion of their activities. Some of the visitors rated this Area higher than others on organizational effectiveness because they felt the Area Coordinator, Dr. Neil Andrews, who has occupied the position for approximately 18 months, is attempting to increase small staff at a time when it is difficult to attract good people to the program, will get the Area moving.

Area III - Stanford

This Area's track record bespeaks good organizational effectiveness. The rather traditional emphasis on continuing education must be viewed also in light of the Area's early involvement in activities that require effective and cohesive staff liaisons. Its Core is funded at less than $250,000 and it serves 2.5 million people.

From the information presented at the site visit, Area III appears to have laid the goundwork for an Area Health Education Center. There is also a readiness in this Area to pursue new approaches to health care delivery and is a likely opportunity for the formation of an HMO. Another example is the program "Action Associates", a type of clerkship of medical students who deal with problems of rural medicine.

During the visit questions were asked about the apparent fact that many Committees of the Area Advisory Group have never met; nor do they reflect adequate minority groups representation. The Coordinator, Dr. Fowkes, promised the visitors to present additional information on these two points.

Dr. Fowkes made the point that Area III is very much interested in attempts to contain expanding costs of medical care. He gave as an example of the success of their efforts, the limitation of number of colbalt therapy units going into a certain portion of the area. This limitation is being brought about by liaisons established with RMP personnel to CHP and other agencies.

Area IV - UCLA

This group embarked on a formalized planning process to identify the health needs, resources and priorities of its ten districts some time ago. Its Community Task Force has clarified the routes to be taken, revitalized to a considerable degree the district committees, and generated a systematic identification of problems and solutions. Its early cosponsorship with Area V of the Watts/ Willowbrook district is evidence of its foresight. A very effective staff, well distributed throughout the Area, characterizes its organizational effectiveness. This Area has generated 61 projects; 15 were approved by the Area Advisory Group; 13 were approved by the Regional Advisory Group; 10 were approved by the National Advisory Council. However, only four have been funded. Several of the approved but unfunded activities have been partially activated through Core personnel and funds. In all, 118 activities have been initiated, all characterized by joint support from Area Core funds and community sources. Some receive support from contiguous Areas. The Area was rated "excellent" on these items by the team. Program planning on health manpower and health care delivery is formalized and involves both providers and consumers and all Core staff. A mechanism has been established to educate staff and volunteers regarding HMO legislation, guidelines and strategy and an "HMO Development Fouincation" has been established.

Over four million people reside in the territory covered by this Area. It was obvious that Area IV is operating a program comparable to a "region" and in the opinion of the visitors is probably one of the half dozen nationally outstanding ones.

Area V - USC

Late in 1970, Dr. Donald Petit, the Area Coordinator, appointed three task forces to begin a projection of activities for the next three years. These were composed of a combination of Area Advisory Group members, Committee Chairmen and Core staff members. The task forces formed were: Health Care Delivery and Organization; Manpower; and Target Groups.

The principal purpose of the Groups was to bring the planning process for Area V in tune with the general change in national priorities, and the reports of these Task Forces presented to the January 1971 meeting of the Area Advisory Group give insight to the Area's work plans.

This Area has long been and continues to be an instigator of inter-Area arrangements. Drs. Petit and Brayton were early framers and supporters (both with financial and personnel assistance) of the Watts-Willowbrook District. The Regional Kidney Plan is another example. County-wide planning (with Area IV and IX as well as CHP)is another. One such activity is the development of a "profile" evaluation method to apply to health service plans including health maintenance organizations. The essence of this strategy is the building of a profile for comparing aspects of these organizations with existing phenomena. Some site visitors felt the organizational effectiveness of this Area is second only to Area I in its capacity to produce programs appropriate to local socio-political movement.

Area V programs, although small as well as numerous, appear to be directed toward improving the quality and methods of health care rather than involvement of health providers for the sake of involvement alone.

Area VI - Loma Linda

A very low level of organizational effectiveness was detected in this Area. Dr. Walden, the Area Coordinator, described the vastness and remoteness of the geography encompassed by his boundaries. A glance at a map certainly substantiates his statement but also suggests that the northern portion of Area VI could be logically related to Area II. Dr. Walden emphasized the fact that Loma Linda University does not form a good base for local action because of its very objectives -- to train selected physicians from all over the world and have them go back to their place of origin. In his opinion, should an Area Health Education Center be developed, it should not be in the University but in Riverside or San Bernadino.

Another item that Dr. Walden brought out (and which in the opinion of the site visitors, identifies a need to re-examine the boundaries of this Area) is that 75% of the population in Area VI is located near Los Angeles. The team concluded that some adjustments may be necessary, especially since the Area's leadership has not, thus far, exhibited innovative approaches.

This appears to be a very weak Area. If it were being looked at nationally, in comparison with all regions, it probably would fall in the lowest 20 percent from a quality standpoint.

Area VII - San Diego

The visitors were unanimous in their conclusion that this Area is operating ineffectively. The Area is known as being the territory of conservative providers. However, present program activities do not lend themselves to the introduction of more creative and innovative programs. The master design was described as continuing education and Mr. Price, the Deputy Coordinator, (who presented the Area's program in Dr. Shimkin's absence) stated they are just beginning to learn the initials HMO. A reevaluation of Area leadership and direction is needed and CCRMP should be advised that it must address this problem.

Area VIII - Irvine

This is an Area with a small Core staff that encompasses a territory in which approximately four million people live and which left the site team with bland impressions about its organizational effectiveness.

Core is supported at $178,000. The essence of the program is a very successful Comprehensive Community Stroke activity. It has made a significant contribution regionally and is outstanding.

Some of the visitors felt that with careful selection of full-time staff the Area might make a meaningful contribution to the regional effort. This is complicated by the fact that the allocated Core positions are all filled (nine professionals, only three of whom are full-time). Decisions must be made by CCRMP regarding this problem.

There was some feeling that the Area Advisory Group may have potential for being led into more innovative programs.

Area IX - Watts-Willowbrook

This Area was an outgrowth of a District sponsored jointly by Areas IV and V until early 1971. This change in administration has been accompanied by some resentment and dissatisfaction, particularly with the enlarge Area Advisory Group, now 50 members including 20 providers and 30 consumers. Seventeen of the original group are still on the new Advisory Body.

This portion of the site visit took place at the OEO Neighborhood Health Center in Watts, with Mr. Clifford Cole, the Director, reviewing the origin of this health center which was made possible by support through a grant by the University of Southern California. The facility includes 53,000 square feet has a variety of sources of funding, including third party sources, a secondary grant from Model Cities and another from HEW. Under development is an HMO plan, as well as relationships with the King Hospital and the Drew Postgraduate School of Medicine. The staff has 9 full-time dentists and 19 physicians, serving 16,000 patients in 1970, with a service area of 40,000 people.

Dr. Mitchell Spellman, Dean of the Drew School, pointed out that the School will be an arm of the King Hospital, and there is a contract with the L.A. County Department of Hospitals which spells this out. Also, the Markle Foundation assisted in funding of the Department of Community Medicine faculty. The Commonwealth Foundation has provided $170,000 for development of the master plan of the School, and the Bureau of Health Manpower is providing $250,000 to support the development of the Master plan.

The feasibility of proceeding in the development of an undergraduate medical school is under study, and there is pending in the California State Legislature which may produce funds for such planning. There is a contract under negotiation with L.A. County to train allied health personnel. This may be a potential for an Area Health Education Center.

Dr. Spellman's presentation was interrupted a number of times by a privite citizen attendee who represents a dissident view in the the community to express her feeling that the overall efforts in Watts have emphasized the academic side to the neglect of a populace languishing without medical care. In her opinion, the Drew School is too high in its concept, and "it needs to get out where the people are."

Compounding the problems have been the continuing delays in the opening of King Hospital, which is now scheduled for completion between December 1971 and February 1972. Originally there was a budget for 3,200 positions, now reduced to 1,800. These are County Civil Service positions, and examinations are taking place. The site team heard a great deal of criticism from representatives of the community that these examinations are held "downtown", some miles from the Watts area. Some insecurity was expressed about the impact of the unemployment of some 3 or 4,000 hospital workers which was occasioned by the recent earthquake. The site team learned later in executive session that there is an employment office in a trailer at the hospital construction site, but RMP Core staff is reluctant to start training until they can be assured of the actual number of jobs. Also, permission was requested of the County to open temporary outpatient facilities before completion of the hospital, but that was denied.

The site team was concerned about the lack of emphasis on an outpatient department, as well as a seeming lack of liaison with various neighborhood health clinics, such as OEO, and the three Model Cities which exisit in the Watts Community. It was learned, however, that such interrelationships are developing in all of these areas. Dr. Alfred Haynes pointed out that all physicians Practicing in Watts-Willowbrook will have King Hospital privileges.

Dr. Haynes also described the manner in which he believes health and welfare will operate jointly as an organization of "Regional Medical Programs Health Care Administration." Some of the Area's accomplishments he listed were: the development of a health careers program; a Medix project with 21 persons at UCLA (corpsmen) on duty; an allied health program; planning and organization of health care; continuing education; library facilities; and community medicine in the hospital.

A woman physician employed by the County to assist in Watts contributed several very reasonable comments during the morning session, particularly with reference to the training of technicians and allied health personnel. As an example, she cited that graduates of the Van Nuys School of Technology cannot be licensed or registered because the AMA does not recognize the legitimacy of the curricula of the school.

The site team agreed that the organizational structure of Area IX is presently so enmeshed with the Drew School and the King Hospital that it is difficult to separate out the various functions. Dr. Haynes, appointed Area Coordinator late in 1970, is also Chairman of the Department of Community Medicine of Drew. His efforts have been fragmented by explosive community problems, recurring delays in completion of the King Hospital, recruitment of faculty, etc. He has had very little time to develop an effective organization.

The status of the Drew School activity (Project #6) which has a direct bearing on Area IX is discussed in another section of this report. However, the team was glad to learn that a Search Committee has been appointed to recruit a Coordinator for Area IX, after which time, the professional positions will be filled. There is a need to activate some Core staff activity apart from Drew School in order to strengthen the coordination of efforts and liaison with other health activities throughout the Watts community.

C. Involvement of Regional Resources

The following is a synopsis of an assessment of the Region's use of its resources and was made on the basis of information included in the application. The full document will be forwarded to the Office of Planning and Evaluation.

If "involvement" is used in the context of the impact of involvement to influence the mission, and if "resources" is broadly considered as meaning people and institutions, then the involvement of California's resources presents somewhat of a paradox.

The composition of the Area's Advisory Groups, when viewed collectively, is about 80% traditional. The rate varies among the Areas, but the range is not so great as to distort the average.

The institutional resources involved in the program also are predominantly traditional when viewed on the very general classification division of those institutions generally related to the categorical restraints of the original legislation and those agencies embracing direct approaches to reorganizing the delivery of health care.

Areas with predominantly "traditional" advisory groups are sponsoring non-traditional activities with an institutional action base clearly embracing direct approaches to health services reorganization and delivery.

The analysis suggests the need to have more than occupational classification for representation or institutional affiliation classes. For clearly, some individuals slotted into stereotyped categories based on the milieu with which they are associated, must be influencing the framework in which they operate as well as the decisions made by the Group, in ways not associated with their "label."

Also, by label, the involvement of minorities and the disadvantaged is very low which would indicate that critical resources are not well tapped in the decision-making processes. Greater involvement of this resource could assist in the smooth and effective transition to the new objectives.

For this Region which is beginning to move in the direction of stimulating the reorganization of health care delivery systems, a continuing analysis of the composition of its advisory groups, the impact of the involvement of its memberships, and the groups' influence on the Region's success in its new direction is certainly indicated. Clearly though, the impact of the involvement of the Region's resources creates the strange but productive atmosphere of a traditional group producing non-traditional decisions.

D. Assessment of Needs, Problems and Resources

During the December 1970 site visit, a review was made of the Region's ability to assess its needs, identify problems and muster

the appropriate resources for meeting these needs. The Region's performance in this area was judged to be excellent.

E. Program Implementation and Accomplishments

CCRMP as a Whole: The Region is operating effectively as a federation of nine units. A system has been developed that generates initial local autonomy and decision-making but it provides for total Regional overview via the priority for funding mechanism. There are Areas in this federation that do not meet regional standards of performance. CCRMP is aware of this. However, these Areas are funded at a level considerably below the national ratio when viewed in terms of Area geography and residents. The California RMP has dedicated one-fourth of its Developmental Component in the upcoming year to funding activities in these Areas if they pursue the Region's new objectives. For some Areas, however, the team believes that assistance beyond the infusion of developmental funds is needed.

Area I - San Francisco

Of the eight separate ongoing projects (many with distinct sub-project activities) four are terminating this year. Each has developed a degree of self-sufficiency so that either community resources will continue the effort or the activity has pursued its goal to completion.

For the upcoming year, Area I will continue four of the ongoing activities and will implement one new one--the Indian Health project. The operational matrix of this Area displays good balance for the transitional year.

Also proposed by Area I is the proposed plan for a cooperative effort with the Bay Area Model Cities Agencies. It was submitted to the last review cycle and deferred to the site visit team for recommendation. On-site inquiry developed information that indicates that this proposal is a logical link in the relationships of RMP and the Model Cities Agencies. It outlines a plan for the School of Allied Health, and is part of a long range amalgamation of the Model Cities project, existing OEO health centers, the new OEO Outpatient Improvement grant, and the Community Health Service, into a rational health network to provide health services in the San Francisco community. Three projects are already operational: a health care outreach program utilizing indigenous health workers with professional supervision; a health planning team to focus on organizing consumer input into planning; and a learning diagnostic center to improve the learning performance of children. All of these activities are supported by funds other than RMP.

The proposal submitted by Area I will provide for a different kind of staff--one that will assist both the School and the Model Cities Agencies in determining the feasibility of a new resource for the

training of allied health professionals and, to develop plans for implementing a program using present or newly developed resources. This proposal is not specified for funding at the $6.2 level because it was not an approved activity at the time the $6.2 plan was framed. The site visitors view this activity as one that should receive a high funding priority.

The new Indian Health proposal which will identify the resources available in the Area and assist Indians in their utilization of these resources, has all the ingredients for success. With the assistance of the Indian community, two health aides have already been hired under the feasibility study that preceded this project proposal.

Area II - Davis

Under Plan A, this Area will continue its Stroke activities and will implement a previously approved project entitled "Compendium of Extended Learning." It is proposed as a cohesive mechanism to plan, develop, and implement a program of education for the Area's health professionals. Area II has provided some type of education service, relating to one of the categorical diseases, in 72 of the 73 hospitals in its territory.

The Roseville project will not be renewed. A number of the elements of the activity will be continued under local support. The Region is currently negotiating with the community on the matter of continuing the activity.

The activities proposed by this Area for its next year are, at this time, an extension of its present concepts based on education. Its movement in new directions depends on developmental funds.

Area III - Stanford

Two projects will be continued in this Area, the Stroke Program and the San Joaquin Multiphasic Screening. There has been a rather traditional emphasis on continuing education, to the point where five hospitals are actually coming into an affiliation with Stanford.

There was discussion of the San Joaquin Multiphasic screening for rural and urban poor. A total of 4,580 persons were screened and 60% of these needed to be seen by a physician. An OEO Neighborhood Health Center provides space for follow up and care. This was accomplished through local financial support. As a result of this screening activity the Board of Supervisors has requested the development of two more neighborhood clinics. A number of interrelationships with the RMP have evolved: The project is now being coordinated with Project Identity (federally funded) to help in combating drug abuse. The San Joaquin Medical Society has established a referral mechanism and also continues in the staffing of the health center itself. The health center is really a community affair - the Southeast Improvement Center (OEO)

is responsible for community relations; the Medical Society is supplying professional staff; and the County Board of Supervisors is providing medical supplies and financial support. This project is a model of how multiphasic health screening can become the pivotal point in the development of a new approach to health care.

Another multiphasic screening project (East Palo Alto - Menlo Park) has not been as successful. Although it was funded in 1970 for two years its activation was delayed. Area III requests that it be extended six months beyond the original request since experience indicates that multiphasic screening has a very definite role in the development of the whole neighborhood health center concept. This project revolves around what is called the Charles R. Drew Neighborhood Health Center which was established under an OEO grant in November 1968. The target population includes 80 per cent Black Citizens of an estimated 26,000 persons with more than half in the low income category and eligible for ambulatory primary health care at the Center. Multiphasic screening is now working into the program in a way to increase the community utilization of the comprehensive health care services. During March 1970, a total of 126 patients were screened; in April the number was 153 and in May 142. Progress has not been as fast as originally planned due to repeated changes of project director, late completion of laboratory facilities and difficulty recruiting trainees from the local community to perform the tests. It is anticipated that the number of patients screened, after June 1, 1971, will approach 150 per week. The multiphasic screening is an integral portion of a complete plan and there is follow up consultation and examination if indicated.

The Stroke Program consists of the Santa Cruz County Stroke Project, operational now for 11 months and the Stroke Program at the Santa Clara Valley Medical Center which began in October, 1970, pulling together earlier programs begun at the Santa Clara County Heart Association and Deanza College. Thus far, there have been some retrospective comparisons with studies on stroke care in Santa Clara Hospital in 1966, Stanford Hospital in 1967, and by the California RMP in 1968. Data initially shows improvement in all levels of stroke care. It is said that early prompt workup to define the etiology of the stroke; quick assessment of the degree of disability; extension of a therapeutic program throughout the nursing day because of the adequate training in the stroke unit and specialty training of stroke personnel; increased use of consultation; a nurse coordinator acting effectively in liaison between hospital services and between extended care services as well as community resources. All have been accomplished by the Stroke Program. The plan is to extend a variety of activities to all portions of Area III. The development of the pilot program will continue at Santa Clara Valley Medical Center for formal patient-family instruction to reduce long-term dependence on allied health professionals, and promote case finding and treatment of hypertension, particularly in disadvantaged communities to reduce stroke morbidity.

In addition to the two mentioned above, there is a stroke program at Stanford University Hospital. The feeling was that purposes of the stroke program have all been achieved to some extent during the first six months of its existence. Study of comparison groups of patients before the stroke program and since its inception indicate that more patients have had rehabilitation services, have achieved a degree of self-sufficiency and ability to function independently and more have gone directly home, by-passing the extended care facilities, than was true during the same calendar period before the stroke program got underway.

Area IV - UCLA

One of the two renewing activities selected throughout the Region is this Area's Northeast Valley Project. The former project director was appointed to a regional post by OEO and Dr. Brayton stated that negotiations for a replacement are going on. This activity represents one of the several projects initiated earlier by the Califomia RMP that is clearly on target and in line with the Region's new objectives. It is beamed at a disadvantaged community of Mexican American and Black residents and its research has generated widespread interest and assistance to the community. The matrix of this Area's program was viewed by the visitors as excellent. Formalized program planning on manpower and health care delivery has been instituted in all ten Districts of Area IV.

The Northeast San Fernando Valley Project has been funded for three years and has been given high priority as a request to continue funding for another three years. This project exhibits extensive community involvement and community health education. A grant for establishing a health services network is on the verge of being approved by OEO.

Doctor Brayton pointed out that from November 1967 to March 1971, 61 projects were initiated by personnel in Area IV; 15 were approved by the Area IV Council; 12 of these were approved by CCRMP, and subsequently 10 were approved by the National Advisory Council. However, only 4 have been funded! In order to make the funds stretch as far as possible, several approved projects have been partially implemented with core funds. These include: 1) medical information communication services, 2) decentralized coronary care unit nurse training and 3) primary physician continuing education.

Doctor Brayton has initiated program planning concerning manpower and health care delivery in a formalized fashion in all districts involving 575 volunteers (providers and consumers) and all Core staff. In addition, the mechanism has been established to educate staff and volunteers regarding HMO legislation, guidelines and strategy. An "HMO development foundation" has been established.

Area V - USC

Through the planning efforts of this Area and the professional leadership it provides the East Los Angeles Experimental Health Care Delivery System project came into being. It has been selected by NCHS-R&D for funding. This Area also is an early instigator of the free clinic concept and under the $10 million Plan B, proposes an activity to develop coordination through the Southern California Council of Free Clinics the Area's efforts to support existing clinics with professional staff and to develop new clinics. Its proposal on "Urban American Indian Health Needs" scheduled for activation under the $6.2 Plan A is another example of its ability to operate effectively within the Region's new objectives.

Area V spearheaded the San Fernando Valley Health Consortium, a college-community endeavor to meet the needs of the Valley by organizing and implementing the training of allied health personnel. The San Fernando Valley and Pacoima Health Planning project was also focused on this suburban area for low income and indigent families.

The pacemaker project funded May 1970, became effective November 1970. As of May 1, 1971 a total of 451 patients with pacemakers have been identified and 267 fully registered. All are being followed by the Registry. The objective to recover pacemakers is working out well. Also, third objective to provide an information center regarding the use and function of pacemakers is moving along satisfactorily as is the fourth objective which is to provide professional education in the use and function of pacemakers.

The Respiratory Training Institute, originally housed at Olive View Hospital, had to be relocated following the earthquake in February 1971. The courses are now presented at Barlow Sanitarium and the staff is housed at the Los Angeles TB Association Office.

A very interesting activity is the demonstration in integrated health care for senior citizens in East Los Angeles. This activity is proceeding under a $40,000 contract awarded to the County Health Department by Area V, CRMP. Senior citizens will be screened in facilities adjacent to the East Los Angeles Health Center. The focus of the project will be on 1,000 selected older patients of the total group who will receive the services of special "case managers" to insure continuity of care and total followup.

The Area V stroke rehabilitation liaison nurse program, implemented by Area V Core effort (no operational funds involved) has worked with and utilized community resources in training 6 stroke rehabilitation liaison nurses representing a total of 1700 acute beds. The system is well established in each of these participating hospitals, and plans are underway to expand the program into many more acute hospitals.

Area VI - Loma Linda

Under Plan A, the Core for this Area will be supported at approximately $150,000 and one operational activity will continue--the Perinatal Monitoring project.

Dr. Walden described Core staff efforts in the following fields: the self supporting coronary care training project in San Bernadino County Hospital; a library awareness program; continuing education with visiting experts coming in twice a year; and a remote computer terminal for ECG and respiratory monitoring. Some Loma Linda students have worked in South Colton centers with Mexican American communities. Dr. Walden also described an activity associated with health problems of the American Indian, but this was not fully described as an RMP Core activity.

There are two Mexican-Americans and one Black on the Area Advisory Committee. Hopefully more minority representation will be added. Some attempt is being made to bring the University of Redlands and the University of Calfironia - Riverside - into a relationship with Loma Linda to assist in producing additional health manpower. However, this does not sound like a very effective effort at linking these educational agencies together.

Doctor Walden commented that some of the students have gone into a disadvantaged area of Mexican-Americans to work in three treatment centers. There was a small amount of RMP support for this activity, but this has been discontinued. There are some activities associated with the problems of American Indians but these were very hazily defined.

Area VII - San Diego

Under Plan A, the Core for this Area will be supported at approximately $150,000; one operating activity will continue and one previously approved project will be activated.

Six "mini-projects" include: (1) Stroke resocialization; (2) Pulmonary rehabilitation; (3) Mercy Hospital - public health education through community outreach clinic (Mexican); (4) Continuing Education of physicians by using a medical audit with four hospitals banded together; (5) Health Science education ability (core curriculum) in the community college; and (6) School nurse practitioner program working with model cities (Mr. Price said this was actually not underway but they wanted to do it. When asked whether they were attempting to stimulate the public health department to do this, he said "no we're not"!)

This Area's record of accomplishment was far below the Regional effort. CCRMP plans to infuse the Area with selected developmental funding but in the opinion of the site visitors, intensive assistance with future planning is needed as well as a reevaluation of its leadership.

Area VIII - Irvine

This Area will continue its Comprehensive Community Stroke Program. This activity is increasing the quality of care of the stroke patient and integrates all aspects of such care. The team heard an excellent presentation concerning the project's volunteer follow-up after discharge activities. However, it was concluded that no formalized planning for future engagement of the Region's new objectives is underway.

Perhaps selected developmental funding will improve this Area's overall performance, but it will require assistance in its future planning.

Area IX - Watts

Approximately 50 area residents attended the three-hour morning session hosted by Dr. Spellman in the OEO Center. The team later requested that Mr. Ward make arrangements for an executive meeting with Drs. Spellman and Haynes the second day in San Francisco. A previous commitment precluded Dr. Spellman's participation, but the team had an opportunity for an in-depth discussion of some of the problems with Dr. Haynes. A commitment was made to the Watts community that King Hospital would be not only an outreach by the County to provide for health needs, but would be an employer as well. However, the 3,200 positions originally announced for the hospital have been cut to 1,800 by the County. Dr. Haynes' Department of Community Medicine has been eliminated from the L.A. County budget.

The team feels that assistance, over and above financial resources could be provided in an effort to help Drs. Spellman and Haynes at a critical time. Area IX and the Drew School must be able to do more than hold the line until the King Hospital opens.

NOTE: Since the site visit, staff has learned that the County of Los Angeles has agreed to provide support for the Community Medicine and Community Outreach Programs for the King Hospital. This will support an additional 150 positions in the amount of $655,895.

F. Evaluation

The evaluation efforts of the California RMP come to a focus at the CCRMP Central Office level. Based upon data collected by project directors, and channeled through the Areas to the Central Office, CCRMP is currently maintaining information that gives a good overview of the emphasis of its activities. The methods and procedures utilized are designed to provide management information--in other words--information for administrative decision-making. Such results enable staff to present data which reflects percentages of budget expenditures by:: (1) purpose of activity (quality of acts of medical care, accessibility, availability, etc.); (2) aspect of care (prevention, detection, diagnosis, etc.); (3) activity site (university medical center, teaching hospital, mixed community hospital, etc.); and (4) activity method (continuing education, training, data collection, planning, etc.).

The site visit team had some difficulty in understanding the application of these data as they were summarized in pie charts. For instance, the chart illustrating "activity site" could lead one to assume that CCRMP is almost exclusively occupied with university medical center dominated hospitals (61%) with other community sites shown as representing 13%. The team felt that this is not really representative of the CCRMP effort.

The entire program review process, from Districts within the nine Areas, through the CCRMP (RAG), is designed to operate in a consistent manner, with the CCRMP Core Evaluation staff providing consultation. This has produced an operative program of review and evaluation from the time a project activity is developed at the Area level,through the time it is submitted and reviewed at the CCRMP level. The Evaluation staff members described this procedure as designed "to apply to the totality of project activity as a unified program, and is not limited to project-by-project evaluation."

The following criteria are imposed by CCRMP on all data collection efforts for evaluation:

1. The information must be useful in the decision making process;
2. The budget for data collection must not exceed 5% of the total budget;
3. The data must agree in format with the CCRMP integrated information system to foster comparison among projects on a regionwide basis; and;
4. It must be capable of surveillance.

There was somefeeling on the part of the site team that CCRMP evaluation staff (or the process of evaluation) does not provide adequate assistance to Area or project personnel in evaluative techniques or modalities necessary to ascertain the project or program's critical elements. On the other hand, consultation is

available to assure compatibility of data collection, form and reporting methodology, based on the CCRMP model.

Thus far, the region's efforts at evaluation seem, in the opinion of the site team, to be limited to the task of digesting the mass of information that its reporting system generates. This was discussed with the regional representatives, who expressed the hope that RMPS would undertake the evaluation of the impact of certain efforts common to most regions. As an example, they cited the very long chain in linking the impact value of training nurses in coronary care.

It appears that CCRMP is moving in directions that may defy a realistic appraisal or development of a data base capable of conversion to a base for evaluation. An example of this is a free clinic. CCRMP evaluation staff feels this will have to be self-reporting because the participants have been pledged to complete confidentiality.

The team saw some correlation of the evaluation function to the difficulty the region seems to experience in "telling its story" through the application. This may be due to the fact that their evaluation reporting is poor. The team noted, in a few isolated instances (and after extensive questioning), some fairly decent project evaluation is being done. Unfortunately, this was not reflected in the material submitted with the application. The team feels that all of these reports should be reviewed by the Evaluation staff in the Central Office, who should insist that the Area and project personnel submit the very best evaluation data available with their summaries. The team views as part of the central management function an awareness of available evaluation data in each Area.

All in all, the visitors believe that the region has developed a good technique for the collection of data on which to make certain regional decisions. Present efforts seem to be an epidemiological approach, with the "political" approach still to be developed.

G. Conclusions and Funding Recommendations

(1) The $6.2 million plan the Region has developed in order to reach its retrenched funding level is viable and represents good decision-making.
(2) The $10 million plan the Region has developed, should funds become available, proposes the activation of some previously approved activities which the site visitors do not view as being wise to initiate at this time in view of the Region's new directions.
(3) With much the same selectivity that characterized the development of the $6.2 plan, the Region certainly could mount an effective program at the previously Council approved level of $8.3 million which would be consistent with national priorities and the Region's new directions.

(4) The site visitors' concerns regarding the relatively ineffective program administered by Area VII should be relayed to the Region with the advice that CCRMP must address itself to these deficiencies. Also, Areas VI and VIII are in need of intensive assistance with planning for the future. They are below the Regional RMP effort and might profit by assistance from Areas I, IV and V.

(5) The issues and questions identified by Committee and Coucil during the January/February review cycle concerning the Area I proposal (project #85) for a cooperative effort with the Bay Area Model Cities Agencies (San Francisco) were satisfactorily clarified.

RMPS/GRB/7/26/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

CENTRAL NEW YORK REGIONAL MEDICAL PROGRAM
State University of New York
750 East Adams Street
Syracuse, New York 13210

RM 00050 8/71
July 1971 Review Committee

PROGRAM COORDINATOR: Richard H. Lyons, M.D.

This Region currently in its third year of operation, is funded at a level of $645,080 direct cost. In addition, the Region has received $250,534 of indirect costs which represents an average indirect cost on-campus rate of 67.8% and an off-campus rate of 34.3%.

In this triennial application, the Region has requested for its fourth year of operation $1,413,928 direct costs for support of the following activities:

I. The continuation of Core and two ongoing projects ($490,865)
II. The implementation of two previously approved/unfunded projects ($55,481)
III. The implementation of four new projects ($867,582)

(Attached is a chart identifying the components involved with the above items.)

Following are the key issues identified by staff in their review of the continuation application:

1. The need for representation on the RAG from the lower economic consumers, Model City Program, OEO program and the neighborhood health center of the Region.

2. The need for RAG to assume leadership and give direction to the CNY/RMP.

3. The program is overly oriented toward the continuing education of nurses, it needs to broaden its scope of activities to meet the health needs of the Region.

4. Unable to identify what the eleven liaison physicians on Core are contributing to the program.

5. The membership of the RAG Board and RMP local advisory groups are physician oriented with little if any allied health personnel representation.

6. There appears to be little organized interrelationships between RMP Committees, nor do they identify an established operating procedure. These committees appear to be project oriented with little involvement in program planning and operation.

7. There doesn't appear to be a regional plan to which operational activities can be related. There also appears to be little interrelationship between projects.

8. The evaluation process is unclear.

(Attached is a copy of the memorandum of staff's review of the continuation application.)

FUNDING HISTORY
(Direct Cost Only)

Grant Year	Period	Funded
Planning Stage		
01	1/1/67-12/31/67	$192,408
02	1/1/68-12/31/68	211,000
02S	6/1/68-12/31/68	138,268
Operational Stage	**Period**	**Funded**
01	7/1/68-6/30/69	$ 372,355
02	7/1/69-9/30/70	Core 462,500
		Projects 607,262
		Total $1,069,762
03	10/1/70-9/30/71	Core 389,789
		Projects 339,302
		Total $ 729,091
03 (After 12% across the board reduction)		Core 344,385
		Projects 300,595
		Total 645,080

Geography and Demography

The Central New York Regional Medical Program is comprised of 15 counties in Central New York, plus two counties in adjacent northern Pennsylvania. The boundaries were determined by Medical Trade Areas, Medical Education and part graduate educational patterns and to conform with the boundaries of the State Health Department regional efforts. The Region is approximately 96 miles wide in its East-West perimeter and 271 miles long from the Pennsylvania State Line on the south to the Canadian Boarder on the north. Geographically, it is one of the larger but relatively thinly populated Regions in New York State.

Population: Approximately 1,800,000
Approximately 60% Urban
Approximately 97% white
Median age approximately 30

Land Area: 26,016 square miles

Mortality Data: (Rates for New York State - 1964
Mortality rate for heart disease - 437.4/100,000

Mortality rate for cancer - 186.4/100,000

Mortality rate for CNS Vascular lesions - 99.8/100,000

Facilities

State University of New York, Upstate Medical Center, 4 year, medical school, enrollment approximately 406.

There are 19 schools of nursing, 6 of these collegiate affiliated

There are five college and institute based schools of Medical Technology

There are 48 (short-term) hospitals, (1 federal) with 7,654 beds (488 federal).

Personnel

There are approximately 2,700 M.D.s (133/100,000 and approximately 55 D.O.s

There are approximately 15,000 registered nurses of which only about 9,000 are active.

There is a marked difference between the number of physicians residing in some counties and the number who have designated themselves as being in private practice. The marked differences reflect in some instances the presence of large State Psychiatric Hospitals (Broome, Oneida, and St. Lawrence) or major medical and general educational centers (Onondaga and Tompkins).

In 1965 there were 48 hospitals with general medical and surgical beds or a total of 7,564 acute care beds and four hospitals with extended care facilities with 472 beds, in the Central New York region. It is significant that more than 60 percent of these institutions have less than a 125-bed capacity, 20 percent are less than 50 beds--again reflecting the extensive rural character of the area and the need for small hospital units to serve large geographic areas. The largest portion (60%) of beds is, of course, predominately in the group of hospitals which have a larger than 200-bed capacity.

During the post-war period there has been extensive new construction of hospital facilities throughout the Central New York region but many presently utilized beds and some entire institutions are in need of modernization or, indeed, complete replacement.

The physicians in Susquehanna and Bradford Counties in northern Pennsylvania expressed a desire to join the Central New York Regional Medical Program. This area interfaces the southern tier of the Central New York Regional Medical Program as well as the Greater Delaware Valley and Susquehanna Valley Regional Medical Programs. Patterns of medical education and patient referral between the Southern Tier of New York and Bradford and Susquehanna Counties in Pennsylvania have been established for many years and in the recent past, Sayre, Pennsylvania and Binghamton, New York medical communities have been cooperating in the development of training programs. This request was presented to the Regional Advisory Group on October 22, 1967, and it was the consensus that a reasonable and productive affiliation could be worked out.

The population of this area is approximately 88,911 (Bradford County - 54,925 and Susquehanna County - 38,886). There are 60 physicians in Bradford County and 14 in Susquehanna County. There are five hospitals in the area with a total number of beds of 475. Four of these have under 50 beds and the Robert Packer Hospital has 305 beds. There is associated directly with the Robert Packer Hospital the Guthrie Clinic which has approximately 50 full-time practicing physicians organized in a group practice.

History:

In March 1966, the Upstate Medical Center Council, appointed by the Governor of New York, selected a 15 member RAG and approved the Research Foundation of the State University of New York as the Fiscal agent for the applicant institution. Dr. Richard H. Lyons, was appointed as acting Program Coordinator.

In December 1966 the Region's planning grant application was approved for two years support at the amount requested.

In November 1967 the Region submitted its continuation application for 02 year of planning and requested additional funds to expand Core and Planning activities. In addition, the Region requested three years support for 4 projects: Project 1 - Continuing Education in Nursing, Project 2 - Rehabilitation Consultation Service, Project 3 - Oneida County Tumor Conference, and Project 4 - Family Practice Program. Both the continuation application and the four operational activities were approved and an award granted.

At the recommendation of the RMPS Committee, a site visit was conducted to this Region in March 1968, by Dr. Edwin L. Crosby, Dr. Stanley W. Olson, Dr. Dan A. Mitchell, Dr. Philip A. Klieger, DRMP, Dr. Veronica L. Conley, DRMP, and Mr. Robert E. Jones, DRMP. In their assessment of the Region the site visitors had difficulty in determining the overall strategy of the Region which appeared to consist of identifying preceived needs, especially those of physicians and hospitals, to take steps such as epidemiological surveys and meetings that would identify the most critical needs, and then to call upon the resources of the State University of New York to meet those needs. The RAG seemed to be representative of the Region and the medical professions endorsed the regional medical program concept.

It was evident that the Region had not sufficiently developed an organization which was independent and established an identity separate from the Medical School.

Dr. Hughes, President of the New York State Medical Society, described for the site visit team the efforts of the State Medical Society to study, plan and implement improved health services, particularly in the rural areas of the State. Dr. Hughes stated that the Society had received one million dollars from the Empire State Fund to do programming in continuing education. He indicated that the Society most likely would need supportive assistance from such resources as the regional medical program when educational as well as other activities were appropriately related to its mission.

Dr. Winning reviewed the medical care problems of northern New York, especially those of St. Lawrence County where the active physician-population ratio is about 1:3,600 as compared to the generally accepted ratio of 1:750. Continuing efforts to attract physicians to this area have not met with success. He discussed tentative plans to organize a diagnostic and treatment center in St. Lawrence County in cooperation with a 200-bed community hospital. Dr. Winning described his partial success to date in attracting a significant number of the physicians planned for this 24-man group practice.

The site visit team expressed interest in the work accomplished by Dr. Winning and advised that planning activities appropriately related to heart disease, cancer, and stroke might be supportable by the Regional Medical Programs.

The Region submitted in August 1968 a renewal planning grant application requesting support for core and planning activities for a five-year period. At the recommendation of RMPS National Advisory Council a site visit was conducted to this Region in January 1969, by Dr. Henry Lemon, Dr. M. J. Musser and Mrs. Sarah J. Silsbee, DRMP. During this phase of development it appeared that the RAG was representative of the medical needs and interests of the Region. The visitors, however, believed that representation from the 34,000 underprivileged people of Central Syracuse should be added to the RAG from the Neighborhood Health Center Council. By-laws for the RAG were being developed and a study of the practice of making the Upstate Medical Center President the RAG Chairman had been requested by Dr. William Bluemle, President SUNY Medical Center.

The visitors believed that a major defect in RAG organization was the lack of a functional executive committee that could help the RAG develop policy guidelines and act on behalf of the RAG on decisions requiring immediate attention by the Coordinator. Procedures for the review of grant proposals and defined responsibilities in the review and decision-making process had not been well developed. Although a large number of RAG subcommittees had been organized, few were active. It was apparent from the operational projects submitted that there had been insufficient coordination to date. There did not appear to be a regional plan or an obvious strategy for further development of programs in the Region. The visitors found difficulty in clearly identifying those physician continuing education activities

related to the Upstate Medical Center from those of the RMP. There also appeared to be little integration between the nurse in-service training program at the center and the RMP's nursing continuing education project.

The visitors recommended that the University Medical Center (U.M.C.) give priority to the recruitment of physicians for core staff (there were none other than the coordinator). The UMC responded that until vacant departmental head positions were filled it would be difficult to interest physicians in faculty appointments. That once vacant departmental head positions at the Center are filled, top priority would be given to filling the Regional Medical Program positions.

In June 1969, the Region was granted an award combining the planning and operational grants which consisted of Core and 8 projects. Support for an additional project (#12 - Prevention and Effective Recovery from Cardiovascular Illnesses Through Knowledgeable Nursing Instruction).

Present Application:

This is a triennial in which the CNY/RMP has requested funding for continuation of core and two projects, two approved not previously funded projects and four new projects.

Core Staff

The Core staff has been increased from 25 to 33 positions and consists of 16 full-time and 17 part-time employees. Of the part-time employees, 11 are liaison physicians appointed as consultants at 10% time or effort, 3 evaluators at 20% time or effort, 1 assistant nurse coordinator at 50%, 1 secretary at 60%, a physician at 80%, and the coordinator at 90% time or effort. Of the full-time positions, 11 are professionals, 4 are secretarial positions and one a business director. Of the 17 full-time core staff members there are 10 females and one minority.

Core staff activities have, in general, been directed toward reinforcing the operational projects that have been approved and funded, and reviewing the problems of health care in the region so that new or different projects might be developed to meet these needs. In addition, they have been involved in obtaining statistical information in the categorical diseases, evaluation of core and projects, establishing liaison with communities, and educational activities.

The core staff has also been very active in establishing cooperative relationships with federal, state and local organizations involved with the health system. (Ref: Application p. 36-54.)

Core Supported Feasibility and Planning Studies include:

PHASED OUT

1. Medical Library MEDLAP and Health Mobile (Appl. p. 55)
2. Central New York Health Education Program Directory (Appl. p.56)
3. Lay Education Lectures (Appl. p.56)
4. N.Y.-Penn. Health Education Program Directory (Appl. p.57)
5. New Careers Workshop (Appl. p. 57)

NEW ACTIVITIES

6. Continuing Education for School Nurse Teachers and Health Educators (Appl. p. 58)
7. Health Educator Symposium (Appl. p. 58)
8. Leadership Training for Developing the Developers Workshop (Appl. p.59)
9. Leadership Training for Communication Workshops (Appl. p.59)
10. Home Health Aides (Appl. p.60)
11. Human Conservation Display (Appl. p. 60)
12. Food Service Managers (Appl. p. 61)
13. Diabetic Program (Appl. p. 61)
14. Guidance Councilors Upgrading (Appl. p. 62)
15. Combined Surgical Staff Conference (Appl. p. 63)
16. Workshops in Developing Communication Skills for Nursing and Allied Health Personnel (Appl. p.64)
17. Regional Cancer Registry (Appl. p. 64)
18. Library Service (Appl. p. 65)
19. Acquisition and dissemination of professional educational materials (Appl. p. 66)
20. Comprehensive Regional Continuing Education Calendar (Appl. p. 66)
21. Radiotherapy Clinic (Appl. p. 67)
22. Enterostomy Consultation Services (Appl. p.67)
23. RMP Bulletin (Appl. p. 68)
24. Addressograph and Mailing Service (Appl. p. 69)
25. Consultation on Instructional and Managerial Problem (Appl. p.70)

Attached is an organizational chart and following is a listing of Core Staff.

Name	Job Title or Function	% Time and Effort
R. H. Lyons, M.D.	Coordinator	90
P. R. Aronson, M.D.	Liaison Physician	10
C. T. Case, M.D.	"	10
A. M. Decker, M.D.	"	10
H. K. Ensworth, M.D.	"	10
S. R. Mason, M.D.	"	10
D. T. O'Brien, M.D.	"	10
A. J. Smith, M.D.	"	10
L. H. Smith, M.D.	"	10
I. K. Stone, M.D.	"	10
J. T. Walters, M.D.	"	10
E. M. Wyso, M.D.	"	10

Name	Job Title and Function	%Time and Effort
J. J. Murray, B. A.	Assistant Coordinator	100
M. Jordahl	Admin. Ass't	100
W. L. Curry, B. S.	Teaching Coord.	100
J. Kulakowski, M.A.	Health Educator	100
R. Schneider, M.A.	Instr. Com. Coordinator	100
N. Allen, M.A.	Ass't. Nurse Coord.	50
S. H. Murray, M.S.	Library Coord.	100
W. Rothstein	Ostomy Tech.	100
J. Martin	Research Ass't	100
H. Stevens	Research Worker	100
M. Galka	Steno	100
C. Gregory	Steno	100
TBA	Steno	100
TBA	Steno	100
L. Porter, Ph.D.	Evaluator	20
R. Philips, M.S.	Evaluator	20
R. Mullane, M.S.	Evaluator	20
Health Mobile		
TBA	Health Educator	100
TBA	Bus Driver	100
TBA	Reference Librarian	100
TBA	Clerk Typist	100

REGIONAL ADVISORY GROUP

The RAG reports that during the past three years the Central New York Regional Medical Program has done a great deal to overcome the initial fear of government intervention in the care of patients and in the education of physicians, nurses and other hospital personnel. It was enough in 1950 when the State took over the medical school from a private university, Syracuse University, but now to have the government "move in" and help the medical school, a State institution, to help hospitals, nurses, and physicians was an almost impossible concept for the local health vendors. Those in larger communities were less disturbed than those in smaller communities and the nurses in any community could hardly believe that somebody would be interested in their education.

The strong emphasis on nursing education through the Continuing Education in Nursing project has done more than perhaps any other single effort to win recognition for the Central New York Regional Medical Program and to stimulate other educational activities throughout the region.

Other factors that have led to further recognition of the CNY/RMP has been the Mobile Stroke Rehabilitation, the Bulletin of the CNY/RMP and the effort to improve the teaching of family practitioners at St. Joseph Hospital.

The RAG indicates that with the change impetus by the RMPS the region has widened its goals. The new goals are to reach more people through innovative educational methods so that the people may institute better individual health care and to reach out into areas where health care is not at present understood.

The RAG in its report outlines the strategies the region has utilized during the past 3 years for meeting its goals, and the cooperative arrangements it has established. (Appl. p. 14-19)

The CNY/RMP Advisory Group recently increased its membership to 45 with the addition of allied health and consumer representation. These new members included educators, communication specialist, lawyers, nurses and consumers.

It has also developed Regional Advisory Group By-Laws, which were printed October 1969. Nominations are made by the RAG to the Council of the Upstate Medical Center who will select 42 members not including ex-officio members. Members of the RAG may serve two consecutive full three-year terms. The RAG meets at least six times a year at times to be set from time to time by the group. The present membership of the RAG include:

14 Practicing Physicians
6 Hospital Administrators
1 Nurse
2 Government personnel
5 University representatives
2 News Media personnel (T.V. & Radio)
2 Charity organizations
9 Members of the public
1 VA
1 Dentist
1 Osteopath
1 Public school
45

RAG Boards/Committees and RMP Local Advisory Groups

Executive Committee (6 Members) - Helps to set goals and priorities; advises coordinator on major expenditures which are not part of on-going operations; reviews committee reports; makes committee appointments.

Nominating Committee (6 Members) - Maintains list of potentially interested individuals in the region who might serve on the RAG as replacements or new members; nominates new members of RAG.

Community Health Education Committee (9 Members) - Determines the need and best way to continue to promote health education in different areas of society or of the region; reviews proposals in area of health education and mades recommendations to RAG.

Continuing Medical Education and Special Programs (8 Members) - Reviews requests for support of educational programs for physicians and allied personnel in region as well as project proposals for educational programs and make recommendations to RAG.

Evaluation of Services Committee (7 Members) - Evaluates activities of Core as well as the effectiveness of projects and makes recommendations to RAG.

Health Manpower Committee (6 Members) - Works with Committee on Continuing Education in efforts to recruit more people into the health field.

Hospital Committee (8 Members) - Determines regional hospital needs and how they may be met; reviews and mades recommendations to RAG on project proposals dealing primarily with hospital activities.

Primary Patient Care Committee (9 Members) - Concerns itself with the extension of the physician in offering a wider variety of patient care either through the physicians or other mechanisms; reviews project proposals in this area and makes recommendations to RAG.

Categorical Committee on Cancer (11 Members) - Reviews requests for support of education programs in cancer and project proposals in the area of cancer and makes recommendation to RAG.

Categorical Committee on Heart Disease (5 Members) - Reviews requests for support of educational programs in heart disease and project proposals in the area of heart disease and mades recommendations to RAG.

Categorical Committee on Stroke (5 Members) - Reviews requests for support of education programs in stroke and project proposals in the area of stroke and makes recommendations to RAG.

Nursing Steering Committee (17 Members) - Advises project director of Continuing Education in Nursing project.

PROJECTS

It is indicated in the application that there are written procedures for the review of project applications, however, these are not described in the application.

Specific Core staff members are assigned to monitor or provide supportive services to the individual projects which involve responsibilities in the area of accounting, technical or professional consultation, etc. Each project director is required to submit an expanditure report once a month and a progress report once every two months. Project-related evaluation activities undertaken during the past year include visits by staff, reports to the evaluation committee and direct reports from the field.

The region has established the following priority ranking of projects:

1. Area Health Education Centers
2. Home Dialysis Training Program
3. Pulaski Model Rural Ambulatory Care Center
4. Dial Access
5. Nurse Clinician Training Program
6. Health Mobile (Core)
7. Medical Library and Information Service
8. Regional Bio-Medical Electronics Safety Program
9. Feasibility Study for Establishment of a Computerized Central New York Regional Cancer Registry

Continuation of Projects Beyond Approved Period of Support

Project #6 - Home Dialysis Training Program - This project was initially funded in July 1970 during the regions 02 year of operation. It is presently funded at a level of $14,590 direct cost and has a remaining commitment of $27,022 for its 03 year.

Requested First Year $53,757

The region is requesting in this application funding beyond the approved period of support in the region 05 and 06 year.

Progress reported by the region consist of the following:

1. Unit site identified at A. C. Silverman Hospital, Syracuse, N.Y.
2. Negotiations completed with Onondaga County for support for continuing expenses, dialysis supplies etc. and supportive services (estimated at $45,000 per year).
3. Renovation of unit completed.
4. Equipment and supplies purchased.
5. All personnel positions filled.
6. Development plan completed.
7. Training manuals and teaching aids in process of development.
8. Patient evaluation is proceeding for potential trainees.

The activity is to serve as a model in delivery of kidney treatment and rehabilitation in this region. It proposes to train 20 home dialysis patients per year, train six-to-eight hemodialysis nurses per year and serve as a focus for organizing a system of health delivery care in the area for renal disease. Phase out of this program is anticipated by 1974 with Onodaga County taking over total administration of the unit at A. C. Silverman Hospital.

Second Year: $59,339 Third Year: $64,379

Project #9 - Dial Access - This project was initiated in July 1969 and has no commitment remaining. The region is now requesting three-years of additional support to continue the activity. Progress reported indicates that the lead time necessary to purchase the equipment and install the equipment and phone was seven months (7/69-2/70). In the year 2/70-2/71, 2865 calls were received. In addition to the original 80 tapes purchased from Wisconsin RMP, 40 tapes were purchased later in the first program year and six tapes were produced locally.

Requested First Year $20,740

Two user's surveys were conducted with return of 84.7%. The survey indicated that 94% of the respondents found the information was worth the time to make the call, 82% indicated they received the information they were calling for, 52% of the users were general practitioners.

Financial support of $5,000 was received during this program year from the Susquehana Valley RMP. Although the service is paid for by the

two RMPs, it is also available to the following RMPs: Albany, Metropolitan New York, Nassau-Suffolk, New Jersey, Greater Delaware Vally and Maryland. It has not been promoted in those areas since we do not have the hardware nor staff to properly service the number of physicians who would be covered.

The primary objective of this project continues to be to inform physicians with specific and current information on an immediate access basis.

Second Year: $21,580 Third Year: $22,504

Approved Not Previously Funded

Requested First Year $32,704

Project #15 - Medical Library and Information Service - This project was initially approved for three years support by the July 1970 Advisory Council at a reduced level (01-$40,000, 02-$50,000 03-$53,000), however, because of existing fiscal restraints funds for its support were not awarded.

The activity offers to 57 hospitals and 117 nursing homes, and individual health professionals up-to-date information on lastest medical advances needed for better patient care through supplementary library service from the Upstate Medical Center Library.

Second Year: $35,271 Third Year: $37,944

Requested First Year $22,777

Project #17 - Regional Biomedical Electronic Safety Program This project was deferred by the November 1970 Advisory Council because it had much difficulty relating this program to the categorical objectives of this region. They also believed that the activity needed to be regionalized to include other hospitals in the region.

The present proposal has responded to one of the previous concerns of Council in that the program has been regionalized.

Second Year: $36,368 Third Year: $36,947

New Projects (Application Pages 97-107)

Requested First Year $599,547

Project #18 - Area Health Continuing Education Centers This project is an outgrowth of previously funded Project #1 - Continuing Education in Nursing. It proposes to establish Area Health Contining Education Centers for medicine, nursing and allied health personnel in five strategic locations of the region. These centers will promote, initiate and coordinate continuing education at the local level. Each center will be the home base of a staff comprised of professional health education specialists. Each center will be under the direction of an executive committee. The basic structure of this executive committee exists presently in the subregional nurses steering committee which will expand into a multi-disciplinary policy-making organization capable of incorporating.

Second Year: $574,547 Third Year: $574,547

Project #19 - Pulaski Model Rural Ambulatory Care Center - Requested First Year $144,475
This project is an evaluation of the St. Joseph's Family Practice Program presently supported by CNY/RMP. This activity is an effort toward resolving the problems of decreasing numbers of doctors in the rural areas.

The proposal is to demonstrate a model rural ambulatory care center, expose Family Practice residents to rural practice and teach the efficient use of a health team.

Second Year: $144,475 Third Year: $144,475

Project #20 - Computerized Regional Cancer Registry - Requested First Year $3,404
Through this project the Upstate Medical Center proposes to record detailed information concerning cancer patients to allow statistical evaluation of treatment and survival so as to upgrade the delivery of care for cancer.

Second Year: $3,544 Third Year: $3,691

Project #21 - Training of Nurse Clinicians - Requested First Year $120,156
This project proposes to select 32 nurses from geographic areas or from patient care agencies with a poverty of health care delivery. These nurses will be trained to become physician associates (i.e., evaluate patients and manage minor health problems - refer major health problems - control crisis situations until the physicians arrives. It is expected that the nurse trainee upon completion of her training will return to her functional area where the proverty of health care delivery exists. The effectiveness of this program will be evaluated.

Second Year: $120,156 Third Year: $120,156

REGION Central New York
CYCLE RM 00050 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
Core	$416,368*				$ 416,368	$161,117	$577,485
#6 - Home Dialysis Training Program	53,757*				53,757	13,431	67,188
#9 - Dial Access		$20,740			20,740	2,401	23,141
#15 - Medical Library & Information Service			$32,704		32,704	11,708	44,412
#17 - Regional Biomedical Electronic Safety			22,777		22,777	3,918	26,695
#18 - Area Health Continuing Education Centers				$599,547	599,547	130,087	729,634
#19 - Model Rural Ambulatory Care Center				144,475	144,475	30,012	174,487
#20 - Computerized Cancer Registry				3,404	3,404	1,625	5,029
#21 - Nurse Clinician Training				120,156	120,156	11,581	131,737
TOTAL	$470,125	$20,740	$55,481	$867,582	$1,413,928	$365,880	$1,779,808

* 05 & 06 year beyond approved period of support

GRB/5/11/71

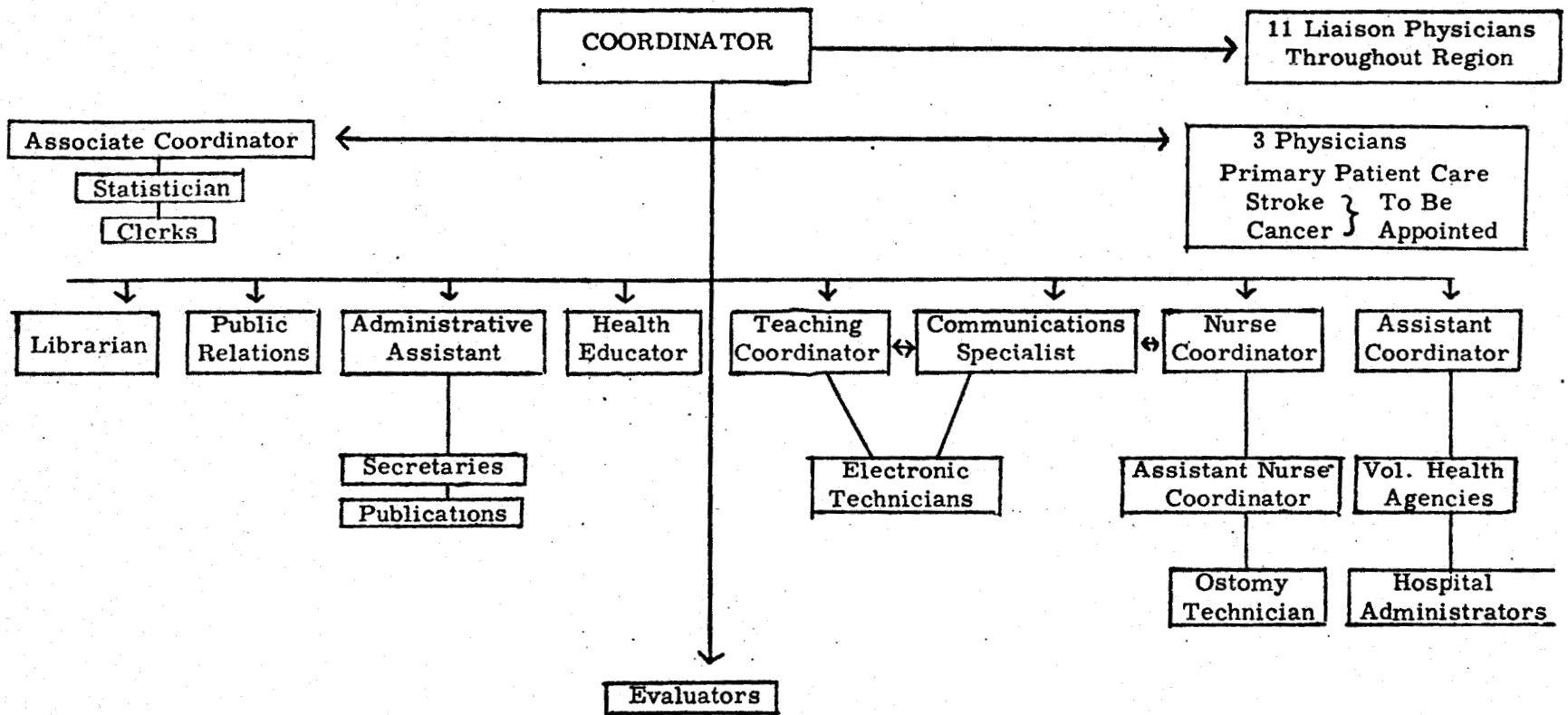
REGION Central New York

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
Core		$372,075			$ 372,075
#6		59,339			59,339
#9		21,580			21,580
#15			$35,271		35,271
#17			36,368		36,368
#18				$574,547	574,547
#19				144,475	144,475
#20				3,544	3,544
#21				120,156	120,156
TOTAL		$452,994	$71,639	$842,722	$1,367,355

REGION Central New York
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
Core		$384,720			$ 384,720	$1,173,163
#6		64,379			64,379	177,475
#9		22,504			22,504	64,824
#15			$37,944		37,944	105,919
#17			36,947		36,947	96,092
#18				$574,547	574,547	1,748,641
#19				144,475	144,475	433,425
#20				3,691	3,691	10,639
#21				120,156	120,156	360,468
TOTAL		$471,603	$74,891	$842,869	$1,389,363	$4,170,646



ORGANIZATION CHART - CORE STAFF

CENTRAL NEW YORK REGIONAL MEDICAL PROGRAM

DEPART NT OF HEALTH, EDUCATION, AND W FARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: May 21, 1971

Reply to Attn of:

Subject: Staff Review of Triennial Application from the Central New York Regional Medical Program for August 1971 Review Cycle.

To: Harold Margulies, M.D.
Director, RMPS

Through: Chairman of the Month

Chief, Grants Review Branch

Chief, Grants Management Branch

Acting Chief, Regional Development Branch

The region has requested in this application, funding for the following activities: (Direct Cost Only)

	*04 year	05 year	06 year	Total
Core	$416,368	$372,075	$384,720	$1,173,163
Continuation Projects #6,#9	74,497	80,919	86,883	242,299
Previously approved/unfunded Projects #15, #17	55,481	71,639	74,891	202,011
New Projects #18, #19, #20 and #21	867,582	842,722	842,869	2,553,173
Total Request *	$1,413,928	$1,367,355	$1,389,363	$4,170,646

*There is a remaining commitment of $397,022 for Core and Project #6 in the 04 year.

In the review of this application staff concerned itself with overall program issues and the identification of concerns for the upcoming site visit on June 3-4, 1971. Major issues discussed by staff were:

REGIONAL ADVISORY GROUP

The CNY/RMP Advisory Group recently increased its membership with the addition of allied health and consumer representation. These new members included educators, communication specialist, lawyers, nurses

and consumers. Staff believes this increase in allied health and consumer representatives has strengthened the RAG, however, consumers from the lower economic population, Model Cities programs, OEO, and the neighborhood health center are not represented.

It is the general impression of staff that the RAG has not assumed the leadership role of the CNY/RMP. The program has always been and continues to be oriented toward the continuing education of nurses. It has not placed enough emphasis in stimulating the health resources of the region to evaluate and attempt to resolve the health problems of the region.

In addition they appear to be project oriented and have not assumed the responsibility for developing a regional plan.

Staff recommends that the site visit team take an in depth look at the RAG operating procedures and how the RAG views its responsibilities with CNY/RMP. (1) Appointment of RAG members; involvement of President of the College of Medicine; (2) Attendance at RAG meetings50%.

CORE

The Core staff has been increased from 25 to 33 positions and consist of 16 full-time and 17 part-time employees. Of the part-time employees 11 are liaison physicians appointed as consultants at 10% time or effort, 3 evaluators at 20% time or effort, 1 assistant nurse coordinator at 50%, 1 secretary at 60%, a physician at 80%, and the coordinator at 90% time or effort. Of the full-time positions, 11 are professionals, 4 are secretarial positions and one a business director.

Staff believes that although the Core staff is small in number, it is a capable staff and has established a good relationship with the CHP "b" agencies in the region. They need, however, to have additional medical staff to support Dr. Lyons with the administration of the program.

Other than the 11 part-time liaison physicians (10%), the only other physician on Core is the Coordinator, Dr. R.H. Lyons. Dr. W. Leavell the only other physician that was on Core has left the CNY/RMP and is now a Dean at the University of Syracuse.

It is the general impression of staff that Dr. Lyons has not given the CNY/RMP the leadership that it needs. It has been recommended in previous site visits that an associate coordinator with administrative capabilities be appointed to assist Dr. Lyons with the day to day operations of the CNY/RMP. Staff suggest that this recommendation be taken into consideration again by the upcoming site visitors.

Dr. Lyons believes that it is difficult to gain the participation of physicians in continuing education activities and so he emphasizes the

continuing education of nurses. He believes that by upgrading the nurses it will influence the physicians to upgrade the quality of delivery in medical care.

It could be because of this philosophy that the region is heavily oriented toward the continuing education of nurses. Of the eight projects proposed in this application five are involved with continuing education of nurses. (#6, #11, #17, #18, #21). Project #17 - Area Health Continuing Education Centers has emerged from Project #1 - Continuing Education in Nursing and has a budget request for 3 years of $1,748,641, approximately 47% of the total funding requested by the region.

Staff recommends that the site visitors discuss with the region what impact past continuing education activities for nurses have had in improving the health care delivery system of the region and how the proposed activities in this application are expected to meet the health care needs of this region.

Staff also suggest that the visitors have the region indentify what is the role of the eleven liaison physicians in identifying local health needs and stimulating activities to meet these needs.

RAG Boards/Committees and RMP Local Advisory Groups:

The membership of these committees consist primarily of physicians with little if any representation of allied health personnel. Staff believes that allied health personnel can contribute and should have an opportunity to participate in these committees.

It appears to staff that there is little organized interrelationships between the committees, nor an established operating procedure which would stimulate an integrated program effort between the committees, RAG, and Core. It is suggested that core staff input be built into the meetings of these groups to keep them abreast of total program activities and to encourage further input by these groups into the CNY/RMP.

The general impression of staff is that the committees have been project oriented and have not assumed the responsibility for developing a regional plan of action for each of the categorical areas they represent. This lack of regional planning is apparent in the projects which have been submitted. There is no mention of how each activity interrelates with others in the same categorical area. There is also little mention of how each activity fits into a regional plan. Several of the committees have met less than 3 times and do not appear to be functional.

Staff recommends that during the upcoming site visit these concerns of staff be included as a topic for discussion.

OPERATIONAL PROJECTS

Staff had difficulty identifying the interrelationships between projects, particularly those involved with the continuing education for nurses.

In general staff's primary concerns are what involvement the RAG, committees and core have with the projects, how these projects relate to a regional plan and what is the expected impact of these activities in the health care delivery system of the Region. Attached is a memorandum on Project #18 - Area Health Continuing Education Centers from the Continuing Education and Training Branch of RMPS.

EVALUATION

Staff was unable to determine how the three part-time evaluators (20%) on Core who are "education specialists" from Syracuse University participate in the evaluation of Core and projects. It was also difficult to determine what interrelationship exist in the evaluation process between the part-time evaluators, the RAG Evaluation Committee, other Core staff, and the project director.

The evaluation report submitted by the evaluation committee gives additional information regarding proposed activities but does not really present a regional plan for the categorical areas and does not sufficiently evaluate the effectiveness of activities in meeting the health needs of the region. Attached is a memorandum from the Program Planning and Evaluation Branch of the RMPS.

GENERAL

It is apparent that the CNY/RMP has continued to follow the initial concept of Regional Medical Programs which was to provide a vehicle by which scientific knowledge could be more readily transferred to the providers of health services, (with emphasis in nursing). They have not altered their course to the evolving mission of RMPS which is to increase the availability of health care while maintaining its quality.

Participants of Type V Meeting:

Bob Morales, Grants Review Branch
Joanne O'Malley, Office of Systems Management
Burt Kline, Regional Development Branch
Lawrence Witte, Office of Program Planning and Evaluation
Frank Nash, Regional Development Branch
Jerry Stolov, Division of Kidney Disease Control
Roger Miller, Grants Management Branch
Veronica L. Conley, Ph.D., Continuing Education and Training Branch

Ismael B. Morales
Ismael B. Morales
Public Health Advisor
Grants Review Branch

Action by Director [signature]

Initials [signature]

Date 5/26/71

RMPS/GRB/6/11/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

CENTRAL NEW YORK REGIONAL MEDICAL PROGRAM
RM 00050 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: Additional funds for one year for core and operational projects with stipulated conditions:

REGION OPERATIONAL YEAR	REQUEST	RECOMMENDED FUNDING
04	$ 1,413,928	$ 850,000
05	1,367,355	-0-
06	1,389,363	-0-
	$ 4,170,646	$ 850,000

The Region's current funding level is $645,080 direct cost and the rationale for the recommended funding level is as follows:

Core	$400,000
Projects (Cont. Ren.,New)	450,000
TOTAL	$850,000

Conditions:

1. That an associate coordinator M.D. to direct a program of health service extention into both rural and urban areas be employed. The region needs someone who is a strong executive and can bring together the many resources in this area to cooperatively resolve the health problems of the region. Positive steps certainly should be taken to ensure strong effective leadership of this program.

2. That the RAG and its Executive Committee expand its membership to include representation from the lower-economic consumers, rural physicians, young activist physicians, allied health personnel and representatives from rural area of the region. They need to have younger representatives on the Regional Advisory Group and the visitors specifically recommended adding two medical students and one nursing student, perhaps as non-voting members.

3. That the region develop a program plan which includes a method for priority establishment, a decision-making process, program planning and evaluation. The visitors believe that this is a basic need for this region because they found it difficult to get any feeling that even the RAC or the coordinator had any sense of what the CNY/RMP expects to be three years from now.

4. That the program establish a balance in the development of activities in relation to their priorities; the continuing education activities for nurses have out-stripped some of the other activities in the region.

5. The visitors also believe that the region should put into action the recommendations documented in Dr. Hughes' evaluation report, especially paragraphs 3 and 4, of the report.

6. That the region consider hiring for Core staff a full-time evaluator rather than continue to utilize the present three part-time evaluators.

7. That operating procedures and responsibilities of the RMP committees be clearly defined with emphasis in involving them in the program planning and operational activities of the program.

8. The visitors recommend a regionalization planning approach in health services; that program activities be integrated as part of a total program plan which can be measured in terms of accomplishment at specified periods of time.

9. It is recommended that not more than 20% ($120,000) of the requested funding level for Project #18 - Area Health Continuing Education Center be utilized for support of this project by the region. The region was encouraged to carry out a demonstration project in one of the sub-regions rather than begin with a region-wide program as proposed in the application.

10. Support Project #6 - Home Dialysis Training Program with RMP funds for only one more year for additional planning. Committee concurs with the findings of the Ad Hoc Panel on Renal Disease. In view of the evident disjointed approach to its needs, a training coordinator at $15,000 , with travel funds of $1,000 could appropriately be recommended for one year to obtain a more orderly and cohesive approach to its personnel problems.

The Region has been using some of their core funds for support of feasibility studies and central core activities. Committee doesn't discourage these activities but recommends that the activities be funded only when approved by the Regional Advisory Group. They should be considered on the basis of what they contribute to the objectives and priorities of the Region as described in the Region's program plan. The Committee suggests that the additional $200,000 recommended be utilized to develop activities that will help improve delivery of health services to the urban and rural poor. These appear to be two real priorities for the Region and this additional funding should be able to provide some progress in these two areas.

The Committee recommends a staff follow-up visit six months following the award of this application to evaluate progress in implementing the above recommendations and to provide assistance if necessary. It also recommends a site visit to the Region when they submit their next anniversary review application in May 1972.

CRITIQUE: Committee believes that the CNY/RMP needs to strengthen its described goals, objectives and priorities because they are not clearly stated in terms of health needs of the Region. The objectives are described in terms of activities rather than anticipated accomplishments.

The RAG is a viable entity with fairly good leadership. It, however, suffers from a lack of allied health personnel and consumer representation, particularly from the inner-city, rural communities, model cities, OEO, and the Neighborhood Health Center. Committee believes that the RAG needs to assume a greater role in giving leadership to the planning and operational activities of the program. They appear to be project oriented and have not assumed responsibility for developing a regional plan.

The Executive Committee of the RAG also needs to expand its membership to include representation from the low-economic consumers, rural physicians, young activist physicians, allied health personnel and representatives from rural areas of the Region.

This Committee certainly needs to enhance its involvement in the planning and operational activities of the RMP, and by doing so rendering the continuous top-level leadership needed by the program.

Committee expressed concerns over the membership of the RMP committees which consist primarily of physicians and the little interrelationships that exists between the committees. Also, there does not appear to be an established operating procedure that would stimulate an integrated program effort between the committees, RAG, and Core. Committee believes that allied health personnel and rural representatives need to be added to the committees and that the operating procedures and responsibilities of the committees need to be clearly defined.

The committees should be involved in total program planning and operational activities, rather than being project oriented and having a very narrow degree of responsibility within the program.

Although the present core staff is small in number, it is a capable staff and has established a good working relationship with many community health related organizations.

Committee believes that the program coordinator, Dr. Richard H. Lyons, has done an unusually good job in pulling together the program since its inception. It does appear, however, that he is somewhat impatient with some of the newer trends in the organization of the Health Care Delivery System and undoubtedly has seen continuing education, particularly of the professionals with whom he has had great contact namely physicians and nurses, as the major responsibility of RMP.

Committee agrees with the recommendation of the June 1971 site visit team that the region hire an associate coordinator, M.D. to direct a program of health service extension into both rural and urban areas. In view of Dr. Lyon's age and history of illness, the associate should be chose with the consideration that he might succeed Dr. Lyons when he retires. Committee believes that in any case positive steps should be taken by the region to insure strong effective leadership of this program.

It appears to Committee that there exists little if any interrelationships between projects particularly those involved with continuing education of nurses. It seems that projects are not stimulated by the program based on need and a regional plan, but rather are spontaneously developed and submitted to the program by independent groups of individuals. In most instances, activities previously funded by the CNY/RMP have not been absorbed into the local health system with the exception of the home health aid program which was really a peripheral development of the program.

Committee observed that there has been a tremendous organization of nursing resources under Mr. Margaret Sovie, Nursing Coordinator, but that this effort has been pretty much divorced from the School of Nursing at the University of Syracuse as well as from nursing schools at Cornell, Utica and elsewhere. Project #18 - Area Health Continuing Education Centers is an outgrowth of these nursing activities and is primarily directed toward continuing education of nurses rather than multidisciplinary approach as projected by the Carnegie report which recommends Area Health Education Centers rather than Area Health Continuing Education Centers for all health disciplines. Committee believes the region should carry out this project by doing a demonstration in one of the sub-regions rather than begin with a region-wide program. It is recommended that not more than 20% ($120,000) of the requested funding level be utilized for support of this project by the region and that a multidisciplinary approach be utilized.

Committee concurs with the site visit that the region should place priority on training nurse clinicians or physician assistants which could help meet the needs for medical manpower identified in the inner city and the northern counties where a great physician shortage exists rather than on general continuing education for nurses.

Committee does not believe that there is a coordinated effort between the three evaluators on core, the evaluation committee and core. They also found it difficult to understand how the three part-time evaluators on core staff functioned within the organization. Committee suggested that the region consider hiring a full-time evaluator to carry out a continuous evaluation process by working closely with the evaluation committee. In addition, they suggested that the region seriously consider the recommendations of Dr. Edward C. Hughes in his summary report, as Chairman of the Evaluation Committee. Although Committee is encouraged by the region's interest in evaluation activities, it has difficulty in determining how the region will implement evaluation activities without first identifying a regional plan with specific objectives that project expected accomplishments and are measurable in terms of evaluation.

Regional Medical Programs in Northern New York

One point that arose repeatedly during the two-day meeting was that three of the four RMPs in northern New York had submitted Triennial applications for this review cycle, had been site visited, and all found to have basic problems in terms of the quality and direction of the programs. The three RMPs are Albany, Central New York (Syracuse), and Rochester. The fourth RMP, Western New York (Buffalo), was reviewed by October/November 1970 Committee and Council. There was some sentiment on the Review Committee that serious thought should be given to combining these three, or possibly four Regions, and that this would represent a better use of limited dollars and perhaps combine the strengths of the various programs. It was recognized at the same time that, politically, any combination of these Regions would be quite difficult. Also, since each of the three Regions being reviewed this cycle was seen as being at a turning point in its development, with some hope for resolution of its problems during the coming year, the reigning attitude was that now would be an inopportune time to suggest any combined superstructure without giving the programs another year to iron out their own difficulties. The Committee also saw the need for more data before considering any possible merger.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 10, 1971

Reply to Attn of:

Subject: Quick Report on the Central New York Site Visit June 3-4, 1971 (Syracuse, New York)

To: Director, RMPS
Through: Acting Deputy Director
Regional Medical Programs Service

I. Site Visit Team

* Effie O. Ellis, M.D. (Review Committee
Special Assistant to Executive Vice-President
American Medical Association
Chicago, Illinois

Henry Lemon, M.D. (Review Committee)
Professor of Medicine
Nebraska Medical School
Omaha, Nebraka

Alfred L. Frechette, M.D.
Commissioner of Public Health
Massachusetts Department of Public Health
Boston, Massachusetts

F. M. Simmons Patterson, M.D.
Executive Director
North Carolina RMP
Durham, North Carolina

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II. The region has requested $1,413,928 direct cost, a total of $768,848 above their current level of funding ($645,080). The visitors recommend approval of this triennial application at a level of $850,000 with the following conditions:

1) That the region obtain an associate director who can serve as backup to the coordinator and assume responsibility for planning

and operational activities, particulary those related to the extension of health services in the region;

2) That the RAG and its Executive Committee expand its membership to include representation from the low economic consumers, rural physicians, young activist physicians, allied health personnel, and representatives from rural areas of the region;

3) That a program priority establishment and decision making process is developed;

4) That Project #18 - Area Health Continuing Education Centers be implemented on a demonstration basis in one of the five sub-regions and an interdisciplinary approach utilized rather than limiting it to the nursing profession. The visitors recommend that funding of this activity by the region be restricted to 20% ($120,000) of the amount requested for its support.

5) That the Core staff hire a full-time evaluator rather than continue with the present 3 part-time evaluators;

6) That operating procedures and responsibilities of the RMP committees be clearly defined with emphasis in involving them in the program planning and operational activities of the program.

7) That the region develop a program plan which can be measured in terms of accomplishments at specified periods of time.

The site visitors recommend a staff follow up visit six months following the award of this application to evaluate progress in implementing the above recommendation and to provide assistance if necessary.

III. Brief Summary of Findings

The goals, objectives and priorities of this program are not clearly stated in terms of the health needs of the region. The objectives are described in terms of activities and not as anticipated accomplishments.

The RAG has been strengthened by the recent addition of allied health and consumer representation, however, the visitors believe that consumers from the inner city, rural communities, Model Cities, OEO, and the neighborhood health center need to be represented.

The visitors believe that the RAG needs to assume a leadership role in the planning and operations of the program. The program has always been and continues to be primarily oriented toward the continuing education of nurses. In addition, they appear to be project oriented and have not assumed responsibility for developing a regional plan. The visitors discussed these concerns with the coordinator and the chairman of the RAG.

The visitors believe that although the present Core staff is small in number, it is a capable staff and has established a good relationship with the CHP "b" agencies in the region. They need, however, to have additional medical staff to back up Dr. Lyons with the administration of the program.

The membership of the RMP committees consist primarily of physicians and there exists little organized interrelationships between the committees. There also does not appear to be an established operating procedure that would stimulate an integrated program effort between the committees, RAG, and Core. The visitors recommended that allied health personnel and rural area representives be added to the committees and that the operating procedures and responsibilities of the committees be clearly defined. In addition the committees should be involved in program planning and operational activities of the CNY/RMP.

The visitors had difficulty identifying the interrelationships between projects particularly those involved with the continuing education of nurses. It appears that projects are not stimulated by the program based on need and a regional plan but rather are developed and submitted to the program by independent groups or individuals.

The visitors believe that Project #18 - Area Health Continuing Education Centers needs to include an interdisciplinary approach rather than limiting it to nurses in its first year of development.

They also suggest that priority be placed on training nurse clinicians or physician assistants which can help to meet the needs for medical manpower in the inner city and the northern counties where a great physician shortage exist rather than on general continuing education for nurses.

Activities in the region which impressed the visitors were the home health aid program, the neighborhood health center and the study on rural health planning by Dr. Edward C. Hughes. Although none of these activities are supported by RMPS funds the Core staff has been greatly involved in their planning and operation.

The visitors had difficulty understanding how the three part-time evaluators on core staff functioned within the organization. There did not appear to be a coordinated effort between the three evaluators, the evaluation committee and core. The visitors recommended that a full-time evaluator on core staff would be more effective in carrying out the evaluation process by working closely with the evaluation committee. In addition, the visitors suggested that the region seriously consider the recommendations of Dr. Edward C. Hughes in his summary report, as chairman of the evaluation committee.

The general impression of the visitors is that the region has continued to follow the initial concept of Regional Medical Programs and has not altered its course to the evolving mission of RMPS. The program appears to have the potential of having a positive influence in the health care delivery system of this region.

Ismael B. Morales
Grants Review Branch

Responses by the Site Visit Team to the RMP Program Review Criteria of May 10, 1971 on the Site Visit to the Central New York Regional Medical Program of June 3-4, 1971

A. Intended results of its program:

1. The activities of the Central New York RMP represent an opportunistic approach rather than through a carefully planned and coordinated approach to answer regional needs, which they have identified. The objectives although non-specific, are congruent with the overall mission and objectives of RMP nationally.

2. Through the Nurse Continuing Education Training Program headed by Mrs. Margaret Sovie, it is obvious that the region has been very active in reaching the majority of the 17,000 nurses in the region and indirectly thereby reaching many of the doctors and into most of the hospitals in the area. It should also be noted that the State Medical Association is involved in planning and evaluation activities concerning the growing deficiencies in rural medical care. The visitors believe that the background is now well established for the development of real advances in health care in the area.

3. The activities of which the CNY/RMP are capable of could indeed lead to improved utilization of existing health care resources, particularly by developing additional health manpower, such as nurse practitioners and physician assistants. The Neighborhood Health Center offers a particularly favorable resource in Syracuse for advances in health care delivery to an inner city population of about 38,000 which is in need of health care services. The Syracuse Medical Center will be taking over the sponsorship of this health center as of this Fall because of the failure of administrative support from the regional health department in its budget and operational activities. This should stimulate a closer relationship between the center and the CNY/RMP.

4. Health Maintenance, Disease Prevention, and early detection are only minor components of the activities which the CNY/RMP has developed.

5. There is no major expansion of ambulatory care or out-patient diagnosis and treatment planned other than of course, the superbly designed and equipped Neighborhood Health Center developed in Syracuse by Dr. Tom Mou. The center, however, has been under-utilized because of inadequate medical staff and due to local consumer prejudices, resident and medical student assistants from the medical center has not been accepted at this center.

6. It seems likely that accessibility of medical care could be improved and that there could be improvement in the relationship between primary and secondary medical care if the region can develop answers to their recognized and identified deficiencies in medical care in the area.

To really accomplish this, the region must alter its direction from continuing education to accessibility of health care for the region.

7. There is no immediate pay-off seen in accessibility, quality, or cost moderation in medical care, although the Neighborhood Health Center in Syracuse obviously offers a better source of assessible medical care than the urban population has had in the past.

8. The Central New York RMP has had some success in linking and strengthening the ability of multiple health institutions in groups to work towards better health care. This has been particularly attributed to Mr. Murray the Assistant Coordinator, who is involved with many neighborhood groups, and, sits on the Syracuse City Council. Also, Mr. Currie of the core staff has been very effective in this regard. The relationship between the RMP and other health agencies exist, however the commitment to work in a cooperative effort may need strengthening.

9. The Central New York RMP has been supportive of a number of other HEW funded projects, such as the Community Health Center in Syracuse. They have also been able to tap other sources of funds for some of their planning activities, including private funds for the survey of rural health needs by Dr. Hughes.

B. Performance Criteria

1. The region has succeeded in establishing its own goals, objectives, and priorities in general terms on the basis of individual agreement by RAG members as to the major objectives. There is, however, no clear statement of the basis for priority in selecting budgetary support of projects, and the visitors view this as a weakness in their performance capability. The objectives are primarily described in terms of activities and not as anticipated accomplishments which clearly relate to the health needs of the region. In addition, there is no time table related to the accomplishment of the regionsobjectives.

2. The previous activities which the region has engaged in, although few in number, have been productive, for example, a survey of health needs in rural areas, the development of a neighborhood community health center by the former associate coordinator, the development of an excellent region-wide continuing education program for nurses, the development of a mobile rehabilitation unit and the establishment of a pattern of cooperative arrangements.

3. The Central New York RMP activities have not been absorbed into the regular health care system in most instances with the exception of the home health aides activity which was really a peripheral activity of the CNY/RMP.

C. Process Criteria

1. The Regional Advisory Group of the Central New York RMP is on the verge of becoming a viable active entity of the CNY/RMP. The visitors however, believe that the RAG needs to assume a greater leadership role in the planning and operational activities of the CNY/RMP. The group has been strengthened by the recent addition of allied health and consumer representatives, however, the visitors believe that the rural communities, model cities, OEO and consumers from the inner city (neighborhood health center) need to be represented. In addition, the RAG needs to add younger activist members representing the rural and urban medically deprived areas. The Executive Committee of the RAG needs to assume a more active role in giving direction to the program and its membership should be increased to include allied health personnel and consumer representation. A difficulty which the region possesses is the severe Winters of the northern area for at least five months of the year, which makes it relatively impossible for representatives on the RAG from the area to participate during that season of the year.

2. There are probably between 100-200 health related agencies who have relations in one way or another with the Central New York RMP, reflecting the very complicated history in development of Public Health Activities in the State of New York. The visitors believe that this is one of the virtues of the CNY/RMP, it has been able to make some headway without too much agency interference, in spite of the traditionalism of the provider elements and the multiple agencies which overlap and duplicate in some cases. There appears to be active relationships between the CNY/RMP and other health-related agencies of the region, however, it was difficult to determine the amount of commitment and active participation of these agencies to CNY/RMP.

3. The coordination of RMP activities with comprehensive health agencies at the "b" level in this area, are carried out chiefly through having the same small number of very excellent provider workers sitting on committees for both agencies. It also seemed apparent that the CNY/RMP was not fully aware of all of the activities that were going on under Comprehensive Health Planning in the area, particularly the plans for a pre-paid insurance program in the Syracuse Area, so that there could be a lack of cross-over on the informational level.

4. The visitors believe that there is no real systematic ongoing operational planning that would coordinate planning and operational activities towards specific program objectives. It was because of this reason a major recommendation of the visitors was that the region hire an associate director at the M.D. level for health services extension to supplement activities of Dr. Lyons and

Mr. Murray and the rest of the core and to bring some focus to their activities.

5. The visitors believe that the Dr. Edward C. Hughes' Chairman, Evaluation committee did a very fine job in identifying in the evaluation committee's report the deficiencies of the Regional Advisory Group and other deficiencies within the RMP. On the other hand the three 20% evaluators on core staff from the University of Syracuse represent different disciplines and have done their evaluation independently with very little effectiveness. It is believed that the Regions needs to hire a full-time evaluator on core staff who can carry out a continuing evaluation process and work closely with the Evaluation Committee of the Central New York RMP. In addition, the visitors believe that the region should seriously consider following up on the recommendations of Dr. Edward C. Hughes outlined in his report.

A PRIVILEGED COMMUNICATION
RM 00050

DRAFT

CENTRAL NEW YORK REGIONAL MEDICAL PROGRAM

SITE VISIT

June 3-4, 1971

I. Site Visit Team

Effie O. Ellis, M.D., Chairman; Special Assistant to Executive Vice-President, American Medical Association; Member of RMP Review Committee.
Henry Lemon, M.D., Member of RMP Review Committee, Professor of Medicine Nebraska Medical School
Alfred L. Frechette, M.D., Commissioner of Public Health, Massachusetts Department of Public Health
F. M. Simmons Patterson, M.D., Executive Director, Assoication for the North Carolina RMP, Durham, North Carolina
William Lawrence, M.D., Chairman RAG, Alabama RMP, Internal Medicine-Cardiology, Birmingham, Alabama
Miss Jean Schweer, R.N., Director of the Division of Continuing Education, University of Indiana School of Nursing

RMPS Staff

Ismael B. Morales, Public Health Advisor, Grants Review Branch
Frank Nash, Operations Officer, Regional Development Branch
Cecilia C. Conrath, Chief, Continuing Education and Training Branch
Robert Shaw, Regional Office Representative, DHEW, Region II

Participants from the CNYRMP

R. H. Lyons, M.D., Coordinator
John Murray, Assistant Coordinator
L. W. Bluemle, Jr., M.D., President, Upstate Medical Center
R. Schmidt, M.D., Dean of Faculty, Upstate Medical Center; Member of RAG
Clarke T. Case, M.D., Chairman, Regional Advisory Group
Bruce E. Chamberlin, M.D., Vice-Chairman of the Regional Advisory Group
E. C. Hughes, M.D., Upstate Medical Center, Past-President of the Medical Society of the State of New York
Gordon J. Cummings, Ph.D., Member of the RAG
Herbert K. Ensworth, M.D., Member of the RAG; Chairman of Categorical Committee on Stroke
C. A. Keeler, Jr., Member of RAG; Chairman of RAG Nominating Committee
C. F. Jacobson, Ph.D., Member of the RAG
Thomas Mou, M.D., University Dean for Health Sciences, State University of New York; Formally Director of Neighborhood Health Center

Participants (cont.)

Mr. James H. Abbot, Vice-President for Hospital Affairs, SUNY, Upstate Medical Center; Member of RAG
Robert Sagerman, M.D., Member of Cancer Committee
Robert Enich, M.D., Member of the Heart Disease Committee
E. A. Aksel, M.D., Executive Secretary Central New York Hospital Association, Member of RAG
R. W. Bacorn, M.D., Regional Health Director, State of New York Department of Health; Member of RAG
Mrs. Virginia McAllister, Chairman of Department of Health Technology, SUNY Ag. and Tech. College, Canton, N.Y.; Member of RAG and member of Commitee on Continuing Medical Education and Special Programs.
Dolores Leonard, Director of Nursing, Faxton Hospital, Utica New York; Member of Nursing Steering Committee of RMP
Sister Ann Moran, Director of Nursing, Our Lady of Lourdes Hospital, Binghamton, N.Y.; member of Nursing Steering Committee

Core Staff of CNY/RMP

Mrs. Margaret Sovie, Nursing Coordinator
Mr. Walter Curry, Teaching Coordinator
Mrs. Jean Kulakowski, Health Educator
Miss Suzanne Murray, Library Coordinator
Mr. Robert Schneider, Instructural Communications
Mr. Anthony Parisi, Instructural Communications
Mrs. Sandra Anglund, Public Relations
James Waldron, Ph.D., Assistant Professor, Educational Communications, SUNY Upstate Medical Center
Mr. Porter, Evaluator (20% Time and Effort)

II. INTRODUCTION

The site visit team arrived in Syracuse, New York on Wednesday, June 2,1971, and had a pre-site visit meeting at 8:30 in the evening to discuss appropriate strategy for the meeting on Thursday June 3rd. The visitors reviewed their responsibilities in determining the credibility of the CNY/RMP decision-making and review process, administrative capabilities, and its overall ability to carryout the proposed plan. The site visit meeting was conducted at the State University Hospital where Dr. R. H. Lyons, Coordinator of the CNY/RMP has his office. This site visit was initiated by Dr. Effie O. Ellis, who clearly indicated to Dr. Lyons, the Regional Advisory Group members present, and others who participated, the purpose of the site visit and its relative significance to the total review process, including Committee and Council review, of the triennial application under consideration. Dr. Ellis explained how the site visitors hoped to acquire a clear understanding of the organizational structure and processes of the Central New York RMP and their effectiveness in reaching the goals, objectives and priorities which the region has set forth.

III. CONCLUSIONS AND GENERAL IMPRESSIONS

The Central New York RMP demonstrated some impressive strengths in its Regional Medical Program, as well as a number of weaknesses which have persisted since the January 1969 Site Visit. The visitors believed, however, that the Regional Advisory Group although provider dominated particularly by physicians, has begun to assume leadership separate from the Syracuse Medical Center and has demonstrated a fairly effective, although not ideal degree of control over the direction of the program. The New York State Medical Association is quite involved with the planning and evaluation of the Central New York RMP through Dr. Edward Hughes, who serves as Chairman of the Evaluation Committee of the Regional Advisory Group and whose summary report of April 26, 1971, demonstrates a degree of sophistication and self-evaluation which the RAG is competent to assume. The site visitors at the conclusion of the second day believed that Dr. Hughes' report adequately pin pointed a number of the most serious weaknesses now existing in the Central NYRMP program. The visitors believe that the Executive Committee of the RAG should be increased in number to contain better representation from allied health personnel and consumers and assume more responsibility in the planning and operational activities of the Regional Medical Program. The site visitors unanimously recommended that the program be funded at a level of $850,000 with conditions later identified and the provisions that there be appropriate staff follow-up and a technical site visit after a year of operation. This follow-up could help assure that at least some of the major recommendations of the Hughes' Report and of the site visit team are implemented into the program.

IV. REVIEW DETAILS

The region has succeeded in establishing its own goals, objectives, and priorities in general terms on the basis of individual agreement by RAG members as to the major objectives. They are, however, not clearly stated in terms of the health needs of the region and are described as activities and not as anticipated accomplishments. Because of this, the visitors believed this to be one of the weaker parts of the Region's performance capability.

The site visitors had an opportunity to meet with most of the Core staff and thought them to be generally competent. The visitors believed that the Program Coordinator, Dr. Richard H. Lyons, has done an unusually good job in pulling together the program since its inception. It did appear, however, that he is somewhat impatient with some of the newer trends in the organization of the Health Care Delivery System and undoubtedly has seen continuing education, particularly of the professionals with whom he has had great contact namely physicians and nurses, as the major responsibility of RMP.

It appeared to the visitors that Dr. Lyons has had little involvement with the development of the Neighborhood Health Center and that since

Dr. Mou, the former Assistant Director for the RMP had left, the RMP and the center have operated quite independently. An Associate Coordinator, M.D. to direct a program of health service extension into both rural and urban areas is obviously needed. They need someone who is a strong executive and can put together the many resources in the region into a multidisciplinary program. In view of Dr. Lyons' age and history of illness, the Associate should be chosen with the consideration that he might succeed Dr. Lyons when he retires.

The Core staff of the CNY/RMP is small in number and does not have the broad range of professional and discipline representation that is present in other RMPs but it is competent and has adequate administrative and management capabilities. The Core staff has been quite active and successful in establishing a good working relationship with the multiplicity of health institutions in the region. This is particulary attributed to Mr. Murray, the Assistant Coordinator, who is involved in may neighborhood groups and is a member of the Syracuse City Council. This type of community participation is also true of Mr. Curry who has been very effective in working with other health organizations of the region. In addition, through the nurse continuation program headed by Mrs. Margaret Sovie, it is obvious that they have been very effective in reaching the majority of the seventeen thousand nurses in the region and indirectly thereby reaching into most of the hospitals and to many of the doctors in the area. The visitors has some difficulty understanding how the three-part time evaluators on Core staff function within the organization. There did not appear to be a coordinated effort between the three evaluators, the Evaluation Committee and the Core. It is because of this that the visitors recommended that a full-time evaluator on Core staff would be more effective in carrying out the evaluation process by working closely with the Evaluation Committee.

The visitors believe that during the early development of the CNY/RMP it may have looked and in fact, may have been a university operation. It appears, however, that the Regional Advisory Group, although provider dominated particularly by physicians, has assumed leadership separate from the Syracuse Medical Center and is beginning to take control over the operations of the RMP. The Regional Advisory Group is a highly viable active entity with good leadership. It, however, suffers from lack of allied health personnel and consumer representation particularly from the inner-city, rural communities, Model Cities, OEO, and the Neighborhood Health Center. The visitors believe that the RAG can assume a greater role in giving leadership to the planning and operational activities of the program. They appeared to be project oriented and have not assumed responsibility for developing a regional plan. It should be taken into consideration, however, that due to severe winters in the area for at least five months of the year it is relatively impossible for certain members of the RAG to participate during this season of the year. The visitors suggested that the region consider the telephone conference device which they have used for educational purposed to extend communications during the winter months

with RAG members from the northern area. The Executive Committee of the RAG needs to expand its membership to include representation from the low-economic consumers, rural physicians, young activist physicians, allied health personnel and representatives from rural areas of the region. This committee as the representative group of the RAG can certainly enhance its involvement in the planning and operational activities of the RMP, and by doing so rendering the top level leadership needed by the program.

The membership of the RMP committees consist primarily of physicians and there is little organized interrelationship between the committees. There also does not appear to be an established operating procedure that would stimulate an integrated program effort between the committees, RAG, and Core. The visitors recommend that allied health personnel and rural area representatives be added to the committees and that the operating procedures and responsibilities of the committees be clearly defined. In addition, the committees should be involved in total program planning and operational activities of the CNY/RMP. It is apparent that the committees have been project oriented and have assumed a very narrow degree of responsibility within the program.

The CNY/RMP has been successful in establishing a relationship with a multiplicity of health institutions and groups, however, this relationship has come about in an informal manner such as overlapping of committee memberships and through picking up bits of information here and there and incorporating such information into plans or programs. Activities which have contributed toward visibility of the CNY/RMP and have helped in improving relationships between the RMP and other health organizations on the survey of health needs in rural areas, development of a community health center by the former associate coordinator, the development of excellent continuing education program for nurses, the mobile rehabilitation unit activity which has been phased out and in the establishment of apattern of cooperative arrangements. These established relationships can certainly be considered one of the strengths of the region, however, there is little evidence that these relationships have stimulated active involvement in planning and operational activities, particularly in development of a regional plan for improvement of health services. On the other hand, a virtue of the RMP is that it has been able to make some headway without too much agency interference in spite of the traditionalism of the provider elements and the multiple agencies which overlap and duplicate in some cases. The coordination of planning with Comprehensive Health Agencies at the B level in this area are carried out chiefly through having the same small number of very excellent provider workers sitting on committees for both agencies. It was, however, apparent that the representatives of the CNY/RMP were not fully aware of all of the activities that are going on under comprehensive health planning in the area particularly the plans for a pre-paid insurance program in the Syracuse Area, so that there could be come lack of cross over on the informational level with these agencies. The visitors believe that operational commitments

from other agencies could be enhanced if the RMP would develop a systematic ongoing operational planning system to coordinate plans and programs toward specific program objectives. It is for this reason that one of the major recommendations is that they hire an Associate Director for Health Service extension at the M.D. level to supplement the activities of Dr. Lyons, Mr. Murray and the rest of the Core and bring about a coordinated effort in program activities.

The Central New York RMP, during its planning phase, conducted a demographic survey concerning the population and total numbers of physicians compared to those in private practice. The hospital bed capacity was determined along with a summary of the resources for heart cancer and stroke patient care. These meetings and studies helped familiarize the people of the region with the intent of CNY/RMP and gave the program some rough estimate as to the needs of the various communities within the region. Dr. Edward C. Hughes, past-president of the New York State Medical Association is presently directing a study in rural medical care which was initially funded at a level of $75,000 by the Avolon Foundation. Dr. Hughes is a practicing physician with considerable depth and great interest in the distribution of health services in the State of New York and appears to be a major asset to the RAG. The visitors were, however, informed that the grant from the Avalon Foundation was terminating so that Dr. Hughes will be unable to continue this study unless he is able to locate support from other sources. The primary areas where there is a desperate need for improved medical care are the 34,000 underprivileged people of Central Syracuse and the northern counties of the region of St. Lawarence, Franklin, and Jefferson. The Neighborhood Health Center located in this central Syracuse underprivileged area offers a particularly favorable focus on Syracuse for advance in health care delivery service although it is presently serving approximately only 8,000 of the population. It is expected that when the Syracuse Medical Center takes over the sponsorship of this health center this Fall and utilizes its medical manpower resources to help staff the center it than can be more responsive to the Medical Care needs of the 38,000 population in the area. The basic health problems of the northern area of the region are the limited number of physicians and the age of the physicians which are available because they are retiring at a much faster rate than they can be replaced. Dr. Bluemle, President of the Medical Center, sees this as the number one problem in the region. The RMP through its field staff has been working with consumer groups in St. Lawrence County and hopefully out of this consumer activity will come a program to provide more health care for the people of that area.

The region has continued to follow its initial concept of Regional Medical Programs; it has not altered its course to the evolving mission of RMPS. it continues to view its role in the area of continuing education and not placing the needed emphasis on access of care to meet the needs identified in the proverty pocket of Syracuse and the Northern Counties of the Region.

In program implementation, the activities of the CNYRMP represent an opportunistic approach to feasible objectives as determined by local opportunities rather than through carefully planned and coordinated answers to regional needs, which they seem to be quite well aware of. Availability of health care was mentioned several times by representatives of the region as a major health problem, however, there was little evidence of a planned effort to develop a program in this area. The activities of the Central New York RMP have not been absorbed into the regular health care system in most instances with the exception of the home health aide program which was really a peripheral development of the program. There has been a tremendous organization of nursing education resources under Mrs. Margaret Sovie, but it should be emphasized that this effort has been pretty much divorced from the School of Nursing at the University of Syracuse as well as from other nursing schools at Cornell, Utica and elsewhere.

The region has formed a coordinating committee with representation from the CNY/RMP, Health Department, Hospital Association, OEO and other health related organizations so that they could keep each other informed and avoid duplication among agencies, particularly the four agencies mentioned. The visitors believe the CNY/RMP could use this committee to establish a coordinated planning effort for health care delivery services in the region rather than just to oversee what each other is doing. This is something that the region could explore for future program planning and development. The activities of which the Central New York RMP are capable , could indeed lead to improved utilization of existing health care resources, particularly in developing additional manpower such as nurse practitioners which the region is just now beginning to consider. Although few in number, the Central New York RMP as been successful with many of its activities in meeting its objectives. The nursing coronary care training activity in Utica is meeting the needs of two community hospitals by having them pool their talents to provide training for smaller outlying hospitals in the area and has been able to continue this activity with much success.

A very impressive activity in community health education is now in process under the direction of Mr. Horace Ivey, who is utilizing the Mobile Unit previously of the Mobile Stroke Program which has been phased out to carryout community health education activities. Mr. Ivey, has requested that RMP support a feasibility study in which the Mobile Unit can be utilized for community health education, immunizations, lead poisoning, survey, screening and bringing an awareness to the community of the health resources which are available to them in the community. The visitors believe that the Mobile Rehabilitation Stroke Unit Program which was phased out was one of the better activities in this region; one which was giving the CNY/RMP much visibility. The visitors were also quite impressed by the Home Health Aide Program, the Neighborhood Health Center in Syracuse and the study of rural health planning by Dr. Edward C. Hughes. Although none of these activities are supported by CNY/RMP funds the core staff has been greatly involved in the planning and operational activities of their programs. It appears that the RMP is beginning to develop a good relationship with the medical groups of the region and loosening its ties with the University.

Project related evaluation activities which have been undertaken by the region during the past year include visits by staff, reports to the Evaluation Committee and direct reports from the field. It is, however, evident that the basic evaluation activities implemented by the region have been toward evaluation of each project component in relation to its own objectives. There appears to have been very little effort in evaluating each of these components in relation to what they have accomplished in meeting regional objectives and meeting the health care needs of the region. The reviewers believe that it will be difficult for this region to carry out a thorough evaluation plan without first outlining specific objectives on the basis of expected accomplishments and related to a time table. The evaluation process should also be one that is done continuously throughout the year and can be utilized to adjust program direction as needed rather than the once a year evaluation of the program.

The visitors recommend the following funding level in direct cost, which is approximately $200,000 above their present level of funding with the following conditions:

	Requested	Recommended
1st Year	$1,413,928	$ 850,000
2nd Year	1,367,355	850,000
3rd Year	1,389,363	850,000
Total	$4,170,646	$2,550,000

1. That an associate coordinator M.D. to direct a program of health service extention into both rural and urban areas be employed. The region needs someone who is a strong executive and can bring together the many resources in this area to cooperatively resolve the health problems of the region.

2. That the RAG and its Executive Committee expand its membership to include representation from the lower-economic consumers, rural physicians, young activist physicians, allied health personnel and representatives from rural area of the region. They need to have younger representatives on the Regional Advisory Group and the visitors specifically recommended adding two medical students and one nursing student, perhaps as non-voting members.

3. That the region develop a program plan which includes a method for priority establishment, a decision-making process, program planning and evaluation. The visitors believe that this is a basic need for this region because they found it difficult to get any feeling that even the RAG or the coordinator had any sense of what the CNY/RMP expects to be three years from now.

4. That the program establish a balance in the development of activities in relation to their priorities; the continuing education activities for nurses have out-stripped some of the other activities in the region.

5. The visitors also believe that the region should put into action the recommendations documented in Dr. Hughes evaluation report, especially paragraphs 3 and 4, of the report. (Copy of the evaluation report by Dr. Hughes is attached.)

6. That the region consider hiring for Core staff a full-time evaluator rather than continue to utilize the present three part-time evaluators.

7. That operating procedures and responsibilities of the RMP committees be clearly defined with emphasis in involving them in the program planning and operational activities of the program.

8. The visitors recommend a regionalization planning approach in health services; that program activities be integrated as part of a total program plan which can be measured in terms of accomplishment at specified periods of time.

9. It is recommended that not more than 20% ($120,000) of the requested funding level for Project #18 - Area Health Continuing Education Center be utilized for support of this project by the region. The region was encouraged to carry out a demonstration project in one of the sub-regions rather than begin with a region wide program as proposed in the application.

The region has been using some of their core funds for support of feasibility studies and central core activites. The visitors do not discourage these activities but recommend that the activities be funded only when approved by the Regional Advisory Group. They should be considered on the basis of what they contribute to the objectives and priorities of the region as described in the region's program plan. The visitors suggest that the additional $200,000 recommended be utilized to develop activities that will help improve delivery of health services to the urban and rural poor. These appear to be two real priorities for the region and this additional funding should be able to provide some progress in these two areas.

The site team members recommend a staff follow up visit six months following the award of this application to evaluate progress in implementing the above recommendations and to provide assistance if necessary.

RMPS/GRB/6/29/71

Responses by the Site Visit Team to the RMP Program Review Criteria of May 10, 1971 on the Site Visit to the Central New York Regional Medical Program of June 3-4, 1971

A. Intended results of its program:

1. The activities of the Central New York RMP represent an opportunistic approach rather than through a carefully planned and coordinated approach to answer regional needs, which they have identified. The objectives although non-specific, are congruent with the overall mission and objectives of RMP nationally.

2. Through the Nurse Continuing Education Training Program headed by Mrs. Margaret Sovie, it is obvious that the region has been very active in reaching the majority of the 17,000 nurses in the region and indirectly thereby reaching many of the doctors and into most of the hospitals in the area. It should also be noted that the State Medical Association is involved in planning and evaluation activities concerning the growing deficiencies in rural medical care. The visitors believe that the background is now well established for the development of real advances in health care in the area.

3. The activities of which the CNY/RMP are capable of could indeed lead to improved utilization of existing health care resources, particularly by developing additional health manpower, such as nurse practitioners and physician assistants. The Neighborhood Health Center offers a particularly favorable resource in Syracuse for advances in health care delivery to an inner city population of about 38,000 which is in need of health care services. The Syracuse Medical Center will be taking over the sponsorship of this health center as of this Fall because of the failure of administrative support from the regional health department in its budget and operational activities. This should stimulate a closer relationship between the center and the CNY/RMP.

4. Health Maintenance, Disease Prevention, and early detection are only minor components of the activities which the CNY/RMP has developed.

5. There is no major expansion of ambulatory care or out-patient diagnosis and treatment planned other than of course, the superbly designed and equipped Neighborhood Health Center developed in Syracuse by Dr. Tom Mou. The center, however, has been under-utilized because of inadequate medical staff and due to local consumer prejudices, resident and medical student assistants from the medical center has not been accepted at this center.

6. It seems likely that accessibility of medical care could be improved and that there could be improvement in the relationship between primary and secondary medical care if the region can develop answers to their recognized and identified deficiencies in medical care in the area.

To really accomplish this, the region must alter its direction from continuing education to accessibility of health care for the region.

7. There is no immediate pay-off seen in accessibility, quality, or cost moderation in medical care, although the Neighborhood Health Center in Syracuse obviously offers a better source of assessible medical care than the urban population has had in the past.

8. The Central New York RMP has had some success in linking and strengthening the ability of multiple health institutions in groups to work towards better health care. This has been particularly attributed to Mr. Murray the Assistant Coordinator, who is involved with many neighborhood groups, and, sits on the Syracuse City Council. Also, Mr. Currie of the core staff has been very effective in this regard. The relationship between the RMP and other health agencies exist, however the commitment to work in a cooperative effort may need strengthening.

9. The Central New York RMP has been supportive of a number of other HEW funded projects, such as the Community Health Center in Syracuse. They have also been able to tap other sources of funds for some of their planning activities, including private funds for the survey of rural health needs by Dr. Hughes.

B. Performance Criteria

1. The region has succeeded in establishing its own goals, objectives, and priorities in general terms on the basis of individual agreement by RAG members as to the major objectives. There is, however, no clear statement of the basis for priority in selecting budgetary support of projects, and the visitors view this as a weakness in their performance capability. The objectives are primarily described in terms of activities and not as anticipated accomplishments which clearly relate to the health needs of the region. In addition, there is no time table related to the accomplishment of the regionsobjectives.

2. The previous activities which the region has engaged in, although few in number, have been productive, for example, a survey of health needs in rural areas, the development of a neighborhood community health center by the former associate coordinator, the development of an excellent region-wide continuing education program for nurses, the development of a mobile rehabilitation unit and the establishment of a pattern of cooperative arrangements.

3. The Central New York RMP activities have not been absorbed into the regular health care system in most instances with the exception of the home health aides activity which was really a peripheral activity of the CNY/RMP.

C. Process Criteria

1. The Regional Advisory Group of the Central New York RMP is on the verge of becoming a viable active entity of the CNY/RMP. The visitors however, believe that the RAG needs to assume a greater leadership role in the planning and operational activities of the CNY/RMP. The group has been strengthened by the recent addition of allied health and consumer representatives, however, the visitors believe that the rural communities, model cities, OEO and consumers from the inner city (neighborhood health center) need to be represented. In addition, the RAG needs to add younger activist members representing the rural and urban medically deprived areas. The Executive Committee of the RAG needs to assume a more active role in giving direction to the program and its membership should be increased to include allied health personnel and consumer representation. A difficulty which the region possesses is the severe Winters of the northern area for at least five months of the year, which makes it relatively impossible for representatives on the RAG from the area to participate during that season of the year.

2. There are probably between 100-200 health related agencies who have relations in one way or another with the Central New York RMP, reflecting the very complicated history in development of Public Health Activities in the State of New York. The visitors believe that this is one of the virtues of the CNY/RMP, it has been able to make some headway without too much agency interference, in spite of the traditionalism of the provider elements and the multiple agencies which overlap and duplicate in some cases. There appears to be active relationships between the CNY/RMP and other health-related agencies of the region, however, it was difficult to determine the amount of commitment and active participation of these agencies to CNY/RMP.

3. The coordination of RMP activities with comprehensive health agencies at the "b" level in this area, are carried out chiefly through having the same small number of very excellent provider workers sitting on committees for both agencies. It also seemed apparent that the CNY/RMP was not fully aware of all of the activities that were going on under Comprehensive Health Planning in the area, particularly the plans for a pre-paid insurance program in the Syracuse Area, so that there could be a lack of cross-over on the informational level.

4. The visitors believe that there is no real systematic ongoing operational planning that would coordinate planning and operational activities towards specific program objectives. It was because of this reason a major recommendation of the visitors was that the region hire an associate director at the M.D. level for health services extension to supplement activities of Dr. Lyons and

Mr. Murray and the rest of the core and to bring some focus to their activities.

5. The visitors believe that the Dr. Edward C. Hughes' Chairman, Evaluation committee did a very fine job in identifying in the evaluation committee's report the deficiencies of the Regional Advisory Group and other deficiencies within the RMP. On the other hand the three 20% evaluators on core staff from the University of Syracuse represent different disciplines and have done their evaluation independently with very little effectiveness. It is believed that the Region8 needs to hire a full-time evaluator on core staff who can carry out a continuing evaluation process and work closely with the Evaluation Committee of the Central New York RMP. In addition, the visitors believe that the region should seriously consider following up on the recommendations of Dr. Edward C. Hughes outlined in his report.

SUMMARY REPORT

Evaluation Committee
Dr. Edward Hughes, Chairman
April 22, 1971

Recommendations

1. The RAG should amend their by-laws to indicate that RAG members who miss three consecutive meetings are dropped from the rolls unless they contact the Chairman and a legitimate reason is given. Our 50 per cent attendance at meetings has not been good and although representation of geographic areas and disciplines has been excellent, we need a greater percentage of RAG members attending.

2. Medical societies of smaller counties should be represented on the RAG, perhaps on a rotating basis. This would give us a closer relationship with the practitioners in those smaller counties. There should be a further diversification of the RAG by having additional members who represent rural groups (Extension, MIDNY), political groups (Senator Lombardi is the Chairman of the Health Committee, Assemblywoman Cook is a ranking member of the Education Committee which has jurisdiction over licensing), and medical planning groups, like CHPs (we have Board members of CHPs but no staff members).

3. Review the function of Categorical and other committees. They should constantly be re-evaluating their priorities in their area of interest. They should be charged with considering solutions to problems they pose. For the most part, they have been review committees of proposals that have been submitted to them. There have been exceptions to this. The Community Health Education Committee, the Primary Patient Care Committee, and the Cancer Committee are three examples of committees who have sought out the problems.

4. RMP should attempt to create a modern health care system in Central New York by investigating and determining by regional studies, the local health needs and locations of medical coverage in this region. The studies should be completed with the cooperative support of comprehensive health planning groups, county medical societies, third party payors, and consumers. This is in concert with the recent federal emphasis on experimental health systems and HMOs.

5. RMP investigate and encourage modern record data processing and standardization of medical terminology for hospitals in the region, thereby establishing a method of quality control and record comparability.

6. Establish education health centers in various areas of our region. This is in line with the Area Health Continuing Education Centers proposal as well as the President's health message and the Carnegie Report calling for the establishment of health education centers.

7. All teaching projects should have some form of testing before the course is given and testing after the course is complete to determine if the participants have progressed as a result of the course.

8. Recommendations regarding projects.

Mobile Stroke Unit - It is academic now since the project has been terminated, but we recommended continued emphasis on nursing homes, holding as many subregional sessions as possible in one nursing home with four or five surrounding nursing homes also participating.

Home Dialysis - Has yet to get off the ground so would recommend a three-year application in the new proposal.

Family Practice - The Family Practice Continuing Education concept should be expanded to other hospitals in other subregions. This recommendation should be tied in with our Area Health Continuing Education Centers. We also highly recommend the establishment of a model clinic in a rural area to give us a location for offering experience to residents.

Oneida County Tumor Conference - Expand this approach to other subregions through the use of the Area Health Continuing Education Centers.

Medical Briefs - Individual tapes should be constantly evaluated for relevancy and outdated tapes immediately withdrawn and replaced. New types of tapes should be prepared dealing with information about services that are available in our region. There should be tapes which highlight specific items of interest in the local community such as drug abuse and venereal disease information. The Physician Dial Access should have a companion service for nurses.

Learning Resource Center - RAG should appoint an advisory committee to give guidance and further direction to the Learning Resource Center. The Learning Resource Center should be turning some of its efforts to producing public health information software that can be used on local TV and radio stations. This should be done in concert with the Community Health Education Committee.

Continuing Education in Nursing - Rather than a recommendation we would like to give a star for a job well done. We heartily endorse, as stated above, the Nurse's Steering Committee's approach to Area Health Continuing Education Centers.

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

Georgia Regional Medical Program
Medical Association of Georgia
938 Peachtree Street, N.E.
Atlanta, Georgia 30309

RM 00046-04 8/71
July 1971 Review Cycle

Program Coordinator: Charles Adair, M.D.
Program Director: Gordon Barrow, M.D.

This Region is currently funded at $1,779,862 (d.c.) for its third operational year ending 8/31/71. Core is supported at $648,435 (d.c.) and 23 projects at $1,131,427 (d.c.). Indirect Costs of $203,227 are provided representing 11.42 % of Direct Costs. The Region has submitted a triennium application that proposes:

I. A Developmental Component
II. Continuation of Core and six projects into the 04 year
III. Continuation of 10 projects beyond the Council-approved period of support.

5 projects for three additional years
4 projects for two additional years
1 project for one additional year

IV. The implementation of 15 new activities
V. The termination of 12 activities

The Region requests $3,920,034 (d.c.) for its fourth year of operation, $4,349,497 (d.c.)for the fifth year and $3,942,724 (d.c.) for its sixth year. A breakout chart identifying the components for each of the three years is presented on pages 2-4 of this summary.

A site visit is planned for this Region. Staff has conducted a preliminary review of the application, and has identified the following as areas which need further clarification by the site visitors. These are covered in greater detail in the staff review attached to this summary.

1. Goals and objectives
2. Core staff positions and functions
3. RAG - its composition and its control over policy
4. Committee structure and its relevance to the new program
5. Practical functioning of the 140 Local Advisory Groups
6. Development and review of projects
7. Project and program evaluation

REVISED 6/7/71

REGION Georgia
CYCLE RM 00046 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
#18 - Core	$ 683,430 *				$ 683,430	$ 81,750	$ 765,180
D00 - Developmental**				$ 177,986	177,986	---	177,986
#1 - Clinical Training		$ 60,000			60,000	---	60,000
#3 - Visiting Cons. Prog.		30,500			30,500	2,369	32,869
#6 - Communication Network		161,200			161,200	---	161,200
#13 - Statewide Cancer Prog.		450,257			450,257	16,017	466,274
#14 - Ped. Resp. Center		86,250			86,250	20,040	106,290
#20 - Area Fac. for C.E.	267,700*				267,700	---	267,700
#22 - Physiology for Nursing Instructors	30,970*				30,970	5,843	36,813
#27 - Community Hypertension	183,323***				183,323	21,125	204,448
#30 - Fac. Plan. & Devel.	32,365				32,365	---	32,365
#31 - CV Area Facilities	202,960				202,960	---	202,960
#32 - Stroke Area Fac.	126,850				126,850	---	126,850
#36 - Kidney Disease				211,588	211,588	51,646	263,234
#37 - Fac. for Resp. Dis.				75,940	75,940	---	75,940
#38 - Emergency Care				336,460	336,460	---	336,460
#39 - Health Maintenance				107,290	107,290	---	107,290
#40 - UNASSIGNED							
#41 - Electrical Hazards				7,290	7,290	1,820	9,110
#42 - High Risk Maternal & Infant				63,040	63,040	20,120	83,160
#43 - Pat. & Family Educ.				85,000	85,000	---	85,000
#44 - Computerized Dietary				87,700	87,700	---	87,700
#45 - C.E. in Nursing				33,575	33,575	8,684	42,259
#46 - Learning Resources				42,060	42,060	3,479	45,539
#47 - Consultant Dietitians				30,936	30,936	7,740	38,676
#48 - Shared Allied Health				68,100	68,100	---	68,100
#49 - Health Car. Counseling				23,917	23,917	---	23,917
#50 - Phys. Assistant				228,147	228,147	13,360	241,507
#51 - CE Health Prof. in Optimal Diabetes Care				25,200	25,200	4,170	29,370
TOTAL	$1,527,598	$788,207		$1,604,229	$3,920,034	$258,163	$4,178,197

* 05 & 06 years are Continuation Beyond the Approved Period of Support
** Request amended to 3 years per telephone conversation W. Reist and Region 5/12/71
*** 06 year request is Continuation Beyond the Approved Period of Support

GRB/5/13/71

REGION Georgia

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
#18 - Core		$ 717,602			$ 717,602
D00 - Developmental				$ 177,986**	177,986
#1		60,000			60,000
#3		30,500			30,500
#6		161,200			161,200
#13		446,479			446,479
#14		84,250			84,250
#20		267,700			267,700
#22		25,873			25,873
#27	$185,280				185,280
#30	34,820				34,820
#31		284,006			284,006
#32		206,045			206,045
#36				301,523	301,523
#37				155,634	155,634
#38				294,800	294,800
#39				138,560	138,560
#40 - UNASSIGNED					
#41				4,140	4,140
#42				63,812	63,812
#43				85,000	85,000
#44				94,072	94,072
#45				33,575	33,575
#46				64,850	64,850
#47				40,172	40,172
#48				68,100	68,100
#49				20,168	20,168
#50				303,350	303,350
#51				---	---
TOTAL	$220,100	$2,283,655		$1,845,742	$4,349,497

** Request amended to 3 years per telephone conversation W. Reist and the Region 5/12/71

REGION Georgia

BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
#18 - Core		$ 753,481			$ 753,481	$ 2,154,513
D00 - Developmental				$ 177,986**	177,986	533,958
#1		60,000			60,000	180,000
#3		30,500			30,500	91,500
#6		161,200			161,200	483,600
#13		332,884			332,884	1,229,620
#14		84,250			84,250	254,750
#20		267,700			267,700	803,100
#22		25,873			25,873	82,716
#27		191,765			191,765	560,368
#30		---			---	67,185
#31		360,197			360,197	847,163
#32		257,345			257,345	590,240
#36				396,426	396,426	909,537
#37				199,687	199,687	431,261
#38				147,400	147,400	778,660
#39				16,320	16,320	262,170
#40 - UNASSIGNED						
#41				4,140	4,140	15,570
#42				---	---	126,852
#43				85,000	85,000	255,000
#44				---	---	181,772
#45				33,575	33,575	100,725
#46				53,360	53,360	160,270
#47				41,074	41,074	112,182
#48				68,100	68,100	204,300
#49				---	---	44,085
#50				194,461	194,461	725,958
#51				---	---	25,200
TOTAL		$2,525,195		$1,417,529	$3,942,724	$12,212,255

** Request amended to 3 years per telephone conversation W. Reist and Region 5/12/71

8. Relationship of projects to objectives
9. Method for priority-ranking of projects
10. The need to request continued funding of 10 projects beyond the Council-approved period of support.
11. Minority involvement in GRMP

FUNDING HISTORY

(Planning Stage)

Grant Year	Period	Funded (d.c.)
01	1/1/67 - 12/31/67	$208,781
02	1/1/68 - 3/31/69	$589,066

(Operational Program)

Grant Year	Period	Funded (d.c.)	Future Commitment (d.c.)
01	7/1/68 - 6/30/69	$1,427,810 1/	------
02	7/1/69 - 8/31/70	$2,470,103	------
03	9/1/70 - 8/31/71	$1,779,862	
04	9/1/71 - 8/31/72	-----	$1,096,536
05	9/1/72 - 8/31/73	-----	$289,902

1/ Includes only 3 months of Core

GEOGRAPHY & DEMOGRAPHY

The Region encompasses the entire state; interfaces with Alabama to the west and with northern Florida to the south.

Counties: 159 Congressional Districts: 10

Population: (1970 Census) - $4,589,000

Urban: 60.3% Density: 79 per sq. mile

		U.S.
Age Distribution:	Under 18-37%	35%
	18-64 yrs.-55%	55%
	65 & over -8%	10%

Average per capita income - $3,040 (compared with $3,680 for U.S.)

Metropolitan areas: (4) Total population - 2,040,700

Atlanta -	1,373.6	Columbus, Ga.	234.3
Augusta -	249.8	Savannah	183.0

Race: White	-	3,395,860	74%
Non-White	-	1,193,140	26%

Vital Statistics

Mortality - deaths per 100,000 pupulation, 1967

	State of Georgia	U.S.	Age specific death rates/100,000 (all causes)
Heart Disease	288.1	364.5	45-64 yrs. 1380.8
Malignant neoplasms	122.5	157.2	65 & over 5839.1
Vascular lesions (aff. CNS - stroke)	122.0	102.2	compared with U.S. 45-64 yrs. - 1143.5
All causes	853.9	935.7	65 & over - 6042.5

Resources and Facilities		Enrolled	1969/70 Graduate
Medical Schools	- Emory University School of Medicine Atlanta	333	75
	Medical College of Georgia, Augusta	418	98
Dental School	- 2 Emory and Medical College of Georgia		
Pharmacy	- 2 University of Georgia, Athens;	Southern School of Pharmacy,Mercer Univ. Atlanta	

Professional Nursing Schools
27-(18 of them based at Colleges and universities)

Practical Nurse Training
44 - majority are vocational schools

Other Programs

CHP - A agency -$315,000 (10 professional staff)
(2) - B agency -$400,000 (15 professional staff) Atlanta, Brunswick

Allied Health School -- University based: Georgia State University, School of Allied Health Services, Atlanta; Emory University School of Medicine,Division of Allied Health Professionals.

Accredited Schools: Cytotechnology -2
Medical Technology - 15
Radiologic Technology - 23
Physical Therapy -------
Medical Record Librarian - 2

Community and Junior Colleges: Eight Jr. Colleges

Hospitals: Community General and V.A. General

	#	Beds
Short term	141	15,198
(special)Long term	1	120
	1 VA incl.long-term care unit	1,450
V.A.(General)	2	917
Long-term Care Units	24	1,146
Skilled Nursing Homes	203	13,184

Manpower:

Physicians*- Non-Federal M.D.s (1967)

Active - patient care	4,106
other professional activity	364
Inactive	258

Osteopaths (D.O.s) - 66

Ratio of active (per 100,000 pop.) 93 (U.S.132)
*Percent by specialty: General practice -22%
Medical Specialty - 23%; surgical specialties -33%

Graduate Nurses, 1966	#	Ratio Per 100,000	
Actively employed in nursing	6,956	156	(U.S. 313)
Not employed in nursing	3,111	---	

Licensed Practical Nurses	
Total employed in nursing(adj)	3,912
Not employed in nursing	1,046

HISTORY AND DEVELOPMENT: The Region's initial planning year began on January 1, 1967 and was supported at $208,781 (d.c.).

Three awards totaling $589,066 (d.c.) were made for the second year of planning 1/1/68-3/31/69.

A pre-operational site visit was conducted to GRMP in June 1968 by Stanley W. Olson, M.D. who was then Coordinator of the Tennessee Mid-South RMP, Mack I. Shanholtz, M.D., Lionel Bernstein, M.D., and RMPS Staff Ira Alpert and Peter Clepper. The site visitors agreed there was evidence of careful and thoughtful planning by GRMP and substantial involvement of large groups of people in every section of the state. The involvement of the Medical Association of Georgia as applicant agency was felt to insure the full support of the organized medical profession and the selection of Dr. Barrow as full-time Director represented a wise move in that he brings to the position substantial organizing ability and experience in public health, in academic medicine and as a hospital director of medical education.

While the major criticism of the application was that the conceptual strategy guiding the RAG was not explicit, the visitors made a substantial effort to explore this matter and were statisfied a reasonably well defined "strategy" did exist which was described as follows. The applicant seemed well aware that implementation of a RMP would involve participation by all health professionals and lay persons interested in health matters, but that the primary group which could either stimulate the program or inhibit its development was the medical profession. The Medical Association of Georgia, by assuming a leadership role, had assured the widest level of support

by the physicians of a state which traditionally has had strong conservative leanings. The two medical schools, sensing the importance of having full support from the practicing medical profession endorsed the proposal that the Medical Association take the lead. This in fact produced a certain freedom on the part of the schools to participate to the extent they feel they can do so without interfering with what are considered their primary responsibilities of teaching and research. The plan for GRMP envisioned that the resources of the two medical schools would be made available to health personnel and health institutions of the state and that physicians and other health professionals would look to the medical centers for training and assistance. GRMP would assist in establishing throughout the state a series of area facilities of excellence for heart and cancer. As a result of this visit and subsequent action by Committee and Council, GRMP was awarded support of $1,427,810 for 14 projects for the year 7/1/68 - 6/30/69 and Core support for the period 4/1/69-6/30/69.

A second site visit was conducted to the Region in July 1969 following GRMP's submission of a supplemental application in early 1969 which consisted of 14 projects and a core supplement. The team consisted of Philip White, M.D., of Committee, Glen Turner, M.D., Edmund McTernan, M.P.H., and RMPS Staff, Jessie Salazar, Frank Nash and William Reist. The visitors were convinced the Region had active plans for the improvement of health care for the disadvantaged and poor. There appeared to be close cooperation between GRMP and the Office of Comprehensive Health Planning and a Joint effort was being made to develop a project for a health information system. The general structure of the GRMP appeared good and local involvement was considered adequate as evidenced by the establishment of 100 Local Advisory Groups which would interdigitate with the five subregional offices. It was difficult for the team to conceive the degree of participation of the individual members of the large 60 member RAG until it was explained that the Steering Committee serves as the major decision-making body, but that the RAG does maintain veto powers. Concern was expressed regarding representation of minority groups, particularly at the local level; however, it was felt at that time that there were realistic problems which might prevent more adequate representation, the most significant being the fact there were only a few black physicians in the state and most of them practiced in Atlanta. It was also felt there was inadequate representation of the Schools of Nursing at the Universities. While the length of time, 9 to 15 months , involved between the initiation of a proposal and the review of it by the RAG was viewed by the visitors as too long, the Region believed it did not create any excessive problems. The visitors saw a need for the Region to develop a standard format and system for writing and developing project applications. GRMP had been very effective in stimulating the interest of doctors and getting community hospitals to contribute and participate. There was no apparent conflict between the RAG and the Medical Association of Georgia, and the administrative set-up seemed to be quite adequate. With the addition of Dr. Gullen to the staff, the Evaluation Division was considered to be strengthened appreciably. Methodology

permitted a built-in mechanism for assessment from the inception of each project. Staff was also in the process of "back tracking" on all existing projects to assure consistency in all evaluation procedures. All in all, evaluation techniques were believed to be appropriate and adequate.

The Region was awarded $2,623,512 (d.c.) for support of Core and 23 projects during its 02 operational year.

In August 1970 Staff reviewed the Region's continuation application for the 03 year of operation. While staff concluded that as a whole the program appears to be well organized, under strong leadership, and functioning well, the interrelationships of the projects were not always clear, nor was it possible to fullunderstand how a particular project relates to the total program. Staff found the evaluation aspect of numerous projects extremely weak and the Region was requested to submit additional evaluation information on a number of projects. Project #6 was cited as having severe weaknesses and was recommended for a technical review. The technical review group recommended the project be phased out, however, in consideration of the Regions concerns and objections it was agreed the project should receive a technical site visit.

In September a technical site visit team visited Project #6. The team consisted of Winston Miller, M.D., Gordon Titus, Rhoda Bowery, and Elsa Nelson and Frank Nash of RMPS. The project appeared plagued with deficiencies, poor program planning and inadequate evaluation. The team concurred with the technical reviewers' findings and the Region was requested to submit phase-out budgets, which it did.

The Region has been awarded a total of $1,779,862 (d.c.) for its 03 operational year 9/1/70-8/31/71.

PRESENT APPLICATION

Goals and Objectives: The overall goal of GRMP is to "Improve regional health resources and enhance the capabilities of providers of care at the community level in a way that will influence present arrangements for personal health services to permit maximum availability, accessibility, and use of the best in modern medical care for heart disease, cancer, stroke, kidney disease and related diseases."

More specific objectives are:

1. To increase the availability and efficiency of health manpower in Georgia through:

    a. The provision of the new types of health manpower such as physician assistants.

    b. Training all types of health manpower in new skills to allow each of them to expand his role and effectiveness.

c. Making scarce types of health manpower and their skills more widely available, particularly in rural areas.

d. Encouraging disadvantaged students as well as others to enter the health field.

2. To improve the quality of medical care in Georgia, including prevention, diagnosis, treatment, and rehabilitation through:

a. Assisting the medical care institutions in meeting the highest existing standards for facilities, construction, equipment, and maintenance.

b. Providing health professionals with opportunities for new skill development and continuing education.

c. By making new and improved methods quickly available from the laboratory to the practicing health professional.

3. The improvement of the availability and accessibility of of primary medical care and of specialized diagnostic, prevention, treatment, and rehabilitative services to all persons in Georgia through:

a. The promotion of innovative models of primary care for rural areas without adequate services.

b. The promotion of innovative models of primary care for urban ghetto areas without adequate services.

c. Encouraging community screening, casefinding, and prevention programs which may provide an entrance into the health care system.

d. Promoting the regionalization of certain primary care services such as emergency and ambulance services which cannot economically be provided without such regionalization.

e. Providing area facilities of excellence in the major categories of disease.

f. Improvement of the skills of personnel in these area facilities to allow them to serve more effectively and more efficiently.

g. Developing regional cooperative arrangements for the more effective and efficient use of these specialized facilities and services.

Requested 04 Program Year
$683,430

CORE: Core Staff consists of 27.6 (full-time equivalent) professional and technical personnel and 13.5 (FTE) secretarial and clerical personnel. Core organization is divided into three major divisions each sub-divided into smaller units:

I. Administrative Division
   - Staff Services Section
   - Budget & Fiscal Section
   - Communications & Information Section

II. Program Planning & Development Division
   - Facilities & Services Section
   - Continuing Education & Manpower Section
   - Categorical Diseases Section
   - Program Assessment Section

III. Area Programs Division
   - North Area
   - East Central Area
   - Southwest Area
   - Southeast Area
   - West Central Area

Liaison is maintained with the universities through a Medical Colleges Staff Services Division, under which an epidemiologist and biometrician at the medical college are each supported at 50% and an Associate Dean at Emory is supported at 33%.

Of the 27.6 (FTE)professional staff 8.5 are female and 2 are Black.

Of the 13.5 (FTE) secretarial staff 13 are female and 2 are Black.

Core activities fall into eight general areas:

1. professional consultation
2. subregionalization
3. planning and feasibility studies
4. central regional services
5. project development & review
6. program assessment
7. program management
8. administrative management

Significant accomplishments of Core staff over the past year have been:

1. Strengthened subregionalization and decentralize certain program management functions to the area program staffs in subregions.

2. Strengthened administrative and grants management functions of staff.

3. Strengthened program assessment capability of core staff and building in the continuing evaluation of the ongoing program as an integral part of program planning in the future.

4. The de-emphasis of the categorical nature of the program and planning ways to assist the providers to improve the health care delivery system.

The most important area of core activity over the next Triennium will be "to continue to explore ways in which this GRMP can assist the providers in improving the system in line with the priorities of this Administration."

GRMP has no active feasibility or planning studies supported through Core.

Requested 05 Program Year	Requested 06 Program Year
$717,602	$753,481

REGIONAL ADVISORY GROUP: The RAG which consists of 65 members appears for the most part to have representation of the key resources and interests in the Region, and is equally balanced geographically. Physicians influence is strong with a contingency of 32 of which 12 represent the Medical Association of Georgia and 4 represent the Georgia State Medical Association, a Black organization. While the CHP "A" agency is represented on the RAG, neither of the two "B" agencies have such representation, nor is there representation of the Appalachian Program or the 66 practicing osteopaths of the State. Of the 65 RAG members, nine are female and six are black. All of the eight public or consumer representatives are professional executive types.

Like most RAGs of this size, it does not appear to be particularly strong, but rather out of necessity relies heavily on the Steering Committee, the Task Forces, and Core. Attendance at the tri-annual meetings which was 37%, 52% and 61% last year, is about average for a RAG of this size.

COMMITTEES: The committee structure consists of a Steering Committee (Executive Committee) six Task Force Committees and approximately 198 standing and ad hoc committees. (There is some contradiction in the application regarding the standing and ad hoc committees.)

The Steering Committee consists of five RAG members elected by the RAG, and the RAG Chairman. Its primary function is to oversee the day to day administration of the program.

There are six major task forces, each consisting of 12 members elected by the RAG, two of whom are RAG members. They are:

1. Task Force on Continuing Education.
2. Task Force on Facilities and Services.
3. Task Force on Cardiovascular Diseases, Diabetes and Hypertension
4. Task Force on Stroke and Renal Diseases.
5. Task Force on Cancer.
6. Task Force on Chronic Pulmonary Diseases

Each Task Force is responsible for recommending to the RAG the goals, objectives, priorities and strategy in its area of competence. Each

also serves as a technical review group for the project applications which are within its area of competence.

Ad Hoc committees are appointed from time to time by each task force. Current ones are:

1. Committee on Black Manpower
2. Committee on Nursing Education
3. Maternal and Child Health Committee
4. Multiphasic Screening Committee
5. Committee on Patient and Family Education

(These committees are identified as Standing Committees on Form #5 of the application.)

Other Ad Hoc Committees are:

1. Cancer Care in Atlanta
2. Board of Directors for a Cancer Facility in Augusta
3 Board for Project #6 - Communications Network

Black representatives serve on four of the six task forces and on six of the eight Ad Hoc Committees.

Staff felt it would be interesting to know if the Region foresees any alteration in committee structure in view of new trends and de-emphasis of categorical disease, and continuing education activities.

SUBREGIONALIZATION: Local Advisory Groups (LAGs) have been established in 140 hospitals (representing 93% of beds) throughout the Region, their function is to:

1. Advise GRMP on local problems
2. Assist in planning and developing a local program
3. Provide communication between GRMP and the community
4. Coordinate local activities in accord with Task Force reports

While in theory each LAG was to consist of a physician, a hospital administrator, a nurse and a member of the public, the number of representatives varies among the LAGs from two to seven. Four have some black representation. A total of 233 meetings were conducted by 88 LAGs last year. The number of meetings conducted by the LAGs varied from 1 to 11. Areawide meetings are held annually for all LAGs.

Staff feels it would be interesting to learn more about these meetings and about significant contributions they have made to the total program. It is difficult to see how this form of subregionalization can encourage cooperative planning and activities among the LAGs when, aside from annual meetings, there is no indication that the individual groups meet or exchange ideas. Also, it might be noted, the LAGs in most instances are overwhelmingly hospital oriented.

DEVELOPMENTAL COMPONENT: Proposals for use of developmental funds will originate from the RAG, Task Forces, LAGs, other agencies, institutions and individuals. They will be considered in relation to both national and regional objectives. A tentative agenda of opportunities that are likely to present themselves over the next three years are:

Requested 04 Program Year $177,986

1. Assist in extending health services to the poor and blacks of the rural and urban areas by increasing the availability and accessibility of primary medical care.

2. Utilize unique working relationships with health organizations and health professionals in the region to assist them in the careful development and implementation of health-maintenance organizations.

3. Support and promote the development of key elements related to establishing the area health education centers.

4. Assist providers to develop better health delivery systems in the regions, and to study alternate approaches for necessary modifications.

The review procedures for developmental applications will follow the established procedures for project development, review and management. The review process for proposals is not expected to exceed 90 days.

Requested 02 Program Year $177,986

Requested 03 Program Year $177,986

REVIEW PROCESS: The Review Process is briefly stated as follows:

1. Suggestion for a specific operational activity originates from the RAG, a Task Force, LAG, other agencies or institutions, or from an individual and is summarized in a brief narrative.

2. The proposal is acknowledged and referred to the appropriate Staff Coordinator, who proceeds to work with the proposer in its development.

3. The proposal then undergoes preliminary review at the next categorical section staff meeting, at which time, a staff recommendation is prepared.

4. The proposal is referred to the appropriate task force for technical and program review.

5. Proposals approved in principle begin a phase of staff development which may take varied forms depending on its naivete and the degree of sophistication required to make it functional.

6. As the proposal reaches final draft stage each task force chairman appoints several members of his task force to provide an in-depth review. There is also in-depth staff review by the Program Director, the Planning Director, the Program Assessment Coordinator, and several other key staff members. A recommendation is sent on to the task force.

7. The task force rates the proposal for its technical merit and gives it a priority based on its potential contribution toward meeting the task force goals.

8. Prior to review by the RAG completed elements are sent on to the Office of Comprehensive Health Planning for its review.

9. The proposal is then reviewed by the Steering Committee and RAG.

Using a checklist designed to assist in the assessing of the appropriateness of each proposal, the relative importance, and the potential contribution to the overall program balance, the RAG assigns each approved proposal a priority placement of either Crucial, Very Important or Important.

Of the eleven projects identified as Crucial seven are ongoing, and four are new.

Of the nine identified as Very Important, three are ongoing, and seven are new.

Of the six identified as Improtant, one is ongoing, and five are new.

PROPOSED PROJECTS

The Region's proposed projects are divided into six Program Elements:

I Cancer
II Cardiovascular
III Continuing Education
IV Facilities and Services
V Respiratory
VI Stroke and Hypertension

I Cancer Element

Project #13 - Statewide Cancer Program - Medical Association of Georgia

Requested Fourth Project Year $450,257

Priority - Crucial

This proposal requests continued support of the ongoing program, which consists of 12 area cancer facilities, and extension of eight additional facilities to provide treatment in the vicinity of the patient's home. Also requested is the development of a computerized treatment planning program, continuing education and physics support for high voltage radiation therapy equipment, and to provide standardization and quality control in its use. Major budget items are for personnel and travel. The personnel are utilized in developing, coordinating and maintaining the area facilities and tumor registries. The facility directors coordinate all cancer activities in their medical trade area to improve treatment facilities, referral procedures and training of health professionals.

Progress - This project was previously supported for 3 years: 01 - $174,500; 02 - $401,276; 03 (current)-$234,095. This program supported 12 area cancer facilities during the past year, each with a tumor registry element. All facilities participated in tumor conferences, seminars and workshops. Two workshops for physicians were conducted during this period and programs have been developed for three additional statewide cancer workshops. Two workshops were held for tumor registry personnel and two additional workshops are planned. Two workshops for allied health are planned.

Fifth Year - $446,479 Sixth Year - $332,884

Project #30 - Facility Planning and Development - Augusta Radiation Therapy Center

Requested Second Project Year $32,365

Priority - Important

The purpose of this proposal is to continue the initial planning and development of an area cancer treatment facility in Augusta which will provide for major radiation therapy support wherein proper patient referrals can be made.

Progress: This project which was previously approved for three years is currently in its 01 year. However,due to late allocation of funds and budget cuts, staff will not be hired until July 1, 1971.

Third Year: $34,820

II Cardiovascular Element

Project #31 - Cardiovascular Area Facilities - Medical Association of Georgia — Requested Second Project Year $202,960

Priority: Crucial

This project is designed to expand and extend patient services that cannot be provided by local physicians in hospitals which are potentially capable of serving as referral facilities for the smaller satellite hospitals. This will be accomplished by providing services, education programs and screening activities. Nine additional facilities will be phased in at a rate of 3 a year.

Progress: This project which was previously approved for 2 years is currently in its 01 year of operation (59,984), during which time five cardiovascular area facilities have received funds. No other progress is reported.

Third Year - $284,006 Fourth Year - $360,197

Project #27 - A Community Hypertension Program - Georgia Department of Public Health — Requested Second Project Year $183,323

Priority: Very Important

The purpose of this project originally was to investigate methods for identifying asymptomatic hypertensives in an urban indigent community and the methods for achieving good blood pressure control. In the second year it is planned to explore the effect of having a resources center for education of the majority of patients, follow-up of all patients, and diagnosis and therapy for the more severe patients who have no source of medical care. It is hoped that the study will show various factors that deter a patient from seeking care and what can be done to motivate more patients to comply with therapy.

Progress: This project which was previously approved for three years is currently in its first year of operation ($84,000). The first statistical run of program data indicates the prevalence of unrecognized, untreated hypertension in the study population. Of 3,809

interviews completed, 1,096 (28.8%) persons were hypertensive, 305 (27.8%) hypertensive subjects were totally unaware of their conditions and of those who were aware, only 468 (59.2%) were under medical care. Programs on education were geared toward the lay community. An unspecified number of women with no previous medical experience have been trained to become blood pressure technicians.

Third Year - $185,280 Fourth Year - $191,765

Project #51 - Educating Health Professionals in Model Diabetes Care - Emory University — Requested First Project Year $25,200

Priority: Very Important

This project is part of a plan to develop a center designed to provide optimal care, education, and follow-up for 8,000 diabetic patients who are dependent on Grady Hospital (Metropolitan Atlantic City Hospital) for their primary care. Physicians, nurses, and allied health professionals from throughout the Region will be taught optimal patient care techniques and methods. GRMP support for one year will be applied toward: the salary of a computer programmer, who will develop a system of computer program need instruction on the nature and treatment of diabetes; consultant services necessary in video tape production and editing; purchase of projection equipment to be utilized in the teaching program; purchase of a collection of pertinent books; computer time and supplies necessary for programmer and supplies for the education plan. No support is requested for second and third year.

III Continuing Education Element

Project #1 - Clinical Training Conferences for Health Professionals - Medical Association of Georgia — Requested Fourth Project Year $60,000

Priority: Critical

This project is designed to provide continuing education conferences for physicians, nurses and allied health personnel of the Region so they might acquire new skills in clinical medicare and patient care. It is intended that those people trained will then serve as resource consultants when they return to their own environment. Training will be given at either of the two medical schools in the state, professional schools, teaching hospitals or other suitable institutions. The budget request is for tuition of 30 physicians based on $1,000 for each 10-day conference and for 60 nurses or other allied health personnel, $500 for each 10-day conference.

Progress: This project was previously supported for 3 years at: 01 - $47,795; 02 - $106,985; 03 (Current) - $41,000. During the

current year, 88 clinical days were spent by physicians from the Region at medical schools. The Medical College of Georgia devoted much of its time reorganizing so the department of continuing education could become more directly related and responsive to these special needs. The clinical participation at Emory was apportioned as follows: Medicine, 69 days; Pediatrics, 11 days; and Surgery, 8 days.

Fifth Year - $60,000 Sixth Year - $60,000

Project #3 - Visiting Consultants Program for Community Hospitals - Medical Association of Georgia

Requested Project Year $30,500

Priority: Crucial

This project provides a flexible mechanism to provide rapid technical consultation and education programs to many and varied requests for such activities arising in the Region. Support is requested for 50 visits from each of the 2 medical schools, 50 visits from M.D.'s in private practice and 30 visits from nondoctorial level consultants.

Progress: This project has been supported for the past 3 years at: 01 - $16,800; 02 - $24,500; 03 (Current) - $21,000. During the first 2 years more than 125 visits were made to 36 community hospitals. During the current year 27 hospitals requested and received visits from a total of 84 consultants. Consultant contacts were made with 1,546 M.D.'s, 168 dentists, 474 R.N.'s and 531 allied health personnel. Topics ranged over a wide spectrum.

Fifth year - $30,500 Sixth Year - $30,500

Project #6 - Communications Network - Medical Association of Georgia

Requested Fourth Project Year $161,200

Priority: Crucial

This project proposes the production of 80 one-inch videotapes by Emory University and 12 such tapes by the Medical College of Georgia in each of the next 3 years. These tapes will be made available to 60 hospitals equipped with video tape recorders. Most of the tapes will also be broadcasts by Emory to medical institutions in Metro Atlanta are via the 2500 Megahertiz/AM system.

Progress: This project was previously supported for 3 years at: 01 - $616,662; 02 - $355,882; 03 (Current) - $148,561. At the end of its 02 operational year it was reviewed by RMPS Staff and was site visited by a technical review group. Both review groups recommended the project be phased out during the 03 year and the Region submitted revised reduced budgets designed to carry out the recommendation.

Since September 1968 Emory University produced and broadcast 900 hours (1100 programs) of programming time on the Metro Network and 28 additional one-hour programs (over public television) throughout the Region. On 12/7/70 Statewide broadcasts were discontinued in favor of a tape-lending library.

Fifth Year - $161,200 Sixth Year - $161,200

Project #20 - Area Facilities for Continuing Education - Medical Association of Georgia — Requested Third Project Year $267,700

Priority: Crucial

This project proposes supporting two levels of continuing education area facilities. The first is the hospital affiliated with a medical school. Faculty assistance is given by the medical school to the hospital in developing the usual medical divisions of hospital services and in securing and training chief-of-service to monitor these services and to coordinate continuing education. The second level is the area facility located in a hospital which relates to smaller hospitals in the area.

Progress: This project was previously supported for two years at: 01 - $95,900; 02 (Current) - $68,110.

Five first level area facilities have been established and educational programs have been initiated: Columbus Medical Center, Columbus; Athens General Hospital, Athens; Macon Hospital, Macon; Memorial Medical Center, Savannah; Pineview General Hospital, Valdosta.

In its 3rd year it is incorporating in its Project #5 - Affiliation for Teaching - Columbus Medical Center which was previously supported for 3 years: 01 - $42,691; 02 - $42,843; 03 (current) - $28,000.

Fourth Year - $267,700 Fifth Year - $267,700

Project #22 - Physiology for Nursing Instructors and Practitioners - Emory University — Requested Third Project Year $30,970

Priority: Very Important

This project provides six three-week courses, two per year for three years, to update and expand knowledge of nursing instructors and clinical practitioners, with priority given to instructors. The cardiovascular physiology training courses will be concluded during 1971 at which time the program will be extended into neurophysiology.

Progress: This project was previously supported for two years at: 01 - $26,116; 02 (Current) - $14,084. In the last year, instruction in cardio vascular physiology was provided to 26 nursing instructors at Emory University. In one group of 10 instructors it was found that each instructor taught an average of 58 students per year. Extrapolated to the full group of participants, this would mean about 1,580 students would benefit from the project each year.

Fourth Year - $25,873 Fifth Year - $25,873

Project #45 - Continuing Education Program in Nursing - Medical College of Georgia

Requested First Project Year $33,575

Priority: Important

The School of Nursing proposes, with additional instructors supported by RMP funds, to take unspecified courses into geographically distributed smaller communities across the state. This is intended to bring high caliber continuing education to nurses remote from larger medical centers and teaching hospitals. The courses will have basic care content as well as clinical application and orientation. Priority will be given to nursing personnel at the area facilities. At the termination of GRMP support the Medical College will extend the program.

Second Year - $33,575 Third Year - $33,575

Project #47 - Strengthening the Role of Consultant Dietitians - Emory University

Requested First Project Year $30,936

Priority: Important

This project proposes supporting a 5-day short course for dietitians of smaller hospitals, at Emory University, each year of the project. Each course would be followed by 2 visits to participants during the succeeding 6-month period. Participants would then return to campus for a 2-day evaluation and summary session. After the training program the participants will serve as consultants to the smaller hospitals providing similar services to those provided by GRMP area facilities. Priority will be given to the dietitians or nutritionists from hospitals who have GRMP area facilities in CV, cancer, stroke, kidney and pulmonary diseases.

Second Year - $40,172 Third Year - $41,074

Project #46 - Learning Resources Services - Medical Association of Georgia

Requested First Project Year $42,060

Priority: Important

This regionwide activity proposes to increase the effectiveness and outreach of education efforts through a centralized learning resources service designed to provide stimulation, education, training, consultation, production assistance and coordination of regional resources and the application of education technology, audiovisual media, and programed instructional materials. This project has been planned to meet many requests for assistance that are coming to GRMP and to encourage the use of practical media applications to learning problems. A fee-for-service mechanism will be developed for all activities, increasing yearly until the project becomes self-supporting at the end of five years.

Second Year - $64,850 Third Year - $53,360

Project #49 - Health Career Counseling to Disadvantaged Students - Medical Association of Georgia — Requested First Project Year $23,917

Priority - Very Important

This project proposes to utilize high school counselors to encourage disadvantaged high school students with potential to enter the health career field. As this is a pilot study a select number of counselors and students will participate. Ten counselors will each select ten students who possess the potential to become a health professional. Through the counselors and project coordinator the students will be exposed to a broad view of the health field and professionals. Support is requested for a project director, payment of counselors for extra time, and workshop expenses. It is expected that hospitals will support such efforts in the future if the project proves successful.

Second Year - $20,168

Project #48 - Shared Allied Health Program - GRMP — Requested First Project Year $68,100

Priority: Very Important

This project is the outgrowth and expansion of a feasibility study supported by GRMP which initiated a program of shared physical therapist activity in N.E. Georgia. GRMP proposes that services be expanded to include nurse anesthetists, clinical nurse specialists, pharmacists, inhalation therapists, social workers, occupational therapists, speech therapists and radiation physicists. It is anticipated many of the allied health professionals will become self-supporting within 12 months, however, until they do a percentage of the net income will be returned to GRMP.

Second year - $68,100 Third Year - $68,100

Project #50 - Physician Assistant Development Program - Medical Association of Georgia

Requested First Project Year $228,147

Priority: Very Important

This project is an expansion of Project #15 - Medical Specialist Assistant and, as such, contains 3 component programs. Emory University will continue its Medical Specialty Assistants Program for an additional 3 years. The Medical College of Georgia and Georgia State University have initiated new developmental programs to train physicians assistants. The Medical College proposes a one-year feasibility study prerequisite to an operation program. Georgia State anticipates an enrollment of 30 students during the first year and 30 during the second year. Emory-Grady anticipates an enrollment of 20 students during the 2-year period. GRMP support will be used by the institutions to pay faculty, supplies and stipends. The programs will provide college credit offering career mobility for the graduate.

Progress: A forerunner to this project is the training of Medical Specialty Assistants Program at Grady Memorial Hospital (Project #15). This activity was initiated to create a new type of individual who would be trained in the delivery of specialized treatment techniques to patients with myocardial infarction. The total number of students who have graduated or are in training during this reporting period is 19.

Second Year - $303,350 Third Year - $194,461

IV Facilities and Services Element

Project #38 - Emergency Care for South Georgia and North Florida - Pineview General Hospital

Requested First Project Year $336,460

Priority: Crucial

This project proposes an emergency service network which designates two county hospitals as central emergency facilities, manned around-the-clock ER physicians, equipped with intensive care ambulances for transporting critically ill patients and backed by full hospital services and specialists. A communication network will provide controlled dispatch of ambulances and to facilitate consultation with ambulance attendance and with hospitals that do not have around-the-clock physicians. The project will support salaries of ER physicians and intensive care ambulance attendants in the central facilities. Ambulances and commi-cations equipment will be procured under the Highway Safety Act.

Second Year - $294,800 Third Year - $147,400

Project #39 - A Health Maintenance System for Stephens County - Stephens County Hospital

Requested First Project Year $107,290

Priority: Crucial

The Stephens County Hospital and a large physician multispecialty group are prepared to undertake a project to improve health delivery through a health mainetenance center, to be located in a vacant wing of the old Hill Barton Hospital, in Toccoa. It will provide the mechanism to determine the health profile of the community and to treat detected abnormalities. There will be no fee charged for testing during the first two years to insure establishment of the medical profile and to create interest in yearly health maintenance examinations. Test results will be forwarded to family physicians or to an assigned physician for those who do not have a physician. Physicians will call in patients who require treatment regardless of ability to pay.

Second Year - $138,560 Third Year - $16,320

Project #41 - Detection and Elimination of Electrical Hazards - Emory University

Requested First Project Year $7,290

Priority: Very Important

This project will support salaries to develop and conduct training programs in electrical hazards for representatives of hospital staffs throughout Georgia. User personnel and those maintaining equipment will learn how to detect hazards, correct them and to verify the reliability of equipment. A determination will be made on what impact reliability of equipment has on the frequency of accidents due to electrical malfunctions.

Second Year - $4,140 Third Year - $4,140

Project #42 - Statewide High Risk Maternal Infant Services - Medical Association of Georgia

Requested First Project Year $63,040

Priority: Important

This project is the first phase of a plan to develop a network of intensive, intermediate and primary care centers for care of high risk mothers and critically ill infants. This project is requesting support for two years, the time requested to develop the plans for a statewide system. Implementation of the plan into a statewide system will be accomplished by follow-on projects. The project will support project planning personnel and training of health professionals at Emory and the Medical College in the care of critically ill infants and how to operate within the system.

Project #43 - Patient and Family Education - Medical Association of Georgia

Requested First Project Year $85,000

Priority: Very Important

This project will support demonstrations of a patient and family education system in various settings (rural and urban; hospital and public health agency basid health education coordinators, etc), salaries for education coordinators, education expenses, and cost of teaching materials will be supported by GRMP. Coordinators will be responsible for developing procedures for communication of all health professional input to the patients' education. Development of educational programs designed to effectively communicate information to patients will constitute the project output.

Second Year - $85,000 Third Year - $85,000

Project #44 - Computerized Dietary Service System - Georgia Hospitals Computer Group

Requested First Project Year $87,700

Priority: Important

This project will demonstrate in a two-year period the feasibility and cost effectiveness of a shared, automated menu-planning service with remote access for hospitals that cannot support their own computer. Existing dietary and nutrient computer programs will be combined with hospital dietary profiles into an integrated data-base to produce menu-planning, special diet, inventory control, and food purchase services that is tailored to the local situation at each hospital. If the system proves to be cost effective, the Hospitals Computer Group, Inc. will offer the service to the other hospitals on a fee for service basis.

Second Year - $94,072

V Respiratory Element

Project #37 - Area Facilities for Respiratory Diseases - Medical Association of Georgia

Requested First Project Year $75,940

Priority: Crucial

The Task Force on Chronic Respiratory Diseases recommended area facilities as the most feasible approach to increase and expand respiratory services. Five locations will be selected and priority will be given to community hospitals where some respiratory services are already offered and who have qualified personnel to direct the facility. Service components in each area facility will include: 1) continuing education, 2) serving as a planning center for case

funding and prevention, 3) providing special diagnostic services, 4) laboratory facilities, 5) coordinating home health services for respiratory disease patients, 6) serving as out-patient referral centers and 7) serving as acute care in-patient centers.

Second Year: $155,634 Third Year: $199,687

Project #14 - Regional Pediatric Respiratory Center - Medical College of Georgia — Requested Fourth Project Year $86,250

Priority: Very Important

This project proposes to continue defining the health needs for respiratory diseases in children and young adults and will provide and further develop health care services and training opportunities relating to Chronic Respiratory Diseases in the state. The project will support the development of a "2-platoon system." This will allow the addition of a "circuit riding team" to rotate through selected hospitals. This team will consult with local physicians, examine selected patients and present case conferences, demonstrating techniques, teaching exemplary care, and expanding the awareness of upgrading the knowledge concerning Chronic Respiratory Diseases.

Progress: This project has been supported the last 3 years at: 01 - $143,980; 02 - $170,810; 03 (Current) - $114,098. The program at the Medical College is one of several specifically developed centers developed nationally and one of the few with primary emphasis on out-of-hospital patients. During the eight-month period ending 2/28/71, 552 patients from 73 counties were seen--a total of 2,432 out-patient visits. Direct physician involvement totalled 130. Ninety-two physicians were involved in 5 meetings and workshops. A clinical training program for nurses was initiated.

Fifth Year - $84,250 Sixth Year - $84,250

Vi Stroke, Hypertension, Renal Element

Project #32 - Stroke Area Facilities - Medical Association of Georgia — Requested Second Project Year $126,850

Priority: Crucial

A total of nine additional area facilities for stroke are planned for the Region. The overall goal of the project is to provide services to the surrounding community hospitals through a cooperative management to be established by the base hospital and participating smaller hospitals within the medical trade area. Service components that will be developed

include: 1) continuing education, 2) provision of angiographic and other radiologic services, 3) provision of special diagnostic consultation services, 4) serving as coordinating centers for home health services, 5) serving as planning centers for case finding and prevention programs, 6) offering laboratory facilities, and 7) serving as outpatient referral centers for indigent patients. Fees will be charged for services so the facilities can become self-supporting after an initial support period.

Progress: The allocation of funds to support one facility was approved to begin 1/1/71. There is no progress to report.

Third Year - $206,045 Fourth Year - $257,345

Project #36 - A Kidney Disease Program for Georgia - Medical Association of Georgia

Requested First Project Year $211,588

Priority: Critical

This project is divided into three components. The first component incorporates existing projects #23 and #24 to retain the highly sophisticated teaching capabilities at the two regional centers at the medical schools. These centers offer taining in nephrology, urology, and transplantation to selected medical students and M.D.'s as well as to their supporting staff. The second component is for development of Area Facilities for Kidney Disease throughout the state for specialized diagnosis and treatment of patients with kidney disease. Services would be definitive diagnosis and follow-up , patient education, continuing education for community M.D.'s and nursing personnel, and prevention and screening programs. The third component is a demonstration of computer assistance with diagnosis and management of electolyte and acid base imbalances.

Second Year - $301,523 Third Year - $396,426

SUMMARY OF PROJECTS CURRENTLY BEING
SUPPORTED IN THE 03 OPERATIONAL YEAR

#	PROJECTS Title	AMOUNT
1	Short Term Training for Physicians - Emory University	41,000
2	Ped. Card. & Hypertension Ren. Dis. - Medical College of Georgia & Emory University	20,000
3	Visiting Consultant Program to Comm. Hosp. -Emory - MCGA	21,000
4	Inter-Library Copying Service - Emory - MCGA	1,850
5	Columbus Medical Center Cont. Ed. & Med. Library College of Medicine Center & Emory	28,000
6	Communications Network for the Region - Emory - MCGA	148,561
8	Improvement and Coordination of Facilities for Cardiovascular Diagnostic Services - Med. Assoc. of Ga.	12,600
10	Cardiopulmonary Resuscitation - Ga. Heart Association	72,702
11R	Coronary Care Feasibility Study - Med. Assoc. of Ga.	10,000
13	Statewide Cancer Program - Med. Assoc. of Ga.	234,095
14	Pediatric Chronic Pulmonary Disease Center Medical College of Georgia	114,098
15	Specialist Assistant Program - Grady Memorial Hosp.	44,297
18	Core - Medical Association of Georgia	648,435
20	Area Facilities for Cont. Ed. - Med. Assoc. of Ga.	68,110
21	Coronary Care Training - Med. Assoc. of Ga.	52,145
22	Cardiovascular Physio. Med. Surg. Nursing Trng. - Ga. State University	14,084
23	Renal Failure - Medical College of Georgia	29,364
24	Hypertension & Nephrology Program - Emory Univ.	36,422
27	Community High Blood Pressure in Atlanta - Georgia Department of Health	84,000
28	Statewide Stroke - Med. Assoc. of Georgia	14,075
29	Chronic Pulmonary Disease - Athens General Hospital	8,805
30	Area Cancer Facilities - Augusta Rad. Therapy Center	5,735
31	Cardio. Area Facilities - Atlanta Med. Ctr. Columbus	59,984
32	Stroke Area Facility - Kennestone Hospital, Chandler General Hospital & University Hospital	10,500
	TOTAL	1,779,862

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: May 25, 1971

Reply to Attn of:

Subject: Staff Review of the Triennium Application Submitted by Georgia Regional Medical Program for Consideration During the August 1971 Review Cycle

To:
Director
Regional Medical Programs Service

Request: Georgia RMP which is currently in its 03 operational year (9/1/71-8/31/71) has submitted a Triennium Application requesting the following consolidated budgets (direct costs).

	04 Year	05 Year	06 Year	Total
Core	$653,425	$686,095	$720,402	$2,059,922
Projects (26)	3,058,618	3,458,939	3,011,257	9,523,784
Developmental	177,986	177,986	177,986	533,958
Total	$3,890,029	$4,317,990	$3,909,645	$12,117,664

Georgia's initial award for the current year was $725,828 (d.c.) for Core and $1,296,743 (d.c.) for 23 projects, totaling $2,022,571. As a result of recent imposed cuts on all Regions, Georgia RMP support has been reduced to $648,435 for core and $1,131,427 for projects, totaling $1,779,862.

Review: In view of the fact GRMP is scheduled for a site visit in June, the Reviewers agreed the continuation component of the application should be considered in relation to the total program and no recommendation regarding support would be appropriate at this time.

The Reviewers felt a more appropriate course would be for them to make observations for the site visitors regarding the Georgia Program as it is presented in the application. Following are observations, questions and concerns raised by this review.

Goals and Objectives: The "specific objectives" are consistent with RMPS trends, in fact, they appear to read like direct excerpts from current HEW literature. While each objective is somewhat specific in itself, when taken collectively they represent a very broad and all inclusive program. This is particularly true when considering the Region has given them no priority ranking, nor has it identified some for special emphasis. In addition none are stated in measurable terms or related to time-frames for accomplishment. The linkage between the objectives and the ongoing and new projects is not clear. It is implied that the various Task Forces are responsible for

developing the objectives, however no specifics are provided on the process involved. The visitors will want to learn more about this process, how needs are assessed, and what resources are used in this assessment.

Core Staff: Core Staff which consists of 27 professionals and 12 secretarial types appears to be logically organized for the program as it currently exists. However, it is difficult to understand the need for the large six-member continuing education staff, particularly in view of what appears to be reduced emphasis on continuing education as indicated by the objectives and the new projects.

While part-time positions at Emory and the Medical College are "to coordinate and supervise RMP activities at the universities", it would be interesting to learn specifically what these people are involved in and whether in fact they are justified. There are a number of discrepencies within the application that should be clarified:

1. It is stated that all Core Staff are full time yet three positions are shown at less than 100%.

2. One person (Hallman) shown at Emory University on the organization chart does not appear on Core Personnel Forms (#6).

3. There are position discrepencies between the Organizational Chart and Core Personnel Form (#6) on the positions of Drury, Ross, Wilkins and Usher.

4. In addition the organization chart omits an accountant (Wilson) and a sixth person in Continuing Education (Brown).

Regional Advisory Group: The RAG which consists of 65 members appears for the most part to have representation of key resources and interests in the Region, and is equally balanced geographically. Physician influence is strong with a contingency of 32. It appears the RAG might be strengthened by including some representation of the CHP "B" Agencies, the Appalachia Program and the 66 practicing osteopaths of the state. It would be interesting to learn how active the black representatives on the RAG are and of their impressions of GRMP. Like most RAGs of this size, it does not appear to be particularly strong, but rather out of necessity it relies heavily on Steering Committee, the Task Forces and Core. It is difficult to determine to what degree it exerts policy control. Attendance at the tri-annual meetings, which was 37%, 52%, and 61% last year, is about average for a RAG of this size. However, it would be interesting to learn what constitutes a quorum.

Committees: The committee structure consisting of a Steering Committee (Executive Committee), six major Task Force Committees, and various Ad Hoc Committees appears well tailored for the current Georgia Program. However, given the objectives as stated, which appears to de-emphasize categorical diseases, it would be interesting

to learn how the four disease oriented committees will relate, and/or if the Region envisions any need for committee alteration in the future.

Subregionalization: GRMP has established Local Advisory Groups in 140 hospitals throughout the Region, whose function it is to: advise GRMP in local problems, assist in planning and developing a local program, provide communication between GRMP and the community, and coordinate local activities in accord with the task force reports. While in theory such elaborate subregionalization is impressive, in practical application it appears it might be quite cumbersome. In the absence of information on the 233 meetings held by 88 of the LAGs it would be interesting to learn what of significance has resulted. It is difficult to see how this form of subregionalization encourages cooperative planning and activities between the LAGs, when asside from annual meeting of LAGs sponsored by GRMP, there is no indication that the individual Groups meet or exchange ideas. Also it might be noted, the LAGs in most instances are over-whelmingly hospital-oriented, in that, they consist of a physician, a hospital administrator, a nurse, and a member of the public.

Project Development and Review: There appears to be no Staff effort to stimulate projects related to specific objectives, rather project ideas appear to be spontaneously generated. However, once an idea is presented, Staff does give extensive advice and assistance in the development of a project, even to the point of writing it up. There appears to be a well organized and thorough review process designed to take less than 120 days, which involves Core, the Task Forces and the RAG.

Guidelines have been developed for the RAG to assign priority placement of Crucial, Very Important or Important to each approved project. A project is given priority placement primarily on the number of program objectives to which it will make a contribution. While this may be a valid mechanism for project ranking it probably in many instances encourages potential project directors to develop broad all inclusive proposals which, in fact, may not be desirable or appropriate, Might it not be more valid to give some priority ranking to program objectives and then determine the importance of projects based on its contribution to meeting the more important objectives? The priority ranking of program objectives would also provide more positive and identifiable program direction.

It would be interesting to learn how many proposals have been submitted to GRMP by applicants, how many were rejected, and at what stages of the review process were the rejections made. How many were appealed?

Evaluation: It is difficult to make any assessment of the effectiveness of the project evaluation process based on the brief information provided on this subject, and on the project progress reports. However, in view of the Region's history of weaknesses in this area, this aspect of the program whould receive considerable attention by the site visitors. Clarification needs to be made of the precentage of ongoing projects which are periodically evaluated, the frequency of evaluation, by whom is the evaluation done and once completed how is the evaluation used, including examples of project changes due to such evaluations.

Program evaluation is conducted by measuring the extent of which activities contribute to overall program objectives. While this is the logical approach; it is difficult to see that it is effective in that the objectives as stated are open-ended and provide no frame of reference. It would be of interest to learn specifically the roles of Core Staff, the Task Forces and the RAG in the program evaluation process.

Projects: Although all of the projects representing the Georgia program in some way related to one or more program objectives, it is difficult to see how those other than the area facilities relate to, and compliment, each other toward achieving a specific goal. Many projects appear randomly designed to serve some isolated need.

While it is understandable that the Region has generated a certain amount of momentum in certain program areas, and it probably cannot make any sudden shifts at this time, it would be of interest to learn why a large number of ongoing projects will need support beyond the council-approved period of support.

Keeping in mind the Region's authority for choosing projects it cares to support and establishing project priority ranking, the visitors will want to learn how the Region justifies the large request for support beyond the Council approved period for one project in particular, #6 - Communications Network. This project has been funded for three years at $585,829, $355,882 and $148,561. At the end of its second year of operation a technical site visit team visited the project and determined the project did not justify continued support. In accord with this determination the Region submitted phase-out budgets. This project could also serve as a case-study to determine how the Region: assesses needs; plans for continued support; establishes priorities for projects; conducts project evaluation and coordinates related projects and activities.

The Area Facility Concept is designed to provide centers of excellence in categorical diseases throughout the Region, however, the number and location of these facilities is not clearly specified nor is it clear how those facilities which have continuing education components will relate to the facilities for continuing education. Since the area facility aspect represents a significant part of the program, the Region should be asked to elaborate on it, at the time of the site visit.

Minority Involvement: Of the 27.6 (FTE) professionals on Core Staff, two are black and of the 13.5 (FTE) secretarial staff two are black.

Of the 70.33 (FTE) Professional on Project Staff 10.50 are black and of the 38(FTE) secretarial staff 3 are black.

Of the 65-members of the RAG 6 are black.

Of the 744 members on other planning groups and committees 22 are black.

There are no Indians, Orientals or persons with spanish surnames represented in GRMP in any way.

Based on these observations and the fact that approximately one quarter of the Regions population is black the site visitors will want to learn to what degree the GRMP is attempting to involve more blacks as voluntary participants in committees, etc., and if there is any plan to hire more blacks on Core Staff or to encourage their employment as project staff.

William S. Reist
Public Health Advisor
Grants Review Branch

RMPS Staff participants were:

Veronica Conley, Ph.D. - Allied Health Section
Lyman Van Nostrand - Program Planning and Evaluation
Glinter Johnson - Office of Systems Management
Frank Nash - Regional Development Branch
Larry Pullen - Grants Management Branch
William Reist - Grants Review Branch

GRB/RMPS
5/27/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

GEORGIA REGIONAL MEDICAL PROGRAM
RM 00046-04 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: Committee recommended that the Region be awarded $2.8 million (direct costs) for each of three years, including developmental funding.

DIRECT COSTS ONLY

	REQUEST			RECOMMENDED
Core	$ 683,430	$ 717,602	$ 753,481	$ 683,430
Developmental	177,986	177,986	177,986	177,986
Projects	3,316,381	3,453,909	3,011,257	1,938,584 1/ 2/
TOTAL	3,920,034	$4,349,497	$3,942,724	$2,800,000

1/ (Funding of Project #49 - Health Careers Counseling - is precluded by RMPS policy which prohibits fundings of direct operational support of Health Careers Recruitment projects. The Committee suggests, however, that Council give special consideration to see if there is some way in which Project #49 might be funded without violating policy. There is a desperate need in Georgia for all types of health professionals. Further, there is an urgent need for ways to bring members of disadvantaged populations into health careers fields.)

2/ (Funding of Project #39 - Health Maintenance Program for Stephens County - is precluded by RMPS policy which prohibits funding of new multiphasic health testing projects pending evaluation of those currently being supported through RMPS. Since Committee believed that the project was basically designed to conduct multiphasic screening, a detailed examination of the proposal by staff was requested. Staff has concluded that the project is, in fact, a multiphasic health testing proposal.)

CRITIQUE: The Review Committee member who chaired the June 1971 site visit presented the findings and recommendations of the team. In addition, another site visitor was present to reinforce the team's findings. The Committee shared the team's conclusion that Georgia is a strong program, with exceptional management and organizational strengths, outstanding leadership, involved and committed state and local relationships. The team reported that cooperative relationships between the two medical schools can to a large degree be credited to

GRMP efforts. The relationships with other Federal programs (CHP, Model Cities, Appalachia and OEO), however, consist primarily of cross-representation on advisory groups and cross-review of applications. The Committee believes that Georgia should extend its staff resources to help these agencies develop their health program.

The Committee questioned the representation of Blacks on the RAG. The visitors reported that the Black physicians on the RAG are deeply involved and highly supportive of the program. They also reported that the few Black staff members were the result of low turnover of staff and lack of additional positions; the Region is prepared to employ more Blacks as funds permit.

The visitors reported that the six-man Steering Committee, the locus of real work, included only physicians. The Committee felt the Region should take steps necessary to broaden the representation on this group.

The Committee's primary concern related to three areas: 1) the lack of phase-out of projects; 2)the lack of program development to serve the health needs of the ghetto population, particularly in Atlanta; and 3) the high costs of new project proposals.

In answer to the first concern, the visitors explained that the Region has phased-out some projects; in fact, the CPR project is now entirely supported by other funding. Furthermore, while it may seem that an area facility project is being renewed, it is in actuality changing either its function or its locus. The visitors empathized with Committee members who only had the application to guide them, but explained that the on-site presentations and discussions had clarified the area facility program plan which is the foundation upon which the whole program is built. The visitors cited evidence of changes resulting from the support of the Columbus area facility which have far reaching impact on health care: 24 new physicians have moved into the community, 5 new clinics have been opened, which by the GRMP contract clause have to be open to <u>all</u> patients. This facility is no longer supported by RMP; the project is still proposed, but for another area of the State.

With respect to the second concern, the visitors also explained that the developmental fund plans were primarily directed toward the health problems of the poor; one example is the store-front facilities to be developed. The Committee, however, felt the Region should exert more effort in this direction.

The visitors were unable to provide information to the Committee's satisfaction concerning the reason for the high costs of new proposals such as emergency health care. The visitors did, however, point out that the team had recommended funding at a reduced level.

FUNDING RECOMMENDATION: Committee concurred with the site visitors' funding recommendation.

The rationale for this reduced level is not based on any serious deficiencies of the Georgia program or the technical review of projects. Rather it is based on the exclusion of, or only giving partial support to, projects which:

1. were thought to have little or no relationship to the overall program;

2. are not likely to have viable independent support in the future;

3. could be incorporated with another project;

4. would be more appropriately funded from other sources of support.

The Committee concurred with the conclusion of the Ad Hoc Panel on Renal Disease that Project #36 - A Kidney Disease Program for Georgia - did not merit support. In view of the sophistication of end-stage kidney activities which exist in the Georgia Region, the proposal is disappointing. The application was considered extravagant, and seemed to "share the pie" and duplicate facilities rather than seek to organize a cohesive, efficient dialysis and transplantation program. It appeared that existing dialysis facilities are capable of meeting the Region's needs if they are coordinated with a functioning transplantation program. Inadequate or ineffective local funding efforts are reflected in the request for physician salaries. A key element is lacking in the failure to demonstrate deeply involved surgical interest, particularly in view of the organs which already have been procured. The Region's capability to move ahead with transplantation at this time was seriously questioned in view of the recent departure of the physician and head nurse who, heretofore, have provided the central momentum to these activities.

The Kidney Disease Control Program provided grant support for 1966 - 1969 which enabled the dialysis unit at Grady Memorial Hospital to be established. More recently, the Program has funded a cadaver organ procurement project, now in its third and final year, negotiated in June at $32,000. This project has also received funds from the Southeast organ procurement project funded at Richmond, Virginia. There seems to have been sufficient support by now to have established a well-functioning transplantation program which could have reduced, if not eliminated, the Region's backlog of dialysis patients. The computer-aided diagnosis and consultative project was viewed as without merit, and the Area Facilities were termed excessive.

The Committee concurred with the site visit team's recommendation, including approval of developmental funding. Staff was asked to make certain that Committee's concerns as well as the site visitors' concerns be conveyed to the Region.

RMPS/GRB

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 29, 1971

Reply to Attn of:

Subject: Quick Report on the Georgia Regional Medical Program Site Visit June 23-24, 1971 (Atlanta, Georgia)

To:
Director, RMPS
Through: Acting Deputy Director
Regional Medical Programs Service

I. Site Visit Team

*Philip T. White, M.D. (National Review Committee)
Associate Dean
Medical College of Wisconsin
Milwaukee, Wisconsin 53226

John R.F. Ingall, M.D.
Program Director
Western New York Regional Medical Program
State University of New York at Buffalo
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W. Lester Henry, Jr., M.D.
Professor and Chairman of the Department of Medicine
Howard University College of Medicine
Freedman's Hospital
North West, Washington D.C.

Jurij Savyckyj, M.D. (Intern)
St. Johns Hospital
Yonkers, New York

*Chairman Site Visit Team

RMPS STAFF

Veronica Conley, Ph.D.
Continuing Education and Training Branch

Rhoda Abrams
Planning and Evaluation Branch

Frank Nash
Regional Development Branch

Ted Griffith
Regional Representative
Region III (DHEW)

Carl Taylor
Office of Management & Budget

William Reist
Grants Review Branch

II. BACKGROUND: Georgia RMP is currently in its 03 operational year (9/70-8/71) and funded at $1,779,862. It has submitted a Triennium application requesting support for three years at 04-$3,920,034; 05-$4,349,497 and 06-$3,942,724. Each year includes a request of $177,986 for Developmental Component.

III. GENERAL IMPRESSIONS: It was the general impression of the site visitors that Georgia is a strong viable Region. While some aspects of the program appear weak and in need of strengthening, they are not, for the most part, of a significant nature and in most instances corrective measures are being planned or employed. GRMP does appear to have a good concept of the problems and resources within the region and a specific plan in the "area facility concept" to employ some of the resources in resolving some of the problems.

The visitors were highly impressed with the management and organizational strengths of the Region and the outstanding leadership provided by the Director and Key members of Core Staff. The involvement and commitment of state and local resources is very strong and the cooperative relationship between the two medical schools, which to a large degree can be credited to GRMP, was considered somewhat phenomenal. The visitors were disappointed to learn that while "cooperative" relationships have been established with other various federal programs (CHP, Model Cities, Appalachia and OEO) these relationships consist of little more than cross-representation on advisory groups and cross-review of applications. It was felt that given the strong leadership and management qualities of GRMP it should feel an obligation to extend itself and lend assistance to these other agencies in the development of their health programs.

While the visitors initially had some reservations about the composition of the RAG, they were pleased to learn that black physicians, who represent the black communities, are deeply involved and are highly supportive of the program. In addition the Region has plans to include representatives of other federal programs on its RAG.

It was not clear to the visitors the extent of the participation of the individual members of the RAG in the decision-making process, for example, in the establishment of priorities, or the review of projects. It appeared that much of the decision-making occurred at the Steering Committee level and although the RAG had an opportunity to discuss or disagree with decisions reached by the Steering Committee, in fact, this did not often occur. The visitors expressed concern over the size of the six-man Steering Committee, and the fact that only on one occasion has a non-physician ever served on this body.

While the visitors were favorably impressed with the regionalization concept as it is being developed through area facilities, which are designed to provide education and improve patient services, they were disappointed that GRMP has demonstrated little concern for the primary care problems of the ghettos. However, they were heartened by the Region's intention to support, with developmental funds, the medical schools' efforts to develop store-front type facilities for provision of such services to the poor.

The visitors retained serious questions as to the extent and worthiness of the evaluation aspect of the program. However, it was observed that while the evaluation process per se may be weak at the present time, a fairly stringent effort is being made to keep abreast of progress of individual projects. A new evaluation specialist has been acquired recently and upon examining his credentials and talking with him the visitors were optimistic that an effective evaluation process will evolve.

The visitors initial concern regarding the functioning of the Local Advisory Groups was somewhat confirmed in that some rarely met or functioned. Even so, they were convinced that this form of sub-regionalization indeed did permit an avenue of activity for representatives of local areas and that some of them have been active, and specific projects have been generated by the concerns of these groups. The Region admitted to not stimulating activity at the LAG level at this time when funding possibilities are remote.

RECOMMENDATION: While the Region is requesting support for three years at 04-$3,920,034; 05-$4,349,497; 06-$3,942,724, the site visitors recommend a reduced level of $3,186,293 for each of three years which includes a Developmental Component of $177,986 for each year.

The rationale for this reduced level is not based on any serious deficiencies of the Georgia program or the technical review of any projects. Rather it is based primarily on the exclusion of, or only giving partial support to, projects which:

1. Are inconsistent with policy.
2. Have little or no relationship to the overall program.
3. Are not likely to have viable independent support in the future.
4. Could be incorporated with another project.
5. Committee and Council are still deliberating the role of RMPS.

The visitors had concerns regarding one particular project #49-Health Careers Counseling. This project appears to be directed at the recruitment of disadvantaged high school students into health careers and thus is inappropriate for funding. However, the visitors would ask Council to consider if there is a possible way in which this project could be approved and yet not be in opposition to present policy. This request is made in view of the desparate need for ways in which the disadvantaged of Georgia can be brought into health career fields.

William S. Reist
Public Health Advisor
Grants Review Branch
Regional Medical Programs Service

A Privileged Communication

SITE VISIT REPORT
GEORGIA REGIONAL MEDICAL PROGRAM
June 23-24, 1971

Table of Contents

I. Site Visit Participants

A. Site Visitors

(Chairman) Philip T. White, M.D. (National Review Committee)
Associate Dean,Medical College of Wisconsin
Milwaukee Wisconsin

John R. F. Ingall, M.D.
Program Director, Western New York RMP
State University of New York at Buffalo
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Professor and Chairman of the Department of Medicine
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DHEW Region III

Carl Taylor
Assistant Budget Examiner
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William Reist
Public Health Advisor
Grants Review Branch

C. Review of the GRMP Organization and Relationships:

Louis L. Battey, M.D., RAG and Steering Committee
A. Jay Bollet, M.D., RAG and Steering Committee
Louis C. Brown, M.D., President Georgia State Medical Association
Robert L. Brown, M.D., RAG and Steering Committee
Curtis H. Carter, M.D., Associate Dean, School of Medicine, Medical College of Georgia
F. William Dowda, M.D., Chairman, RAG and Steering Committee
J.B. Ellison, M.D., RAG and Steering Committee
Eugene J. Gillespie, M.D., Director,"A" Agency and RAG Member Comprehensive Health Planning
Bernard L. Hallman, M.D., Regional Advisory Group and Steering Committee
Glenn M. Hogan, Executive Director and RAG Member, Georgia Hospital Association
J. Willis Hurst, M.D., RAG and Steering Committee
Boisfeuillet Jones, RAG Member representing Public Interest, Consumer Groups
Jacquelyn B. Keese, Program Director, Georgia Heart Association, Voluntary Health Agencies
James C. Metts, Jr., M.D., Chairman, Candler General Hospital LAG, Savannah Local Advisory Groups
Elton C. Osborne, Jr., M.D., Deputy Director, State of Georgia Department of Public Health, Official Health Agencies
Arthur P. Richardson, M.D., Dean, Emory University School of Medicine
Evelyn Rowe, M.N., RAG Member representing State League for Nurses Allied Health Professional Groups
Jack G. Whelchel, Health Advisory Council, Inc., Northwest Georgia

D. Review of GRMP Program:

J. Gordon Barrow, M.D., Director Georgia Regional Medical Program
Morris M. Bradley, Director Division of Planning and Program Development
Don J. Trantow, Program Assessment Coordinator, Georgia RMP
James J. Cobb, Director, Division of Administration and Coordinator Facility and Service Section,Medical Association of Ga.

E. Increase Availability and Efficiency of Health Manpower:

William B. Fackler, M.D.,(Chairman) Continuing Education and Health Manpower Task Force
Raymond C. Bard, Ph.D., Vice President for Academic Affairs & Acting Dean, School of Allied Health Sciences, Medical College of Ga.
Alda Ditchfield, B.S.N., M.A., Professor of Nursing, School of Nursing Medical College of Georgia (in charge of Continuing Education for Nurses)
Luther G. Fortson, Jr., M.D., (Private practice of medicine) Member, Continuing Education and Health Manpower Task Force
Shelby J. Lacy, R.N. Nurse Coordinator, Continuing Education, Area Facility, Athens
Glen E. Garisson, M.D., Coordinator for Continuing Education at the Medical College of Georgia; Member, Continuing Education and Health Manpower Task Force

Bernard L. Hallman, M.D., Associate Dean and Coordinator for GRMP Programs, Emory University School of Medicine
Stephen H. King, M.D., Director, Continuing Education Area Facility, Athens

F. Improvement of Quality of Medical Care:

John D. Watson, Jr., M.D., Cancer Task Force
Charles R. Hatcher, M.D., Chairman, Cardiovascular Disease, Hypertension and Diabetes Task Force
Walter S. Dunbar, M.D., Chairman, Chronic Respiratory Diseases Task Force
Joseph A Wilber, M.D., Chairman, Stroke, Renal Disease Task Force
Frank P. Anderson, M.D., Pediatric Respiratory Disease Center
Gerald F. Fletcher, M.D., Director, Cardiovascular Area Facility, Georgia Baptist Hospital, Atlanta
James C. Metts, Jr., M.D., Director Stroke Area Facility, Candler General Hospital , Savannah
Gladys Thames, R.N., Coordinator of Nurses Training Program in Coronary Care, John D. Archbold Memorial Hospital, Thomasville
Elbert P. Tuttle, Jr., M.D., Kidney Program
R.J. Weinzettle, Hospital Administrator, Memorial Medical Center, Savannah

G. Improvement of the Availability and Accessibility of Primary and Preventive Medical Care:

Harold E. Smalley, Ph.D., Facilities and Services Task Force
Paul Boumbulian, Coordinator Model Cities Evaluation Project, Athens
Bernard Hallman, M.D., Associate Dean and Coordinator for GRMP Programs, Emory University School of Medicine
Robert E. Reynolds, M.D., Associate Dean, Health Care Programs and Coordinator for GRMP Programs, Medical College of Georgia
Mary F. Woody, M.N., Director of Nursing Service, Grady Memorial Hospital, Atlanta; Member, Facilities and Services Task Force

II. BACKGROUND INFORMATION

Georgia RMP is currently in its 03 operational year (9/70-8/71) and is funded at $1,779,862. It has submitted a Triennium application requesting support for three years at: 04-$3,920,034; 05-$4,349,497; 06-$3,942,974. Each year includes a request of $177,986 for Development Component

The visit was conducted in accord with routine procedures for evaluating the readiness of a Region to be reviewed on a triennium basis and to receive developmental funds. The application and the site visit report will be considered by Committee in July 1971 and Council in August 1971.

It might be noted that Georgia RMP has always been considered by Committee and Council as one of the better managed and more progressive Regions. It has encountered no serious problems and the only significant, and somewhat persistent weakness has been in the area of evaluation, which might also be cited as a characteristic of most Regions.

An executive meeting was held the evening prior to the site visit, at which time the individual members of the team were asked to express their views as to what they saw as problems or areas that needed exploration. While numerous observations and questions were raised it was agreed the major emphasis would be placed on the areas of concern that had been raised by Staff review of the application. As a result of that review, it was believed explanation and clarification was needed on the following points:

1. The method for establishing goals and objectives, the assessed needs on which they based, their priority-ranking and the time-frame for their accomplishment.

2. The organization of Core staff and identification of the functions of the part-time positions at Emory and the Medical University.

3. The relationships with other federal program and plans for cross-representation on governing bodies.

4. The committee structure and its relevance to the program.

5. The functions of the Local Advisory Groups and their significance to the program.

6. The process by which projects are generated and the method for giving them a priority ranking.

It was also agreed that each individual member of the team would have the privilege of addressing himself to the GRMP representatives for answers to specific questions.

III. GENERAL IMPRESSIONS

It was the general impression of the site visitors that Georgia is a strong viable Region. While some aspects of the program appear weak and in need of strengthening, they are not for the most part, of a significant nature and in most instances some corrective measures are being planned or employed. However, the visitors did feel two weaknesses which were identified do warrant immediate attention by the Region, they are; programming for primary care in medically deprived areas, and developing broader representation on the Steering Committee.

GRMP does appear to have a good concept of the problems and resources within the region and a specific plan in the "area facility concept" to employ some of the resources in resolving some of the problems. Early in the history of the Region a task force spent a considerable amount of time developing the background material which was required for their recognition of problems and for the development of programs which would attack these problems. They had at that time, their own epidemiologist and data expert. In the meantime other sources of information have developed, as for example the CHP "A" agencies, hospital associations, state medical societies, state board of health and voluntary health agencies. GRMP now sees no need for continuing the accumulation of data since much of it is available from other sources.

The visitors were highly impressed with the management and organizational strengths of the Region and the outstanding leadership provided by the Director and key members of Core staff. They were pleased to learn that each of the two part-time coordinators which are assigned to the medical schools do indeed seem to serve the appropriate functions for GRMP, rather than for the medical schools per se. In addition, they have been instrumental in helping the Region develop outreach programs in conjunction with programs legitimate to the interests of the medical schools. The involvement and commitment of state and local resources is very strong and the cooperative relationship between the two medical schools, which to a large degree can be credited to GRMP, was considered somewhat phenomenal. The visitors were disappointed to learn that while "cooperative" relationships have been established with other various federal programs (CHP, Model Cities, Appalachia and OEO) these relationships consist of little more than cross-representation on advisory groups and cross-review of applications. It was felt that given the strong leadership and management qualities of GRMP, it should feel an obligation to extend itself and lend assistance to these other agencies in the development of their health programs.

There is a clear demonstration of an organizational structure which permits strong inter-regional medical program relationships with thirteen other surrounding Regions.

While the visitors initially had some reservations about the composition of the RAG, they were pleased to learn that black physicians, who represent the black communities, are deeply involved and are highly supportive of the program. In addition, the Region has involved more nurses and allied health personnel on the RAG. Each of the two Appalachia programs which serve areas of Georgia are to become CHP "B" agencies. Once this occurs, plans are to include them on the RAG.

It was not clear to the visitors the extent of participation of the individual members of the RAG in the decision-making process, for example, in the establishment of priorities, or the review of projects. It appeared that much of the decision-making occurred at the Steering Committee level and although the RAG had an opportunity to discuss or disagree with decisions reached by the Steering Committee, in fact, this did not often occur. The visitors expressed concern over the size of the six-man Steering Committee, and the fact that only on one occasion has a non-physician ever served on this body. It was observed that the by-laws call for four of the six positions to be filled by the RAG Chairman, a representative of the Medical Association of Georgia, and a representative from each medical school, so that the Nominating Committee have the option of appointing non-physicians to only two other positions. It was apparent in the discussions with GRMP staff that they recognized the visitors concern and might attempt to take corrective measures.

While the visitors were favorably impressed with the regionalization concept as it is being developed through area facilities, which are designed to provide education and improve patient services, they were disappointed that GRMP has demonstrated little concern for the primary care problems of the ghettos. It was interesting to learn that Dr. Barrow does not see GRMP stimulating or supporting related projects in the Model Cities areas. His rationale being, the needs of such areas are so great GRMP could put all of its support in these areas and still not fill the needs. He sees other federal programs as resources designed to serve these needs. The visitors were heartened by the Region's intention to support, with (approximately $150,000) developmental funds, the medical schools' efforts to develop store-front type facilities for provision of primary care to the poor. While this plan is somewhat contradictory to Dr. Barrow's statements, the visitors did not have the opportunity to explore the apparent inconsistency.

The visitors retained serious questions as to the extent and worthiness of the evaluation aspect of the program. On the previous site visit, a new man had recently been hired with the thought that he would strengthen the evaluation process. Apparently he left or for other reasons the process was not strengthened. A similar situation currently exists in which a new education specialist has been recently acquired and the visitors are again hopeful that this will lead to strengthening of the evaluation

process for the whole region. Upon examining this individuals' credentials and talking with him, the visitors optimism was heightened. Although, the evaluation process per se may at the present time seem weak, a fairly stringent effort is being made to keep abreast of progress of individual projects. Weekly meetings involving central core staff and area representatives are scheduled so that there is a fairly continuous review of activities and the opportunity to change the direction or alter these activities, provided proper evaluation processes evolve.

The visitors expressed concern as to what appears to be a fairly subjective method used for determining priorities and for selective funding based upon program priorities. This may reflect a weakness in the decision-making process. On the other hand, perhaps it is justifiable to consider that, by having this rather subjective methodology, it permits some flexibility to take advantage of opportunities which might arise from implementation of certain projects, even though they might not be of the highest priority. The visitor's initial concern regarding the functioning of the local advisory groups was somewhat confirmed in that some rarely meet or function. Even so, they were convinced that this form of subregionalization indeed does permit an avenue of activity for representatives of local areas and that some of them have been active, and specific projects have been generated by the concerns of these groups. Some of the apathy and inactivity on the part of these groups might be a reflection of the limitation of funds, which have been disappointing to some of the local groups and the fact that some of the projects which they have felt were pertinent to the local needs have not been activated. Dr. Barrow admitted reluctance to stimulate activity at the LAG level at this time when funding possibilities are remote.

It was noted that there was a great emphasis on continuing education activities and that a significant proportion of the budget proposed was related to projects underwriting such activities. It might be viewed, however, in the context of an immense shortage of physicians in the state of Georgia and that perhaps certain types of continuing education would at least produce better and more efficient services by those physicians available. Hopefully, the continuing education activities proposed would not just be the traditional types of post-graduate courses, but rather aimed at making physicians have a greater awareness of different methods of care, as for example, in the use of allied health personnel, thereby leading to increased productivity. In addition, this seems pertinent to the concept of area health education and care centers, and that only through the development of an education center is it possible to attract quality physicians and other professionals into such an area health facility.

It should be pointed out that the central theme of the GRMP relates to the concept of the development of area health facilities. These facilities have both service as well as an educational function. They are of two types. The one type would be fairly major community hospital or hospitals which would relate closely to one of the

two medical schools in the development of full-time faculty members, the development of residency and internship training programs, the development of inservice and community training programs and the development of additional services in that area. Many of the projects proposed relate closely to area facilities concept and should be viewed in that context rather as simple separate projects. Comment was made many times that this concept seemed to be in keeping with the national view of health problems, and the Carnegie Commission report on the need of area health education facilities. Beyond the type I facility was envisioned a type II facility which would be a smaller hospital with more limited areas of expertise. Through the creation of the medical schools of type I and type II relationships, a network of care would evolve which could help meet all of the objectives outlined by the RMP which relate to increasing availability and efficiency of health manpower, the improvement of the quality of medical care in Georgia, and the improvement of the availability and accessability of the primary medical care with specialized diagnostic procedures for all persons in Georgia, including the medically indigent.

Discussion was held with the Director and Core staff in reference to the funding for the Area Facilities for Continuing Education. The discussion did point out the need for being aware of the availability of other funds for these types of activities and that when these became available they should be sought and that requested money freed up for other purposes in the region.

IV. REVIEW DETAILS

Goals and Objectives: The Region's objectives are stated as follows:

1. To increase the availability and efficiency of health manpower in Georgia.
2. To improve the quality of medical care in Georgia, including prevention diagnosis, treatment and rehabilitation.
3. The improvement of the availability and accessibility of primarily medical care and of specialized diagnostic, prevention treatment and rehabilitative services to all persons in Georgia.

While these are stated fairly explicitly, and sub-objectives elaborate somwhat on them, they seem to lack a great deal of specificity or direction. However, on the basis of the information provided they appear to have some relevance to the problems in the State of Georgia, and have been established after a somewhat subjective assessment of regional needs, problems and resources. The Director contends that the needs identified by GRMP are obvious, and indepth studies would only be a waste of time, money and effort. The visitors found no inconsistencies between the Regions objectives and the national priorities. The objectives appear to be relatively well understood and accepted by members of the organizations associated with GRMP, however, their usefulness in determining the funding of operational proposals was unclear. In the absence of priority-ranking

of objectives, they are used more as a general guide which allows the flexibility of shifting funds from one project to another, on other bases. In part, this is related to the time-frame and consideration as to whether other sources of support might be available. While the visitors were somewhat skeptical of this method of procedure, it was obvious the program did have certain emphasis in that those projects relating to the establishment of area facilities were given the highest priority rating, Crucial, while most other projects fell into the Very Important or Important categories.

Organizational Effectiveness

The Director is indeed effective, he lends a strong sense of direction to the program and seems effective in developing close relationships between core staff members and their counterparts at the medical schools, on the RAG, and in other agencies around the state. While he is strong-willed and at times gives the impression he might dominate the program,he appears to be responsive to the desires of the RAG and moving the program accordingly.

The quality of the Core staff, who were visible to the visitors, was exceptional and there was obviously good morale and a high degree of esprit de corps. They reflected a broad range of disciplines and demonstrate an adequate administrative and managerial capacity. The two part-time members of Core staff, who are assigned to the medical schools for liaison purposes, do not represent an over-balance of institutional influence and infact appear to be satisfactorily fulfilling their function. The organization of Core appears to serve the Georgia program well and there is reasonably good balance between central and field workers.

The Medical Association of Georgia is the grantee organization and functions primarily as a fiscal agent. Although it strongly influences program direction, it does not appear to interfere significantly with the functioning of the Director or the Core staff. Dr. Adair, who is the part-time Coordinator of GRMP, has responsibility for fiscal matters and serves as "financial watchdog" over the program.

The Committee structure which consists of six standing committees and some five ad hoc committees appears adequate. While the standing committees play a significant role in the setting of objectives, it is the 6-man Steering Committee which appears to be the real decision-making body. The visitors questioned the fact that while the by-laws call for five members of the Steering Committee to be elected, they also call for three of these five to be representatives of the Medical Association of Georgia and the two medical schools. The RAG Chairman serves as the 6th member. It was felt this vastly limits participation of the other interests. This was reflected by the fact that only on one occasion has a non-physician served on this body.

While final authority lies with the RAG, it appears this body relies heavily on the Steering Committee for guidance. The RAG does not appear to always function as effectively as might be possible, however, it does seem to have reasonable control over the establishment of policy and is concerned with the credability of the RMP within the Region.

Involvement of Regional Resources

As observed previously there appears to be fairly strong relationships and involvement with local and regional resources, as for example, the medical schools, physician associations, the hospital association and voluntary medical groups. Involvement of these resources and their expertise is found either at the RAG, LAG or Task Force levels. While some have served as sponsors of projects, others serve more as resources for data and as consultants in the development of the various GRMP components.

The visitors expressed concern that the relationships and the use of resources as represented by other federal agencies was not as strong as might seem possible. While much was heard about "coordination" and "cooperation" between GRMP and other federal programs there is little evidence that much of significance has evolved. Apparently Dr. Barrow's philosophy that GRMP will only provide administrative and planning assistance to the Model Cities programs, also extends to other federal programs. It appears unlikely that any co-sponsored programs or projects will result from GRMP relationships with other Federal programs.

While the Medical Association of Georgia does not appear to dominate GRMP it must be recognized as the most influential force. This is evidenced in the direction the program is following and the types of projects which have evolved. It is also evidenced by the fact that Dr. Barrow feels he must proceed with caution in altering the direction of GRMP in order to preserve relationships which have been cultivated within the more conservative elements of the medical community. The visitors felt he may be too cautious and that he might be more agressive in his attempts to move this practical element.

Assessment of Needs, Problems and Resources

The overall needs of the Region, while not based on an analysis of collected data, are systematically identified by the RAG in a subjective manner. The Region argues that the major needs in Georgia, which are identified by the RAG, and to which program objectives relate, are so obvious as to make any studies based on data irrelevant and a waste of time and money.

In the development of program and projects it does appear that data obtained from relevant resources are used in determining approaches and in giving priority to certain aspects. In reviewing applications from hospitals to become area facilities, related data plays a significant role.

Program Implementation and Accomplishments

Core activities have resulted in action-oriented planning and the development of 140 Local Advisory Groups whose function it is to plan at the local level and through one of the five field representatives coordinate plans and activities with GRMP. While only some 80 of these LAGs appear to be active, the visitors saw some logic in the Director's reluctance to stimulate the slow-comers at a time when competition for RMP support is so keen. The cooperation and coordination of these LAG's is probably best reflected in their support and contribution to the area facility concept which is designed to provide centers of excellance and education in major hospitals, to which the smaller hospitals can relate. However, it should also be noted that a number of projects have originated with the LAG's.

The visitors found it difficult, in the absence of project review, to judge the quality and productivity of ongoing projects. However, on the bases of the somewhat subjective testimonies by Core staff and other participants, the visitors did get the impression that the projects are moderately productive. Some skepticism of such testimony was raised by the fact that projects have not been intensely evaluated.

In response to the visitors concern that slightly under half of the Regions ongoing projects are requesting renewed support, Dr. Barrow argued that while most of these projects retain the same titles, they in fact are substantially altered and represent new activities. He sees those projects related to area facilities to be of a ever-expanding nature, so as to always require GRMP support.

Evaluation:

There is little evidence that any extensive evaluation activities have taken place in Georgia. Most of the projects have not received intensive scrutiny to date, although a few head counts have been done in some of the educational projects. This can be attributed to the lack of a full-time director of evaluation which was remedied by the hiring of Mr. Don Trantow last October. His credentials are impressive and, given time, he may construct an effective evaluation activity. He has spent his first several months in Georgia building evaluation protocols into all ongoing projects by visiting and meeting with project directors. He contributed significantly to the application under review by developing an internal system for project directors to specify objectives and develop self-evaluation protocols. It is anticipated that project evaluation will be done for the most part by the project director himself and that a monitoring function will be performed by the subregional field staff who meet on a weekly basis with the Coordinator, the Evaluator, and other senior staff. Mr. Trantow expects to evaluate specific activities on a selected basis. Since he is the only evaluation staff person right now, he will probably hire consultants to aid him.

In addition, Mr. Trantow has met with the Regional Advisory Group and the core staff and conducted essentially an education process on the significance and character of evaluation. Hopefully, by the next site visit, the evaluation activity will be producing data useful to the decision-making activities of the Regional Advisory Group.

Review Process: The review process in Georgia has evolved over the past three years into an extensive but efficient system involving staff consultation and assistance, written procedures, and broad community involvement. Proposal review has been reduced to 90 days.

Project proposers submit brief outlines of proposed projects to the Core Staff which reviews the activity internally and develops it further with the proposer. If there is agreement that the outline should be developed into a proposal, the project director, with a written set of guidelines, writes up the proposal which is reviewed again by core staff. Recommendations are developed and the proposal referred to the appropriate one of six task forces. The task force decides to accept or reject the core staff recommendation. If the proposal is disapproved by the task force, official documentation of the action is made. Otherwise, it is reviewed, with written guidelines, for technical adequacy and relevancy to the RMP program and given a priority (Crucial, Very Important, Important). It is then referred to the Steering Committee where it is again reviewed. If rejected by the Committee, it does not go to the RAG, (however, the proposer may appeal the action, although this has never been done.) The Regional Advisory Group then reviews the proposal and the recommendations of the Steering Committee and makes its own decision. It has on occasion overturned a decision of the Steering Committee, although apparently not too frequently. The RAG also assigns priorities (Crucial, Very Important, Important) using a standard set of written guidelines.

V. CONCLUSION

Funding Recommendation: While the Region is requesting support for three years at 04-$3,920,034; 05-$4,349,497; 06-$3,942,724, the site visitors recommend a reduced level of $2,800,000 for each of three years which includes a Developmental Component of $177,986 for each year. (This recommendation takes into consideration the Kidney panel's recommendation of disapproval of Project #36 A Kidney Program for Georgia, which was reviewed after the site visit.)

Rationale: The rationale for this reduced level is not based on any serious deficiencies of the Georgia program or the technical review of any projects. Rather it is based primarily on the exclusion of, or only giving partial support to, the following projects:
(Note: The following recommendations would reduce the recommended level to below $2,800,000, however, the visitors rounded it off to $2,800,000.)

Project #6 - Communications Network

Request: 04-$161,200; 05-$161,200; 06-$161,200

The site visitors had difficulty seeing how this project related directly to the Georgia program and failed to understand how it received a priority rating of Crucial. It was felt the previous Staff recommendation to phase out this project was warranted. The advice following the site visitors review of this project in March 1970 was well stated. Support for this project could legitimately be encumbered from other continuing education projects within the program, but this should be very carefully weighed by the Region, especially in relation to the market demand for video-tapes and the measured use of them.

Project #13 - Statewide Cancer Program

Request: 04-$450,257; 05-$446,479; 06-$332,884

The site visitors were concerned that the activities in this area to date had not demonstrated that these were likely to have viability independent from support of the RMP. In spite of this they were projecting the establishment of additional centers. In addition, there was concern expressed about the value of the registries as used by these programs. It appeared to the visitors that support for the registry portion could legitimately be borne by hospitals or other sources. While this did reflect the part of the area facility concept, nevertheless, it would appear that this particular program could continue functioning and seek other sources of support for ongoing activities devoting most of the new monies into the development of new projects. Therefore, it is recommended that this project be funded at $200,000 each year.

Project #14 - Pediatric Respiratory Center

Request: 04-$86,250; 05-$84,250; 06-$84,250

Project #37 - Facility for Respiratory Disease

Request: 04-$75,940; 05-$155,634; 06-$199,687

The visitors felt that these projects were closely related and indeed might profit from being operated in conjunction with one another. It was recognized that these projects were important to the area facility concept, but that they perhaps should not be developed independently of each other and that certain types of teaching methods, personnel and resources could be used conjointly thereby permitting a lower level of funding, a total of $100,000 each year.

Project #22 - Physiology for Nursing Instructors

Request: 04-$30,970; 05-$25,873; 06-$25,873

It was difficult for the site visitors to see the relevance of this project to the total goals and objectives of the Region. This focus on neuro-physiology for nurse instructors seemed to really have one of the remotest connection with increasing the availability and accessability of care. No attempt was made to judge the merits of this project but it would be recommended for no funding.

Project #43 - Patient and Family Education

Request: 04-$85,000; 05-$85,000, 06-$85,000

Project #46 - Learning Resources Services

Request: 04-$42,060; 05-$64,850; 06-$53,360

It appears that there is some commonalty of efforts in these two projects. Both tend to be developmental projects without specific areas of activity being defined. It would appear that these could be developed in conjunction with one another. Accordingly it is recommended that these be combined into a single project and funded at the level of $50,000 each year.

Project #49 - Health Careers Counseling

Request: 04-$23,917; 05-$20,168

In the discussion of this particular project the site visitors were unable to see any feature of this which was not in conflict with the policy statement of the National Council. This appeared to be directed at the recruitment of disadvantaged students into health careers and related to health career councils. It would appear therefore, that this was inappropriate for funding at this time. The visitors would like to being to council's attention however the desperate need of the State of Georgia for all kinds of health professionals and also the urgent need for ways in which the disadvantaged can be brought into the health career fields. Council may wish to consider this somewhat unique project in relation to the desperate need to see if there is some way in which it may be funded and yet not be in opposition to its present policy.

Project #50 - Physicians Assistant

Request: 04-$228,147; 05-$303,350; 06-$194,461

In the discussion of this project it appeared that the Medical College of Georgia is really in the planning stages of operations and not ready for a full-fledged operational educational program. Further,

the Emory Medical School is also in a planning stage. Even though they had had a physician assistant training program they are now planning on changing directions and training generalists rather than specialists. It was noted that funds may be made available for such programs through the Bureau of Health Manpower. In addition it was observed that in previous deliberations by Committee and Council there has been some question as to the legitimacy of Regional Medical Programs involvement in the development of a physicians assistant concept since other agencies were involved and that ongoing studies as to the value of physicians assistants were underway. Consequently, it might be of value to consider reducing the funding of this project so that it can support planning but not operations until we have more information as to the value of physicians assistants and the availability of funds from other sources. It is our recommendation therefore that this project be funded at the level $100,000 for each of 3 years.

Project #36 - A Kidney Disease Program for Georgia

Request: 04-$211,588; 05-$301,523; 06-396,426

The visitors accepted the Ad Hoc Kidney Disease Panel's recommendation of disapproval for this project, and subsequently recommends no funds.

Project #39 - Health Maintenance Program for Stevens County

Request: 04-$107,290; 05-$138,560; 06-$16,320

While the title of this project would indicate it relates to a system of health care, the visitors believed it in fact is little more than a project which would provide for multi-screening of residents. They were sympathetic to the needs for ways to improve health care to the rural disadvantaged, but felt in view of policy regarding multi-phasic screening, funds should not be provided for this project.

Project #44 - Computerized Dietary Services System

Request: 04-$87,700; 05-$94,072

The visitors were somewhat skeptical of the need to use the gagetry of a computer to provide this service. They also found it difficult to understand the relevance of this project to the Region's goals and objectives, and its relationship to the total program. They would recommend no funds for this project.

Developmental Component:

Request: 04-$177,986; 05-$177,986; 06-$177,986

In reference to the developmental funds it appears that some thought has been given to the legitimate use of such funds. One major sphere of activity would probably be in relationship to the development of store-front facilities in core areas of cities, to provide residents with greater access to primary care. This is an area of activity which is not heavily emphasized

by this Region at this time and might be well served by the use of developmental funds. The management leadership and organizational strengths of this Region are good and the visitors would therefore assume that developmental funds would be used legitmately and well. It is therefore recommended that the developmental component be funded at the level requested for each of three years.

VI. RECAPITULATION IN TERMS OF RMPS MISSION STATEMENT REVIEW CRITERIA

A. Performance Criteria:

1. Whether a Region has succeeded in establishing its own goals, objectives and priorities - The goals and objectives lack specificity and have no priority ranking. While they do not provide certain direction to the program, they do serve as a general guide, which allows some flexibility for shifting funds from one project to another.

2. The extent to which activities previously undertaken have been productive in terms of the specific ends sought - Core activities appear to have resulted in action-oriented planning. In the absence of project review. The achievement of such activity is difficult to evaluate, however, much testimony by regional personnel would suggest projects have been moderately productive.

3. Whether and the degree to which activities stimulated and initially supported by RMP have been absorbed within the regular health care financing system - Of twenty-two projects currently supported 12 are to be phased out and 10 are requesting renewal support. The Region argues that those requesting renewed support, while retaining the same titles, do in fact, represent new activities.

B. Process Criteria

1. The viability and effectiveness of an RMP as a functioning organization, staff, and advisory structure - The organization and committee structure appears to serve the GRMP well. While the RAG does exert policy control it relies heavily on the six-man Steering Committee. This committee has been dominated by physicians and the visitors would suggest efforts be made to include non-physicians.

2. The extent to which all the health-related interests institutions and professions of a region are committed to and are actively participating in the program - Relationships and involvement with local and regional resources appear strong.

3. The degree to which there is an adequate functioning planning organization and endeavor, developed separately or in conjunction with CHP, at the local level (or subregional) level - While the GRMP and CHP Directors serve as representatives on each others advisory group and review each others applications, little in the way of cooperative endeavors has evolved. To date relationships with the two CHP "B" Agencies has been

insignificant, however, plans are to strengthen cooperation, first by establishing cross-representation on each others advisory groups. Coordination with Model Cities is remote and there does not appear to be immediate plans to strengthen it.

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 regions continuously evolving plans and priorities - The Region feeling its needs are obvious, does not base them on analysis of collected data. However, programs and projects designed toward the subjectively established objectives do take into consideration data analysis and resources.

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 - As with most other regions GRMP has had a persistent problem with evaluation. While there is evidence that the Region does monitor activities fairly closely and has occasionally modified and rebudgeted projects, there is also evidence that evaluation may be overlooked in the consideration of some "pet" projects.

C. Program Criteria

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 - The Region's goals and objectives, while they are broad and subjectively determined, do represent a guide for the program to which providers endorse, understand, and adhere. Although consistent with RMP's mission much of the Georgia program takes an indirect approach to achieving these goals.

2. The degree to which new or improved techniques and knowledge are to be more broadly dispersed so that large numbers of people will receive better care - Much of the Georgia program continues to relate to continuing education and increasing the knowledge of health providers who do not have easy access to major learning facilities.

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 - Georgia's Area Facility Concept and the continuing education projects which relate to it have the basic components to increase the efficiency of personnel and effectiveness of community health facilities.

4. Whether health maintenance, disease prevention, and early detection activities are an integral component of the action-plan - For the most part the Georgia program only relates to these activities in an indirect way. Only one project has any direct relationship.

5. The degree to which expanded ambulatory care and out-patient diagnosis and treatment can be expected to result - It can be assumed that by increasing and improving services of area facilities and by increasing the efficiency of health providers, ambulatory care and out-patient services will be considerably increased.

6. Whether they will strengthen and improve the relationships between primary and secondary care, and thus greater continuity in and accessibility of care will result - Again, it is assumed the area facility concept will have a direct influence on greater continuation and accessibility of care, particularly for the indigent.

7. The extent to which more immediate pay-off in terms of accessibility, quality, and cost moderation, will be achieved by the activities proposed - These factors will be influenced by the degree to which the area facilities can expand services and through the related continuing education program improve the competence and efficiency of health providers.

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 - The area facility concept has genuine regionalization qualities and is designed to improve the quality and provision of care, in both the major hospitals and smaller hospitals throughout the state. This will be accomplished by strengthening the relationships between the medical schools and the larger hospitals, and the larger hospitals and the smaller ones.

9. The extent to which they will tap local, state and other funds or, conversely, are designed to be supportive of other Federal efforts - While a substantial number of Georgia's programs include non-Federal support, they see a need for the continuance of Federal support, in the area facility program, for many years to come. Unfortunately the Georgia program fails to relate well to other Federal efforts.

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF ANNIVERSARY REVIEW AND AWARD GRANT APPLICATION
(A Privileged Communication)

HAWAII REGIONAL MEDICAL PROGRAM
Harkness Pavilion
1301 Punchbowl Street
Honolulu, Hawaii 96813

RM 00001 8/71
July 1971 Review Committee

PROGRAM COORDINATOR: Masato Hasegawa, M.D.

This region in its third year of operation, is funded at a level of $835,762 direct cost. In addition, the region has received $101,523 of indirect costs which represents an average of 12.5 percent.

In this anniversary application the region has requested for its fourth year of operation $1,658,831 d.c. for support of the following activities:

I. The continuation of core and 5 ongoing projects ($849,186)
II. Funding for nine new projects ($730,748)
III. Funding for a previously approved unfunded developmental component ($78,897)

(Attached on the back of the Summary is a chart identifying the components involved with the above items p.20-22.)

Following are the key issues identified by staff in their review of the continuation application.

1. The need for specificity in the region's objectives and priorities
2. The need for the RAG to develop its By-Laws and assume the responsibility for directing the planning and operational activities of the RMPH.
3. The need for a deputy or associate director to help administrate the day to day operations of the RMPH.
4. The RAG Technical Review Committee and Categorical Committees' need to be given an opportunity to have input in the planning and operational activities of the RMPH. The operating procedures and responsibilities of these committees need to be clearly defined.
5. The need to relate evaluation efforts to specifically identified objectives.
6. Development of a feasible plan of action for the Pacific Basin
7. The need for a feasible regional plan of operation to be developed.

FUNDING HISTORY
(Direct Cost Only)

GRANT YEAR	PERIOD		FUNDED
Planning Stage			
01	7/1/66-6/30/67		$108,006
02	7/1/67-6/30/68		122,297
Operational Stage			
01	9/1/68-8/31/69	Core	362,872
		Projects	475,031
		Total	837,903
01	5/1/69-8/31/69	Pacific Basin Planning	30,000
02	10/1/69-9/30/70	Core	336,101
		Projects	471,503
		Pacific Basin	17,082
		Total	824,686
02	6/1/70-9/30/70	Projects	90,000
03	10/1/70-9/30/71	Core	365,511
		Projects	563,758
		Pacific Basin	17,270
		Total	946,539
03	10/1/70-9/30/71 (After RMPS 12% across the board reduction)	Total	835,762

Georgraphy and Demography: The Regional Medical Program of Hawaii (RMPH) is responsible not only for the Hawaiian Islands, but also for the Pacific Basin--Trust Territories (Micronisia), Guam, American Samoa. The State of Hawaii includes a long chain of islands almost exactly in the middle of the Pacific. It stretches from the Island of Hawaii to tiny Kure Island, approximately 1,500 miles to the northwest. The populated part of the state includes the seven major islands: Hawaii, Maui, Molokai, Lanai, Oahu, Kauai, and Niihau. These seven major islands are relatively close to each other. Hilo, Hawaii, is about 200 miles from Honolulu. Both Kahului, Maui and Sihue, Kauai are approximately 100 miles from Honolulu airport. The Molokai Airport is about 54 miles from Honolulu. Lanai and Molokai are only eight miles apart at their closest point.
Honolulu, the state capitol and largest city of Hawaii, is located on Oahu, as is Waikiki, the major tourist destination area.

The resident population of Hawaii, according to the preliminary 1970 census count, is 748,182 persons, including 41,362 military personnel. The population has increased 18 percent since 1960 and is expected to reach more than one million by 1980. In addition to the resident population, Hawaii has approximately 1.4 million visitors each year. This number is expected to double by 1975. Medical needs of these visitors have a distinct bearing on medical planning for the state. Ethnically, the population of the Hawaiian Islands is 67 percent oriental and/or Polynesian, 32 percent Caucasian and 5 percent Negro. The median age is 24.3.

The economy of Hawaii has expanded tremendously in the past two decades and is based on four major industries: sugar, pineapple, military expenditures and tourism.

In addition to the University of Hawaii which has approximately 20,000 students in undergraduate and graduate programs, there are five small private colleges and five two-year public community colleges within the state.

There are thirty-three hospitals in the State of Hawaii. Nineteen of these are accredited by the American Hospital Association and eight have approved training programs for interns and residents.

The University of Hawaii's College of Health Sciences includes a two-year School of Medicine, a School of Nursing, School of Public Health, and School of Social Work. The community college system provides training for licensed practical nurses and other allied health workers.

The Trust Territories include 2,100 islands (700 square miles of land) spread over 3,000,000 square miles of Pacific Ocean-an expanse greater than the territory of the continental United States. Guam is a single island (209 square miles) 3,300 miles southwest of Honolulu. American Samoa includes seven islands (76 square miles), 2,300 miles south-southwest of Honolulu. There are 92,000 Micronesians in the Trust Territory, 76,500 mixed Chamorro in Guam and 26,000 Polynesians in American Samoa.

History of Regional Development: The Region submitted its initial planning application in September 1966 (the first application received from any region) for establishment of a RMP consisting of Hawaii, Trust Territories, Guam, and American Samoa.

In June 1966, the Region received its 01 year planning award at a funding level of $90,005 d.c. Very little progress was made in the first year. the Coordinator, Dean Cutting, has been unable to spend much time on RMP and the Deputy Coordinator, Dr. Graham, has apparently not stimulated either planning efforts or community involvement. Only $20,000 of the $90,000 award was spent. Concern was expressed that RMP was conceived mainly as a means of supporting the new medical school.

In June 1967, Hawaii was awarded its 02 year planning award at a level of $91,978 d.c. In July 1967, a staff visit was made to Hawaii (Dr. Sloan, Dr. O'Bryan, Mr. Anderson). Staff was impressed with the enthusiastic and strong leadership of the RAG. The medical school did not appear to dominate the RMP; as a result, the physician community appeared to be warming up to the program. It was decided that the RMP offices would be moved out of the Leahi Hospital (next to the Dean's office) and into a "neutral" building at the Queens Medical Center. It became clear that a new program coordinator would be chosen.

In April 1968, Dr. Masato Hasegawa was appointed Program Coordinator. Dr. Hasegawa, a pediatrician, was a prominent member of the medical community, with great interest in "community medicine."

In October 1968, the Grantee changed from the University of Hawaii to the Research Corporation of the University of Hawaii.

The RMPH submitted its first operational application consisting of continuing core support and 10 project proposals in September 1, 1968. The major thrust of this application was in continuing education using Region Wide (Hawaiian Islands only) resources, in the absence of a fully-developed medical school.

The application also stated that RMPH goals included development of "advanced health systems" which would improve the delivery of health care.

A site visit was conducted to the Region in September 1968 (Drs. Millikan and Slater, Mr. Lewis and Mr. Jones). The site visitors were very impressed with the leadership of Dr. Hasegawa. In the few months he had been with RMPH, Dr. Hasegawa had clearly begun to involve diverse elements, overcome earlier hostility, and develop a separate identity for RMPH. Also, the visitors were profoundly impressed with Mr. Wilson Cannon, Chairman of the RAG, and with the vigor of the RAG as a whole. The visitors believed that the Core staff was developing well.

In April 1969, this RMP received a $30,000 award for planning activities in the Pacific Basin-Trust Territories, Guam, Samoa. In making this award, Council sharply reduced the $100,000 requested out of concern that RMPH might "spread itself too thin" and not concentrate its efforts sufficiently on building RMPH in Hawaii.

During 1969, the Core staff expanded beyond the approved total level, and this posed a problem for the Region in terms of continuing support. The fiscal elements of the continuation application were particularly confusing, despite repreated inquiries to the Region. Finally, the Division asked the Region's fiscal officer to meet with Division staff in Bethesda, where the difficulties were ironed out.

In January 1970, a site visit was conducted to the Region (Dr. Millikan, Dr. Besson, Dr. Zippen, Dr. Komaroff, Mr. Morales). The visitors were encouraged by the increasing involvement of the Medical Society, hospitals,

and paramedical personnel; Core staff has grown stronger; the RAG had become more broadly representative; and planning activities in the Pacific Basin had been initiated. The visitors were disappointed at the diminishing involvement of the previously vigorous RAG chairman, Mr. Cannon. They also believed that the RMPH had progressed to the point where Dr. Hasegawa required administrative assistance.

Staff reviewed on September 28, 1970, the RMPH 03 year continuation application and believes that this RMP has made remarkable strides in the past year. The RAG's role and strength is still not clear, but an ad hoc evaluation committee and established policies and procedures provide hope that the RAG effectiveness will be improved. The Executive Committee of the RAG is the strong force; two of its members also serve on the RAG. Also strong forces are the categorical committees, which appear to have veto powers that vitiate the RAG's role.

In December 1970, a site visit was conducted to the Region (Dr. Besson, Miss Conrath, Mr. Gardell, Mr. Morales, Mr. Spain and Mr. Currie). The visitors were impressed with the considerable progress made by the Hawaii RMP toward developing the general principles of regionalization. The region had developed a framework for planning the achievements of goals and objectives. Methods for evaluation were being developed. The visitors did not review projects but rather focused the review on the established organizational structure and an administrative process of the HRMP, its interrelationships with the health care system of Hawaii and its capabilities to implement the program in accordance with stated goals and objectives.

In many respects the region appeared to have made little progress since the previous site visit in January 1970. Many of the problems that existed in January still persisted in the December visit and are similar to those identified by staff in their review of this application. (Copy of staff's memo and the December Site Visit Report are attached p.23-38.)

Organizational Structure and Processes

The Regional Advisory Group of the RMPH is composed of 42 members, 33 from Hawaii, 3 members each from Guam, American Samoa and the Trust Territory.

The members from Hawaii are appointed by a Nominations Committee for three-year terms. The members from Guam, American Samoa, and the Trust Territory are designated by their respective chief executive. The membership of the RAG includes physicians (20), Registered Nurses (2), Hospital Administrator (1), Social Behavioral Scientists (2), consumers (18), labor official (1) and a high chief from Samoa. The RAG activities have centered around project review and approval. Other major activities of RAG during the past year included the following:

Establishment of appointment procedures and functions of RMPH, RAG and other Committees as appended.

Recommendation for a change in grantee institution to RMPS which was approved. The new grantee institution is the Research Corporation of University of Hawaii.

Recommendation for the use of project summaries to facilitate the review process.

Selection of the ad hoc Evaluation Committee of RAG of RMP-Hawaii.

Discussion about regional priorities and input from specific health professions.

An ad hoc Evaluation Committee of RAG is presently doing a study to determine how the RAG can function as a policy and decision-making body.

The core staff of the RMPH has nineteen employees, all at 100% time or effort. The core staff organization has been revised to include an Administrative Manager and a Consultant in Medical Education. Exclusive of the secretaries, the core staff consists of eleven presently active members plus an Administrave Manager and a Consultant in Medical Education.

Following is a list of the Core staff members.

Name	Job Title	Time or Effort % Hours
Masato Hasegawa, M.D.	Program Coordinator	100
Alexander Anderson, M.D.	Consultant/Med. Education	100
Vacancy	Medical Economist	100
Vacancy	Administrative Manager	100
Satoru Izutsu, Ph.D.	Chief of Planning and Operations Pacific Areas	100
Omar A. Tunks, MBA	Chief of Operations	100
Rosie K. Chang R.N., M.S.	Chief of Allied Health Services	100
Kanae Kaku, M.D.	Biostat./Epidemiology	100
Norman Kuwahara, CPA	Comptroller	100
Nancy Crocco, MA.	Ass't. Chief/Coop. Comm. Health Services	100
Clyde Winters, MLS	Medical Librarian	100
Martha Kaplan, BA	Administrative Ass't	100
Paul Okumoto	AV Technician	100
Ethel Kawano	Exec. Secretary	100
Elizabeth Munoz	Secretary	100
Elizabeth Medeiros	Secretary	100
Verna May Okano	Secretary	100
Jeanne Tucker	Secretary	100
Thelma Fujisawa	Bookkeeper	100

Following are the names and functions of the Committees of RMPH:

Allied Health Committee - Facilitates community liaison with allied health groups. Identifies needs, proposes projects to meet needs and evaluates ongoing allied health activities.

Cancer Advisory Committee - Encourages project development and community coordination in cancer area, isolates needs, determines priorities and recommends projects to Technical Review Committee, Executive Committee, Long-Range Planning Committee, and R.A.G.

Executive Committee - Reflects community's interest in on-going programs and guides core staff activities in coordination with new directions and new priorities as well as reviews project progress monthly.

Heart Advisory Committee - Encourages project development and community coordination in heart area, isolates needs, determines priorities, and recommends projects to Technical Review Committee, Executive Committee, Long-Range Planning Committee & R.A.G.

Kauai County - Facilitates regionalization of projects throughout the county, assesses county health needs and reviews and encourages proposals with these in mind. Works in close cooperation with the county CHP advisory committees. In some cases memberships are identical.

Hawaii County - Facilitates regionalization fo projects throughout the county, assesses county health needs and reviews and encourages with these in mind. Works in close cooperation with the county CHP advisory committees. In some cases memberships are identical.

Cooperation Community Health Programs - Did not elicit desired input from proverty area residents, as it was too structured; therefore it has been dissolved and other mechanisms for obtaining proverty community involvement that are more informal are sucessfully being used.

Maui County - Facilitates regionalization of projects throughout the county, assesses county health needs and reviews and encourages proposals with these in mind. Works in close cooperation with the county CHP advisory committees. In some cases memberships are identical.

Regional Advisory Group - Provides overall advice and guidance the the RMP-H through policy setting and priority establishment; fosters cooperative efforst on part of community agencies and grouns in improving health care equity of access, maintenance of quality in health care and in the constraints of cost in health care. It also aims to influence improvements by providers towards the economical regionalization of health care. It reviews all project proposals before submission to the NAC of RMPS.

RAG Evaluation Committee - Provides independent assessment of overall program development. Informs R.A.G. how activities are functions relate to goals and priorities and proposes recommendations for the future of the program.

Stroke Advisory Committee - Encourages project development and community coordination in stroke area, isolates needs, determines priorities and recommends projects to Technical Review Committee, Executive Committee, Long-Range Planning Committee & R.A.G.

Finance Committee - Reviews expanditures and budgets; guides and advises Executive Committee and staff through fiscal policies.

Operational Support Team - Monitors operating projects and through evaluation and feedback improves the ongoing projects' ability to achieve their objectives more realistically; provides comments, assistance and specialized consultation to Operations Branch.

Continuing Medical Education Advisory Committee - Membership overlap with Continuing Health Education Council, Inc., therefore, meets only when RMP physician education projects need community guidance.

Long-Range Planning Committee - Identifies needs, assesses resources, suggests improvements in organization patterns, establishes priorities, recommends evaluation procedures.

Technical Review Committee - Reviews all project proposals, making specific recommendations for changes and improvements in the proposals with respect to substantive conent, adequacy of supporting materials, relevance and accuracy of technical data and general quality of the document text.

Selections Committee - Nominates members and Chairmen of the categorical disease committees for appointment by the Executive Committee to maintain the high caliber and broad representation of the membership.

Pacific Basin - Acts as liaison between its assessed health needs and project proposals to make the latter effect the former in Guam, American Samoa and the Trust Territory.

Personnel Committee - Recommends employment of supplementary and replacement personnel to augment core staff strengths as new directions emerge.

Nominations Committee - Nominates members of Regional Advisory Group and Executive Committee to replace those members whose terms expire to keep membership broadly representative.

Project Review Process: Each project proposal begins the review process as a letter of intent submitted to the Director of RMPH. Ideas for project proposals are generated by individuals, agencies or organizations in the health field. The Director and Core staff assess the revelance of the idea, proposed in the letter of intent, to the overall plan of RMPH. If it seems relevant, the Director assigns an appropriate staff member to assist in further development of the project with the advice of the committee set up for this. The development of the project often takes several months. The Core staff works closely with the applicant organization throughout,to construct a proposal which follows RMP Guidelines. After the final draft of a proposal has been completed, it

is channeled through the appropriate Categorical and Technical Review Committees, then through the Executive Committee and the Regional Advisory Group. Upon final approval of the RAG, the proposal is sent to RMPS for national review.

All proposals are reviewed in terms of:

(1) Relevance to the overall plan of RMPH and the degree to which the proposal furthers regionalization and cooperative arrangements, to improve our present health care system in Hawaii.

(2) Identification of needs and opportunities within the region.

(3) Definition of objectives in clear, measurable terms.

(4) Assessment of resources, including the identification and use of existing resources, avoidance of duplication, and the initiation of cooperative arrangements and closer linkages between the available resources.

(5) Involvement of individuals, organizations and institutions within the region.

(6) Indication of the priority level of the proposal in relation to the overall goals and objectives of RMPH.

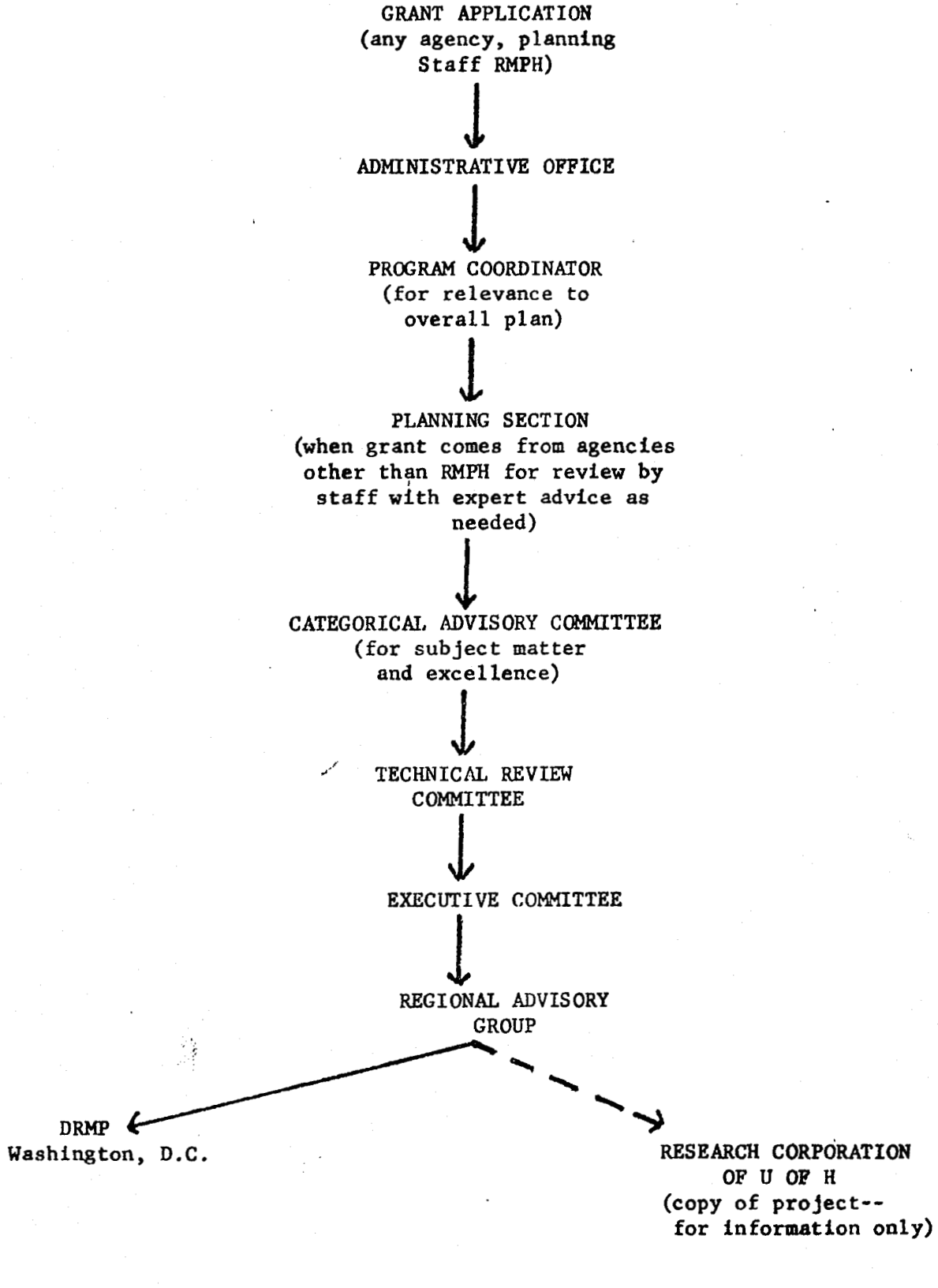
(7) Implementation, including strategy, methodology and techniques for accomplishing the stated objectives.

(8) Evaluation protocol developed to measure achievement of the objectives and assess the overall effect of the proposal.

Although there is no formal review relationship with CHP, projects are often discussed with CHP personnel during the preliminary stages of project development.

A problem encountered with the present review mechanisms is the difficulty attendant upon the veto power of any one review committee. Clarification is required with respect to the effect of one review committee's veto on the continued progress of a proposal through the local review mechanism.

PROJECT REVIEW FLOW CHART



Annual Report of the Regional Advisory Group

The Regional Advisory Group of the RMPH report their satisfaction of progress made by the RMPH to meet goals and objectives set forth for the past year. The RAG indicates its awareness of the new direction of RMPH and acceptance of the present national priorities on improving health care delivery. While supporting this innovative potential for changing the health care system, the committee continues to support continuing education for providers, general public education and provision of technical and professional assistance in the development and implementation of new concepts, standards and practices with particular attention to the evolution of health care delivery, reform and eventual constraints in cost. The Regional Advisory Group proposes the following future goals and objectives:

1. Concur in shift in direction of RMPH to improvement in health care system, particular accessibility and quality of care.

2. Activities should relate to identification of needs, assessment of resources, improve organization patterns, develop cooperative arrangements, establish priorities, institute evaluation procedures and improve communications.

3. Specific proposals to reach objectives include: studies and research; study groups and workshops; activation of county advisory committees; organization of Honolulu Hospital Committee; funding of part-time county and hospital M.D. coordinators; work to catalyze and establish cooperative arrangements among health interest; and development of new techniques of continuing education.

The RAG sees the core staff members playing a more active and dominant role by assisting in the development of new and innovative methods of improving the health care sytem related to greater accessibility, and quality of care.

The RAG reports that the RMPH works cooperatively with other federally sponsored programs such as Model Cities Cities, Community Action Programs, and Comprehensive Health Planning, and others. In addition, the RMPH has good relationship with professional associations, health agencies, educational institutions and groups interested in categorical diseases.

Following are a list of recommendations which the RAG has approved for implementation for the issuing year:

a) Each RAG member should be assigned to a Committee.
b) There should be an educational workshop annually for all RAG members.
c) There should be a manual published for each RAG member setting forth the goals and objectives of RMPH with an outline of the duties and responsibilities of each RAG member.
d) The Director, Chairman of the Executive Committee, and Chairman of the RAG should meet personally with each new RAG member at time of appointment.

e) The Director and designated members of the core staff should meet periodically with all RAG members to review RMPH activities from time to time.
f) The RAG members should receive a copy of the minutes of each Executive Committee meeting immediately following meetings of the Executive Committee.
g) Communicate frequently, regarding RMPH program and activities, to RAG and committee members for their information.
h) A RAG Evaluation Committee should be established as a standing committee to meet regularly during the year to evaluate RMPH programs and activities rather than once a year on an ad hoc basis.
i) Continue to strengthen the evaluative process and procedures for the qualitative aspects of the Regional Medical Program of Hawaii and the individual operational projects and activities. Attention to be directed toward determination of behavioral changes in health professionals as well as the real influence on morbidity and mortality rates of health care. Establish specifically, evaluation tools and measurements for each project and significant core staff activity.
j) A representative of the Hospital Association of Hawaii and the Nurses Association of Hawaii be appointed to membership on the Executive Committee. This Committee recommends that action be taken to implement this Executive Committee membership as soon as possible but not later than June 1, 1971.
k) An Associate or Deputy Coordinator be employed or designated.
l) RMPH continue active involvement with core-staff activities and demonstration projects in the Pacific Basin with the maximum limits that the budget will allow.
m) A clearly defined process for all ideas and proposals for RMPH projects and activities should be established. This should include the mechanism for continuing feedback to individuals and agencies proposing projects in order that they may know the exact status of a project at any time.
n) Provide extention of training and education to health personnel in extended care facilities, nursing homes, and care homes to strengthen programs related to rehabilitation and out-of-hospital services.
o) The RAG Evaluation Committee recommends that the Executive Committee be charged with the responsibility to carry out the foregoing recommendations as expeditiously as possible.

Evaluation

The RMPH has an Evaluation Committee which provides independent assessment of overall program development. The Evaluation Committee informs RAG how activities and functions relate to goals and priorities and proposes recommendations for the future of the program. The region indicates that the activities and achievements in operating projects and by core staff members are measured and evaluated in terms of the stated RMPH goals and that final evaluation of results rests with the Director, Executive Committee and ultimately the RAG.

Developmental Component

The Developmental Component of the Regional Medical Program of Hawaii will follow the presently working review cycle and monitoring.

The Region states that the Developmental Component provides the needed opportunity for RMP-Hawaii to establish innovative activities in continuing education as pilot studies; to test their feasibility, palatability and productivity on a limited experimental basis before extending their scope and insuring their longevity through the formal mechanism of project proposals. These educational programs will include:

A. Demonstration Projects of innovative patient care systems
B. Feasibility and utilization study projects
C. Staff development training programs

The Region believes that the availability of the Developmental Component will provide an immediate opportunity for the Regional Medical Program of Hawaii to influence the need for organizational change of individual hospitals and in the overall hospital system of Hawaii. The Region believes that instituting organization change in the present hospital system is the most economical and feasible way of insuring that comprehensive care is accessible to every citizen that is in need of medical care. Activities which are being considered for improvement of the hospital system under the Developmental Component include:

(a) Studies of hospital emergency care departments
(b) Shared services with hospitals joining together for the operation of certain basic facilitative and supporting services, clinical and non-clinical in nature
(c) Educational seminars for board members, hospital administrators and medical staff in understanding the role changes that are necessary in the organizational structure to provide comprehensive medical care
(d) The operation of one or more sub-units of patient care by one central parent hospital corporation
(é) Study of the feasibility of training doctor's assistants in hospitals
(f) Development of health manpower pools
(g) Investigation of the possibility of establishing an all-inclusive hospital rate
(h) Promotion of an identification program related to designating routes and publicizing availability of hospital and emergency care services to the public.

The Region is requesting a funding level of $78,897 for the developmental component which is an amount equal to 10% of the annual direct cost funding level (not including carryover) of the Region at the present time.

Core Central Regional Service Activities

Medical Library: Services which have been extended to members of the medical community in the Region through this activity have included

literature searches, translation, book selection, consultation, and data collection.

Audiovisual Services: The core staff includes an audiovisual specialist who provides community service and consultation to hospitals, physician group, voluntary health agencies, government agencies as well as RMP projects.

Consultant Service in Medical Education: Core staff members provide a variety of consultation services to health-related organization in the community.

Health Maintenance Organization: RMPH core staff are meeting actively with interested hospitals, medical groups and other agencies who have expressed an interest in the development and organization of an HMO. Future involvement will include assistance in the feasibility decision, resource review, subscribes market, systems for performance monitoring and evaluation alignment of resources to deliver HMO services, health systems design, record keeping system, medical and paramedical education, development of monitoring system for internal management and external audit. To date four specific groups have requested RMPH assistance and involvement in discussing the development an HMO.

Cooperative Community Health Services: The purpose of this core service is to act as a resource and provide assistance to citizen groups in disadvantaged areas in order to improve the health status of this community. Target groups for this service are primarily the two Model Neighborhood Areas and Community Action Program target areas. The nature of the assistance provided by this RMPH service includes: familiarizing the community with the health care system and its effective utilization, identifying community resources, identifying problem areas and needs, increasing the accessibility of health services, assisting in planning programs to fill the need and problem areas, providing back-up health statistics and research material, and facilitating assistance from appropriate agencies.

Projects

The region indicates that specific core staff are assigned to monitor and evaluate progress of all projects to determine if they are meeting objectives on a qualitive and timely basis. Periodic reports which are required for each project includes: monthly expenditure reports; monthly progress reports; and periodic documentary of mainland travel; employment of consultants and utilization of project faculty members. All reports are reviewed by the core staff, executive committee and the Director. Following are the projects for which the region has requested support.

Continuation Within Approved Period of Support

Project #15 - Regional Cooperative Chemotherapy Program - This project was initiated June 1970 and has the remaining commitment: 04 year $110,000; 05 year $73,333.

The region has requested support to continue operation of this project: 04 year $110,000 and 05 year $73,333.

The objectives of this project continue to be to provide improved care for cancer patients; evaluation and/or treatment of patients in the units; improved data collection, storage and feedback to the physicians; improved education for physicians and dissemination of information in use of chemotherapy.

The program reports that it has organized a regional oncology therapy program (6 active chemotherapy units) established an educational program on oncology and progress has been made in establishing a computer program and a Telephone Task Force to aid in consultation.

Project #20 - Constant Care Unit - Guam Memorial Hospital - This project was initiated in June 1970 and it has the remaining commitment: 04 year $39,909, 05 year $23,314. The region has requested in this application support to continue operation of this project: 04 year $39,909 and 05 year $23,314.

The primary objectives of this project continue to be to improve the delivery of intensive and coronary care to 71,696 Guamarians and referrals from the Trust Territory.

It is reported that two physicians, six nurses and one engineer have been trained in Hawaii and the mainland U.S. in the cooperation of the constant care unit, Guam Memorial Hospital. In addition, an existing ward was renovated and put into operation. Equipment has been ordered from the mainland U.S. with installation and maintenance services furnished by an authorized subsidiary of the American manufacturers located in Japan.

Continuation Beyond Approved Period of Support

Project #3 - Promotion and Extension of the Home Care Concept — Third Year Requested $52,800

This project was initiated in February 1969 and has no remaining commitment. The region reports that through this project, workshops and training of health personnel in Home Care Services and techniques have involved 425 physicians, nurses and allied health members. The caseload of home care patients was 330 in 1970 and 275 a year earlier or an increase of 20% in Hawaii. There have been 11 site consultation visits and several audiovisual training films have been developed to publicize the home care program and train health personnel in home care service procedures and techniques.

The region has requested 3 years of additional support to continue this project. The primary objectives of the project are to popularize the home health services among providers and consumers through trained staff and educational media and to gather and present evidence that expenses are saved by insurance companies which subsidize home care without previous hospitalization and that home care service in general reduces acute and long term care facilities expenditures.

Fourth Year: $39,875 Fifth Year: $40,004

Project #7 - Cardiopulmonary Resuscitation - This project was initiated in February 1969 and has no remaining commitment. It is reported that this project has met the objectives of: 1) retraining and stabilization corps of 300 instructors; 2) initiating in-service training programs in 31 hospitals; 3) getting eight hospitals to require CPR certification to maintain staff privileges; and 4) developed a standardized report form. The objective of training 20,000 people was not obtained; only 9,581 have been trained in CPR and 1,275 retrained.

Requested Third Year $35,000

The region has requested two years of additional support for this project which would provide about five years of funding through RMP. It proposes to conduct 12 instructor workshops, train 12,000 hospital, rescue paramedical and high risk industry people; to provide consultants for related training programs; to achieve and improve first contact care and transporative care for victims of respiratory and cardiac arrest.

Fourth Year: $19,700

Project #11 - A Regional Approach to Pediatric Pulmonary Care This project was initiated in Feburary 1969 and has no remaining commitment. The region reports that since the Pediatric Pulmonary Center opened, 218 infant patients have been treated at the center. The education program in Pediatric Therapy and Care has involved 286 physicians and 554 nurses and allied health personnel in training sessions and organized hospital in-service training programs. An education program has begun for family members to care for children at home who labor under respiratory distress. In addition, an ambulance service has been developed and equipped to transfer sick babies between hospitals and from neighbor island hospitals through the Honolulu International Airport.

Requested Third Year $94,853

The region has requested in this application an additional three years support to continue this activity.

The project proposes to;:1) train 36 nurses, 18 physicians, 36 paramedicals and 18 administrative personnel; 2) to evaluate 17 key areas in the state for chest clinics; and 3) to develop air evacuation-transfer of critically ill patients.

Fourth Year: $82,285 Fifth Year: $77,335

NEW PROJECTS

Project #28 - Medical Library Information Network - The primary objective of this proposal is to improve and expand library facilities of the 33 medical institutions in the Pacific Basin through augmentation and cooperation, including library personnel training and medical forces education. It provides for a network coordinator who will

Requested First Year $78,021

be responsible for service development, data collection, user surveys, resource evaluation studies, and will effect cooperative agreements among libaries for the most efficient and economical means of satisfying identified needs.

Second Year: $41,756 Third Year: $41,506

Project #29 - Intensive Care Nursing - This project proposes to train 72 professional nurses in six-week training programs to become qualified members of intensive care units. Activities planned during the first year will train two classes of 12 nurses each in a six-week educational program based at the University of Hawaii with clinical practices at the Queen's Medical Center, St. Francis Hospital and Kuakini Hospital. Two courses will be taught each year. Annually 24 nurses will complete the course.

Requested First Year $75,610

Second Year: $67,718 Third Year: $67,718

Project #30 - Waianae Coast Comprehensive Health Center The Waianae Coast has a multi-ethnic population of 25,000 and is characterized by high unemployment, lack of local employment opportunities, low income, low educational levels, limited transportion, inadequate job skills, inadequate and substandard housing and limited and uncoordinated health services. The area is a target for Model Cities and Community Action Program.

Requested First Year $267,300

There is an immediate need for health, medical and related social services in the target area. Since 1965 the community has been working toward improving health services. The Waianae District Comprehensive Health and Hospital Board, Inc.,has been working with various public and private agencies to implement their program concept for comprehensive health services in the area. Included in the cooperative planning have been RMPH, CHP, Governor's Office, Model Cities, Departments of Health, Social Services, and Accounting and General Services, Schools of Medicine and Public Health, Hawaii Hospital Association, Dental Society, Medical Society, Health and Community Services, OEO, Honolulu Home Care, and Human Services Center.

RMPS support is being requested for coordination and administrative personnel, some diagnostic equipment for screening and early detection, computer and data processing costs for the Medical/Environmental Data System, and consultant services for evaluation.

It is indicated that program evaluation will be conducted in three primary areas of concern, accessibility, quality of care, and cost. The Region believes that this program has great potential for conversion to a Health Maintenance Organization.

Second Year: $248,857 Third Year: $257,049

Project #31 - Upgrading of Bedside Nursing Care in Rural Community Hospitals - The Hawaii Community College will be the sponsoring agency for this project, with Dr. Jack Humbert as project director. The primary objective is to provide bedside instruction to nurses on the lastest medical concepts in practical application of modern nursing care in 5 rural hospitals on the island of Hawaii. This program will be evaluated on an on-going basis for both quantity and quality. The region has requested only one year support for this activity.

Requested First Year $29,250

Project #32 - Monitoring of Physiologic Data From Outlying Community Hospitalsat Medical Centers in Honolulu. The Queen's Medical Center is the affiliate institution for this proposal. Alfred Morris, M.D. and Philip Foti, M.D. are co-project directors. Participating hospitals in the project are Maui Memorial, Wilcox Memorial, Kauai Veterans, Hilo, Kona, Wahiawa, Castle, Kahuku, St. Francis, Kuakini and the Queen's Medical Center.

Requested First Year $77,811

The primary objective of this proposal is to connect electronically 8 coronary care units from neighboring islands and remote rural areas to 3 medical centers in Honolulu so that physiological data can be monitored and rapid consultation education to coronary care professional and allied health personnel can be provided.

Implementation of this program will be accomplished in four distinct phases: 1) installation of a DATATEL monitoring system; 2) initiation of immediate consultation services to outlying islands; 3) didactic electrocardiographic monitoring training courses; 4) weekly conferences utilizing DATATEL hookup. Evaluation has been built into the program.

Second Year: $63,178 Third Year: $65,176

Project #33 - Community Involvement for the Physically Retrained - The Pacific Institute of Rehabilitation Medicine is the sponsoring agency for this proposal and Dr. R.F. Shepard is the Project Director. The primary objective is to teach or educate key people of 20 community agencies to develop realistic approaches in the utilization of the energies of 500 retrained handicapped and assist them to develop skills and interest, find social contacts and to use their time and residual abilities to give purpose to their life.

Requested First Year $79,109

Second Year: $76,629 Third Year: $75,958

Project #34 - Cardiac Disease Detection and Rehabilitation - Nine hospitals, Central YMCA, and various health agencies will participate with the Queen's Medical Center in this proposal. Jack Scaff, M.D. will be the Project Director. The primary objective of this proposal is: 1) early detection of 600 potential heart disease patients; 2) administer prevention care to 300; 3) rehabilitation of 200 patients with cardiovascular disease to prevent recurrence; and 4) to train 100

Requested First Year $61,221

health professionals, including new types of allied health and lay personnel.

Second Year: $52,131 Third Year: $53,683

Project #35 - Respiratory Therapy Training - The affiliate institution for this proposal is the Kapiolani Community College in Honolulu. This is a three-year project to upgrade the capabilities and accessibility of respiratory care in Hawaii, Guam and American Samoa. The primary objective of the activity is to train 60 selected nurses and allied personnel each year in 2 four-week training programs and two physicians in 2 three-day preceptorship training programs in the special techniques of respiratory care.

Requested First Year $26,900

Second Year: $26,900 Third Year: $26,900

Project #36 - Improving the Accessibility of Care to Stroke Patients in Hawaii - The primary objectives of this proposal are to train eight multidiscipline (RN, OT,PT, SW, Dietitian, Speech Therapist), stroke teams; five on Oahu, and one each of the outer islands: Maui, Kauai and Hawaii.

Requested First Year $35,526

Second Year: $43,428 Third Year: $39,088

RMPS/GRB/6/17/71

REGION Hawaii
CYCLE RM 00001 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR., NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
D00 - Developmental			$78,897		$ 78,897	---	$ 78,897
#1 - Core		$516,624			516,624	---	516,624
#15 - Reg. Cooperative Chemotherapy Prog.	$110,000				110,000	$ 27,800	137,800
#20 - Constant Care Unit	39,909				39,909	---	39,909
#3 - Home Care		52,800			52,800	20,048	72,848
#7 - CPR Training		35,000			35,000	---	35,000
#11 - Ped. Pulmonary Prog.		94,853			94,853	26,369	121,222
#28 - Med. Library Info.				$ 78,021	78,021	---	78,021
#29 - ICU Nurse Training				75,610	75,610	---	75,610
#30 - Compreh. Health Center (Waianae Coast)				267,300	267,300	---	267,300
#31 - Bedside Nurse Care in Rural Hospitals				29,250	29,250	---	29,250
#32 - Physiological Data Monitoring System				77,811	77,811	20,823	98,634
#33 - Comm. Involvement for the Phys. Retrained				79,109	79,109	21,992	101,101
#34 - Cardiac Detection & Rehabilitation				61,221	61,221	24,640	85,861
#35 - Resp. Therapy Proj.				26,900	26,900	7,478	34,378
#36 - Improving Access to Care for Stroke Pat.				35,526	35,526	---	35,526
TOTAL	$149,909	$699,277	$78,897	$730,748	$1,658,831	$149,150	$1,807,981

GRB/5/17/71

REGION Hawaii
BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
D00 - Developmental			$78,897		$ 78,897
#1 - Core		$533;457			533,457
#15	$73,333				73,333
#20	23,314				23,314
#3		39,875			39,875
#7		19,700			19,700
#11		82,285			82,285
#28				$ 41,756	41,756
#29				67,718	67,718
#30				248,857	248,857
#31					---
#32				63,178	63,178
#33				76,629	76,629
#34				52,131	52,131
#35				26,900	26,900
#36				43,428	43,428
TOTAL	$96,647	$675,317	$78,897	$620,597	$1,471,458

REGION Hawaii
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
D00			$78,897		$ 78,897	$ 236,691
Core		$555,332			555,332	1,605,413
#15					---	183,333
#20					---	63,223
#3		40,004			40,004	132,679
#7					---	54,700
#11		77,335			77,335	254,473
#28				$41,506	41,506	161,283
#29				67,718	67,718	211,046
#30				257,049	257,049	773,206
#31					---	29,250
#32				65,176	65,176	206,165
#33				75,958	75,958	231,696
#34				53,683	53,683	167,035
#35				26,900	26,900	80,700
#36				39,088	39,088	118,042
TOTAL		$672,671	$78,897	$627,078	$1,378,646	$4,508,935

SITE VISIT REPORT
HAWAII REGIONAL MEDICAL PROGRAM
DECEMBER 3-4, 1970

Chairman

Gerald Besson, M.D., Member RMPS Review Committee

Regional Medical Programs Service Staff

Ismael B. Morales, Public Health Advisory, Grants Review Branch
Daniel Spain, Operations Officer, Regional Development Branch
Gerald T. Gardell, Chief, Grants Management Branch
Cecilia C. Conrath, Chief, Continuing Education and Training Branch
Ronald S. Currie, Regional Office Representative, DHEW Region IX

Regional Advisory Group

Mr. E.E. Black, E.E. Black and Company
Mr. Edward C. Bryan, Vice Chairman, Chairman Executive Committee
Mr. Masaichi Tasaka, President-elect, Hospital Association of Hawaii--representing Mr. Ollie Burkett
Neal Gault, M.D., Chairman, Evaluation Committee , Associate Dean, School of Medicine, University of Hawaii
Richard K. C. Lee, M.D., (ex officio), Research Corporation, Executive Director
Mrs. Sylvia Levy, Comprehensive Health Planning Officer
Harold Sexton, M.D., Straub Clinic
Mr. George Sumner, Jr., Vice President, Blythe and Company
Bernard J. B. Yim, M.D., Chairman of Long-Range Planning Committee (member of Executive Committee
Mr. Harold Ajirogi, Member Executive Committee, Sr. Officer, East-West Center
Unogi Goto, M.D., Member Executive Committee, Honolulu Medical Group
John Lowrey, M.D., Member Executive Committee, President-Elect, Hawaii Medical Association
William R. Coops, (ex officio member, Executive Committee)
Mrs. Kazue K. McLaren, Assistant Chief, Public Health Nursing Branch
Senator George Mills, M.D., Medicine Director, Kamechamehu School
Walter B. Quisenberry, M.D., Director, Department of Health

HRMP Categorical Disease Committees and Technical Review Committee

Cancer Advisory Committee
James Banta, M.D.
Mr. James Bunker
Mr. Richard Hager
Livingston Wong,M.D.

Heart Advisory Committee
Miss Charlotte Dennis, R.N.
H.H. Chun, M.D.
Mrs. Ruth Iwata, R.N.
Miss Janice Lacosa, R.N.

Stroke Advisory Committee
Elizabeth Anderson, M.D. (Vice Chairman)
Abraham Kagan, M.D.
David Lee Pang, M.D.

Technical Review Committee
Reginald Ho, M.D.
Donald Leton, Ph.D.
Ming Pi Mi, Ph.D.
Robert Weiner, M.D.
Drake Will, M.D. (Chairman)

Hawaii Health Agencies

Mr. James Bunker, Executive Vice President, American Cancer Society--Hawaii Division
Mrs. Mary Lee Potter, Executive Director, Hawaii Nurses Association
Wilbur S. Lummis, Jr., M.S., M.D. Deputy Director, Department of Health, State of Hawaii
Edward O'Rourke, M.D., Dean, School of Public Health, University of Hawaii
Mr. Donald Stapp, Executive Director, Hawaii Heart Association
Raymond Corsini, M.D., American Cancer Society--Hawaii Division-Consultant
Mr. Richard Hoag, Executive Director, American Cancer Society --Oahu Unit
Clifford Straehley, M.D., President, American Cancer Society--Oahu Unit
Harlan Cleveland, President of the University of Hawaii

Grantee Institution Research Corporation of the University of Hawaii

Richard K. D. Lee M.D., Executive Director, Research Corp.
Mr. William R. Coops, Administrative Officer, Research Corp.
Mr. G. C. Dixon, Comptroller, Research Corp.

Hawaii RMP Core Staff

Masato Hasegawa, M.D., Director
Alexander Anderson, M.D., Consultant in Continuing Medical Education
Mrs. Nancy Crocco, Assistant Chief of Cooperative Community Health Services
Mrs. Rosie Chang, Chief of Allied Health Services
Mr. Paul Cook, Associate Chief of Operations
Mrs. Ruth Denney, Chief of Planning and Research Services
Satoru Izutsu, Ph.D., Chief of Planning and Operations for American Samao, Guam, and the Trust Territory of the Pacific Islands
Kanae Kaku, M.D., Biostatistician/Epidemiologist
Mr. Norman Kuwahara, Comptroller
Mr. Robert Murranka, Administrative Assistant
Mr. Paul Okumoto, Audio-Visual Technician
Mr. Omar Tunks, Chief of Operations
Mr. Clyde Winters, Medical Librarian

Background: The previous site visit to the Hawaii Regional Medical Program took place January 26-27, 1970, and its primary purpose was to review program development. In general, it was the opinion of the site visitors that, considering problems involved, regionalization was moving forward. Problem areas at that time revolved around the following issues:

1. Mr. Ollie Burkett, a member of the RAG, and Executive Director of the Hawaii Hospital Association, did not believe that hospitals were involved enough in the decision-making process and planning phase of the RMP.

2. No representation for the 22 osteopaths in Hawaii on the RAG or committees.

3. Core staff lacked strong top-level administrative direction for their activities.

4. The visitors believed Dr. Masato Hasegawa required the assistance of a full-time deputy or associate director to help him administrate the day-to-day operations, so that Dr. Hasegawa could be free to spend more time in developing the philosophy and direction of the program.

5. The visitors believed that the Region needed staff in certain categorical areas; such as a specialist in continuing education.

6. The RAG played a minor role in the Regional Medical Program, compared to the Executive Committee which appeared to be the emerging powerful force in directing the Regional Medical Program.

7. The visitors believed that there was needed representation on the RAG from organized labor and low-level consumers.

8. It appeared that the RMP core staff was only belatedly identifying the problems of urban and rural, disadvantaged communities in their Region.

9. The visitors found it very difficult to consider the question of Hawaii RMP's role in the Pacific Basin. It was obviously a question that has perplexed the Region. The site visitors agreed with Dr. Satoru Izutsu that operational projects would serve as a tool by which the RMP of Hawaii could help introduce a better system of health care in the Pacific Basin.

Concerns of this Site Visit: To determine the maturity of this Region and its readiness for a developmental component award by focusing on:

1. A review of program development to date, with particular regard to the development of core staff activities, the Regional Advisory Group, categorical disease committees, and the relationship among the key institutions in the Region, including the medical school, hospitals, State Health Department, and the Medical Society;
2. The relationship of the development component request with total program development.

General Comments: Dr. Gerald E. Besson clearly indicated to Dr. Masato M. Hasegawa, HRMP Coordinator, the Regional Advisory Group members present and each group of committee members as they participated, the purpose of the site visit and its relative significance to the total review process, including Committee and Council review of the application under consideration.

It was evident to the site visitors that there has been considerable progress made by the Hawaii RMP toward developing the general principles of regionalization. The Region has developed a framework for planning the achievement of goals and objectives. Methods for evaluation are being developed. The visitors did not review projects but rather focused the review on the established organizational structure and administrative process of the HRMP, its interrelationships with the health care system of Hawaii and its capability to implement the program in accordance with stated goals and objectives.

Statement of Accomplishments of Regionalization: It is easy to recognize that this Region has significant problems created by the mixture of ethnic groups, the dispersion of the counties (islands) of the State by distances as great as 200 miles (with all inter-island travel being essentially by air), the absence of a fully-developed four-year medical school, and the loyalties created by affiliation with a single hospital, which make it difficult for people to think of the community problems at large.

The relationship of the Hawaii Medical Association to the Hawaii Regional Medical Program as described by John Lowery, M.D. appeared to be satisfactory. He stated that the Hawaii Medical Association wants to cooperate with the Regional Medical Program because it believes that it can relate better to the Regional Medical Program than it can to the Comprehensive Health Planning or other Federal health programs.

Dr. Neal Gault, Jr., Associate Dean, University of Hawaii School of Medicine, was present and explained that the relationship and spirit of cooperation between the University School of Medicine and the HRMP is good. The visitors, however, believe that the Medical School has an extremely limited capacity to play a significant role in attempting to actually get a four-year medical school

underway. Dr. Gault expressed interest in the hospital-oriented activities to which the developmental component is directed. He would like to see these funds utilized to integrate hospital services and believes the University Medical School could be utilized as the coordinating point for its implementation.

Deputy Director of Health was present during the site visit and he indicated that the relationship between the State Health Department and the Regional Medical Program is satisfactory. The RMP and the State Health Department have exchanged planning data, and participate on committees which have a common interest, and the Health Department is represented on the Regional Advisory Committee.

Mrs. Sylvia Levy, Director, Comprehensive Health Planning, explained that the State of Hawaii has a 314 (a) Agency operating out of the State Health Department and reporting directly to the Governor of Hawaii. There are no "b" Agencies in the Hawaii Region. It appears that the relationship between the Regional Medical Program and Comprehensive Health Planning is of a positive nature and that Mrs. Levy will be asked to join the Long Range Planning Committee of HRMP. The HRMP and the CHP have been jointly doing a study on the distribution of health manpower in Hawaii: Mrs. Levy believes that the CHP and RMP should merge if possible to facilitate utilization of manpower available rather than compete for it. The activities of the CHP are restricted because it only has a staff of three professionals. The general agreement seemed to be that Regional Medical Programs could and should work more closely with CHP.

Mr. Ollie Burkett of the Hospital Association was not present at the meeting, which was a disappointment to the site visitors: however, the spokesman for the Hospital Association indicated that the relationship between the RMP and the Hospital Association has been gradually improving. The visitors believe that Mr. Burkett has had a great influence on the HRMP since becoming a member of the RAG and the Executive Committee of the RAG. This is certainly reflected in the strategy outlined by the region which gives primary emphasis toward improving the health of Hawaii through better and increased utilization of hospital facilities.

The School of Public Health at the University of Hawaii has been involved with the Regional Medical Program since its early development. The primary contribution that the school has made to the Regional Medical Program, both actual and potential, involves its relationship with the Pacific Basin and its epidemiology competence. The School of Public Health has also been very active with OEO, Model Cities, and Comprehensive Health Planning with whom it has a training grant. Dr. Edward O'Rourke, Dean, School of Public Health emphasized the interests of the School of Public Health in making its resources available to the Regional Medical Program. He anticipated and encouraged a close working relationship with RMP in the future.

Dr. O'Rourke explained how as a result of a special student seminar on National Health Insurance held in April 1970, in Honolulu, a technical proposal was developed and submitted by the School of Public Health to the National Center for Health Services Research and Development. The purpose of this proposal is to explore the feasibility of developing a broadly representative community organization which will take responsibility for development and the implementation of desirable and acceptable modifications in the present health services system in Hawaii. The overall goals are stated as (1) improving the quality of health care, (2) moderating health care costs and (3) increasing accessibility to services for all members of a community. Hawaii is the setting for this project to develop a program which can be used as a model for ultimate statewide health insurance on a national basis if the model proves successful. The Governor of Hawaii has appointed a seven-member board, a new administrative and organizational unit to set health policy. The Board represents several major health institutions among which the Regional Medical Programs, the School of Public Health, the Hawaii Medical Association and the State Department of Health are members.

A great deal of concern was expressed by the constituent institutions of RMPH that this Governors committee would duplicate the functions of RMPH as well as CHP. Furthermore, there was concern that the vesting of authority for staffing this Board under the auspices of the School of Public Health might tend to undermine the credibility of RMPH as the focal point for institutional linkages of the health care provider and health related consumer interest. There has been one meeting of the Board at which RMPH was present. A great deal of concern was expressed that the political development at the Governor's level might impose a political plan for the creation of a new health care structure without direct involvement and concurrence of the major health institutions.

In a meeting with Harlem Cleveland, President of the University the site team members discussed with President Cleveland the School of Public Health proposed plan for a "Model National Health Insurance Demonstration Program". President Cleveland explained that the proposal was still in the primary stages of development. The visitors explained that the proposal was still in the primary stages of development. The visitors explained to President Cleveland the significant role the HRMP can assume as the coordinator for the development and implementation of the model program with the providers of Health Services. President Cleveland appeared interested and receptive toward the visitors commentaries.

The visitors also briefly discussed with President Cleveland community involvement of the University in the health field, particularly in continuing education. President Cleveland indicated that he foresees a greater involvement in the future of the University with the community in the field of health.

Following this meeting the site team members suggested to Dr. Hasegawa

for his consideration the idea of appointing a member of the Board of Regents of the University to the RAG of the HRMP. Dr. Hasegawa appeared very receptive to this suggestion.

Mrs. Kazue McLaren, member of the Regional Advisory Group and Assistant Chief of Public Health Nursing Branch indicated that the nursing profession is now fairly well represented on the RMPH committees and that the cooperation between the nurses and the Regional Medical Program has improved much during the past year.

There are 22 osteopaths in Hawaii, and these individuals are still not represented on the Regional Advisory Group. Dr. Hasegawa stated that the osteopaths have been contacted and will be drawn into some of the RMPH activities.

The allied health personneld of the Region have been actively joined together by the Regional Medical Program.

Core Staff: Similar to the previous site visit team of January 1970, the site visitors expressed concerns over the effectiveness of the Coordinator who is salaried on a 50% time and effort. The limited administrative capability of the present part-time Coordinator creates a serious impediment to the realization of the goals outlined by the RMPH. The visitors re-emphasized last year's recommendations to the Coordinator that he employ a full-time deputy or associate director to help him administrate the day-to-day operations, so that he could be free to spend more time in developing the philosophy and direction of the program.

The question was discussed in detail with both the Chairman of the RAG, Chairman of the Executive Committee and with the Coordinator himself. It was indicated to the visitors that steps are being taken to modify the existing situation by appointment of a deputy coordintor at this time. The Core staff has been strengthened by the addition of Dr. Alexander Anderson, who has assumed the position of Chief of Continuing Medical Education.

The site visitors believed the the core staff is generally competent and seem to work very well together, however, they have lacked strong top-level administrative direction for their activities in the past. The visitors believed that the addition of a full-time deputy coordinator may remedy this situation.

Regional Advisory Group: Mr. Richard Davi, present Chairman of the Regional Advisory Group, was not available at the site visit meeting because he was on the mainland. It was apparent to the visitors that the RAG was not assuming their responsibility in giving direction to the RMPH. They have played a minor role in stimulting project proposals, and have not assumed responsibility in the review of applications. When inquiring to each individual member of the RAG about the Developmental Component it was highly disappointing to discover that almost none of them was aware of what was included in the developmental component. They

seemed also unaware of any long-range goals of the RMPH. In spite of their unfamiliarality with the developmental component they had given it a stamp of approval. Close scrutiny of this approval revealed a degree of reservation by RAG members, leading the visitors to believe that the Region may not be fully ready for a developmental component award.

It is apparent that one of the weaknesses of the RMPH is the poor communication with the RAG and non-involvement of the RAG in the decision-making process.

Discussions with Mr. Edward C. Bryan, the Chairman of the Executive Committee who is a consumer representative and a very competent businessman and other members indicate the Executive Committee has adequate representation of the major provider institutions and they have significant insight into the health distribution problem and the problems of the cost of health care in Hawaii. This Committee is tuned in with the general thrust as well as the problems of the RMPH. Realizing the managerial deficiencies in the RMPH, the Executive Committee has contracted with the Hawaii Education Council Incorporated to do a study of RMPH. This organization will study the total operation of the RMPH and will make recommendations for development of policies, performance and the organizational structure of the RMPH that may increase its administrative efficiency.

Categorical Committees: The communications between the Technical Review Committee, Categorical Committees and Core staff have been very poor. The committees have not been involved either in identifying the health needs of the Region nor in having an input in program direction of the RMPH. The members of these committees have been merely passing judgement on projects which are presented to them without knowing how they relate to RMPH goals and priorities. The visitors recommended that core staff input be built into the meetings of these committees to keep them abreast of total program activities and to encourage committee input into the RMPH. They also recommended that guidelines delineating committee responsibilities and functions should be made available and discussed with all committee members. Many committee members seemed surprised and glad to know that they can have an input into the total program operation of the RMPH. It was obvious to the site visit team when meeting with these committees that there is a wealth of brainpower ready to be explored on these committees, and that if utilized properly by the RMPH its program will be strengthened.

Pacific Basin: Dr. Satoru Izutsu, Chief of Planning and Operations for the Trust Territory (Micronesia), American Samoa and Guam, explained Regional Medical Programs in the Pacific Basin. The team was impressed with the capability of Dr. Izutsu in creating the initial linkages and the progress made by the RMPH in this diversely culturally isolated area. The RMP has been coordinating its efforts with CHP in Micronesia because CHP has been active for several years in health planning throughout the Trust Territory

and has come up with a comprehensive health plan for the area. They have also coordinated their efforts with the Hawaii School of Public Health and the East-West Center.

The RMP has also established ties with the Department of Interior, the Micronesian Businessman's Association, and other local community action groups. Three representatives from each of the areas (Trust Territory, Guam, American Samoa) have been appointed to the Hawaii Regional Advisory Group. It is apparent to the visitors that the RMPH needs to have visibility in these areas, prior to establishing linkages with local health institutions. Just as the Cervical Cancer Project served to create visibility in Guam during the past year, the present proposal requesting the development of an intensive care unit training program at the L.B.J. Tropical Hospital in American Samoa will give visibility to RMPH with other existing institutions in Guam.

The concern of Dr. Izutsu expressed in the past and again this time is that the needs of people in the Pacific Basin are so overwhelming and the funds for RMPH so limited that there has been a reluctance to become extensively involved in program and project development in the Pacific Basin.

The added travelexpenses required for travel of the nine RAG representatives of the Pacific Basin with the limited budget awarded($17,270) does not allow the Coordinator any flexibility. He would like to have the fiscal flexibility to travel to the Pacific Basin when advantageous situations occur and when the occasion presents itself to support the travel of persons from the Pacific Basin who want to participate in a training program conducted in Hawaii. It will also allow him to utilize the services of other core staff members in the Pacific Basin such as Dr. Alexander Anderson, Chief, Continuing Education and Mrs. Rosie Chang, Chief, Allied Health. The site team believes that funds awarded to the Pacific Basin should be earmarked so that if the Coordinator of the Pacific Basin wishes to rebudget funds from activities supported in the area he will not infringe on funds allocated to Hawaii proper.

DEVELOPMENTAL COMPONENT: The primary area of concern for the site visitors was the Developmental Component and it was obvious to the visitors that a great deal of thought by the Region coordinator and his staff went into this application. The long-range goal of the developmental component involves three major items: a) a focus on hospitals as a major mechanism for the delivery of comprehensive health care; b) the use of continuing education programs; c) and the development of a data acquisition system that will help to assess the quality of health care in Hawaii. The technical projects proposed for implementation of long-range plans regarding the relationship between RMPH and the hospitals in the community appear to be well thought out and implementation could do a great deal towards realization of the articulated goals. The review procedures

normally used for project review will also be utilized for review of applications requesting developmental component funds. The visitors, however, expressed concern over the lengthy process (4 to 5 months) utilized for these reviews. The Region indicated that they intend to make changes in their review process that would reduce the time span.

In many respects, this Region appears to have made little progress since the previous site visit in January 1970. Many of the problems outlined in the background section of this memorandum still persist.

There seems to be however an increased sophistication which allows them to now look at program rather than project and to more realistically consider program priorities. While progress has been slow it has been in the direction of a broadening and deepening involvement of RMPH with the provider of health services and the community. It is on the basis of this evident maturation that the site visit team was inclined to encourage the process by recommending approval of the developmental component in spite of the managerial shortcomings previously discussed. The visitors believe that the RMPH will become better prepared with the developmental component to assume a leadership role with the implementation of new major health programs in Hawaii, such as the model National Health Insurance Demonstration Program in Hawaii referred to by Dr. O'Rourke. The RMPH as the representative organization of the health provider must be involved with the development of such programs. It will give flexibility to the RMPH to implement with greater facility continuing education programs stimulated in the community by Dr. Alexander Anderson. Dr. Anderson has in a short time become greatly involved in many continuing education activities, as a consultant. The developmental component will also give the RMPH the flexibility it needs to implement its plan for coordinating and expanding the availability of hospital services to the people of Hawaii. The site visit team members are convinced that the hospitals have been and will continue to be the major providers of health services in Hawaii.

In general, the major concerns of the visitors which the RMPH must resolve are as follows:

a. Greater involvement of the RAG in the planning, operation and decision-making process of the RMPH.
b. Identification of responsibilities, establish operating guidelines and involve all committees of the RMPH in planning and operations of the RMPH.
c. Employment of an Associate Coordinator with management and administrative skills to run the day to day operations of RMPH.
d. Better communication between the Coordinator, Core Staff, RAG Executive Committee and other committees of the RMPH. Communication between the RMP and other health organizations must also be improved.

e. Clarification of the commitment of the RMPH to the Pacific Basin area consisting of American Samoa, Guam, and Micronesia. Consideration should be given toward earmarking funds awarded for this program.
f. The RMPH must assume a leadership role in the development and implementation of the Model National Health Insurance Demonstration Program being negotiated for Hawaii by the School of Public Health, University of Hawaii with the National Center for Research and Development, HSMHA, USPHS, HEW.

RECOMMENDATION: It is recommended that the developmental grant be funded for one year to the RMPH at the requested level of $92,314 and that Projects #24,#25,#26 and #27 be funded at the requested level in 01 year of $273,986, 02 year $285,182 and 03 year $285,119. Project #23 is not recommended for funding with RMP funds because of Council's decision not to fund new mobile coronary care projects. The total funding level recommended for three years is as follows:

REGIONS OPERATIONAL YEAR	03	04	05	TOTAL
I Developmental Component	$92,314			$92,314
II Six New Projects	273,986	$285,182	$285,119	844,287
	$366,300	$285,182	$285,119	$936,601

GRB/RMPS
12/28/70

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 10, 1971

Reply to Attn of:

Subject: Staff Review of Triennial Application from the Hawaii Regional Medical Program 5 G03 RM 00001

To: Director
Regional Medical Programs Service

Through: Acting Deputy Director, RMPS

Chairman of the Month

Chief, Grants Review Branch

Chief, Grants Management Branch

Acting Chief, Regional Development Branch

The region has requested funding in this triennial application for the following activities: (Direct Cost Only)

	*04 Year	05 Year	06 Year	Total
Core	$ 516,624	$ 533,457	$ 555,332	$1,605,413
Developmental Component (Previously approved/unfunded)	78,897	78,897	78,897	236,691
Continuation Projects #15, #20, #3, #7, #11	332,562	238,507	111,339	688,408
New Projects #28, #29, #30 #31,#32,#33,#34,#34,#36	730,748	620,597	627,078	1,978,423
Total	$1,658,831	$1,471,458	$1,378,646	$4,508,935

*There is a remaining commitment of $149,909 for Projects #15, #20 in 04 year.

In review of this application, staff concerned itself with overall program development.

On the basis of this review and because the region has failed to follow through on past recommendation from the RMPS staff suggest to Committee and Council for their consideration the following recommendation:

Approve one year of funding for core and operational projects and disapprove Developmental Component support until the following

- Director, RMPS

1. The region identify specific objectives and priorities that relate to the health needs of the region. That the objectives delineate anticipated accomplishments in terms of a realistic time schedule.

2. The RAG develop its By-laws and assume their responsibility for directing the planning and operational activities of the RMPH.

3. That a deputy or associate director to help administrate the day-to-day operations of the RMPH be employed.

4. That the RAG Technical Review Committee and Categorical Committees be given an opportunity to have input in the planning and operational activities of the RMPH. Clearly defined operating procedures and responsibilities of these committees should be clearly delineated.

5. That evaluation mechanisms to be implemented relate to projected accomplishments indicated in specifically identified objectives.

6. That the RMPH clearly identify its commitment to the Pacific Basin and develop a feasible plan of action for this area.

7. That a feasible regional plan of operation be developed that will meet the health needs of the region, based on measurable accomplishments at specific periods of time of program development.

It is suggested that staff conduct a follow-up visit six months following notification to the region of these conditions to determine progress and provide assistance if necessary.

Goals, Objectives and Priorities

Program goals are described, however specific objectives and priorities are not clearly stated in terms of the health needs of the region. The objectives are described in terms of activities and not in terms of anticipated accomplishments.

Regional Advisory Group (RAG)

In a January 1970 site visit, it appeared to the visitors that the Coordinator was the sole authority in the decision-making process. The RAG had not assumed their responsibility in giving direction to the RMPH. They had played a minor role in stimulating project proposals, and had not assumed responsibility in the review of applications. It was apparent that one of the weaknesses of the RMPH was the poor communication of Core with the RAG and the non-involvement of the RAG in the decision-making process. The visitors discussed this problem with the RAG and encouraged them and their Executive Committee to assume the leadership of the RMPH.

When site visited again in December 1970, the visitors discovered that the Executive Committee had assumed a position of authority within the

- Director, RMPS

program, but that the RAG still remained passive. Since then there has been some indication that the RAG may have been motivated by the site visitors to assume greater responsibility. It is, however, apparent to staff that at the present the RAG has had little, if any, input into the development of plans or in the operations of the program. For example, during the December 1970 Site Visit the visitors discovered that the RAG had little if any involvement with the planning of the developmental component and few members had reviewed the application.

Staff suggests that a message should be sent from Council to the Coordinator and RAG Chairman of the RMPH that future funding of this region may be influenced by the degree to which the RAG assumes greater responsibility for direction of this program.

Core

In both the January and December 1970 site visits the visitors expressed concerns over the administrative effectiveness of the Coordinator who was salaried on a 50% time and effort. The visitors on both occasions recommended to the Coordinator that he employ a full-time deputy or associate director to help him administer the day-to-day operations, so that the Coordinator could be free to spend more time in developing the philosophy and direction of the program. This concern has been discussed in detail with both the Chairman of the RAG, Chairman of the Executive Committee and with the Coordinator himself. Both the Chairman of the RAG and the Executive Committee explained that they did not care to see Dr. Hasegawa assume work on a 100% time and effort. They preferred that the Coordinator remain on a part-time basis and that a deputy coordinator with administrative capabilities be hired to carry on the day-to-day operations of the program. It is, however, indicated in this application that the Coordinator will be working on 100% time and effort.

Staff has been informed that Dr. Hasegawa is considering giving up his private practice and that the region intends to hire an administrative specialist rather than hire a deputy coordinator. A position for a deputy director has not been included in the request for support of core staff.

New positions added to core include, Medical Economist, Administrative Manager, Biostatistician/Epidemiologist, and Administrative Assistant. Positions omitted from Core are the Associate Coordinators, Chief of Planning, Associate Chief of Operations, Associate Chief for Planning and Research, researchers and a secretary. Staff believes that the present core personnel are competent and seem to work very well together, however, because they have lacked strong top-level administrative direction for their activities, each appears to go his own separate way in carrying out RMPH activities.

Categorical Committees

The communications among the RAG, Technical Review Committee, Categorical

Committees and Core staff have been very poor. The committees have not been involved in the planning and have not had input in planning and operational activities of the RMPH. Instead the committee members have been passing judgement on projects out of context or clear understanding of RMPH goals and priorities. During the December 1970 site visit many committee members seemed surprised and glad to know of the possibility that they could have input into the total program operation of the RMPH. The visitors felt that these committees represented a wealth of untapped brainpower which if utilized properly by the RMPH, would strengthen the program.

Staff re-emphasizes the previous recommendations of site visit team that core staff input be built into the meetings of these committees to keep them abreast of total program activities and to encourage committee input into the RMPH. They also recommended that guidelines delineating committee responsibilities and functions should be made available and discussed with all committee members.

Developmental Component

Following the advice of the December 1970 site visit team, the February 1971 Advisory Council approved the RMPH for a Developmental Component award but because of existing fiscal restraints additional funds for this purpose were not released. The region has requested in this application funds for support of the developmental component, however, staff does not believe that the region should be authorized a developmental component award. The site visit team recommended approval of the developmental component inspite of existing managerial short comings because it believed that these problems would be resolved and that the long-range goals in the developmental component were in line with regional needs. It is, however, evident to staff that the managerial problems still persist and that the region has not reached the level of sophistication required for proper management of developmental funds.

Operational Projects

Staff had difficulty identifying the interrelationship between projects and how each of these activities fitted into a program plan that would have an influence in meeting the health care needs of the region.

In summary, staff's primary concerns are what involvement the RAG, committees, and core have with the projects, how these projects relate to a regional plan and what is the expected impact of these activities on the health care delivery system of the Region.

Staff was encouraged in that some of the new activities proposed in this application have an emphasis toward access of care and reaching out into the rural low economic areas of the region.

Evaluation

The region proposes in this application to evaluate projects and total program effectiveness. Although encouraged by interest in evaluation

activities staff has difficulty in determining how the region will implement evaluation activities without first identifying a regional plan with specific objectives that project expected accomplishments and are measurable in terms of evaluation.

Ismael B. Morales

Ismael B. Morales
Public Health Advisor
Grants Review Branch

Attendance at Hawaii Type V:

Ismael B. Morales, Grants Review Branch
Mary E. Murphy, Kidney Disease Control
Loren Hellickson, Office of Systems Management
Nancy McGuire, Office of Systems Management
Cecilia Conrath, Continuing Education and Training Branch
Cleveland R. Chambliss, Office of Organizational Liaison
Rodney C. Mercker, Grants Management Branch
Spencer Colburn, Regional Development Branch
Rhoda Abrams, Office of Program Planning and Evaluation

Action by Director _____

Initials _____

Date _____

BRIEF RESPONSES BY STAFF TO THE QUESTIONS IN THE REVIEW CRITERIA

A. Program

1. The region reflects a provider action plan of high priority needs which appears congruent with the overall mission and objectives as described in Dr. Wilson's memo of May 12, 1971. (Reference made to pages 2-4 of the application.)

2. Past performance has not demonstrated success, however, the region has now built this into its planned core staff activities and proposed projects. (Reference is made to pages 2-3 of the application.)

3. Same response as in No. 2.

4. There is no action plan for implementation of such activities, however, the region is conscious of these activities and has submitted project #32 which involves screening.

5. The proposed operational projects, to a large degree are expected to demonstrate expanded ambulatory care and out-patient diagnosis and treatment.

If successful in accomplishing proposed activities in this area it is expected that activities in the direction of ambulatory care will be expanded by the region.

6. Several of the regions proposed activities could enhance greater continuity of care. The potential is there.

7. There is no regional plan to measure the impact of RMP activites in access of care, quality and cost moderation for health care. It is however, mentioned in Project #30 that its evaluation will include three primary areas of concern, accessibility, quality of care and cost.

The proposed program goals and objectives (Core and projects) need to have a time schedule for accomplishment so that a more immediate pay-off can be achieved.

8. The region has established a good relationship with many of the health institutions in the region. They have made efforts toward linking the resources of these institutions to provide health care but have experienced many problems. The 14 projects which they have submitted have good dispersity in that they relate to, OEO, Model Cities and CHP.

Of the 14 projects submitted by the region two are receiving funds from local sources. (Project #7 - Heart Association and Project #30 State Funds.) Three projects mention a relation to other federal programs on Form 15 of the application but mention no funding. (Projects #20, #33, #20)

Performance

1. Goals are described, however specific objectives and priorities are not clearly stated. Activities are described as objectives but not stated in terms of what is to be accomplished.

2. Because the region's program objectives are non-specific productivity in terms of program accomplishments cannot be measured. It is, however, possible to measure productivity within the limits of each project.

3. Very little evidence of this in this region.

C. Process

1. At present, the viability and effectiveness of the RMP is less than effective. Reference is made to the two previous site visit reports dated January 1970 and December 1970. Progress to rectify the situation has been very slow.

2. Active participation exist, but the level of commitment is questionable. No real common objective or effort to meet health needs of the region.

3. This kind of participation by the RMPH with CHP is functioning better in the Pacific Basin Islands than in the Hawaiian Islands. (Reference is made to the regions last continuation application.)

4. Very little evidence of this, what is going on appears to be fragmented.

5. Very little evidence of this in the past, future planning in this area has potential.

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION
JULY 1971 REVIEW COMMITTEE

HAWAII REGIONAL MEDICAL PROGRAM
RM 0001 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

Recommendation: Additional funds for one year for core and operational projects and disapproval of the developmental component until the stipulated conditions are met.

Region's Operational Year	Request	Recommended Funding
04	$1,658,831	$1,072,000
05	1,471,458	-0-
06	1,378,646	-0-
Total	$4,508,935	$1,072,000

The region's current funding level is $835,762 direct cost and the rationale for the above recommended funding level is as follows:

Core	$400,000
Projects (continuation renewals, new)	672,000
Developmental Component	-0-
	$1,072,000

Conditions Stipulated by Committee

1. The region identify specific objectives and priorities that relate to the health needs of the region. That the objectives delineate anticipated accomplishments in terms of a realistic time schedule.

2. The RAG develop its By-laws and assume their responsibility for directing the planning and operational activities of the RMPH.

3. That the RAG Technical Review Committee and Categorical Committees be given an opportunity to have input in the planning and operational activities of the RMPH. Clearly defined operating procedures and responsibilities of these committees should be delineated.

4. That evaluation mechanisms to be implemented relate to projected accomplishments indicated in specifically identified program objectives.

5. That the RMPH clearly identify its commitment to the Pacific Basin and develop a feasible plan of action for this area from which RMPS can determine future funding needs.

6. That a feasible regional plan of operation be developed that will meet the health needs of the region, based on measurable accomplishments at specific periods of time of program development.

Committee suggested that staff conduct a follow up visit six months following notification to the region of these conditions to determine progress and provide assistance if necessary. In addition, a site visit is recommended to the region when it submits its anniversary review application in May 1972.

Critique: The Committee reviewed this triennial application in relation to the January and December 1970 site visits to this region. It is apparent that the RMPH continues to have a good working relationship with the Hawaii Medical Association, University of Hawaii, State Health Department, CHP, Hospital Association, etc. These relationships were discussed in a report of a site visit to this Region conducted on December 3-4, 1970.

It was noted that core staff of the program has been strengthened with the addition of Dr. Alexander Anderson who has assumed the position of consultant in Medical Education. The staff appears to be generally competent and seems to work very well together, but has not received sufficient leadership. In past reviews of this region, the RMPS Council has recommended that the coordinator hire a full-time deputy to help him administrate the day to day operations of the program. In response to this recommendation the coordinator is presently considering full-time employment with the RMPH and has moved Mr. Omar Tunks, Chief of Operation into the Administration Manager position. The Committee hopes that these steps will help the program develop the effective leadership it requires.

The RAG still continues to have a passive influence in the development of plans and in the operational activities of the program. The Executive Committee is the decision-making body for the program but functions indepently of the RAG rather than as an extension of RAG leadership. When last site visited in December 1970 the Executive Committee was attuned to the general thrust as well as the problems of the RMPH.

The goals, objectives and priorities of the program are described, however, they are not clearly stated in relation to the specific health needs of the region. In addition, they are described in terms of activities rather than in terms of anticipated accomplishments.

The communications among the RAG, Technical Review Committee, Categorical Committees and Core staff have been very poor. The committees have not been involved in the planning and have not had input in planning and

operational activities of the RMPH. Instead the committee members have been passing judgement on projects out of context or clear understanding of RMPH goals and priorities. During the December 1970 site visit many committee members seemed surprised and glad to know of the possiblity that they could have input into the total program operation of the RMPH. The visitors felt that these committees represented a wealth of untapped brainpower which if utilized properly by the RMPH, would strengthen the program.

Committee re-emphasizes the previous recommendations of site visit team that core staff input be built into the meetings of these committees to keep them abreast of total program activities and to encourage committee input into the RMPH. They also recommended that guidelines delineating committee responsibilities and functions should be made available and discussed with all committee members.

Committee had difficulty identifying the interrelationship between projects and how each of these activities fitted into a program plan that would have an influence in meeting the health care needs of the region.

Committee's primary concerns are what involvement the RAC, committees, and core have with the projects, how these projects relate to a regional plan and what is the expected impact of these activities on the health care delivery system of the Region. Committee was encouraged, however, in that some of the new activities proposed in this application have an emphasis toward access of care and reaching out into the rural low economic areas of the region.

The region proposes in this application to evaluate projects and total program effectiveness. Although encouraged by interest in evaluation activities, Committee has difficulty in determining how the region will implement evaluation activities without first identifying a regional plan with specific objectives that project expected accomplishments and are measurable in terms of evaluation.

Following the advice of the December 1970 site visit team, the February 1971 Advisory Council approved the RMPH for a Developmental Component award but because of existing fiscal restraints additional funds for this purpose were not released. The region has requested in this application funds for support of the developmental component, however, Committee doesn't believe that the region should be authorized a developmental component award. The committee took into consideration that previous approval of the developmental componet was given by Council in spite of existing managerial shortcomings because it believed that these problems would be resolved and that the long-range goals in the developmental component were in line with regional needs. It is, however, evident that the managerial problems still persist and that the region has not reached the level of sophistication required for proper management of developmental funds.

In the Pacific Basin the RMPH has been coordinating its efforts with CHP because they have been active for several years in health planning throughout the Trust Territory and has come up with a comprehensive health plan for the area. They have also coordinated their efforts with the Hawaii School of Public Health and the East-West Center. It is apparent to the visitors that the RMPH needs to have visibility in these areas, prior to establishing linkages with local health institutions. Just as the Cervical Cancer Project served to create visibility in Guam during the past year, the present proposal requesting the development of an intensive care unit training program at the L.B.J. Tropical Hospital in American Samoa will give visibility to RMPH with other existing institutions in Guam.

It is recommended by Committee that the RMPH develop a plan for the Pacific Basin which identifies specific objectives based on expected accomplishments and includes projection of funding needs. In this fashion RMPS can consider the needs of the Pacific Basin and Hawaii independently when reviewing its request for support of program activities.

RMPS/GRB/7/15/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

MAINE'S REGIONAL MEDICAL PROGRAM
295 Water Street
Augusta, Maine 04330

RM 00054 8/71
July 1971 Review Committee

Program Coordinator: Manu Chatterjee, M.D.

This Region was awarded $842,636 for its third operational year ending September 1971. The 03 year award included indirect costs of $5,417 which represents an average indirect cost rate of 15½%. Originally the 03 year award was for $904,473 but due to RMPS fiscal restraints was reduced. The current application is a Triennial one which requests the following:

I. Developmental funds which were approved by the November Council but not yet funded.

II. Core for three years at an increased level; one year of commitment remains and two years are requested beyond that.

III. Support for three operational objectives, based on projects previously approved and funded and now extended and project approved but not yet funded.

A breakdown of the funding requests follows this page.

This Region was site visited in October 1970 to assess its readiness for a developmental component. An excerpt from the site visit report describes the team's assessment succinctly.

> "The site visitors saw the evolution of Maine's Regional Medical Program as being remarkably consistent with that of the program at the National level - starting with the categorical emphasis but expanding to include a clear commitment to the development of an integrated system of medical care which provides access to medically depressed populations as well as improvement of availability of care to the community at large."

Because of the October 1970 site visit findings and Council's recommendation that Maine receive a developmental component, another site visit was not scheduled to review its triennial application. Staff has reviewed the application in relation to its past and their comments are reflected in the summary following.

REGION MAINE
CYCLE RM 00054 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR., NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
CORE	$567,786 1/				$567,786	---	$ 567,786
D00 - Developmental			$ 78,653	3/	78,653	---	78,653
#21 - New Methods for Health Serv. Del.	105,192 2/		205,631		310,823	$ 6,521	317,344
#22 - New Health Manpower	116,138 2/		163,671		279,809	3,833	283,642
#23 - Public & Professional Health Ed.	96,377 2/		170,424		266,801	5,948	272,749
TOTAL	$885,493		$618,379		$1,503,872	$16,302	$1,520,174

1/ 05 and 06 year are Continuation Beyond Approved Period of Support.

2/ Maine has allocated funds previously assigned to projects into operational objective budgets designated as #21, #22, and #23. Several former projects, such as the Kennebec Valley Development, Continuing Education and Coronary Care Training have one more year of commitment. Two additional years of support are requested in this Triennium Application. Other projects were approved but unfunded.

3/ Maine was approved for 2 years developmental funding in December 1970, and is requesting a third year of funding per telephone conversation by Mr. Spencer Colburn and the Region 5/17/71.

GRB/5/18/71

REGION MAINE
BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
CORE		$624,565			$ 624,565
D00			$ 78,653		78,653
#21		115,711	226,194		341,905
#22		127,752	180,038		307,790
#23		106,015	187,466		293,481
TOTAL		$974,043	$672,351		$1,646,394

MAINE RMP

RECION MAINE
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

ıpport Codes)	(5)	(2)	(3)	(1)		
:IFICATION OF ONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
RE		$ 687,022			$ 687,002	$1,879,373
0				$78,653	78,653	235,959
1/		127,282	$248,813		376,095	1,028,823
2		140,527	198,042		338,569	926,168
23		116,617	206,213		322,830	883,112
OTAL		$1,071,448	$653,068	$78,653	$1,803,169	$4,953,435

FUNDING HISTORY

Planning Stage

Grant Year	Period	Funded (Direct Costs)
01	5/67 - 4/68	$193,909
02	5/68 - 4/69	358,170

Operational Program

Grant Year	Period	Funded (Direct Costs)	Future Commitment (Direct Costs)
01	7/68 - 6/69	$ 428,106	---
02	7/69 - 9/70 (15 mos.)	1,229,634	---
03	10/70 - 9/71	842,636*	---
04	10/71 - 9/72	---	$637,642
05	10/72 - 9/73	---	57,333

*Reduced from original award of $904,473 due to RMPS fiscal constraints. Includes $50,693 in carryover funds used for planning Maine Medical School and three feasibility studies.

GEOGRAPHY AND DEMOGRAPHY

The Maine Regional Medical Program includes the entire State of Maine. The character of the area is similar to northern New Hampshire and Vermont, but poor transportation connections among these sections was one of the considerations in the original establishment of MRMP boundaries to include Maine only. The RAG feels the present Region is valid and a workable one, and no redefinition of boundaries is contemplated at present.

Maine is a rural and geographically isolated state, and its population of almost a million is concentrated in the southempart of the state on the Atlantic coastline. The largest city, Portland, has 70,000 residents. As was mentioned before, interstate transportation services are limited.

In addition to the University of Maine which has an enrollment of approximately 18,000, there are several small liberal arts colleges throughout the state. There is no medical school, but there are hopes for one as part of a "health science" education center. Many of the efforts of the Maine RMP are directed toward the successful establishment of a medical school.

The Maine Medical Center is the Region's largest health facility (573 beds), and there are four other voluntary hospitals of over 200 beds. A total

of 4,266 beds exists in the 61 voluntary acute general hospitals, and there are nearly 5,000 long-term and chronic care beds throughout the state. The physician population of Maine is 1,078 MDs and 221 DOs. There are 3,856 active nurses.

HISTORY OF REGIONAL DEVELOPMENT

When early interest regarding Regional Medical Programs was generated, the possibility of Maine's becoming part of a New England RMP was discussed. Maine, however, chose autonomy and a search was begun for an appropriate grantee organization. Existing organizations which were considered were found to be unacceptable to some segments of the medical community, so Medical Care Development, Inc., was formed -- it had no pre-existing health complex affiliation and was regarded as an acceptable component of the medical care system. The Bingham Associates Fund and the Maine Medical Center were particularly active in pre-planning phases.

In December 1966 the first planning request was submitted to the Division of Regional Medical Programs. It designated Medical Care Development, Inc., as the application organization; Bingham Associates Fund as the fiscal agent, and the Field Director of Bingham Associates (on loan 100% to Medical Care Development) as planning coordinator. The Committee and Council reviewers thought that the plan was unique in that although there was no medical school in Maine, Tufts University in Boston was actively involved and a number of its medical faculty were on the MRMP staff. Although the planning application proposed the appointment of hospital coordinators to serve as liaisons between the community hospitals and the MRMP, there was no evidence of favorable community hospital reception of this idea. The plan also proposed the formation of a committee of practicing physicians to advise the MRMP staff in policy and program matters. There was some concern among the reviewers about the exact relationship between this group and the Regional Advisory Group. In general, the planning grant application was thought to be a good one, and an 01 year planning award was made in May 1967.

Under the planning grant the program's professional staff was assembled and Dr. Manu Chatterjee was appointed full-time program coordinator. Periodic meetings with regional health and education agencies became established practice, hospital coordinators (or acting coordinators) were appointed in 56 hospitals and held meetings, two feasibility studies were initiated, the RAG membership was completely divorced from the grantee organization to eliminate the possibility of legal problems and overlap of membership, and an operational proposal was developed.

The first operational request was submitted in February 1968. A May 1968 site visit team was satisfied as to the Region's readiness for an operational award; many concerned individuals and groups in the Region felt that MRMP could help overcome the problems and were willing

to work toward the Region's success. It was noted that, initially, emphasis was given to development of the regional medical program rather than to establishment of priorities among unmet needs. The program had developed around activities which were already started, and the RAG had not yet been confronted with the need to select among several activities. The site team suggested that the RAG develop a mechanism for Regional priority setting. The hospital coordinators were considered an effective group in expressing community hospital needs. The site team recommended that MRMP investigate the possibility of developing a data collection program. In July 1968, the Region received an operational award for support of three projects: Visiting Guest Resident Project, Kennebec Valley Regional Health Agency, and Smoking Control Project. A fourth activity, Physician Seminar, was not considered an appropriate use of RMP funds. At this juncture, MRMP assumed fiscal responsibility for its own program and operational projects. A supplemental award to the 01 operation year was made in March 1969 for support of a Coronary Care Project and the Physicians Continuing Education Program

During the 02 year the Region continued to fund core and the original projects. In addition, the Region rebudgeted and utilized unexpended funds to initiate new projects for which supplemental funding was not available: the Directors of Medical Education activity and the Regional Library project. During this same period of time, the Region had submitted several project proposals relating to its objectives #5 and 6, which called for a heavy investment in equipment, not having specific project objectives or design. These were returned for revision.

During the third year, the Department of Community Medicine proposal was resubmitted and approved for partial support by the Council. During staff review for the third operational year, the Region requested continued funding for core and six ongoing projects and developmental funding. Staff recommended approval of funding at $934,473 (direct costs) of which $42,693 was carryover. Since that time, the Region received an 03 award of $904,473, and subsequently a reduced award of $842,636. The Region is presently supporting the following activities:

Core	$429,542
Guest Resident Program	20,551
Kennebec Valley Regional Health Agency	150,644
Smoking Control Program	36,138
Coronary Care Program	133,744
Physicians' Continuing Education	50,128
Regional Library	21,889
TOTAL COSTS	$842,636

The November 1970 Council approved developmental funding for Maine. The May 1971 Council approved a program in Family Nurse Associate Training which would have impact on a Model Cities areas of Portland and Lewistown. This was approved by Council at a level of $27,896. No additional funds have been provided to the Region for either of these activities.

PROGRAM OPERATIONAL OBJECTIVES

Since 1968 the Maine RMP has been defined by six operational objectives. When the October 1970 Site Visit Team visited Maine, the site visitors described the six program objectives as reflecting an emphasis on the development of an integrated system of medical care, which provided access to medically depressed people, as well as improvement of the availability of care to the community at large. The visitors felt the objectives reflected the national priorities but were equally geared to the unique needs of Maine itself.

Since then the RAG has decided that the first three operational objectives should be given priority as far as the Maine program is concerned: (1) To conduct experiments in new methods for delivering health care to disadvantaged areas and for evaluating their potential for positively influencing present arrangements for the practice and financing of services; (2) To develop new health manpower for quality distribution and organization of the full range of medical services to all of the people of this region; and (3) To improve and update the level of medical knowledge of the health professionals and the public at large through continuing education programs.

Former objective #4 "to develop a capability in the five subregions for areawide health planning and the delivery of health services" is a central strategy for achievement for all objectives.

Objective #5 "to maximize the capability for the delivery and distribution of quality medical-care to the community hospitals" and #6 "to maximize the capability for providing specialized diagnosis, treatment, and medical educational leadership and the referral hospitals in each of the five subregions," the RAG feels it cannot now justifiably be singled out for priority consideration because of the present funding available to the Regional Medical Programs Service and to Maine.

Therefore, the first three objectives are now the program priorities; the Chairman of the RAG appointed subcommittees to serve as technical review bodies for indepth analysis of project activities as they relate to these operational objectives. It was a unanimous decision of the RAG to continue the development of the program by organizing both ongoing projects and those approved but not funded in relation to the first three operational objectives. In its review, RMPS staff felt that this change clarified the Maine program approach.

The chart on page 9 describes how each of the projects relates to the three program objectives.

REGIONAL ADVISORY GROUP

The RAG bylaws calls for 33 members; 30 other individuals serve on the Board of Directors. There are six new members on the RAG. When

MAINE RMP

PERCENTAGE EFFORT OF APPROVED PROJECT COMPONENTS BY OPERATIONAL OBJECTIVES

OPERATIONAL OBJECTIVES →	I CONDUCT EXPERIMENTS IN NEW METHODS FOR DELIVERING HEALTH SERVICES					II DEVELOP NEW HEALTH MANPOWER					III UPDATE LEVEL OF MEDICAL KNOWLEDGE OF PROFESSIONALS AND PUBLIC					APPROVED FUNDING LEVEL
APPROVED OPERATIONAL PROJECT COMPONENTS	20%	40%	60%	80%	100%	20%	40%	60%	80%	100%	20%	40%	60%	80%	100%	$
Kennebec Valley Regional Health Agency		X 45.9					X 45.9				X 22.9					114,666
Physicians Continuing Education						X 10.9								X 43.8		54,728
Coronary Care		X 59.3					X 59.3				X 29.7					148,312
Regional Library							X 17.1						X 25.7			42,828
Regional Directors of Medical Education	X 5.5					X 5.5							X 16.5			27,500
Department of Community Medicine-Maine Medical Center			X 30.0			X 10.0					X 10.0					50,000
Interactive Television-Bangor, Blue Hill, Stonington			X 15.1			X 38.4					X 38.4					191,864
Nursing and Allied Health Continuing Education	X 24.8						X 49.7					X 49.7				124,217
Regional Cancer Program		X 30.2				X 15.0						X 30.2				75,422
Family Nurse Associate* (Model Cities)										X 27.9						27,896
TOTAL	310,823					279,809					266,801					857,433

FUNDED NOT FUNDED

* Approval Pending

the site visitors studied the RAG, they suggested that the Region take steps to: (1) change the character of consumer representation on the RAG, to include non-medically oriented consumers and those of modest means; (2) develop a subcommittee in task force structure for the RAG; and (3) clearly separate the functions of the Board of Directors from those of the RAG. Staff feels that steps have been made in this direction, although there appears to be only one new member from the low income consumer groups. The Board of Directors is completely separate from the RAG and their functions are completely separate.

Since October 1970 site visitors, and subsequently Council, recommended that the Maine decision-making process and the function of the RAG was sufficiently mature to utilize developmental funds, the RAG functioning does not seem to be a major area of consideration now. A chart on decision-making process as it appears in the application appears on page 11 of this summary.

Developmental Component - The Region has outlined a number of specific studies and activities that they intend to undertake with developmental funds. These are related to the three major objectives of the Region and are spelled out in considerable detail, including an estimate of the staff time that is to be involved in their development. A listing of the types of studies follows:

	First Year Request
	$78,653

Health System Organization including definition of Health Maintenance Organization - $15,000.

Subregionalization - Health Manpower - experimental activities for new types of management personnel and development of evaluation procedures for studying their impact - $20,000.

New Technologies in Communications and Transportation - $5,000

Area Health Education Centers - $30,000

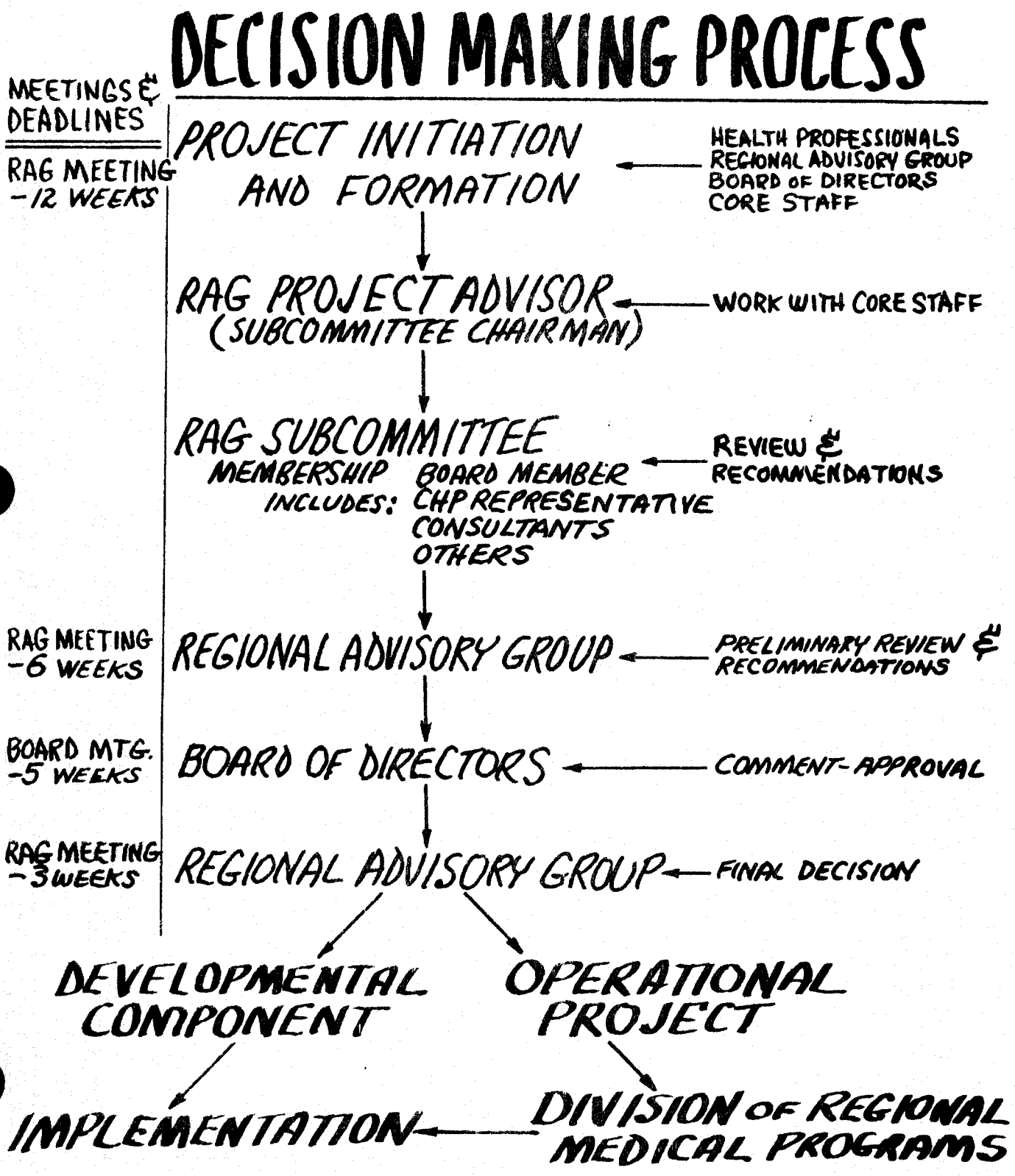
Community Organization for those areas that have a shortage of health manpower and must depend on citizen organization - $25,000.

Peer Review Mechanisms - peer review on a subarea basis among a number of small community hospitals - $10,000.

Speciality Care Projects - information and referral in cancer - $5,000.

Health System Components - small feasibility program in health service delivery staff education and manpower utilization for small hospitals, nursing homes and ambulatory centers - $20,000.

THE REGIONAL ADVISORY GROUP IS INFORMED, MATURE, CREATIVE, AND ENTHUSIASTIC. MRMP'S DECISION-MAKING PROCESS IS SUMMARIZED IN THE FOLLOWING DIAGRAM:



Subregionalization Related to the 314(b) Development - $15,000.

Health Care Financing - $10,000.

Problem-Oriented Medical Records - to help expand the demonstration project at Augusta General Hospital - $15,000.

Public Education in Smoking - $10,000

Interregional Communications Utilizing ETV and other technologies - $15,000

Rehabilitation Workshop - $5,000

These developmental activities have been chosen because they can be implemented, they contribute toward the achievement of the operational objectives and they have potential as expanded projects. The review process for the developmental funding and the management procedure for allocation of funds is carefully outlined in the application.

02 Year - $78,653 03 Year - $78,653

Core Staff - At present there are 14 individuals on the core staff representing a full-time equivalency of 9.4. Of the ten professional positions, four are female. No minority groups are represented on the core staff. Core personnel are now budgeted at approximately $255,000. The projected personnel budget calls for 23 full-time employees and an equivalent of two full-time trainee positions at a total cost of $413,112.

First Year Request
$567,786

Staff had some questions about the rate of increase in salaries and the rationale for the projected full-time support of the Associate Coordinator for evaluation, if he continues to spend approximately half-time as Director of the Health Council of Maine. The objectives of the two organizations are closely intertwined however, and MRMP is credited by the RAG as having been responsible for the revitalization of the health council which has a primary role in health career development.

Cooperative arrangements are described in the application with the Comprehensive Health Planning Agency, Department of Health and Welfare, the Interagency Council on Smoking and Health, Health Council of Maine, the Maine Medical Association, the Maine Osteopathic Association, the Maine State Nurses Association, Model Cities, OEO and the University of Maine.

Core supported feasibility studies are described: a student program has completed surveys on patient flow and nursing manpower and in the future will be working on HMO development and peer review development. Another feasibility study describes student research activities conducted by the

Antioch students which has provided data on emergency care and physician and hospital costs. Completed feasibility studies include personnel education, cancer clinics in which about 1200 women received detection examinations at the hospitals and a physician manpower inventory.

The one central resource described is the Planning Reference Library which provides materials to community hospitals. Performance sites listed for the ongoing activities in Maine show that project and core activities now reach 34 different health care institutions in the State of Maine.

The October 1970 visitors were impressed with the sincerity and effectiveness of the coordinator and his core staff and the fact that the MRMP has developed productive relationships with many organizations in the State and with the surrounding Regions. Staff in its review felt that the Maine core staff may have increased its effectiveness in the past year.

02 Year - $624,565 03 Year - $687,022

Projects

Two projects have been phased out this year; the Smoking and Health and the Guest Resident Program. Smoking education will become a core activity. The Guest Resident Program will be continued on a limited scale by Tufts with the Maine RMP as the coordinator. One of the reasons for phasing out MRMP support of this project was the failure to attract enough residents. Only 30 residents a year were willing to come up and serve in the hospitals. About 10 hospitals were serviced in this fashion. Progress reports are given on the ongoing projects in Kennebec Valley, Coronary Care, Physicians' Continuing Education and the Regional Library, but the triennial program proposed is described in terms of the operational objectives, rather than in projects.

#21 - Objective Number I - To conduct experiments in new methods for delivering health care. First Year $310,823 (d.c.)

Eighty percent of the rural poor are 20 miles from the nearest hospital. The community's studies to date show major difficulties in seeing a physician, in transportation and in distance. The per capita income in Maine is $2,477 - the lowest in New England. The study to date indicates that 50% of the low income women have never had a pap smear, 30% of low income families have never had a chest X-ray. Five times more family members whose income is $6,000 and over have had physicial examinations than those families whose income is less that $3,000. Objectives of these activities are: (1) to develop means for the rural disadvantaged to enter the medical care system; (2) introduce new communication technology in three areas; (3) to experiment

with new health system organization format in five locations; and (4) to expand the health system component staff interrelationships via organization and communication system usage.

Details on the locations of these activities are not included.

02 Year - $ 341,965 03 Year - $376,095

#22 - Operational Objective II - New Health Manpower Program objectives for this activity are: (1) to define and evaluate the use of physicians' assistants in seven varied practice settings; (2) to develop and expand home health/ ambulatory care teams in three locations; and (3) to continue the development of nursing and technician capabilities in the Region for coronary, intensive, family and cancer care.

First Year Request $279,809 (d.c.)

Maine has approximately 100 physicians for 100,000 civilian population compared to the 160 in New England, 130 in the United States. The distribution pattern for the physicians varies from one to every 668 people in Cumberland County to 1 to 2,000 in Washington County. Studies in rural Maine indicate 30% of the population have difficulty in seeing a physician and additional 25% feel they cannot get an appointment. The application states that the feasibility studies for developing the types of personnel projected have already been carried out by the Maine RMP in conjunction with area hospitals, community groups and the University of Maine.

Staff noted that the coronary care training which has been supported for three years should be phased out according to Council policy. The Region does not seem to be planning this phase-out.

02 Year - $307,790 03 Year - $338,569

#23 - Objective III - Public and Professional Health Education. Program objectives are: (1) to establish regional directors of medical education; (2) to develop practice models in primary, family and community medicine; (3) to continue the physicians' continuing education program and initiate full scale operation of the nursing and allied health education program; and (4) target expanded public health education to the schools and community health councils throughout the Region.

First Year Request $266,801 (d.c.)

02 Year - $295,481 03 Year - $322,830

RMPS/GRB
6/18/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

MAINE REGIONAL MEDICAL PROGRAM
RM 00054 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: The Review Committee recommended that Maine be awarded triennial funding at a graduated level for each three years and that developmental funding be approved.

DIRECT COSTS ONLY

YEAR	REQUEST	RECOMMENDED
04	$1,503,872	$1,100,000
05	1,646,394	1,200,000
06	1,803,169	1,300,000
TOTAL	$4,953,435	$3,600,000

CRITIQUE: Since the principal Committee reviewer had participated in the October 1970 site visit to study the Region's application for developmental component funding, she was able to relate the written triennial application to firsthand, recent experience in Maine. She felt that the application reinforced the site visit team's appraisal of the Maine RMP, as a Region with demonstrated ability, a superior Coordinator and a capable Core staff. She felt that the RMP staff were effectively carrying out a "brokerage" function in providing staff help and small amounts of money to other agencies and in finding non-RMP sources of funds for activities that are in line with Maine's program priorities.

The Committee was somewhat concerned about the lack of specifics in Maine's three year program proposal. The Region has broken up its previously approved and sometimes funded projects into broad program objectives and the Committee had difficulty relating this to previous applications. Both the principal and secondary reviewers, however, thought that the change was a forward step in program development, developed by a special RAG subcommittee with staff assistance but that careful evaluation would be required to appraise the effects. Another concern of the Committee related to the increase in Core staff, both in size and salary levels. Staff was asked to determine the rationale for these changes. It was agreed that the Maine RMP has moved ahead with plans for the use of developmental funds in line with the three program objectives.

After considerable discussion, the Committee finally arrived at a recommendation to provide funding at a reduced graduated level for each of the three years, to include developmental funds. Staff was advised to keep close scrutiny of the salary levels, specific program activities and accomplishments during the triennial period. The Region should be advised that certain of the former project activities, particularly in the coronary care training area, could not be continued indefinitely because of Council policy.

RMPS/GRB
7/16/71

REGIONAL MEDICAL PROGRAMS SERVICE

SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

Memphis Regional Medical Program
1300 Medical Center Towers
969 Madison Avenue
Memphis, Tennessee 38103

RM 00051 8/71
July 1971 Review Committee

Program Coordinator: James W. Culbertson, M. D.

The Region's current third year award for core and 13 projects is $1,371,916 ($1,086,048 direct costs and $285,868 indirect costs). In addition, a second year supplemental award for 16 months in the amount of $701,344 ($655,172 direct costs and $46,172 indirect costs) included support of 2 projects during the third year. The estimated current level of support for direct costs is $1,668,144. In keeping with funding restraints, an amended award in a reduced amount is in process. The present application proposes:

1) Authority for a developmental component in the event new funds become available for this aspect.

2) Continuation of 5 projects (14, 17, 18, 19 and 25) within the currently approved periods, 2 for two years and 3 for one year. Support is also requested for one additional year beyond the current approved period for projects Nos. 19 and 25.

3) Three years additional funding for Core and 7 projects (1, 2, 3, 5, 6, 7 and 8).

4) Three-year funding for 12 new projects (29-40).

5) Termination support of 3 projects (4, 10 and 24).

The Region requests $2.754.233 (direct costs) for its fourth year, $2,549,008 the fifth year and $2,397,991 the sixth year. A breakout chart identifying the components for each of the three years and a list of core activities follows:

REGION Memphis
CYCLE RM 00051 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes) IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(3) APPR. NOT PREV. FUNDED	(1) NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
Core		799,548			799,548	168,816	968,364
#1 - Stroke Project		84,200			84,200	41,400	125,600
#2-Postgraduate Ed. in G.I. Diag. Lab. Procedures		41,594			41,594	23,598	65,192
#3-Improve Prev. & Early Treat. of Skin Cancer		29,340			29,340	15,525	44,865
#5-Cardiopulmonary Care Trng.		67,650			67,650	31,050	98,700
#6-Emphysema & Cor Pulmonale		115,694			115,694	53,613	169,307
#7A-Control Rheumatic Fever & Acute Glomerulonephitis		123,230			123,230	57,034	180,264
#8-Electrocardiograph Prog.		62,575			62,575	27,600	90,175
#14-CCU - St. Bernards Hosp.	20,343				20,343	--	20,343
#17-Prev. Serv. - Heart, Ca., Stroke & Related Dis.	193,500				193,500	64,486	257,986
#18-Mobile Multiphasic Hlth. Screening in N. Miss.	181,500				181,500	28,936	210,436
#19- N. Miss Cardio. Clinics	38,046				38,046	7,656	45,702
#25-Home Health Care	27,657				27,657		27,657
#29-Production & Dist. of Radiopharmaceuticals				87,615	87,615	30,705	118,320
#30-Comprehen. Kidney Dis Prog.				81,932	81,932	19,734	101,666
#31-Peripheral Vas. Clinic				10,711	10,711	5,037	15,748
#32-Model Hosp. Learn. Cntr.				37,922	37,922	11,730	49,652
#33-Improve Death Statistics				47,211	47,211	18,837	66,048
#34-Dev. Leader. in In-Serv Ed.				42,758	42,758	18,561	61,319
#35-Eva. of Test for Endoc. & Metabolic Disease				58,030	58,030	20,010	78,040
#36-Expan. of Neigh. Hlth. Cntrs.				438,710	438,710	65,212	503,922
#37-Improve Quality of Nursing Care Available				48,378	48,378	24,426	72,804
#38-Multidisciplinary Trng. in Int. & Coronary Care				30,592	30,592	--	30,592
#39-CE for Phys. in Tenn.				48,320	48,320	--	48,320
#40-Hyper. Control Demon.				37,177	37,177	3,599	40,776
TOTAL	461,046	1,323,831		969,356	2,754,233	737,565	3,491,798

REGION Memphis

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
Core		799,548			799,548
1		102,350			102,350
2		51,824			51,824
3		30,783			30,783
5		71,502			71,502
6		130,210			130,210
7A		133,201			133,201
8		59,796			59,796
14	--				--
17	129,000				129,000
18	121,000				121,000
19	16,468				16,468
25	16,120				16,120
29				54,830	54,830
30				60,242	60,242
31				11,697	11,697
32				27,999	27,999
33				52,211	52,211
34				36,550	36,550
35				51,702	51,702
36				430,295	430,295
37				50,372	50,372
38				28,032	28,032
39				44,804	44,804
40				38,472	38,472
TOTAL	282,588	1,379,214		887,206	2,549,008

REGION Memphis

BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
Core		799,548			799,548	2,398,644
#1		118,720			118,720	305,270
#2		53,746			53,746	147,164
#3		33,431			33,431	93,554
#5		74,605			74,605	213,757
#6		141,940			141,940	387,844
#7A		143,035			143,035	399,466
#8		63,002			63,002	185,373
#14		--			--	20,343
#17						322,500
#18						302,500
#19					--	54,514
#25		--			--	43,777
#29				30,192	30,192	172,637
#30				63,608	63,608	205,782
#31				11,882	11,882	34,290
#32				29,555	29,555	95,476
#33				7,000	7,000	106,422
#34				36,400	36,400	115,708
#35				54,026	54,026	163,758
#36				563,358	563,358	1,432,363
#37				52,960	52,960	151,710
#38				29,669	29,669	88,293
#39				47,120	47,120	140,244
#40				44,194	44,194	119,843
TOTAL		1,428,027	--	969,964	2,397,991	7,701,232

FEASIBILITY & PLANNING STUDIES & CENTRAL SERVICES ACTIVITIES

RMPS staff reviewed this application, particularly the continuation portion and their comments in a memo to the Director are appended.

FUNDING HISTORY

Grant Year	Awards No.	Date	Period	Total Amount
Planning				
01	1S02-01	4/10/67	4/67-3/68	$173,119
02	5G02-02A1	10/17/68	4/68-3/69	183,443
	3G02-02S1	9/23/68	9/68-3/69	192,397
03	5G02-03A1	6/20/69	4/69-9/69	249,490
Operational				
01	1G03-01A1	10/7/68	7/68-6/69	$663,746
02	5G03-02	6/27/69	7/69-8/70	755,859
	3G03-02S1	1/30/70	10/69-8/70	599,767
	*3G03-02S1	6/16/70	5/70-8/71	701,344
03	5G03-03	11/2/70	9/70-8/71	1,371,916

*overlaps the 03 year

Commitments (direct costs)

04	05
$395,342 (projects 14, 17 and 18)	$250,000 (projects 17 and 18)

GEOGRAPHY AND DEMOGRAPHY

This Region encompasses twenty-one counties centered around Memphis in southwest Tennessee overlapping 25 counties in northern Mississippi, 13 counties in Arkansas, 5 Kentucky counties and 3 in Missouri. The total population of the area served is 2,393,000 (59% urban). There are only two metropolitan areas, Memphis, Tennessee (767,100) and Pine Bluff, Arkansas (83,400). The negro population is 19% in Tennessee and 37% in Mississippi. Average per capita income: $2,810 - Tennessee and $2,192 Mississippi ($3680 - U.S.). Mortality rates per 100,000 population:.

	Tennessee	Mississippi	U.S.
Heart	336.0	311.8	364.5
Malignant	140.5	132.8	157.2
Vascular	128.8	126.8	102.2
All Causes	919.7	963.8	935.7

Manpower training facilities include the University of Tennessee (College of Medicine, School of Dentistry, and School of Pharmacy). In 1969/70 there were 764 students enrolled in the College of Medicine and 165 graduates. Other schools: 5 professional nursing, 1 practical nurse, 1 cytotechnology,

4 medical technology, 4 radiology technology, 1 physical therapy and 1 medical record librarian.

Medical manpower includes 1518 physicians (ratio 130/100,000 in the 21 Tennessee counties). According to the initial planning application the Regional ratio of physicians was 95/100,000 and 153/100,000 for active graduate nurses. Hospitals in the Region 87 (13,319 beds) including the V. A. (1,256 beds).

REGIONAL DEVELOPMENT

Planning for a better health care system in Memphis began in 1946 when the Commission Government of Memphis, in collaboration with the University and hospitals of that City, employed a firm to survey patterns of referrals, medical facilities and future needs of the area. Among the recommendations carried out was the formation of the Mid-South Medical Foundation to function as the planning agent for the Memphis Medical Center. The Center is a five block area which includes two general (2,438 beds), the VA hospital a tuberculosis hospital, a state psychiatric hospital, a children's hospital, a rehabilitation center, children's heart out-patient facility, a speech and hearing center, child development center, Memphis and Shelby County Health Department, University Medical Units, cancer out-patient clinic and the Campbell Clinic. Beginning in 1965, the Memphis and Shelby County Medical Society established the Mid-South Medical Center Council for Comprehensive Health Planning, Inc. (MMCC). The first Board was appointed in 1966 when the state charter was obtained. Since that time the membership has been expanded to include representation from the Region outside of Memphis and Shelby County.

By common consent and by resolution of the Memphis and Shelby County Medical Society, the University of Tennessee College of Medicine was designated and continues to be the applicant organization for the Memphis Regional Medical Program.

The Mid-South Medical Center Council for CHP "B" also serves as the MRMP Regional Advisory Group. The Region received planning awards for two years and six months, April 1967 through September 30, 1969. Planning was merged with operational activities in the second planning year. Operational awards were received for three years ending August 31, 1971.

The Region was site visited June 1968, April 1969, and July 1969. During the last site visit it was noted that program development during the first operational year had been set back by at least nine months due to a series of problems resulting from the sanitation employees' strike, the assassination of Martin Luther King and the hospitals' personnel strike. The visitors found the goals and objectives vague and broad. There was also no clear relationship between Regional goals and project components. The visitors informed Regional representatives of RMP's concern that a majority of operational projects appeared to be oriented to further development of the medical center, rather than to involve the Center in outreach activities. An attempt was being made to develop programs in the periphery through local advisory groups; fifteen had been established at local hospitals, two in

Arkansas, five in Mississippi, three in Missouri and five in Tennessee. Evidence of attempts to develop rural area activities was two projects in northern Mississippi, #18 Mobile Multiphasic Screening and #19 Cardiovascular Clinics. According to testimony, RMP relationships with the medical community including the health department were good. Some problems in alterations and renovations within operating projects in the City of Memphis Hospitals had been solved. A new hospital authority, a fifteen-member board was being established for administration of city and county hospitals. The visitors gave considerable attention to clarifying the MMCC & MRMP relationships. The 100-member Board of MMCC heads CHP "B" and served as the MRMP RAG. Although the arrangement might be expected to provide good interfacing relationships, some complications had arisen. The role, functions and interrelationships of the two staffs had not been clarified. It also appeared that RMP staff was not working directly with the RAG. MRMP communications with the RAG, including proposals, had to be processed through the MMCC staff which caused some hangup. The MMCC board was heavily weighted with Shelby County representatives, and the visitors did not believe this was the desired equitable membership for a RAG. There also seemed to be a power struggle between the Medical School and MMCC. The visitors expressed some concern about core staffing patterns. Some staff had been employed for operational projects proposed, which were not approved. Also, there were a significant number of part time personnel. The visitors believed that MRMP might develop faster utilizing full-time personnel to concentrate efforts on generating outreach programs and supervising project development. Too many projects were improperly designed and lacked Regional implications.

On review of the third year continuation application during August 1970, RMPS staff noted program development was still slow. The MMCC Board had expanded to 134 members. The overall goals, objectives and priorities were still not clearly defined. The organization structure appeared diffuse and the problems in the CHP-RMP relationships enumerated by the site visitors were still apparent. Although progress in the peripheral areas had improved, the main thrust continued to be medical-center focused. A move in the right direction, the Region planned to relocate its quarters off campus. An innovation in organization was the development of an RMP Review and Policy Committee, a group through which it was thought RMP could better communicate to the MMCC (also the RAG). It was recognized that a major effort of the Region was to assemble a central core staff with appropriate expertise. Progress was poorly presented. It was also recommended that the Region be advised that it should begin planning for phasing out support of projects after the duration of current funding.

ORGANIZATION STRUCTURE

The application includes a list of 156 members of the RAG and Steering or Executive Committee. The legal voting body of the RAG is 44 persons, the MMCC Board. The MRMP Policy and Review Committee, 37 members, makes recommendations to the RAG. An MMCC-MRMP Evaluation Committee of nine members develops annual reports of the RAG. A Planning Board (Program Committee) of fifteen advises coordinator on policy, administration and applicability of project proposals, and meets jointly with the Policy and Review Committee. There are also twenty-one other Committees including disease categories. The total membership of the Board and all Committees is 338 (may be

some overlap of members). An organizational chart is appended.

Initially projects were submitted directly to the Central Committee at which point they were referred to technical reference committees if necessary. The Central Committee either held proposals for further study, returned them for revision or approved them. Approved and rated applications were submitted to RAG. After review and comment by the Health Services Committee, final action was taken by the RAG.

The current review structure (chart attached) now includes assistance in the development of proposals by a staff team. Final proposals are submitted to a Consulting Panel, then to the Planning Board and the Policy and Review Committee for review and rating before final action by the RAG. The RAG does not determine priority ratings of components until after the National Advisory Council action.

A joint CHP-RMP task force has been formed to develop an Experimental Health Management System for coordination of the delivery of health services. A contract has been proposed to HSMHA. New directions describe the immediate future role of MRMP as aiding operational planning and evaluation research of the new experimental health services planning and delivery system. The MMCC CHP "B" Agency is responsible for policy planning for health services, facilities, manpower, and health needs research. The operational activity of the system will be the responsibility of a new corporation of MMCC to be formed and named Health Systems Management, Inc. Its function, under the direction of a Management Board, will be to negotiate linkages of a contractural nature between segments of the delivery system, develop and coordinate grants for health services, promote new developments, and manage evaluation data acquisition process.

GOALS, OBJECTIVES, PRIORITIES AND STRATEGY

These are fully described in Volume I of the application pages 115-119.

The MRMP goal is improving the level of health care; including prevention, diagnosis, treatment and rehabilitation for the Regions' population.

Objectives:

1. To stimulate the provision of optimum health care to the entire population of the Region, with priority to the economically poor, the near poor and the medically indigent.

2. To promote continuity of care for all patients, particularly those with stroke, heart disease, cancer and kidney disease.

3. To emphasize rehabilitation as a necessary component of the spectrum of comprehensive health services to return individuals to maximal functioning.

4. To promote continuing education for physicians, dentists, nurses, and allied health professionals in order to assure the consumer of the benefits of the latest knowledge and skills.

5. To promote health education for the public with the aim of enabling all individuals to participate in and make effective use of the health care system.

6. To stimulate the expansion of the health manpower pool and to make more effective use of all levels of health manpower.

7. To increase and improve local involvement in both the problems of health care and their solutions, by assisting providers.

8. To assist sub-regional areas in defining their health needs.

9. To develop closer working relations with DHEW Region IV Officials, State and areawide CHP agencies, and other existing Federal, State and local health and health-related organizations.

10. To perform continuing evaluation on the various components of the MRMP in an effort to assure maxim program effectiveness within a framework of limited resources.

Special priority will be placed on activities which emphasize:

1. Effectiveness and quality of service (preventive, diagnostic, therapeutic, and rehabilitative).

2. Health education for consumers, as well as for providers of all professional types.

3. Active local involvement of both consumer and provider groups in the planning process.

4. Efficient use of total community health care resources.

5. Placement of patients at appropriate levels of care.

6. Development of mechanisms for stable financing.

7. New kinds, or improved distribution, of manpower.

8. Program components, projects, and activities which can be shown to have a high benefit-to-cost ratio.

9. An improved system of primary care with appropriate access, outreach, and referral to other levels and sites of health care and to supporting services (such as nutrition, education, welfare, and family planning), as well as appropriate follow-up procedures.

10. Development of an improved functional data profile of the health care needs of the region's population; the social, attitudinal, political and financial constraints; and the efficiency and capacity of the delivery systems throughout the region.

PROFILE OF ONGOING ACTIVITIES

A RMPS-MIS computer printout December 31, 1970, reveals the following funding pattern characterists of 15 operational projects supported by the Memphis Regional Medical Program contrasted with the aggregate of 599 activities for all 54 regions.

	Percent of Dollars	
Sponsoring Agency	MRMP	All Regions
Medical School	3	41
Med. Sch. Univ. Hosp.	0	2
Univ. Affiliated Hosp.	37	9
Univ. Health School	0	4
Public Health Ag.	2	5
Vol. Health Ag.	0	7
Other Hospital	34	16
Health Prof. Society	0	2
Combination	22	7
Other	2	5
Training Health Prof.		
Physicians	13	19
RN's	4	9
Allied Health Pers.	22	3
Technicians/Aides	0	3
Combined Phy. & RN's	9	19
Other Combinations	22	33
Other	0	2
Not Applicable	30	12
Disease Category		
Heart	26	26
Cancer	5	12
Stroke	12	13
Kidney	0	3
Other	6	8
Multi-categorical	52	38
Target Population		
A. Minority		
Black	15	7
Minority	8	0
Other Poor	0	8
Not Applicable	85	85

Sponsoring Agency (cont'd)	Percent of Dollars MRMP	All Regions
B. Age		
Children	0	5
25-39	0	0
40-65	16	6
over 65	0	1
Gen Pop.	84	71
Other	0	1
Not Applicable	0	16
Health Care		
Prevention & Screening	47	11
Diagnosis & Treatment	34	34
Rehabilitation	0	6
Comprehensive	1	26
Combinations	19	16
Not Relevant	0	7
Primary Purpose		
Continued Ed.	0	21
Train Existing Health Pers.	13	22
Train New Health Pers.	0	2
Patient Services	61	24
Half Training & Half Pt. Service	1	14
Coord. Health Services	3	8
Research & Develop.	22	8
Geography		
Regional	40	55
Subregional	9	27
Rural	29	6
Inner City	0	8
Interregional	0	3
Not Applicable	22	1

PRESENT APPLICATION

The application includes a RAG report in three parts, from the points of view of the Chairman, the Policy and Review Committee and Evaluation Committee.

Equal opportunity data: of 22 1/2 Core full-time professionals, 11 3/5 are female, no minority staff; of 13 core support-personnel, all are female and 5 represent minorities; of 41 3/4 project professionals, 10 3/4 are female and 7 are minority members; of 386 RAG and Committee members, 48 are female and 68 are minority members.

Priority ratings of goals and objectives, priority and strategy, core, and projects (Volume II p. 112-113) are reasonably close. Rating by RAG is not planned unit after RMPS review.

A minority report by Dr. C. O. Dougherty, private practicing physician and a member of RAG is included in Volume II p. 114. The report deals with lack of evaluation data by MRMP.

Continuation of Core — Fourth Year Request $799,548

The amount requested for core reflects an increase of 45%. Vacant positions account for $127,504 (6 professional at $104,200 and 5 support positions at $23,304).

Twenty-five (25) feasibility and planning studies and central service activities are listed on page 4 a of this summary. These are described in Volume I pages 92-104.

Accomplishments:

1. Mobilization and organization of individuals and groups concerned with nursing, allied health professions, and rehabilitation; regionalization of a program of conferences and workshops on rehabilitation in community hospitals; development of two project proposals for increasing numbers and effective use of non-physician members of the health team.

2. Development of new concept and format of continuing education for physicians in their own community hospitals through the organizing, scheduling, and conducting of Advanced Clinical Conferences, using their own patients for discussion of problems and topics of their own choice by visiting specialists from the private practice sector.

3. Inauguration of a central regional library and medical information service for all physicians and other health professionals in the region; development of a model learning center project proposal from a large community hospital serving a 13-county subregional referral area, to serve as a prototype for a regional network of fifteen area learning and referral centers.

4. Development of an audiovisual studio with basic cinephotographic and other equipment providing capability for production of teaching material especially pertinent to our peculiar regional needs, designed to assist all professional staff members and project directors in their work.

5. Completion of surveys and publication of directories of health, education, and welfare services in southeastern Missouri and in eastern Arkansas (second and third volumes in a series); study of

subregionalization patterns in southwestern Kentucky, western Tennessee, and northern Mississippi; extension of liaison contacts with a wide variety of community agencies and organizations, both metropolitan and rural - with special efforts in the fields of family planning, nutrition, and poverty.

6. Conduct of the Memphis Household Health Survey (1100 metropolitan households) to study accessibility and utilization of health services and to define socioeconomic and attitudinal characteristics of respondents; a companion study of accessibility of health care in a rural population (Lafayette County, Mississippi - collaboration with Mississippi Regional Medical Program); a study of birth control attitudes and practices among 500 Memphis mothers in collaboration with the Memphis Planned Parenthood Association; tabulation, analysis, and editing of Memphis Regional Hospital Inventory, in collaboration with our areawide comprehensive health planning agency (Mid-South Medical Center Concil); analysis of 900 physicians' responses to preferential questionaire regarding continuing educational content and methodology; a study of motivation for entering an allied health profession (dental hygiene); and a continuing program of long range collection of health data to demonstrate changes from baseline characteristics.

7. Initiation of studies by a joint task force with areawide comprehensive health planning agency (MMCC) which led to the development of preapplication to the National Center for Health Services Research and Development for a grant to establish a Health Services Management Corporation for tri-county metropolitan Memphis and after a site visit, the further development of a proposal for contract to establish the corporation as an operational agency development of active liaison with all agencies in metropolitan Memphis dealing with problems or interests of disadvantaged citizens; liaison with personnel of the neighborhood clinics operated by the Memphis and Shelby County Health Department, as well as the voluntary (Wesley House) clinic for primary health care operated by the North Memphis Community Health Organization; arranging for meetings with representatives of the Welfare Rights Organization and other groups in a vigorous effort to identify and become well acquainted with the indigenous leaders among low income groups in metropolitan Memphis and elsewhere in the region.

8. Establishment of a Section of Evaluation staffed by a system analyst and a demographer, with an epidemiologist (M.D., M.P.H.) as a consultant, to develop a complete and detailed program of evaluation of both central staff efforts and project accomplishments - with appropriate consultation service to project proponents during the evolution of the initial project application.

9. Considerable expansion of the Information Services' program, with acquisition of the full-time services of an Assistant Information Officer, who has versatile skills as an artist-illustrator; publication of three

issues of the Memphis RMP newsletter CURRENT in an attractive new format; publication of proceedings of a health care symposium at the 1970 Annual Meeting of the Regional Advisory Group; design and printing of the program for (a) the 1971 Annual Meeting and Scientific Session of the Tennessee Heart Association, (b) symposium on the counseling role of the therapist, and (c) a symposium on malnutrition; printing of a new descriptive booklet on The University of Tennessee Medical Units and the Memphis Medical Center; five press releases, thirty news stories, and eight feature stories, two radio and three television interview programs, preparation of two exhibits, multiple new latern slides, and various other educational and informational graphics.

0. Formation of a committee on community medicine comprising public health officers and practicing physicians to study means of strenghtening out-of-hospital services offered by health agencies in the region; development of a project proposal to augment the primary care services now provided in community clinics operated by the Memphis and Shelby County Health Department staffed by nurse practitioners, to provide more active physician supervisory and consultative participation, in order to broaden the health services offered; discussions with health officers in rural counties looking toward development of a regionwide network of such facilities, based on the Memphis prototype model.

1. Exploration by the Communications Officer and the Automation Committee of services - both administrative and clinical - which can be offered by the staff of The University of Tennessee (Memphis) Computer Center to community hospitals in the region and to emerging comprehensive primary health care organizations; study of possibilities for pooled clinical data from City of Memphis Hospitals, Shelby County Hospitals, Memphis and Shelby County Health Department, and private community hospitals in the Memphis medical center.

2. Active collaboration with the Tennessee State Office of Comprehensive Health Planning and local areawide 314(b) agency (MMCC) in organizing new 314(b) committees in southwest Tennessee (District 8) and northwest Tennessee (District7); exploratory meetings at the Mississippi State Office of Comprehensive Health Planning looking toward organizing a 314(b) agency for northeast Mississippi, including local meetings with two interested local groups; transmission of our survey data on community resources in southeast Missouri to the chairman of the 314(b) committee there, which had been organized under the auspices of the Missouri State Office for Comprehensive Health Planning, and continuing liaison with that committee; liaison with existing 314(b) committees in eastern Arkansas; offer of staff services to aid in organizing the eight counties of southwest Kentucky (the "Jackson Purchase Are") for areawide comprehensive health planning.

Projects next year include continuation of the above with expansions based on availability of RMPS funds. A proposed new dimension is project evaluation as alluded to in Volume I page 49.

The application includes statements on core cooperative arrangements with more than 15 organizations (Volume I pages 60-85). Core consultation, community relations and liaison activities are described in Volume I pages 68-91.

Fifth Year - $799,548 Sixth Year $799,548

Developmental Fourth Year - 0 -

Because of the MRMP's understanding that no new funds are available to support these activities, no funds are requested. However, authority to undertake these types of activities is requested in the event additional funds become available. Areas to be sighted in on include: 1) subregionalization by assisting in the establishment of CHP "B" agencies throughout the Region; 2) establishment of a network of satellite information and learning centers; 3) cooperative public education programs; 4) assistance in Health Maintenance Organizations.

Continuation of Projects Within Currently Approved Periods

#14 Coronary Care Unit - St. Bernard's Hospital Fourth Year $20,343

This project now in its second year was approved for three years and was funded for $54,380 the first year, $26,884 the second year and $20,342 was committed for the third year (4th MRMP operational year). The activity provided equipment for a four-bed Coronary Care unit at a hospital in Jonesboro, Arkansas. The construction of the unit was provided by other sources. The unit is utilized to train registered nurses in coronary care techniques with the understanding that these trainees pyramid their learning to other hospital personnel.

In addition to patients now being cared for in the unit, 129 have been treated. The project reports adequate reception by professional staff and an increase in trained personnel. No significant change, however, has been noted in coronary mortality.

Fifth Year - 0 - Sixth Year - 0 -

#17 Prevention Services Heart, Cancer, Stroke and Related Diseases Fourth Year $193,500

This project is now in its first year with authorized funds of $269,470 (16 months). Commitments: 2nd year, $180,000 and 3rd year, $120,000.

The project is an adjunct to the previously existing Chronic Disease Screening program, a cooperative effort of the University of Tennessee Medical School, the City of Memphis Hospitals and the Memphis and Shelby County Health Department. In addition to screening for glaucoma; diabetes syphilis, cancer of the cervix and tuberculosis; additive procedures were to include blood pressu spirometry, EKG, hemoglobin, urinalysis and occult blood. The project anticipated screening 20,000 patients annually drawn upon the City of Memphis Hospital Out-patient Clinic and recipients of the Tennessee Welfare Department.

The July 1969 site visitors were impressed by this project and the competence of the Director. However, there was some concern that the anticipated case load might be unrealistic.

Delays were encountered in tooling up (recruitment, development of facilities, purchase of equipment etc.). During nine months, July 1970-March 1971, 7,200 persons were screened.

Fifth Year $129,000 Sixth Year - 0 -

#18 Mobile Multiphasic Health Fourth Year $181,509

This project was approved for three years and $312,633 was authorized for its first year. Commitments: 2nd year, $195,000 and 3rd year, $130,000. Sponsored by two northern Mississippi Hospitals, a mobile trailer screening unit serves the five-county trade area of these two hospitals. Annual case load predicted was 20,000. Procedures include a short history, measurements of blood pressure, height and weight; chest X-ray; EKG; spirometry; cervical cytology; urinalysis; blood chemistry; tonometry; and self breast-examination.

The July 1969 site visitors recognized that this was a community-generated activity from a part of rural Mississippi where there is great need for improved health care. Some problems foreseen by the team: 1) anticipated case load overly ambitious; 2) ability of the two hospitals to deal with resulting pathology; and 3) referral patterns in a general practitioner-oriented area.

Full scale screening did not begin until April of this year due to delay in developing the trailer unit. Meanwhile some screening was done by using a Mississippi State Board of Health Mobile Medical Clinic. During four months, September-December 1970, 2792 children were screened with a yield of 1355 abnormal findings. During the three-month period January-March 1971, 1832 adults were screened leading to the detection of 1386 abnormalities. One third of the abnormal findings warranted referral to their family physicians.

Fifth Year $121,000 Sixth Year - 0 -

#19 Cardiovascular Clinics in Northern Mississippi Fourth Year $38,046

This project, approved for three years, was begun in the second operational year and received $25,752 for seven months from carryover funds. It received $13,000 for a second year in the Region's third operational year with no commitment for its continuation. Support is requested for an additional year and six months to complete the three year project period.

Sponsored by the Mississippi State Board of Health, this project proposes expanding a network of diagnostic and consultative heart clinics which had been established in forty-six locations. The regularly scheduled clinics are manned by physicians from the Mississippi State Board of Health, the Universities of Tennessee and Mississippi, and the private sector. The project proposed broadening the clinic services by increasing the frequency of clinics from twice each month to weekly. Post graduation educational programs were also to be conducted for physicians, nurses, and other health personnel.

The July 1969 site visitors believed this to be a worthy project. They were satisfied with adequacy of follow-up and of University consultative assistance.

During the past ten months, 42 clinics were held in 12 locations. Of 466 patients worked up, 198 were diagnosed as having some form of heart disease. One hundred and fifty patients seen in the clinics were referred by private physicians.

Fifth Year $16,468 Sixth Year - 0 -

#25 Home Care in a Hospital Based Agency Fourth Year $27,657

This project was approved for three years, 01 - $20,600, 02 - $23,972, 03 - $27,657.

Beginning in the Regions second operational year, RMPS authorized $10,493 (6 months) to begin this project. The Region's third year award included $12,630 to continue the project for a second period with no commitment for future support. The Region is requesting funds for one year and six months to complete the project period.

This is a home care project based in an Arkansas hospital to serve as a demonstration to other hospitals in the area where this service is not available. The project aims to shorten hospital care and return patients to economic usefulness. The activity is responsible for nursing care, physicial thereapy, dietetics, as well as as coordination of other available services. It was anticipated that 1200 home visits would be made the first year.

During the first seven months of operation, 552 visits were made (230 professional nurse visits and 322 by trained nurse aides). Hospital readmission has not been necessary in a significant percent of the patients served because of successful home care programs.

Fifth Year $16,120 Sixth Year -0-

RENEWAL PROJECTS

#1 Stroke Center Fourth Year $84,200

This is a request for support for an additional three years. Previous funding: 01 - $81,606, 02 - $148,522 and 03 - $68,546.

Specific objectives continue to be: 1) establishment of a model center for stroke management including intensive care; 2) development of a training program to provide the necessary medical skills; 3) dissemination of information by a multi-disciplinary stroke team; 4) expansion of medical center training facilities for physical therapists; 5) development of facilities for psychometric evaluation of stroke patients; and 6) improvement of rehabilitation techniques and facilities.

Construction of the new six-bed stroke intensive care unit at John Gaston Hospital is almost complete. Meanwhile a temporary unit is operated at the

City of Memphis Hospitals. A major problem has been the understaffing of nurses in the unit and has precluded offering short term courses for physicians and nurses. The stroke team is described as moderately successful in continuing education. A professional education film is being developed. A retrospective study is being done to aid in evaluation of stroke intensive care.

Fifth Year $102,350 Sixth Year $118,720

#2 - Gastrointestinal Mucosal Suction Laboratory Fourth Year $41,594

Support is requested for an additional three years. Previous funding: 01 - $18,000, 02 - $23,325 and 03 - $24,821.

The project was developed in the Memphis area to serve the entire Region charging private patients who are able to pay and processing biopsies from indigent patients without charge. In addition to its functional service, the laboratory also serves as a teaching facility for technicians, medical students, interns, and residents.

During the past year, 158 biopsies of 141 patients were processed. During the same period, five second-year residents of the University of Tennessee, Department of Medicine and five technicians received training in the laboratory. The project Histotechnician lectured technologists and students at Memphis State University and one hospital. Physicians from outside of Memphis have not utilized the laboratory to the extent anticipated.

Fifth Year $51,824 Sixth Year $53,746

#3 - Prevention and Early Treatment of Skin Cancer Fourth Year $29,340

This is a request for support of this project for an additional three years. Previous funding: 01 - $29,590, 02 - $34,998 and 03 - $25,435.

Objectives are to demonstrate methods of detecting and providing early management of skin cancer in rural populations of the Region; and to educate health professionals and lay public. Nurses trained in clinical detection of skin cancer and actinic Keratosis, gather data by home interviews and examinations in a rural Tennessee County. Questionnaires have also been sent to appropriate physician specialists. In cooperation with a pharmaceutical firm, field trials have also been conducted in using "5 Fluorouracil" in treating skin lesions. The project reports its study has revealed a significant number of untreated skin cancer and substantial solar Keratosis. The findings have lead project staff to proposing an educational campaign to educate physicians and others in the use of "5 Fluorouracil" for control of solar Keratosis.

Fifth Year $30,783 Sixth Year $33,431

#5 - Intensive Cardio-pulmonary Care Training Unit Fourth Year $67,650

Support for three additional years is requested. Previous funding: 01 - $130,000, 02 - $106,268 and 03 - $100,000.

As a result of the project, a twelve-bed intensive cardiopulmonary care unit is in operation at the Memphis Medical Center. Training has included the University of Tennessee College of Medicine house officers and fifth-year medical students. Forty nurses received six weeks of training. The circulatory care clinic serves as the treatment unit for the City of Memphis Hospitals and has admitted 327 patients since opening February 1970. The Project Director serves as coordinator for the Northeast Mississippi Cardiac Clinics which serve northern Mississippi health departments. Visiting physician teams consulted on 729 patients. The greatest problem has been the shortage of nurses at the City of Memphis Hospitals.

The project proposal is essentially an expansion of ongoing activities.

Fifth Year $71,502 Sixth Year $74,605

#6 - Emphysema and Cor Pulmonale Fourth Year $115,694

This is a request for support for an additional three years. Previous support (direct costs): 01 - $59,928, 02 - $69,144, 03 - $35,605

The goals of the project have been to set-up a chest clinic within the University Medical Center to provide consultative services and ongoing care for patients with chronic pulmonary disease; as well as to provide a post-graduate and graduate teaching facility. Previous concerns of RMPS have been that this activity is University oriented with almost no outreach, and the need for at least 50% time by a project director. A clinic for diagnosis and treatment of patients with chronic obstructive lung disease has been established. A viral and mycoplasma laboratory has been implemented to carry out special research studies to improve clinical management of patients. About 35 patients have been enrolled in the studies. Educational activities have included the training of medical residents, physical therapy students and senior medical technology students.

Under a new project director, the program anticipates expansion of the clinic to a regional diagnostic facility. Projections include training more allied health personnel. Additional facilities and staff are also planned.

Fifth Year $130,210 Sixth Year $141,940

#7 - Streptococcal Disease Center Fourth Year $123,230

Support is requested for an additional three years to include a new component (7A - Memphis Shelby County Health Department). Previous funding: 01 - $103,252, 02 - 101,310 and 03 - $110,648.

The goal of this project has been to establish a streptococcal disease control center at the Memphis City Hospitals to provide: 1) a service laboratory; 2) clinical services; 3) a registry for follow-up and epidemiology; and 4) continuing professional and public education.

Reported accomplishments: 1) continuing education for nurses, nursing students, house staff of two large Memphis hospitals, Arkansas physicians, medical technologists, and medical students; 2) bibliography and library service; 3) public education and information; 4) in-service training for nurses of county health departments; and 5) research and development studies. The project has 450 patients under surveillance or treatment.

The proposal includes a new component (7A) to fund two additional nurses for the health department program and to furnish prophylactic medication. The application indicated that research and service aspects of this project are almost all funded from other sources.

Fifth Year $133,201 Sixth Year $143,035

#8 - Regional Electrocardiographic Diagnostic Center Fourth Year $62,575

This is a request for support for an additional three years. Previous funding: 01 - $108,687, 02 - $87,158, 03 - $72,985.

The goal of this project has been to provide centralized University-based electrocardiographic recording and interpretation services. Plans were revised to include for the eventual incorporation of computer aided diagnosis. Through continuing education programs, it was hoped that the quality of EKG interpretations would be improved.

With the exception of some telephone transmission with some hospitals, the centralized EKG system, including the computer is operational. Because of conflict with private medicine (competitive aspects) the approach is now limited mainly to the servicing of emergency electrocardiographic situations of coronary care units in the Region. Transmitting units have been place in two hospitals, one in Tennessee out of Memphis and another in Mississippi. Educational Activities consist of an annual course for physicians.

Fifth Year $59,796 Sixth Year $63,002

New Projects (described in the application, Volume II, pages 154-177)

#29 Production and Distribution of Radiopharmaceuticals Fourth Year $87,615

This is a proposal to improve the facilities for production of short-lived, radiopharmaceuticals in the University of Tennessee laboratories, and to

develop means for their distribution to the Region's hospitals within reasonable time and at low costs. This laboratory presently produces these radiopharmaceuticals for use by the City of Memphis Hospitals, but not in sufficient quantity to supply other hospitals.

Fifth Year $54,830 Sixth Year $30,192

#30 - Comprehensive Kidney Disease Program Fourth Year $81,932

A two-phase program, the first year will be spent in surveying Regional renal needs to serve as a basis for program priorities for the remainder of the project period. Needs will be approached by: 1) continuing education seminars at local hospitals and short term courses for physicians and allied health personnel at the Memphis Medical Center; 2) home dialysis training programs for physicians, nurses and paramedical personnel; 3) establishment of regional satellite hemodialysis units for home dialysis patients; 4)improved renal transplantation facilities and establishment of a coordinated system of harvesting and preserving organs, tissue typing and consultative facilities and 6) establish screening programs for early detection of Kidney disease.

Fifth Year $60,242 Sixth Year $63,608

#31 Peripheral Vascular Clinic Fourth Year $10,711

This is an apparent recast of disapproved projects 4 and 27. Funds were awarded to #4 for further planning. The objectives of this proposal are to provide the general public with an understanding of the disease processes and the resources available for medical and rehabilitative services and to disseminate current information in an up-to-date fashion to physicians, nurses, and rehabilitation personnel by clinic visits and educational workshops presented at the outlying hospitals.

Through the Peripheral Vascular Clinic facilities, this project will attempt to educate the public and medical professionals on the diagnosis, prevention and control of peripheral arterial disease. The public is to be reached through pamphlets explaining the causes, warning signs and possible complications of vascular diseases. Approximaterly 10,000 pamphlets will be distributed to such areas as hospital lobbies, county health departments and mobile x-ray units. Professionals will be presented with the latest information through lectures and conferences, with nurses and allied health personnel participating in in-service training programs.

Fourth Year $11,697 Sixth Year $11,882

#32 Model Hospital Learning Center Fourth Year $37,922

This project, based in the Jackson-Madison County General Hospital, is expected to demonstrate the desirability and need for improved and available medical library services to physicians and other health professionals within a 13 - county area of West Tennessee. It is anticipated that this facility

will serve as the first of approximately five similar facilities to be developed later, establishing the basis for an information/communications network in this region.

Fifth Year $27,999 Sixth Year $29,555

#33 Improve Death Statistics Fourth Year $47,211

The objectives of this proposal are to develop and determine post-mortem tests which if available to physicians will improve their accuracy of death certification, to develop those techniques which can be used in lieu of an autopsy and at less cost than performing the autopsy, and to disseminate to and encourage the utilization of these techniques by all physicians in the region.

This project is expected to provide for a maximum degree of accuracy in death certificates with a minimum expenditure of professional time, to provide a far more accurate base line to measure the benefits of all programs within the MRMP, to institute a greater awareness on the part of the physician of the true value of mortality data and thus lead to greater caution on their part in completing death certificates, and to develop a model protocol and plan which could, with relative ease and little cost, be instituted in other regions.

Fifth Year $52,211 Sixth Year $7,000

#34 Leadership in In-Service Education Fourth Year $42,758

In response to need indicated in a 1969 regional survey, the project will assist individual institutions and agencies to upgrade care and services available through the further development of present in-service personnel. In addition, a pool of future in-service educators will be developed for the region.

Six subregions having potential as teaching centers have been identified as willing to work collaboratively with the project director. It is anticipated that much of the first year of the proposed project will be needed to establish a common baseline for in-service education personnel. Participants will be assisted in identifying the education and training needs of health workers in their institution or agency. The ensuing sessions will then be designed to equip in-service personnel with tools to meet the self-identified needs.

Fifth Year $36,550 Sixth Year $36,400

#35 Laboratory Evaluation of Clinical Tests in Patients with Endocrine and Metabolic Disturbances Fourth Year $58,030

The objectives of this project are to educate and acquaint physicians and allied health personnel of this region with the recent advances

in the area of clinical endocrinology and the recent advances in the performance of clinical testing in patients with endocrinologic and metabolic disorders; and to apply a series of more relevant and precise techniques in the field of endocrinology and metabolism for the diagnosis of endocrinologic disorders.

This proposal calls for a pilot study in the region that would utilize tests to determine regional diagnostic patterns. The results of applying these new techniques will be made available to medical personnel in the region. The dissemination of recently gained knowledge will also be promoted by the use of the Veterans Administration Hospital laboratories as teaching facilities.

In order to achieve the above objectives, the following methodology is proposed for this project:

1. Lectures and demonstrations will be given to physicians and allied health personnel and hospitals with 100+ beds in this region. It is anticipated that at least one hospital will be visited each month.

2. A short seminar course and workshop of one week's duration in the VA laboratory will be offered to selected and interested individuals who are in charge of hospital clinical laboratories or physicians whose practice justifies such an educational exposure. It is anticipated that eight to ten allied health personnel and three or four physicians will attend such workshops per year.

3. Relevant tests for large numbers of the population will be used to evaluate the normal pattern in the Memphis Regional Medical Program region.

4. An educational pamphlet will be published for a readily available source of reference for all the hospitals in the region.

Fifth Year $51,702 Sixth Year $54,026

#36 Expansion of Services in Existing Neighborhood Health Centers in Memphis — Year $438,710

This project proposes to expand the role of registered nurses by developing a training curriculum with the University of Tennessee College of Nursing and College of Medicine to upgrade nurses from generalists to nurse specialists within certain fields, and to expand preventive services offered in four existing Memphis health department facilities by implementing primary care.

The project proposal encompasses activities beyond the confined scope of present Regional Medical Programs Service legislation therefore, MRMP proposes to act as a "broker" for services not applicable under

Regional Medical Program legislation - (e.g., dental services are an integral part of the total proposal). Funds requested exclude dental service monies. In its position as broker Memphis Regional Medical Program will seek funds from other federal agencies for partial support for the project.

The primary objective of the project is to improve the general health of the community by providing continuing medical care, comprehensive in nature, of good quality and economical, by building upon existing public health services of four decentralized health centers in Memphis. Subsidiary objectives include the provision of decentralized health and medical care for ambulatory patients, the expansion of the present clinical nursing program to include ambulatory patients with chronic pulmonary disease, certain surgical conditions, psychiatric and chronic cerebral dysrhythmias and the creation of more direct lines of patient referral. Other objectives include the effective utilization of nurses and other allied health personnel in the provision of this care; alleviation of overcrowding of medical center diagnostic consultative facilities by patients receiving maintenance care; the conservation of physician time for activities requiring his degree of skill and expertise; the coordination of medical services with other community health resources; the provision of dental services to an extended segment of the population, and provision of ongoing orientation and in-service training programs for nurse clinicians for the Memphis medical area.

Adult health services offered will include the clinical nursing program, home care activities, anti-partem and post partem activities, medical guidanee and counseling and the development of primary care services. Preventive pediatric services will include a history, a screening physical, and primary pediatric care for treatment of specific conditions such as gastrointestinal upsets, upper respiratory infections, and minor urinary tract disorders.

Fifth Year $430,295 Sixth Year $563,358

#37 Strengthen and Improve Utilization of Existing Nursing Manpower Fourth Year $48,378

Addressing the nurse manpower shortage, the project's objectives will be approached from two angles. The first approach entails the utilization of two nursing specialists --one in chronic disease and the other in the medical-surgical area. Both will work with the various health agencies and hospitals in the region in the areas of consultation and education. The chronic disease nurse will assist health workers in the management and rehabilitation of chronic disease patients, with an emphasis on the improvement of continuity of care. Her position will give her the opportunity to assess the current situation concerning continuity of care in the region and to work to overcome existing deficits. The medical-surgical nursing specialist will be primarily concerned with establishing criteria for quality of care and examining current nursing utilization patterns and roles, especially in regard to the roles they are expected to perform in emerging care delivery systems.

The second approach introduces a nursing audit - a method of nursing care evaluation by nurses - by which nurses can evaluate the quality of nursing care being given. The two approaches are expected to result in the delineation of deficiencies in current patterns of nursing utilization, the improvement of nursing service through the expansion of skills (through conferences and workshops and consultation), the developement of education and training programs that are more relevant to newly defined nursing roles, and a better overall view by nurses of their expanded functions. The programs are to receive continuous feedback from patient, medical and administrative sources in regard to their effectiveness and be further evaluated by the measurement of improvements in the care of the chronically ill.

Fifth Year $50,372 Sixth Year $52,960

#38 A Combined Program for Postgraduate Training of Physicians, Nurses and Allied Health Personnel in Intensive and Coronary Care — Fourth Year $30,592

Through the cooperative arrangements of three hospitals in different communities, two in Arkansas and one in Missouri, separate courses in cardiac care will be offered registered and licensed practical nurses, and combined follow-up courses in intensive care. A conjunct program for physicians will be offered at one hospital.

This project will be an attempt to achieve quality educational programs in cardiac and intensive care at the subregional level. The outreach of these endeavors will be toward the appropriate health professionals in eight counties. The rationale for the approach is that it is felt that optimal participation can be achieved by offering these continuing education programs in the close proximity to the work and home setting of the participants.

Fifth Year $28,032 Sixth Year $29,669

#39 Continuing Education for Tennessee Physicians — Fourth Year $48,320

The continuing education programs in the state of Tennessee are administered by various agencies--medical schools, Regional Medical Programs, medical societies and others--and no one person or organization is responsible for coordinating these. Many programs are instituted without regard to physicians' actual needs and few include procedures to evaluate their effectiveness. Existing programs are carried out in the traditional manner, and fragmentation makes the introduction of innovative education programs impossible. In addition, no central record office exists to aid physicians in getting certification on the basis of their postgraduate studies.

This proposal calls for the coordination by a centralized office of all continuing medical education in the state. Although this organization would not be directly involved in the conduct of education, it will serve as a catalyst, identifying needs in continuing education and teaching resources.

The project is to assess the needs and desires of physicians in the are determine how present programs meet these. The project will also entail inventory available continuing education resources. Physicians will be encouraged to utilize self-assessment methods to determine areas requiring

strengthening. The project will analyze the current geographical distribution of the programs and also establish some type of state certification to provide recognition to those participating in postgraduate programs. An investigation of innovative educational programs will be undertaken.

Fifth Year $44,804 Sixth Year $47,120

#40 Hypertension Control Demonstration Fourth Year $37,177

This project proposes to screen persons in three north Mississippi counties for hypertension. Diagnosis, treatment, and follow-up of these patients will be provided by Mississippi Department of Health nurses with the assistance of medical personnel from The University of Tennessee Medical Units. A consumer education program will be developed.

Objectives: 1) develop a model demonstration hypertension control program for selected county health departments in north Mississippi; 2) demonstrate the ability of public health nurses and allied health personnel to conduct a hypertension screening and control program with a minimum of physician support; 3) increase the awareness of the general public to hypertension and its complications to a point where they will seek care; 4) make treatment resources available at the local level for the majority of medically indigent hypertensives; and 5) assure the continuity of care for the hypertensive patients.

Fifth Year $38,472 Sixth Year $44,194

Previously Funded Projects for which Continuing RMP Support is not Requested

#4 Peripheral Vascular Disease

When this project was originally reviewed by RMPS, it was believed that the proposal was over-budgeted and underplanned. It was not approved but funds were awarded for further planning (01 - $23,936, 02 - $18,454).

A revised proposal (#27) was submitted and disapproved by Council. The value of two community clinics was questioned. The regionalized professional and public education aspects and the peripheral clinics were not well developed. The value of the referral center was recognized, but Council questioned the appropriateness of RMP funds for its support.

#10 Combined Attack on Certain Forms of Heart Disease, Cancer and Stroke

This project has received funding for three years, 01 - $20,000, 02 - $23,332, 03 - $24,465.

This project for the Kenneth (Missouri) Pargould (Arkansas) Area is now in its third year. As a result of the activity three operating proposals were submitted to MRMP during the last two years, 1) Home Health Care(#25 funded), 2) Regional Cancer Center, and 3) Combined Program for Care of Cardiac and Stroke Patients Through Intensive Care.

The continuing education phase of the project is reported to be successful.

Postgraduate education programs at two hospitals have been integrated and expanded. Training has been for registered nurses and para medical personnel. Registered nurse course consists of 96 hours of didactic and practical training. A series of training is planned for physicians.

#24 Feasibility Study of Hospital Infection Control

As recommended by the July 1969 site visit team and Review Committee, Council approved this two-year project without additional funds. It was believed that the study was poorly designed. The project was funded ($5,092) for four months in the Regions second operational year from carryover funds. It received $10,181 for continuation in the current third year.

Accomplishments include:

A registered nurse has been trained and has had six months experience in surveillance of hospital acquired infections. Three selected wards in the City of Memphis Hospital have been studied over six months, October-March. Overall rates of hospital associated infections were 3.1% and 5.5% for two medical wards and 9.5% for a surgical ward.

A computerized bacterial report retrieval system was developed within the City of Memphis Hospitals as a model of what could be done in any community hospital. A computer program was written and developed to produce a series of reports designed to answer pertinent questions of great value to the practicing physicians and to the control of hospital associated infections.

Project members cooperated in a catheterization study done by Dr. Allan Bisno and his staff of the Section of Infectious Diseases of the Department of Medicine. This study a) confirmed the fact that intravenous catheters are greatly overused considering accepted indications for this procedure and b) showed that compared to scalp vein needles, intra-catheters were three times more prone to be contaminated with potential pathogenic bacteria.

Both the principal investigator and nurse employed on this study have made special efforts to become more expert in the field and hospital-associated infections. Both have attended special conferences devoted to various aspects of the problem and are frequently consulted in matters pertaining to hospital infection control.

A reference library of literature dealing with hospital-associated infections has been developed and is growing.

Through this project, there has been established at The University of Tennessee College of Medicine a nucleus of people interested and experienced in the problem of hospital-associated infections.

#9 Obion County General Hospital

This project was funded for two years beginning in the Region's second Operational year, 01 - $20,000 and 02 - $23,332. The purpose of the project

was to upgrade some of its facilities to develop its capability in heart, cancer, and stroke. No funds were expended in 02 year when the project apparently expired because of its inability to recruit appropriate personnel.

Previously Disapproved Projects

#4 Peripheral Vascular Disease (Funds were approved for further planning)

#11 Regional Medical Technology School

#12 Radiological Diagnostic Equipment at Crittenden

#13 Demonstration in Preventative Services

#15 Regional Program for Education in Medical Technology

#16 Improved Quality and Services of Medical Laboratories

#20 Kidney Failure Training Center

#21 Care of High Risk Infants

#22 Nuclear Medicine Research and Training Center

#23 Regional Blood Banking and Transfusion

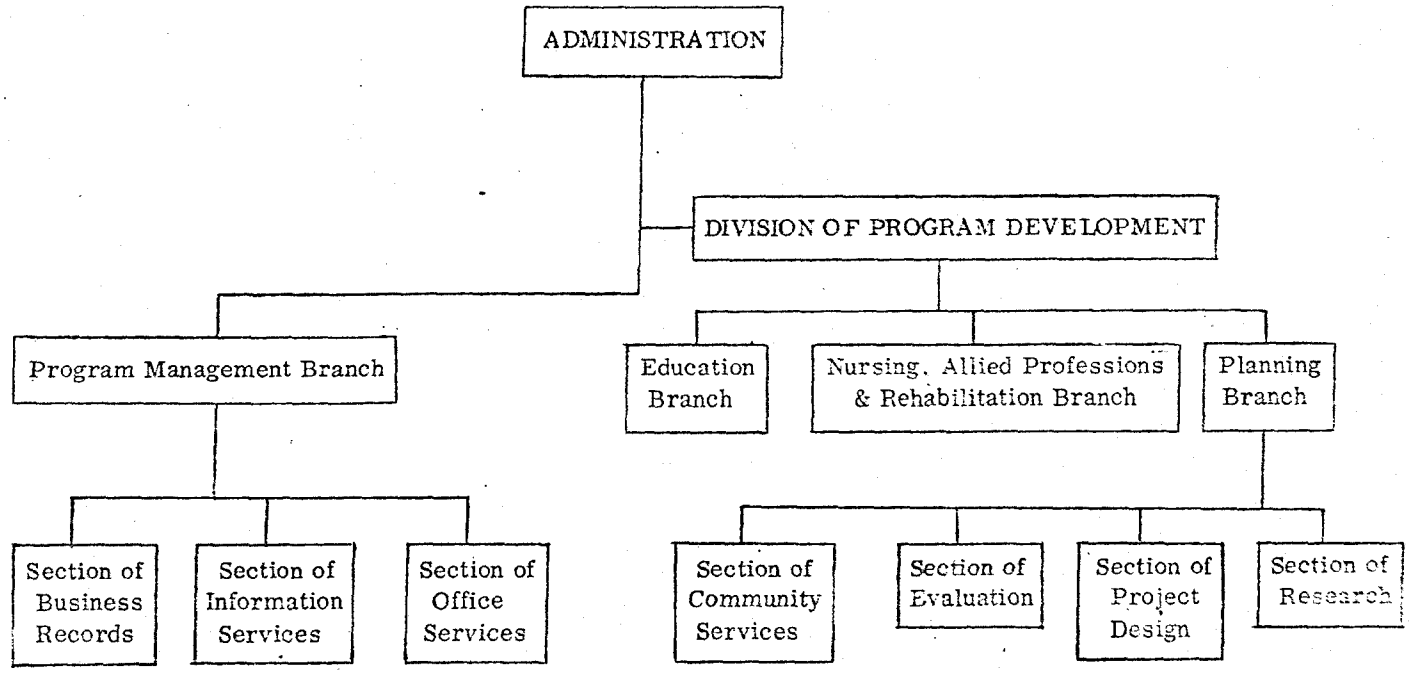
#26 Biomedical Information Network

#27 Peripheral Vascular Clinic

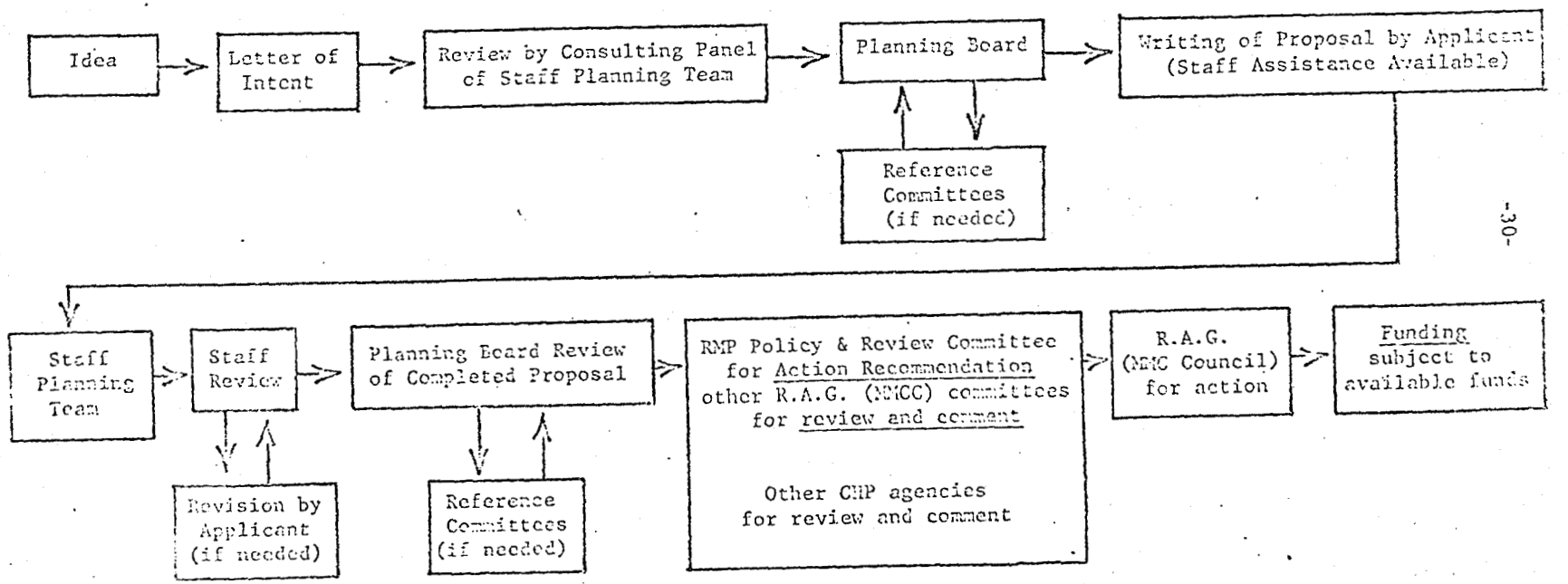
#28 Regional Blood Banking and Transfusion

GRB 6/8/71

MEMPHIS REGIONAL MEDICAL PROGRAM
ORGANIZATIONAL CHART, APRIL 2, 1971



MEMPHIS REGIONAL MEDICAL PROGRAM REVIEW PROCESS



1.) Letters of intent received by the 15th of the month will be reviewed by the Planning Board at its next monthly meeting (second Wednesday).

2.) A project will be in staff review a maximum of one month.

3.) Project applications must be forwarded to the RMP Policy and Review Committee of the R.A.G. at least two weeks in advance of its next quarterly meeting.

4.) Project applications reviewed by the RMP Policy and Review Committee must be submitted to the Regional Advisory Group at least two weeks in advance of its next monthly meeting.

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

MEMPHIS REGIONAL MEDICAL PROGRAM
RM 00051 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

Recommendation: Additional funds be provided for core and projects and disapproval of developmental componet request.

Region's Operational Year	Request	Recommended Funding
04	$2,754,233	$1,627,000
05	2,549,008	1,627,000
06	2,397,991	1,627,000
Total	$7,701,232	$4,950,000

Current funding level of the Memphis RMP is $1,512,795 direct cost and following is the rationale for the recommended funding level.

Core	$ 600,000
Projects (continuation renewal, new)	1,027,000
Developmental Component	-0-
Total	$1,627,000

Committee did not accept the site visit team's recommended $2,000,000 for each year of support requested and during its deliberations considered funding the region at the above recommended level for one year. In view, however, of the potential of the Memphis RMP with its new direction and mission it was decided to recommend support for three years. In addition, committee concurred with the recommendation of the June 1971 site visit team that the MRMP not utilize RMPS funds for Project #39 - Continuing Education for Physicians in Tennessee. The support of general C.E. activities for members of the Tennessee Medical Association was not considered appropriate utilization of RMP funds. It was suggested that support of these activities be acquired by increasing the dues of members of the association. It is also recommended that the region not invest more than $318,710 for Project #36 - Expansion of Neighborhood Health Centers since the National Center of Research and Development was investing $120,000 in the activity. Regarding the seven ongoing projects for which support is requested for an additional three years the Committee believed that if the MRMP chooses to continue its support of these 7 projects, it should not be for more than one additional year.

In addition, Committee believes that RMP funds should not be utilized for Project #20 - Comprehensive Kidney Disease, because it was found to be unacceptable on a technical basis by the Ad Hoc Panel on Renal Disease. It seems that this project was developed with little or no considerations of existing facilities in surrounding areas.

Critique: The Committee considered this triennial application in relation to the June 1971 program site visit. Since a Review Committee member did not participate in the site visit, the report to the Committee was given by a consultant who participated in the site visit and it was reported that the Memphis RMP was at a critical point in its development. The region has responded to some of RMPS past concerns by moving awary from a medical center oriented core staff and establishing a better working relationship with the Mid-South Medical Center Council (MMCC). The region also continues to have a good working relationship with the Medical Society, University, Health Department, CHP Hospital Association, etc.

The complexity of the organizational structure in which the MRMP is situated, has not been clearly understood in past years and has been a concern of RMPS. The complexity of this organization has been heightened by a recent contract awarded to the MMCC for an Experimental Health Planning and Delivery System. Now, however, there is a better understanding of the organization by RMPS. (See Organizational chart)

While the potential exists through this organizational approach for melding RMP and CHP activities, the June 1971 site visit team questioned the legality of the MMCC Board of Directors serving for the MMCC as the RAG. The legality question arises primarily because the Board of Directors membership is representative only of the 14 counties for which the CHP "b" agency is responsible and not the 75 counties of the MRMP. The Committee was informed that in the near future RMPS will be studying the decision-making processes of a number of RMPs, including the Memphis RMP, and that it will not be necessary to seek advice from the Atlanta HEW Regional Office General Council, as recommended by the site visitors.

Committee discussed the Policy and Review Committee which has been in existence for only six months is appointed by the coordinator and has met only twice. This committee was established to serve as an informal RAG because the MRMP needed a policy and decision-making body that would be representative of the region. It is obvious, however, that until this group gains experience and maturity the Planning Board of the MRMP will continue to be the decision-making force of the MRMP. The Planning Board is also appointed by the Coordinator and was established to advise the coordinator in planning and operational activities of the program. Committee believes that if the Policy and Review Committee assumes its intended responsibility the MRMP organizational process could be greatly strengthened and suggest that RMPS should maintain close observation of this development.

Other MRMP committees appeared to have limited input into the planning and operational activities of the program and many are non-functional. Committee believes that the MRMP can be strengthened by developing a resource of knowledge through the committee structure and establishing a process that will ensure active participation of these committees in program activities. Representation on these committees should include physicians, nurses, allied health personnel, and consumers (industry, minorities).

The core staff of the Memphis RMP seems to spend a vast amount of time and effort in helping other health organizations locate resources for funding activities generally related to the umbrella - like goals of the MRMP and the MMCC. In addition, core has been involved with a large number of planning studies, some that have been productive and others that do not appear to be consistant with the RMP's goals and priorities. Committee believes that these core activities have resulted in winning good will and giving visibility to the MRMP, however, their focus appears very diffuse. For better coordinator of activities and to assure that core feasibility and planning activities are in accord with program goals and objectives, Committee suggested that these activities be reviewed and acted upon by the Planning Board and the Policy and Review Committee.

It appears that the various sections of core were pursuing independent objectives and not coordinating their efforts toward a common goal. This fragmented approach could be the result of Dr. Culbertson, the Coordinator, being the only physician on core staff other than Dr. Pate who, devotes only 20% of his time to the MRMP. Committee concurs with the recommendation of the site visit team that the coordinator hire a full-time deputy with administrative experience to help him carry on the day to day operations of the program. Many of the health needs of the region involve the Black population yet there appears to almost no Black professional employees on the MRMP core and committee structure. Although the MRMP reported to the site visit team that there have been concentrated efforts to recruit Black employees for professional positions, committee believes that an increased effort is warranted.

The goals, objectives and priorities of the MRMP are described, however, they are not clearly stated in relation to the specific health needs of the region nor in terms of anticipated accomplishments. Committee believes the MRMP should be more specific in their statement of goals, objectives and priorities.

Committee expressed difficulty in identifying the interrelationships between projects and how each of these activities fitted into a program plan that would have an influence in meeting the health care needs of the region. It appears that past emphasis in the program has been in accepting spontaneously appearing projects that would improve regional cooperation rather than stimulating the development of priority activities based on identified needs.

Committee's primary concerns are the involvement of the RAG, committees, and core with the development of projects, how these projects relate to a regional plan and what is the expected impact of these activities on the health care delivery system of the Region. Committee did express encouragement that a few of the new activities proposed in the application have an emphasis toward access of care and reaching out into the rural low economic areas of the region.

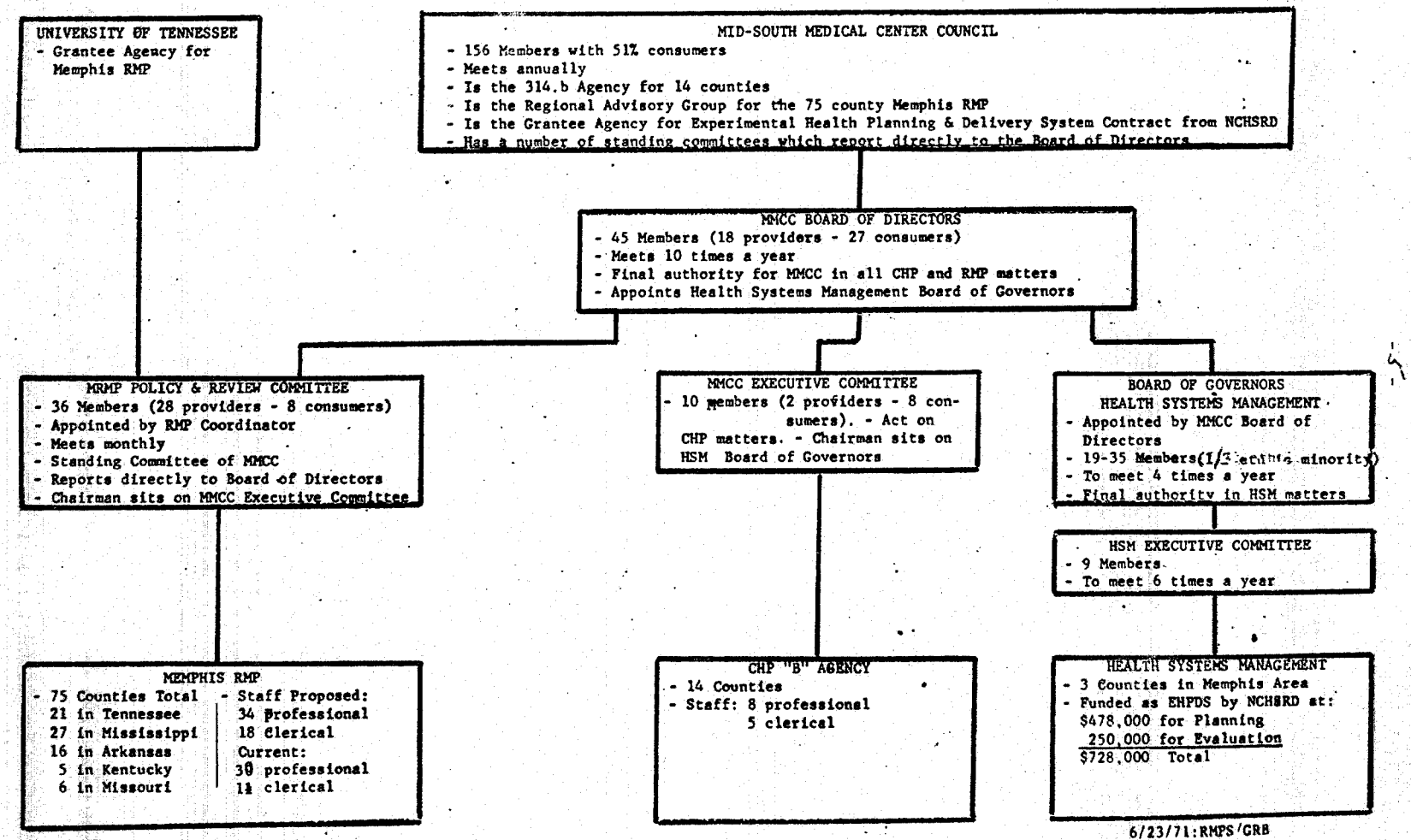
Committee also expressed concerns over the region's inability to adequately phase out its support of projects after three-years of support. There is a tendency on the part of the MRMP to pass the responsibility for saying no to Regional Medical Programs Service. Of the amount requested in the present application for projects 26.8% is for the continuation of 7 projects for an additional 3 years past the original period of approval. Committee recommends that the region phase out RMPS support for these 7 projects by the end of their fourth year. Continuing Education has encompassed a major portion of this region's activities, however, they have not been reaching the Black physician. The reason given to the site visit team was that because Black physicians have inadequate educational qualifications, they do not have hospital affiliations where the training is rendered. The visitors were informed that the MRMP is aware of this problem and hopes to do something about it.

The region proposes in this application to develop a mechanism for evaluating projects and total program effectiveness. Although encourage by interest in evaluation activities committee has difficulty in determining how the region will implement evaluation activities without first identifying a program plan with specific objectives that project expected accomplishments and are measurable in terms of evaluation.

The MRMP has requested in this application developmental component authority without additional funds. Committee recommends disapproval of this request until the region has resolved its exisitng organizational and administrative problems.

RMPS/GRB/7/16/71

ORGANIZATIONAL RELATIONSHIPS BETWEEN MID-SOUTH MEDICAL CENTER, MEMPHIS RMP, CHP, AND NCHSRD
AS PERCEIVED BY SITE VISIT TEAM ON JUNE 16-17, 1971



6/23/71:RMPS/GRB

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Amended

Date: June 28, 1971

Reply to Attn of:

Subject: Quick Report on the Memphis Regional Medical Program
June 16-17, 1971

To: Director, RMPS
Through: Acting Deputy Director
Regional Medical Programs Service

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II. This two-day meeting was held in Memphis to review the Program's Triennial Application which included a developmental-type request. The team was extremely pleased with the structure and conduct of the visit. Appropriate representatives of a large majority of the various interests involved in the Program participated.

III. Summary of Findings

The team was able to elicit specific information which helped clarify the enigmatic organizational structure which has historically characterized the Memphis RMP.

The organizational relationship between the Mid-South Medical Center Council and the Memphis RMP are recognized by both groups to be cumbersome and complicated. The complexity has been heightened by the recent contract awarded to the MMCC for an Experimental Health Planning and Delivery System in the Memphis area. In spite of this complex situation, it appears that these organizational relationships present an excellent opportunity for the groups to take full advantage of the interface between RMP and CHP. The attached chart shows the basic organizational relationships.

While there is a potential for successfully melding the activities of RMP and CHP, the question arose as to whether the current decision-making process for the RMP meets legal requirements regarding the authority of the Regional Advisory Group. The 156-member MMCC, which serves as the MRMP RAG, is not the final authority for the organization it serves. The power of final authority is vested in the MMCC's 45-member Board of Directors. Although mail ballots are solicited from the 156-members of the Council on MRMP applications, the utilization and the influence of these ballots by the Board of Directors was not clearly discernable. Also, there was no indication that a specified number of ballots were required before action could be taken on an RMP application. The team recommended that the MRMP get a ruling on this issue from General Council in the Atlanta HEW Regional Office. If General Council finds the current procedures legal, the team members would not recommend any changes. If, however, the General Council responds negatively, a restructuring of the MRMP would be mandatory if the RMP is to continue.

It was obvious that since the last site visit in July 1969, the working relationships between the MMCC and MRMP have greatly improved. This applies to both the staffs of the two groups and their primary committees. The development of the Experimental Health Planning and Delivery System control was a joint CHP-RMP effort.

Also in response to the previous site visit team's recommendations, the RMP has made a definite move away from a medical center oriented core staff.

The general impression the visitors had of the MRMP were:

1. As with most Regional Medical Programs, the MRMP's goals, objectives and priorities are global and so broadly stated that they are relatively meaningless.

2. The organizational concept is probably excellent, but the manner in which it functions is open to question. The Policy and Review Committee of the RMP appears to be a rather light stamp of the Planning Committee, which is the major volunteer segment in decision-making power. The Planning Committee was established to advise the Coordinator. The decision-making power of this group seems to be equal to that retained by core staff. In some areas the core staff seemed to operate independently of the Planning Committee. Further, it appeared that various sections within core staff also operate on an individual

basis. The Board of Directors of the MMCC is probably effective in assessing the value and decussation of the Memphis RMP. The Board of Directors' effectiveness in policy determination is questionable. The MMCC or RAG appears to be a public relation facade, and if not illegal, certainly ineffective in the review process.

3. Involvement of regional resources seemed complete, probably due to the strange organizational arrangement with the MMCC. Involvement is greatest with CHP and the University of Tennessee, and less in depth with other resources. There seems to be amazing cooperativeness with and among other Regional Medical Programs in the area.

4. Assessment of needs, problems and resources has been adequately determined by RMP and CHP working cooperatively with the MSMCC. The assessment, however, has not necessarily led to solutions to the findings of need. This is probably inevitable with the past emphasis on accepting spontaneously appearing projects to improve regional cooperation. This apparently is beginning to change as staff is reaching out to stimulate the kinds of projects that are needed.

5. Program implementation and accomplishments have a spotty history. The Jackson Hospital's Learning Center would seem to be a case in point for excellence; and yet, in other areas, such as the studies on family planning and the effectiveness of health care in Oxford, Mississippi, appear to be an unnecessary expenditure of funds. The MRMP also seems to have succumbed to the excitement and satisfaction of delivering services in at least two areas. Plans for phasing out projects are less than optimal. Their continuing education program does not seem to be meeting the needs of the most incompetent physicians in the area.

6. Evaluation is in its infancy. The MRMP's projected plan should be very effective and, if implemented in the early planning phases of projects, should be one of the best. Evaluation of ongoing and phased-out projects appears unsatisfactory for program assessment.

IV. Recommendation:

Requested	Recommended
$2,754,233	$2,000,000
2,549,008	2,000,000
2,357,991	2,000,000
$7,701,232	$6,000,000

(Current level of direct cost support $1,512,795)

There was some confusion over whether or not a Developmental Component was actually requested. The MRMP coordinator indicated that if additional core staff funds were made available, a developmental award would not be necessary. The team believed it should report that it could not recommend approval of a Developmental Award. Further, the team recommended that:

1. Efforts to recruit Black employees for professional positions on core staff be increased.

2. Core staff activities be coordinated to justify the time and personnel involved and to assure that the activities are worthy and consistant with the RMP's goals and priorities.

3. The Planning Committee be more involved in deciding which core staff activities should be pursued.

4. The Reference Committees have more input into the total program planning and operational process as well as project evaluation.

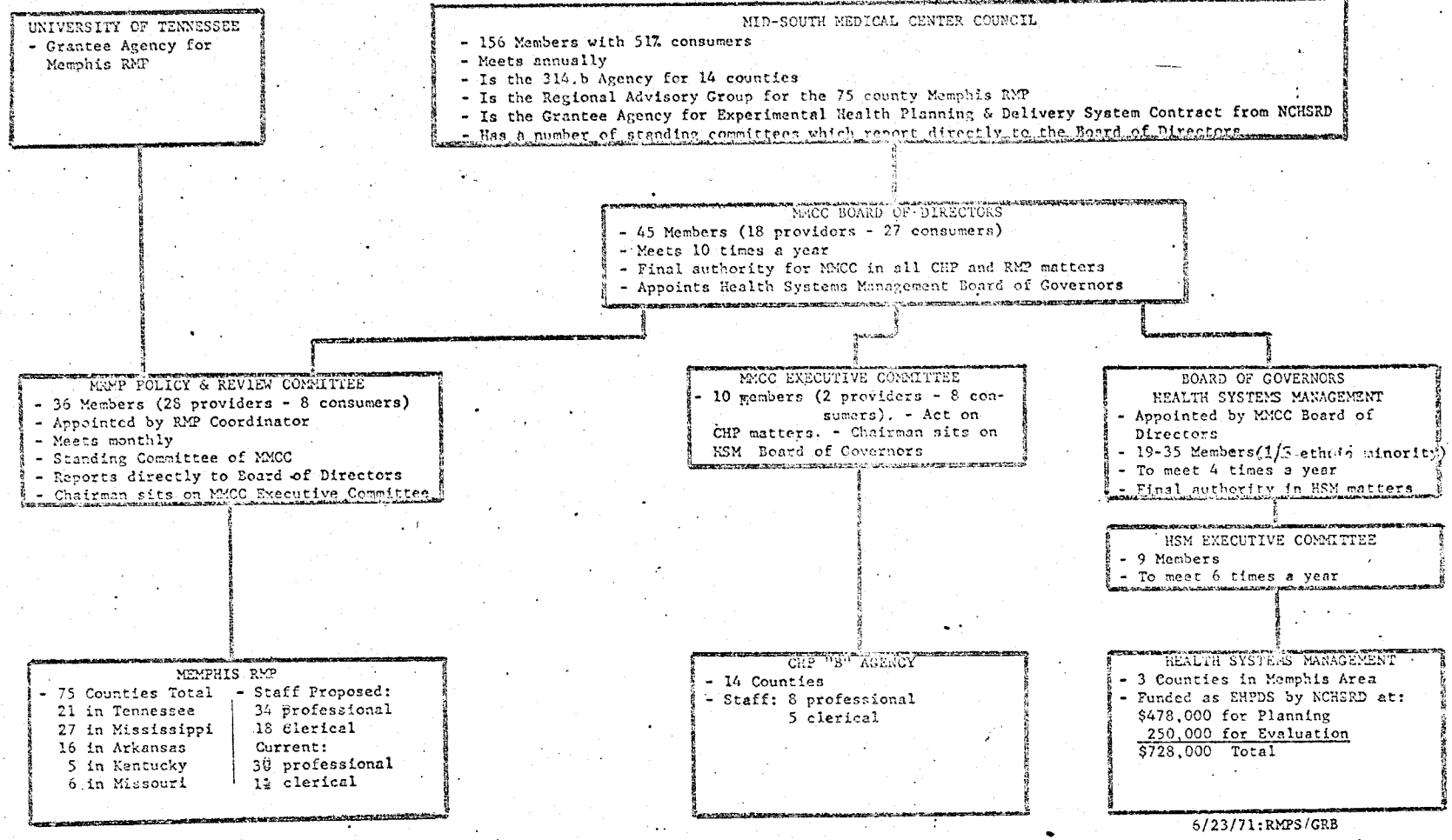
5. The 7 projects for which an additional 3-years' support is requested, be phased-out by the end of their fourth year.

6. The MRMP make a careful study of its patient services activities to assure that direct patient care is not provided beyond the demonstration stage.

In arriving at the amount of funds recommended, the team relied heavily on the Program's potential. The MRMP has shown signs of life and effort since its inception, and with its new direction and sense of mission should be encouraged.

Richard L. Russell
Public Health Advisor
Grants Review Branch

ORGANIZATIONAL RELATIONSHIPS BETWEEN MID-[redacted]EDICAL CENTER, MEMPHIS RMP, CHP, AND NCHSRD
AS PERCEIVED BY SITE [redacted] TEAM ON JUNE 16-17, 1971



6/23/71:RMPS/GRB

D R A F T

MEMPHIS RMP
June 16-17, 1971 Site Visit
RESPONSE TO RMP MISSION STATEMENT REVIEW CRITERIA

PERFORMANCE:

1. The MRMP has established its own goals, objectives and priorities. They are, however, generally stated and in terms of activities rather than anticipated accomplishments within a specified period of time.

2. Activities previously undertaken have been productive to the extent they meet the anticipated objectives of individual activities. There is very little indication, however, that these activities have been productive in meeting the health needs of the MRMP and facilitating the accessibility of health care.

3. Activities stimulated and initially supported by the MRMP have not adequately been absorbed within the regular health care financing system. An indication of this is the MRMP request to continue 7 projects beyond the approved period of support.

PROCESS:

1. While the current state of the MRMP is viable and effective, the manner in which it functions is questionable.

2. The MRMP has good relationships with other health related interests, institutions and professions. There is a need, however, to increase the degree of commitment and active participation of these groups in the Program.

3. The MRMP is currently directing much of its effort in assisting in the development of CHP "B" Agencies in the Region.

4. The assessment of needs, problems and resources has been adequately determined by the MRMP and CHP working cooperatively with the Mid-South Medical Center Council. This assessment, however, has not necessarily led to solutions as determined by needs. This is probably inevitable, since in the past emphasis has been placed on accepting spontaneously appearing projects to improve cooperation. This is apparently beginning to change as core staff is attempting to stimulate the type of projects that are needed.

5. The MRMP's evaluation program is in its infancy. The projected plan should be very effective, if implemented in the early planning phases of projects. The evaluation of ongoing and phased-out projects would seem to be unsatisfactory for program assessment.

PROGRAM:

1. The provider action plan appears to be about 50% effective as it relates to the overall mission and objectives of RMP. The basic problem

is that the MRMP operates in an opportunistic manner rather than in an organized well-planned approach based on expected accomplishments.

2. The MRMP appears to be dispersing improved techniques and knowledge, except to those who are most in need. The emphasis is not directed to access of health care based on identified needs.

3. It appears that some of the MRMP activities will lead to some increased utilization and effectiveness of community health facilities and manpower. The extent to which the program activities will alleviate the present maldistribution of health services can be expected to be minimal.

4. Health maintenance, disease prevention, and early detection activities are an integral part of the MRMP's proposed program, as reflected in six projects. In addition, the Mid-South Medical Center Council is establishing a Health Systems Management program which is to involve the MRMP.

5. The MRMP proposes three activities which will expand ambulatory care. The extent to which these activities will have an impact in the health care delivery system is questionable.

6. To some degree the activities of the MRMP could improve the relationship between primary and secondary care. However, the degree to which these activities will improve continuity and accessibility of care will be minimal.

7. The MRMP activities will have limited impact of immediate pay-off in terms of accessibility, quality, and cost moderation.

8. There are some, but very few, joint efforts stimulated by MRMP activities that facilitate the provision of health care.

9. The MRMP will tap local, state, and other funds when possible and is supportative of other Federal efforts in the University. There has been, however, very little success by the MRMP in locating other sources of funding to pick up activities for which MRMP support has terminated.

SITE VISIT REPORT
MEMPHIS REGIONAL MEDICAL PROGRAM
June 16-17, 1971

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Joseph Johnson, Chancellor	The University of Tennessee Medical Units
Leo Chitman	Member, Board of Directors, Mid-South Medical Center Council, from West Memphis, Arkansas
C. W. Silverblatt, M. D.	Coordinator, Arkansas RMP
J. W. Westbrook, Ph. D.	Memphis City Schools, Planning Board
Harry Cosby, Jr., M. D.	Iuka, Mississippi Policy & Review Committee
T. L. Hunt	Delegate Trustee, National Kidney Foundation and Immediate Past President Tennessee Kidney Foundation, Policy & Review Committ
Jess E. Porter, Mayor	West Helena, Arkansas; Member, Board of Directors, Mid-South Medical Center Council
Norman L. Casey	Executive Director, Mid-South Medical Center Council
Harold Whalum	Assistant Director, Mid-South Medical Center Council
E. W. Reed, M. D.	Vice-Chairman, Mid-South Medical Center Council
Ruth Neil Murry, R. N.	Dean of the College of Nursing The University of Tennessee

J.M. Moore, Jr., D.O.	Trenton, Tennessee - Immediate Past President, Tennessee Osteopathic Association Policy and Review Committee
Stan Epstein	Health Planning Specialist, Comprehensive Health Planning, Jefferson City, Missouri
Robert Metcalfe, M.D.	Tennessee Mid-South RMP
Jack E. Wells, D.D.S.	Dean of the College of Dentistry The University of Tennessee
C.Q. Tipton	Business Manager, The University of Tennessee Medical Units
T.D. Lampton, M.D.	Coordinator, Mississippi RMP
Seldon D. Feurt, Ph.D.	Dean of the College of Pharmacy The University of Tennessee
David James, M.D.	Associate Professor, The University of Tennessee College of Medicine
Sam Rutherford	Executive Director, Memphis & Shelby County Health and Welfare Planning Council
Christopher Martin	Director of Research, Memphis & Shelby County Health and Welfare Planning Council

Conclusions and General Impressions

It was encouraging to the visitors that since the last site visit in July 1969, the MRMP has responded to some of RMPS past concerns. The working relationships between the staffs and Committees of the Mid-South Medical Center Council and the MRMP have greatly improved, and the MRMP has made a definite move away from a medical center oriented core staff. The Region also continues to have a good working relationship with the Medical Society, University, Health Department, CHP, Hospital Association, etc.

Although the program still contains major weaknesses which need to be corrected, the site visitors were encouraged. The Memphis RMP has the potential of becoming one of the better RMPs, in terms of addressing the broad issues of the provision of health care. Further, strengthening of the MRMP organizational and administrative process should permit it to take full advantage of the unique opportunity of working closely with CHP and the recently approved Experimental Health Planning and Delivery System program in Memphis.

In recommending $2,000,000 for each of the programs next 3 years, the team relied heavily on the program's potential. The MRMP with its new direction and sense of mission should be encouraged to develop a program which can bring together the health resources to meet health needs of the Region.

A. Goals, Objectives and Priorities

As is the case with many Regional Medical Programs, the Memphis RMP has established goals, objectives and priorities which are rather meaningless. The Program's aims are broadly stated in terms of activities rather than

anticipated accomplishments within a specified period of time. As a result the MRMP has no difficulty relating all of its project activities to its priorities. The only priority for which there is no related project is the development of mechanisms for stable financing.

B. Organizational Effectiveness

The organizational concept under which the MRMP operates is probably excellent. The manner in which the MRMP functions, however, is open to numerous questions. As indicated by the attached chart, the organizational relationship between the Mid-South Medical Center Council and the MRMP are recognized by both groups to be cumbersome and complicated. The complexity has been hightened by the recent contract awarded to the MMCC for an Experimental Health Planning and Delivery System in the Memphis area. In spite of this organizational labyrinth, there appears to be an excellent opportunity for the groups to take full advantage of the interface between RMP and CHP.

While the potential exists for the melding of RMP and CHP activities, the site visitors questioned the legality of the MRMP's decision-making process in terms of the Regional Advisory Group's authority. The 156-member MMCC, which meets only once a year, is officially designated as the RAG for the Memphis RMP. The MMCC, however, is not the final authority for its own organization. The power of final authority is vested in the MMCC's 45-member Board of Directors, which meets 10 times a year. It is the Board of Directors who acts on RMP matters. Although mail ballots are solicited from the 156 members of the Council on MRMP applications, the utilization and influence of these ballots was not clearly discernible. Further, there was no indication of assurance that a specified number of ballots were required

to insure a majority vote by Council members. The primary issue is that the Board of Directors membership is representative only of the 14 counties for which the CHP "b" agency is responsible and not the 75 counties of the MRMP. It appears that the RAG is a public relations facade, ineffective in the MRMP review process, and perhaps illegal. The visitors' concern of the legality of the RAG was shared by the Executive Director of the MMCC. The team advised the MRMP that it should get a ruling on the legality of its RAG from General Council in the Atlanta HEW Regional Office. If General Council finds the current procedures legal, the team would be satisfied. If however, General Council responds negatively, a restructuring of the MRMP would be mandatory if the RMP is to continue.

The MRMP Policy and Review Committee, which has been in existence for only six months is appointed by the Coordinator and has met only twice. This Committee was established to serve as an informal RAG because the MRMP needed a policy and decision-making body that would be representative of the Region and deal primarily with RMP business. This Committee reports directly to the MMCC regarding RMP matters. Although it was reported that the Policy and Review Committee has the widest lattitude with no restraints in dealing with policies and technical advice concerning project review, it presently appears to be rather light stamp of the Planning Board.

The Planning Board, which also appointed by the Coordinator was established to advise the Coordinator, and is the major segment in the MRMP's decision-making power. The Planning Board not only screens potential project proposals for applicability, but advises the Coordinator as to which applicants should or should not be given Core staff assistance in developing a proposal. The Planning Board meets jointly with the Policy and Review

Committee on a monthly basis. There is limited representation on the Planning Board from the MRMP's 13 Reference Committees.

The Reference Committees, some of which are categorical, appear to have limited input into the total program planning, operational and project evaluation processes. Based on the frequency with which these Committees meet, it appears that many of them have be inactive. It was reported that the limited funding situation had dampened the enthusiasm of many of the key Committee members.

The Core staff seems to have retained, in some areas, decision-making power equal to that of the Planning Board. This is reflected primarily by the number and types of activities which are stimulated, initiated, and conducted by staff members. It appears that the various sections of the core organization are pursing independent and unrelated objectives and simply reporting to the Coordinator. The Coordinator is over extending himself in an attempt to fill two positions: his own and that of a much needed administrator. There has been a concentrated effort to fill the administrative void by recruiting a specific candidate as Assistant Director of Program Management, however, because of the candidate's experience he is being considered for "a position in Program Development." There is some question as to when the core administration might be strengthened.

It seems that the Core staff is overly anxious to please too many groups and interests, all at the same time. There is a reluctancy to say "no," as evidenced by the MRMP's tendency not to phase out its support of projects after three years of support. The tendency of the MRMP has been to pass the responsibility for saying no to the RMPS. In its role as a "broker," the

Core staff seems to devote a vast amount of time and effort to assist other health organizations apply for funds for many and varied services and programs generally related to the broad goals of MRMP and MMCC. While this develops good will and builds a wider understanding of the MRMP, the focus of the approach is extremely diffuse. Whether or not the costs, including the time and effort of personnel involved, are justified is questionable, in terms of the RMP's goals and priorities.

Many of the health needs of the Region involve the Black population. Yet there appears to be almost no Black professional employees on the MRMP Core and Committee structure. Although the MRMP reported to the site visit team that there have been concentrated efforts to recruit Black employees for professional positions, Committee believes that an increased effort is warranted.

C. Involvement of Regional Resources

Involvement of resources seemed complete, primarily due to the organizational arrangement with the MMCC. Involvement is greatest with CHP and the University of Tennessee and less in depth with other resources. There seems to be amazing cooperation with and among the adjoining Regional Medical Programs.

RMP and CHP relationships seem to be part of the difficulty in clarifying the MMCC and MRMP administrative processes. There are 5 state "A" agencies and several "B" agencies which must be consulted and/or involved in varying degrees. The MRMP appears to have been quite active in developing a data base, and also devotes considerable effort in the basic organizational development of the "B" agencies in the Region. MRMP Core staff is currently helping to plan a model health system in Northern Mississippi which is

envisioned as part of a 10-county housing and urban development program now supported through a grant from the Department of Housing and Urban Development.

MRMP Core staff is involved with or maintains liaisons with approximately 40 civic and service organizations. There is, however, a lack of commitment from many of these groups which might be attributed to the independent pursuits of core staff members and the tendency of the MRMP to operate in an opportunistic manner rather than in an organized well-planned approach based on expected accomplishments as a result of its involvement with these other resources.

D. Assessment of Needs, Problems and Resources

The assessment of needs, problems and resources has been adequately determined by the MRMP and CHP working cooperatively with the MMCC. The assessment, however, has not necessarily led to solutions based on needs. This gap in programming is probably inevitable since past emphasis has been on accepting spontaniously appearing projects to improve regional cooperation. This situation is apparently beginning to change as core staff is attempting to stimulate the type of projects that are needed.

There is a need for the MRMP to strengthen its use of allied health resources throughout its program and to place some emphasis on stimulating activities for allied health personnel.

E. Program Implementation

Accomplishments in this area have been spotty. The Jackson Hospital's Learning Center is a case in point for excellence. This program provides a new concept and format of continuing education for physicians in their own

community hospitals. Specialists from the private practice sector, are invited by other physicians to participate in Advanced Clinical Conferences in which patients of the inviting physicians are the subject of discussion. Although this is a well designed continuing education program for practicing specialists and general practitioners which serve a network of small and medium sized hospitals, it does not reach any Black physicians. The reason given is that since Black physicians have inadequate educational qualifications, they do not have hospital affiliation. It is however, obvious that to improve educational qualities these physicians must have access to these continuing education activities which happen to be centered in a hospital setting. In other program areas, however, there appears to have been an unnecessary expenditure of funds. Cases in point are a study of birth control attitudes and practices among Memphis mothers, and the effectiveness of the health delivery system of Oxford-Lafayette County, Mississippi. The MRMP also seems to have succumbed to the excitement and satisfaction of delivering patient services, for example, the Mobile Multiphasic Health Screening Project in Northeast Mississippi. The team was concerns that the MRMP may not be giving adequate attention toward phasing out its support of these types of activities, as well as other projects.

The MRMP plans for phasing out its support of projects are less than optimal; as evidenced by the current application. Of the total amount requested for projects, 26.8% is for the continuation of 7 projects, for an additional 3 years, past the original period of approval. The decision by the MRMP to continue the projects is done so without adequate evaluation of effectiveness of the activities to date. As noted earlier, there is tendency on part of the MRMP to pass the responsibility for saying no to Regional Medical Programs Services review process. This tendency has been noted in the review of

previous applications.

F. Evaluation

In the past, there has not been an effective evaluation process for core staff and project activities in the MRMP. The Region, however, proposes in this application to develop a mechanism for evaluating projects and total program effectiveness. Although encourage by interest in evaluation activities the team had difficulty in determining how the Region will implement evaluation activities without first identifying a program plan with specific objectives that project expected accomplishments and are measurable in terms of evaluation.

It is anticipated that the core staff evaluation section will be deeply involved in the MMCC's Health System Management. Although plans are not clearly defined, the MRMP is to be responsible for the surveillance of HSM activities and the evaluation of the quality of care HSM provides. The contract between MMCC and NCHSRD in its cope of work calls for MRMP involvement.

Health Systems Management Contract

This contract has just recently been signed and is for $728,000 as follows:

$358,000	Planning EHPDS
120,000	Development of Pediatric Nurse Program
250,000	Evaluation
$728,000	Total

Rationale for Funding Recommendations

As noted earlier, the amounts recommended are based primarily on the potential of the MRMP. The team believed, however, that funds should not be provided for Project #39 - Continuing Education for Physicians in Tennessee. The support of general C.E. activities for members of the

Tennessee Medical Association was not considered appropriate utilization of RMP funds. It was suggested that support of these activities be acquired by increasing the dues of members of the association.

It is also recommended that the Region not invest more than $ 318,710 for Project #36 - Expansion of Neighborhood Health Centers since the National Center of Research and Development is investing $120,000 in the activity. Regarding the seven ongoing projects for which support is requested for an additional three years the visitors' believe that if the MRMP chooses to continue its support of these 7 projects, it should not be for more than one additional year.

The MRMP has requested in this application developmental component authority without additional funds. Committee recommends disapproval of this request until the Region has resolved its existing organizational and administrative problems.

(Note: On June 24, the RMPS Ad Hoc Panel on Renal Disease reviewed the MRMP Project #20 Comprehensive Kidney Disease Program, and found it unacceptable in a technical basis. The proposal was found to be ambiguous and seemed to be developed with little or no consideration of existing facilities in the surrounding areas.)

D R A F T

MEMPHIS RMP
June 16-17, 1971 Site Visit
RESPONSE TO RMP MISSION STATEMENT REVIEW CRITERIA

PERFORMANCE:

1. The MRMP has established its own goals, objectives and priorities. They are, however, generally stated and in terms of activities rather than anticipated accomplishments within a specified period of time.

2. Activities previously undertaken have been productive to the extent they meet the anticipated objectives of individual activities. There is very little indication, however, that these activities have been productive in meeting the health needs of the MRMP and facilitating the accessibility of health care.

3. Activities stimulated and initially supported by the MRMP have not adequately been absorbed within the regular health care financing system. An indication of this is the MRMP request to continue 7 projects beyond the approved period of support.

PROCESS:

1. While the current state of the MRMP is viable and effective, the manner in which it functions is questionable.

2. The MRMP has good relationships with other health related interests, institutions and professions. There is a need, however, to increase the degree of commitment and active participation of these groups in the Program.

3. The MRMP is currently directing much of its effort in assisting in the development of CHP "B" Agencies in the Region.

4. The assessment of needs, problems and resources has been adequately determined by the MRMP and CHP working cooperatively with the Mid-South Medical Center Council. This assessment, however, has not necessarily led to solutions as determined by needs. This is probably inevitable, since in the past emphasis has been placed on accepting spontaneously appearing projects to improve cooperation. This is apparently beginning to change as core staff is attempting to stimulate the type of projects that are needed.

5. The MRMP's evaluation program is in its infancy. The projected plan should be very effective, if implemented in the early planning phases of projects. The evaluation of ongoing and phased-out projects would seem to be unsatisfactory for program assessment.

PROGRAM:

1. The provider action plan appears to be about 50% effective as it relates to the overall mission and objectives of RMP. The basic problem

is that the MRMP operates in an opportunistic manner rather than in an organized well-planned approach based on expected accomplishments.

2. The MRMP appears to be dispersing improved techniques and knowledge, except to those who are most in need. The emphasis is not directed to access of health care based on identified needs.

3. It appears that some of the MRMP activities will lead to some increased utilization and effectiveness of community health facilities and manpower. The extent to which the program activities will alleviate the present maldistribution of health services can be expected to be minimal.

4. Health maintenance, disease prevention, and early detection activities are an integral part of the MRMP's proposed program, as reflected in six projects. In addition, the Mid-South Medical Center Council is establishing a Health Systems Management program which is to involve the MRMP.

5. The MRMP proposes three activities which will expand ambulatory care. The extent to which these activities will have an impact in the health care delivery system is questionable.

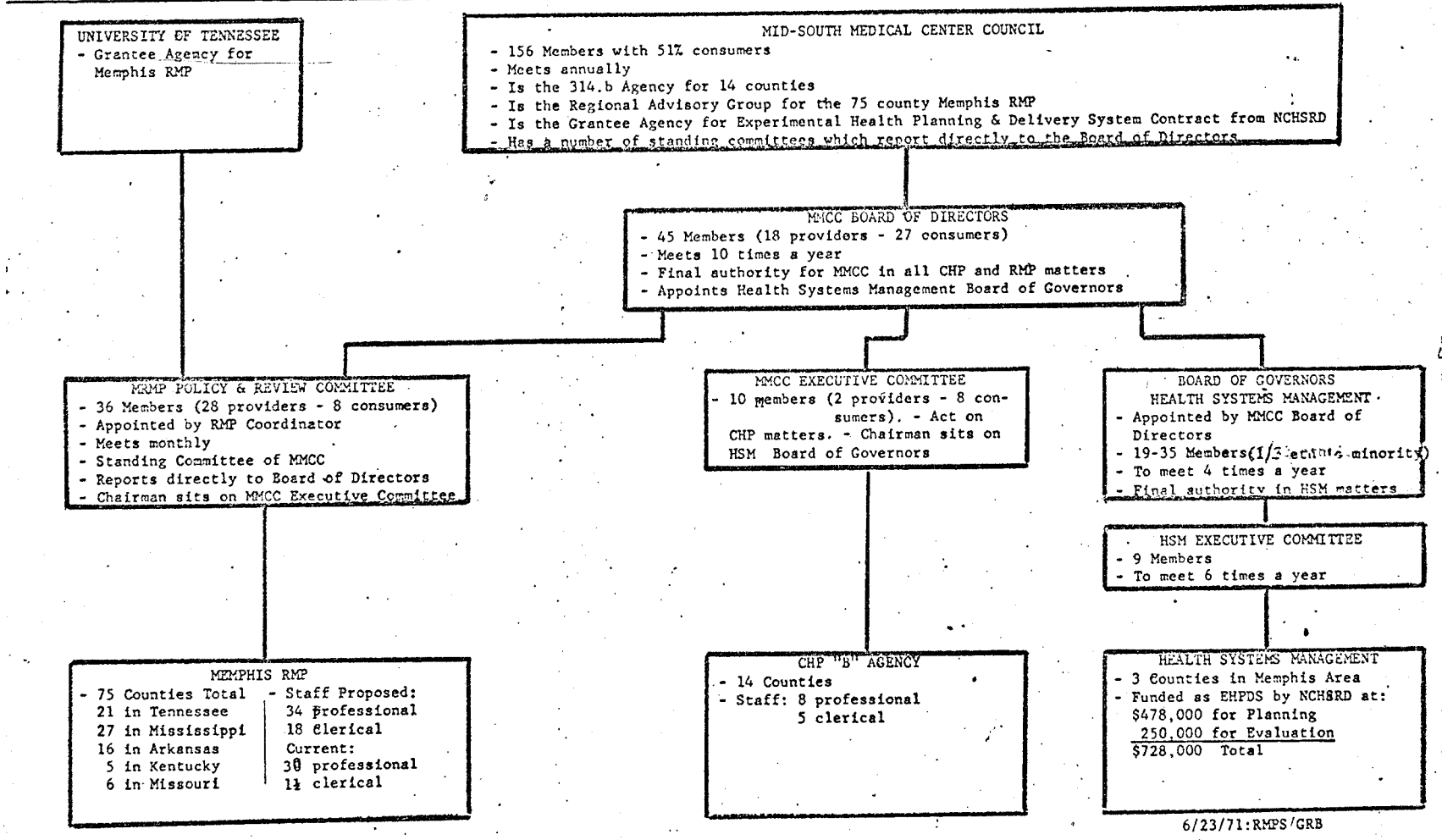
6. To some degree the activities of the MRMP could improve the relationship between primary and secondary care. However, the degree to which these activities will improve continuity and accessibility of care will be minimal.

7. The MRMP activities will have limited impact of immediate pay-off in terms of accessibility, quality, and cost moderation.

8. There are some, but very few, joint efforts stimulated by MRMP activities that facilitate the provision of health care.

9. The MRMP will tap local, state, and other funds when possible and is supportative of other Federal efforts in the University. There has been, however, very little success by the MRMP in locating other sources of funding to pick up activities for which MRMP support has terminated.

ORGANIZATIONAL RELATIONSHIPS BETWEEN MID-SOUTH MEDICAL CENTER, MEMPHIS RMP, CHP, AND NCHSRD
AS PERCEIVED BY SITE VISIT TEAM ON JUNE 16-17, 1971



6/23/71:RMPS/GRB

REGIONAL MEDICAL PROGRAMS SERVICE
A SUMMARY OF A SUPPLEMENTAL APPLICATION
(A Privileged Communication)

Metropolitan Washington, D. C.
Regional Medical Programs
2007 Eye Street, NW
Washington, D. C.

RM 00031 8/71
July 1971 Review Committee

Program Coordinator: Arthur Wentz, M.D.

The Region is currently in its fourth year of operation and is funded at $887,681 direct costs, and $328,998 indirect costs which represents 37% of direct costs.

The Region is requesting this supplemental application, $2,047,869 for three years support of Project #49 - A Comprehensive Kidney Disease Control Program for Metropolitan Washington. This project is the outgrowth of three kidney projects which were considered as part of the Region's Triennium Application in the February 1971 review cycle but which were denied support because they represented a "shotgun approach", lacked planning and a common thread drawing them together into a total program.

		Requested First Project Year
Project #49 -	A Comprehensive Kidney Disease Control Program for Metropolitan Washington - Medical Society of the District of Columbia	$749,167

The overall goal of the proposal is to improve the survival and quality of life of kidney disease patients in the Washington, D. C. Metropolitan area.

The goal will be met by pursuing the following objectives:

1. Establish a community-oriented cooperative centralized organ retrieval and tissue typing center to effectively organize, expand, and utilize the existing transplantation capabilities.

2. Coordinate, expand and improve dialysis capability to meet community needs:

   a. Establish out-of-center home dialysis training programs.
   b. Establish a community home dialysis training center at D. C. General Hospital, which services an indigent population.
   c. Establish low-cost neighborhood dialysis centers to provide an alternative to home dialysis for patients with poor home environments.

3. Improve dialysis capability to provide support for transplantations.

4. Educate medical and paramedical personnel in the necessary procedures associated with transplantation and dialysis and educate the public in the importance of organ contribution.

5. Reduce the incidence of renal disease through early detection and treatment of bacteriuria and hypertension.

6. Establish a representative organizational structure that will assure coordination of community resources, thereby avoiding duplication of efforts.

7. Provide for third-pary insurance carrier cost retrieval, thereby establishing a self-supporting program.

Second Year - $672,344 Third Year - $626,358

(A Privileged Communication)

SUMMARY AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

METROPOLITAN WASHINGTON D.C. REGIONAL MEDICAL PROGRAM
RM 00031 8/71

FOR CONSIDERATION BY THE AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: That this supplemental application which requests support for one project, #49 - A Comprehensive Kidney Disease Control Program for Metropolitan Washington, be disapproved.

Year	Request (Direct Cost)	Recommendation (Direct Cost)
1st	$749,167	-0-
2nd	$672,344	-0-
3rd	$626,358	-0-
Total	$2,047,869	-0-

Critique: The Committee concurred with the observations and recommendations of the Ad Hoc Panel on Renal Disease. The proposal should not be supported. Further, if requested by the RMP, a staff visit should be made to discuss and explore how to expand transplantation as a means of developing the care which the Washington patients need. The committee was aware that the problems of meeting renal disease needs in the Region were very likely not unique to kidney applications. The whole problem of coordination in the MWRMP be taken up if discussions are invited. It is useless at this time to consider expansion of dialysis, which is already being conducted on an active basis, without resolution of an effective way to develop the first efficient transplantation site.

Key to the consideration of this proposal is the pointed need for transplantation capability and the Region's omission of in-depth discussion and planning for such capability. The presumption set forth in the application that provision of a tissue typing laboratory and organ procurement would stimulate interest in transplantation is belied by the quite ample (over 70 in non-Federal Hospitals) patient base which now exists in the Region. The Panel noted four tissue typing laboratories already in the area and the fact that Federal funds will not change the organ donor population which has heretofore been tapped at a rate of only 1.25 organs per transplanting medical school. The Region confronts a dialysis bottleneck because there is no transplantation.

Yet, there is no effective transplantation capability. In the absence of transplantation capability, it seems futile to consider the dialysis proposals. The application does not define the specific needs. Reviewers considered the apparent lack of patient-support resources in the MWRMP but questioned the true magnitude of this

problem in view of the large existing dialysis population. The large proportion of indigent patients was seen as a strong basis for moving quickly into transplantation, especially if organs could be made available to keep the waiting period to 4 months, or less, and thus preclude the expense of carrying out home training.

The reality of a lack of transplantation interest was underscored by reviewers both as a key to understanding why full-blown transplantation is not already underway, and why there is no observable nerve center on which to exert influence to stimulate progress. If there were clear recognition in the proposal that transplantation was the limiting factor in the Region, with an appropriate transplantation program, initiation of any one of the four dialysis proposals would be acceptable. While there might be interest in more than one transplantation activity, one such activity must be established before there can be more.

The proposed bacteriuria screening project seemed to have little merit in view of its research nature and the magnitude of the Region's end-stage problems.

The Reviewers expressed a desire that the Region have a transplantation capability. But it could not identify the appropriate point or institution at which a fruitful approach could be made. It was hoped that consultative conversations on this point with key Washington authorities might be organized by the MWRMP. Key persons in the reviewers' estimation would include the Chief of Medicine, Chief Surgeon, and Chief Nephrologist of each of the applicant institutions.

GRB/RMPS
7/14/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF ANNIVERSARY REVIEW AND AWARD GRANT APPLICATION
(A Privileged Communication)

Michigan Association for
Regional Medical Programs
Suite 200, 1111 Michigan Avenue
East Lansing, Michigan 48823

RM 00053-04 8/71
July 1971 Review Committee

Program Coordinator: Albert E. Heustis, M.D., M.P.H.

(Note: Dr. Heustis had resigned effective May 1, 1971. However, he has agreed to serve as Program Coordinator at least through the period of the June 9 and 10, 1971 site visit.)

The Region is currently funded at $1,898,936 (Direct Costs) for its third operational year which ends 8/31/71. The Region currently receives indirect costs of $393,094 which is 20.7% of the Direct Cost award. Total RMP funding in Michigan is equivalent to approximately ~~40~~ 36 cents per resident.

The Region has submitted a triennial application that proposes:

I A three-year developmental component.

II The continuation of six ongoing activities. Five of these projects request a 6th year of support which is one year beyond the Council-approved support period.

III The renewal of Central Core and 3 subregional planning units for three years plus renewal for varying periods of time for five ongoing activities.

IV Support for four previously approved but unfunded projects for three years.

V Three year support for two new proposals.

An overview of the Michigan Regional Medical Program

The Michigan Association for Regional Medical Programs (MARMP) is about to complete its third full year of operation. The most significant accomplishment during the past year was the adoption of "Program Priorities." These were designed to respond to the most pressing needs of Michigan, as a whole, as well as to the understanding of the major national health concerns. To add to the Guidelines for Stroke, Cancer, and Educational Projects developed earlier, the last year saw the completion and approval of "Heart Program Guidelines," and "Criteria for Cooperative Efforts." Approved in principle was a cooperative agreement with State and Areawide Comprehensive Health Planning Agencies. Further, a policy for the handling of small pilot, feasibility, or demonstration studies was adopted.

In addition, the Michigan Diabetes Association, the Michigan Tuberculosis and Respiratory Disease Association, the Comprehensive State Health Planning Commission and the Wolverine Medical Society were each invited to be represented on the Corporation. This increased the membership of the Corporation and provides additional advice from individuals representing a wide range of professional health organizations, voluntary health agencies, state government, universities, geographic areas, and the public-at-large.

Involved also have been health professionals and other volunteers who advised the Corporation through a Task Force on Continuing Education and Professional Advisory Councils in the fields of Cancer, Heart Disease, Stroke, and Chronic Respiratory Diseases, Ambulatory Care and Kidney Diseases.

EXISTING CORE AND PLANNING PROGRAM COMPONENTS

The Michigan Region supports agencies in addition to the Central (Corporation) staff for program promotion, planning, facilitating, and/or coordinating activities of concern to the Regional Medical Program (RMP). Currently these are Michigan State University, University of Michigan, Wayne State University, and Zieger/Botsford Hospitals.

Michigan State University

The principal areas of concern are coordinating intra-university RMP activities; developing an extra-mural program to facilitate cooperative programs outside of the academic community; and conducting limited feasibility studies to test new ideas.

University of Michigan

The Secretariat was established to assist the University's project directors in grant administration, planning, and evaluation. It also encourages and assists the faculty in developing feasibility and demonstration studies.

Wayne State University is concerned with increasing the availability and accessibility of medical care to the Detroit Model Neighborhood; the evaluation of the educational needs of health professionals and auxiliary workers; and the deprivation in health services utilization.

Zieger/Botsford Hospitals were selected by the Michigan Association of Osteopathic Physicians and Surgeons and the Michigan Osteopathic Hospital Association as the primary group to work with MARMP to plan principally but not exclusively for the osteopathic profession. Activities to date have included contracting with the Professional Examination Service of the American Public Health Association to develop and conduct examinations for physicians; the development of a teaching program based on identified needs; the evaluation of behavioral changes resulting from the educational programs; and the provision of assistance in the development of a neighborhood health center in Pontiac.

Central (Corporation) Staff is the arm of the Board of Directors and Regional Group in carrying out established policy and implementing Corporation priorities and goals. It assisted with the development of the categorical and educational program guidelines, the "Program Plan" and "Program Priorities." It also provides assistance on request to both university and non-university personnel in the development of new program components. It is responsible for the implementation of the RAG program component review system, for the overall management of the grant, and for promoting cooperative efforts among health providers. Additionally, it serves as liaison between the Corporation and Federal Regional Medical Programs Service and between the Corporation and State and Areawide Comprehensive Health Planning Agencies.

The Region requests $3,815,394 Total Costs for its fourth operational year; $3,322,516 Direct Costs for its fifth and $3,328,220 Direct Costs for its sixth operational year. A chart identifying the components for each of the three years follows on pages 4, 5 and 6. The Region is to be site visited on June 9 and 10, 1971.

FUNDING HISTORY
PLANNING

Grant Year	Period	Funded (D.C.)
01	6/67 - 7/68	$1,040,639

OPERATIONAL PROGRAM

Grant Year	Period	Council Approved	Funded (D.C.)	
01	7/1/68-6/30/69	1,495,330	721,763	Core **
			773,567	Projects
02	7/1/69-8/31/70	2,054,020	849,814	Core **
			1,134,863	Projects
03 *	9/1/70-8/31/71	2,031,533	683,293	Core **
			1,215,643	Projects

* Reflects 12% reduction imposed on all RMPS programs.

** Includes central core and subregional planning agencies.

GEOGRAPHY, DEMOGRAPHY AND HEALTH STATISTICS

Geography -The boundaries of the Michigan Regional Medical Program are the same as the state borders. Physically the Region is composed of two peninsulas - an upper peninsula which is separated from the more densely populated lower peninsula by the Straits of Mackinac. The total land area is 57,019 square miles.

REVISED (5/14/71)

REGION Michigan
CYCLE RM 00053 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR., NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
000 - Developmental				180,000	180,000	--	180,000
#1-Core		279,234			279,234	--	279,234
#3-Data Collection		197,982			197,982	12,511	210,493
#4-Coronary Care		146,900			146,900	33,548	180,448
#5-Sub-Regional Planning (Michigan State)		172,798			172,798	82,716	255,514
#14-Sub-Regional Planning (Wayne State)		221,387			221,387	35,218	256,605
#15-Sub-Regional Planning (Ziegen/Botsford)		116,500			116,500	22,736	139,236
#16R-Surveillance of Electric Equipment		133,148			133,148	30,030	163,178
#17-Stroke Base Center	26,865*				26,865	5,000	31,865
#18-Detroit General Stroke	116,174*				116,174	24,225	140,399
#19-Stroke Demo. Unit	99,990*				99,990	17,598	117,588
#20-Compre. Stroke (Sparrow Hospital	72,564*				72,564	10,370	82,934
#21-Public Ed. for Stroke	58,950				58,950	5,715	64,665
#22-Cardiovascular Center		16,530			16,530	4,794	21,324
#25-Cont. Medical Ed.		86,050			86,050	10,670	96,720
#26-Cont. Ed. for Inner-City Hospitals	97,337*				97,337	11,595	108,932
#27-Hlth.Care -Urban Poor			505,269		505,269	76,885	582,154
#29-Care of Stroke in General Hospital			120,530		120,530	11,288	131,818
#30-Regional Cancer Prog.			220,720		220,720	38,505	259,225
#31-Prog. for Community Health Services Coord.			207,353		207,353	--	207,353
#32-Health Services Delivery System				160,000	160,000	40,000	200,000
#33-Stroke Day Care Center				102,350	102,350	3,359	105,709
TOTAL	471,880	1,370,529	1,053,872	442,350	3,338,631	476,763	3,815,394

*06 year beyond approved period of support.

GRB/5/14/71

REGION Michigan

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
D00- Developmental				180,000	180,000
#1 - Core		294,200			294,200
#3		100,000			100,000
#4		142,006			142,006
#5		170,000			170,000
#14		276,800			276,800
#15		123,072			123,072
#16R		133,148			133,148
#17	33,980*				33,980
#18	128,000*				128,000
#19	107,870*				107,870
#20	78,451*				78,451
#21		60,550			60,550
#22					---
#25		91,550			91,550
#26	97,337*				97,337
#27			454,574		454,574
#29			120,880		120,880
#30			229,433		229,433
#31			196,665		196,665
#32				200,000	200,000
#33				104,000	104,000
TOTAL	445,638	1,391,326	1,001,552	484,000	3,322,516

* 06 year beyond approved period of support

REGION Michigan

BREAKOUT OF REQUEST 06 PROGRAM PERIOD

IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
DOO- Developmental				180,000	180,000	540,000
#1 - Core		320,400			320,400	893,834
#3					---	297,982
#4		150,042			150,042	438,948
#5		170,000			170,000	512,798
#14		299,500			299,500	797,687
#15		129,629			129,629	369,201
#16R		133,148			133,148	399,444
#17		38,293			38,293	99,138
#18		138,950			138,950	383,124
#19		107,870			107,870	315,730
#20		78,451			78,451	229,466
#21					---	119,500
#22					---	16,530
#25		97,000			97,000	274,500
#26		97,337			97,337	292,011
#27			477,459		477,459	1,437,302
#29			149,690		149,690	391,100
#30			251,609		251,609	701,762
#31			196,665		196,665	600,683
#32				200,000	200,000	560,000
#33				112,177	112,177	318,527
TOTAL		1,760,620	1,075,423	492,177	3,328,220	$9,989,367

The vast land area coupled with centers of medical excellence and decentralized health resources, its relatively self-sufficient pattern of obtaining care, and its array of health manpower argue well for the one state - one region concept in Michigan.

A. Demography and Health Statistics

1. Population (1970 Census) - 8,875,100
Density of population -- 156 per sq. mile
Metropolitan areas, population in thousands:

Ann Arbor	230.1	Jackson	142.4
Bay City	116.6	Kalamazoo	199.3
Detroit	4,163.5	Lansing	373.5
Flint	493.4	Saginaw	217.8
Grand Rapids	535.7		

9 SMSA's -- total population of 6,472,300

% Urban - 74	% Negro 11
	% Other non-white 1

2. Income -- average personal income (per individual) 1969

Michigan	$3,944	U.S.	$3,680
E. No. Central	3,937		

B. Facilities and Resources

1. Medical Schools	1969/70 Enrollment	Graduates
Univ. Of Michigan, Med.School, Ann Arbor	812	189
Wayne State Univ. School of Med., Detroit	537	132
Michigan State Univ. College of Human Med. (2 yr.) E. Lansing	85	--
Osteopathy - Michigan College of Osteopathic Medicine, Pontiac	--	--
		(1967)
Professional Nursing Schools - 39 22 are college or university-based	5,666	1,463

2. Accredited Allied Health Schools

	#	Student Capacity
Cytotechnology	3	14
Inhalation Therapy	2	60 (commun. colleges
Medical Record Librarian	1	38 affil. with hosp)
Medical Technology *	37	365
Physical Therapy	2	32 (univ. based)
Radiologic Technology	40	752

* Includes 1 school at V.A. Hospital, Allen Park

. Federal Health Programs

	Funds	Prof. Staff
CHP "A" Agency - Lansing	$520,000	5
CHP "B" Agencies:		
Battle Creek	110,000	4
Detroit	500,000	10
Grand Rapids	125,000	4
Lansing	165,000	5
Marquette	60,000	2
	$960,000	25

OEO Neighborhood Health Centers

Baldwin
Detroit

Model Cities

1st Round Planning Grants
- Detroit
- Flint (Genesee County)
- Highland Park
- Saginaw

2nd Round Planning Grants
- Ann Arbor
- Benton Harbor
- Grand Rapids
- Lansing

D. Manpower

	# (1967)	Ratio per 100,000 pop.
Physicians (non federal)	9590	--
*Active (providing patient care)		
Inactive	(951)	
Osteopaths	1932	--
Total active MD's & DO's	11,522	134
Professional Nurses (1966/67)		
Employed in nursing	23,441	277
Not actively empl. in nursing	13,212	--

*Physicians by specialty	Number	% of Total
Total in general practice	2600	27
Total in medical specialties	2275	24
Total in surgical specialties	3310	35
Others	1405	14

Regional Development

During November 1965 the Governor's Council on Heart Disease, Cancer and Stroke met at the Wayne County Medical Society Headquarters in Detroit to discuss P.L. 89-239 and its implication for Michigan. Dr. Albert Heustis served as chairman of the group. Following this, during December 1965, Dr. Marston from N.I.H. met with members of the staff of the Department of Public Health, members of various local medical societies plus representatives of the State Medical Society and various agencies to further discuss anR.M.P. in Michigan.

During June 1966 the Michigan Association for Regional Medical Program, Inc. was incorporated. Following this, during December 1966, the original planning application to support a central planning staff of MARMP was submitted. This was immediately followed, January 1967, by a supplementary request to support Core planning activities at the Department of Public Health, Michigan State and Wayne State Universities. During the January-February 1967 review cycle the planning application and supplemental request were recommended for approval with the comment "In its entirety the applications reflect a comprehension of what a Regional Medical Program should be and makes clear the needs and objectives of the Region."

The Region's first planning award of $1,040,639 (D.C.) was issued during June 1967. Dr. Heustis was appointed full-time Coordinator during September 1967. The Region's first operational proposal was submitted during February 1968.

Following a positive June 1968 preoperational site visit, the Region became operational July 1, 1968. Of a total of $1,495,330 awarded, $721,763 supported a Core/central office and 4 subregional offices plus 10 operational projects. During the Region's first operational year it submitted two separate operational supplementary requests. The supplements requested support for nine new activities plus a renewal request for Project #15 (Survey of Physician Continuing Education - Zieger/Botsford Hospitals). The Region's application for its second year operational funding requested $1,676,824 (D.C.) as compared to a second year 100% commitment of $1,626,398 plus a request to use $127,782 of a projected $470,344 balance from first year funds ($69,118 of the total of $127,782 requested carryover was approved). Staff's review of the progress reported on the first year of operations and the plans described for the second operational year led to a conclusion that the Region (with some minor problems) had exhibited growth and maturity under excellent leadership and that the RAG was on top of things with a review system, both at the technical level and RAG level which appeared superb. Based on this Review, effective 7/1/69, a 14-month award (which realigned the ending of its budget period from July 1 to September 1) was issued for $1,862,244 (D.C.). On August 17, 1970, staff considered the Region's application for its third operational year (no carryover funds were requested). Briefly, as in the 02 year application, staff continued to believe that the Region was on target. The third year request was for $1,555,666 which was $4,504 less than the $1,560,170 previously committed for the third year. Also, in this application the Region reported an estimated 78.9% expenditure rate of its second year funds. Based on staff recommendation, the Acting Director RMPS signed an award totaling $1,601,367 (D.C.) in addition to funds previously awarded on a 16-month basis and still available for expenditure. The actual direct cost funds available for the period 9/1/70-8/31/71 totaled $2,091,100 (D.C.). This amount was later adjusted in line with the HSMHA director's letter of April 7, 1971 which reduced the current level to $1,898,936.

The following chart shows the Region's funding at the time this application was developed, the levels of funding for the continuing life of ongoing projects and specific new and previously approved activities.

Core	Present Funding (Direct Costs)	Core and Projects for Triennium (Direct Costs) 1st Year	2nd Year	3rd Year
Central Office	$ 283,706	279,234	294,200	320,400
Subregional Planning Offices				
Michigan State	163,107	172,798	170,000	170,000
Wayne State	148,160	221,387	276,800	299,500
University of Michigan	23,480	--	--	--
Zieger/ Botsford Hospitals	64,840	116,500	123,072	129,629
Core and Subregional Planning Subtotal	683,293	789,919	864,072	919,529
Developmental Component	0	180,000	180,000	180,000
Projects				
Ongoing Projects, Continuation and/or Renewals	$1,215,643	1,052,490	972,892	841,091
Approved Projects				
Not Initiated		1,053,872	1,001,552	1,075,423
New Projects		262,350	304,000	312,177
Totals	$1,898,936	3,338,631	3,322,516	3,328,220

Organizational Structure and Processes

Board of Directors

The Michigan Association for Regional Medical Program is an incorporated not-for-profit corporation. The corporation is managed by a seven-member board of directors (all board members are also members of the Regional Advisory Group) under specific rules as outlined in the corporation by-laws. The Board meets monthly.

Regional Advisory Group

The Region currently has a 35-member Regional Advisory Group (membership on RAG is synonymous to membership in the association -- members of RAG are automatically members of the Association and vice versa); the RAG meets quarterly with an average 75% attendance. (The by-laws allow for proxy participation and vote) The group presently has representatives from some 22 organizations or institutions plus six representatives from the Public-at-large and one representative from each of six districts recognized by the corporation. There are three black members. New

members to the group are nominated and elected by current members.

In addition to the Board of Directors mentioned above whose function is to be in charge of the corporation property, manage and control the corporation affairs and funds, appoint the Coordinator, establish regulations for corporation conduct, accept all grant applications, recommend to the RAG action on all reports and requests and approve all studies under $8,000, the Region has a rather comprehensive casting of standing professional Advisory Councils. These are in the fields of: cancer, stroke, heart disease, chronic respiratory disease, kidney, ambulatory care, continuing education plus an ad hoc project review committee. These groups have met from a high of 11 meetings last year (Board of Directors) to a minimum of 1 meeting each for the stroke and heart disease.

Professional Advisory Councils

All Professional Advisory Councils are advisory to the RAG in that they:

1) Develop written guidelines relative to RMP effort in a specific area - the following programmatic guidelines and reports have been or are being developed:

A) A Regional Cooperative Cancer Management Program

B) Report on the Diagnosis and Management of Four Neoplasms

C) Regional Cooperative Stroke Education Program

D) Heart Disease Program Guidelines

E) Guidelines for the Preparation and Review of Proposals for Educational Programs

F) Proposed Chronic Respiratory Disease Program Plan

G) Charge to the Professional Advisory Council on Ambulatory Care (Ambulatory here refers to Health Services rendered to all those who are not in-patients)

2) Assess progress being made by such efforts

3) Serve as additional Review Committee to that of a formal Project Review Committee

4) Recommend specific implementation of applicable MARMP Priorities that will accomplish the most with limited funds

Review Procedure

A prospective applicant has many avenues of proposal development assistance in this Region. These will include MARMP staff and may include the four universities having full-time planning capabilities, professional advisory councils, voluntary health organizations, hospitals and other health and educational institutions.

The Ad hoc Project Review Committee has a potential of 64 members, met 8 times during the past year and has the function of recommending approval/disapproval to the RAG of all requests over $8,000. An Ad hoc Project Review Committee is appointed to review each completed proposal and make its report and recommendations to the RAG. While it is known from previous experience with this Region that the Local Review Process is thorough and comprehensive, the upcoming site visitors will have an opportunity to inquire into the specific processes of the system. Inherent in the review process is the right of appeal. Members of the RAG have established an individual rating system which aligns each proposal with a priority listing numerical place and relates it to a program priority.

Program Priorities

On March 13, 1970 the Regional Advisory Group approved and ranked new program priorities for MARMP briefly, these are:

Ranking	Objective
1st Highest	Immediate health service needs of the poor (both black and white) in the major metropolitan centers and in designated areas inhabited by rural poor
2nd Highest	To increase the delivery of health services
3rd Highest	To prevent disease and its complications
Next to Lowest	General professional Continuing Education to improve the quality of treatment services
Lowest	All other things compatible with Public Law 91-912

The total Regional program for the first year of the triennium and related to these priorities is shown on the chart (pg.15). Included in the RAG report portion of the application, the RAG outlines some Regional strategies. However, staff in its review of the total application had some difficulty in establishing a realistic time frame in which the Region planned to implement its priorities. Some of the proposed program did not appear to reflect any new approach but simply a continuation of the "same old thing." Staff also realized that as this application was being prepared, new national health priorities were being established and these would require a fair "turn around" period.

PRESENT APPLICATION
THE DEVELOPMENTAL COMPONENT

The Region requests developmental funds of $180,000 for each of three years. The Region cites examples of how it plans to implement the newly approved program strategies and thus its priorities through the use of developmental funds. Specific ideas are included for the use of these funds to implement actions suggested by the Region's several Professional Advisory Councils as most important in improving the availability, accessibility, and acceptability of quality health care services. Then too, the special funds could be used to quickly respond to new requests within the Region's top three program priorities. Down through the years the Michigan Region has developed an excellent record for using small amounts of funds in problem solving and in gathering necessary information to add strength and promote growth of its program.

The RAG has developed (and approved) a method of procedure for administering these funds. Briefly, any component costing $8,000 or less and meeting six other stated criteria may be handled by the Board of Directors. Other requests will be considered in the Region's usual peer review system. A specific contract will be negotiated with each organization funded. Allocation of funds are to be on a reimbursement basis requiring monthly fiscal and periodic program reports.

Core	Requested (D.C.) Fourth Year (First year of Triennium)
	$279,234

Central core activity is currently supported in the Region's third operational year for a total of $283,706 (D.C.) This amount supports a staff of nine full-time personnel plus the necessary and usual expenses.

This application requests two new field representative positions in the first year of the triennium. If funded, this would increase this type of personnel from the present two to a total of four field representatives.

MICHIGAN REGIONAL MEDICAL PROGRAM TRI[illegible] REQUEST AS OF MAY 1, 1971

CATEGORIZED BY PROGRAM PR[illegible] FOR 04 YEAR - FIRST

YEAR OF TR[illegible]

DIRECT COSTS ONLY

Prepared by GRB - 5/25/71

	Core	Highest Priority Immediate health service needs of the poor (both black & white) in the major metropolitan centers and in designated areas inhabited by rural poor	2nd Highest Increase the delivery of health services	3rd Highest Prevent disease and its complications	Next to Lowest Genral professional continuing education to improve the quality of treatment services	Lowest All other things compatible with P.L. 91-912	Not Rated	Total request
Continuations within approved period of support			#17 - Stroke base center - W.S.U. #19 - Stroke Demonstration Unit. Detroit Osteopathic Hospital. #20 - Central Mich. Comprehensive Stroke Program-M.S.U. #26 - Inner City continuing education Program-W.S.U. $296,756	#18 - Comprehensive Attack on problems of stroke-W.S.U. #21 - Stroke Education Program-Michigan Heart Assn. $175,124				471,880
Continuations beyond approved period of support (Renewal)	#1 Central Core $279,234	#14-Subregional planning-Wayne State $221,387	#22-Develop CVR Center-Mercy Hosp. Benton Harbor #25-Western Mich. Medical Education Program-Blodgett Hospital, Grand Rapids $102,580	#15-Subregional planning-Zieger/ Botsford Hospitals $116,500	#3-Data Collection Dept.of Pub.Health #4-Model CCU-Mich. Heart Assn. #16R-Surveillance of electronic equipment-Michigan Heart Assn. $478.030		#5-Subregional Planning Michigan State $172,798	1,370,529
Approved not previously funded		#27-Comprehensive health care for urban poor-Wayne County General Hospital #31-Community health services coordinators-WSU $712,622	#29 Care of stroke in a general hosp. Detroit Memorial Hospital $120,530	#30-Southeast Michigan Regional Cancer Program-W.S.U. $220,720				1,053,872
New proposals		#32-Lakeside comprehensive health care for the poor-Zieger/ Botsford Osteopathic Hospital $160,000		#33-Stroke Day Care Center-Martin Place D/O Hospitals $102,350				262,350
Developmental Component							Developmental component $180,000	180,000
TOTALS	$279,234	$1,094,009	$519,866	$614,694	$478,030		$352,798	$3,338,631

The application describes a small but energetic and productive core staff operation which moves in the areas of planning, support in identifying needs, assistance with project development and in evaluation of operational effectiveness. Also the fourth year request outlines support for either continued or new support for several core-supported feasibility or planning studies. Example: nursing survey, Detroit General Hospital. The core budget escalates in the 5th and 6th year due to the new staff additions and normal salary increases. No indirect costs are requested for central core.

Request Fifth Year	Request Sixth Year
$294,200	$320,400

Also, the Region currently provides support for four Subregional Planning Agencies (on contract) which are located in 3 medical schools and an osteopathic hospital(s).

These are:

Institution	Current Support (D.C.)	Personnel Full-time Equivalents
Michigan State University	$163,107	7
University of Michigan	23,480	3
Wayne State University	148,160	5
Zieger/Botsford Hospitals	64,840	2

Funds to these four agencies are provided for the planning, promoting, facilitating and/or the coordinating of activities of concern to the Regional Medical Program. These subregional planning offices are discussed below.

Project #5 - Subregional Planning Offices
Michigan State University

Requested (D.C.)
Fourth year
$172,798

This project is currently supported for $163,107 (D.C.). Continued support is requested to assist local health providers to expand and improve health services to medically and economically disadvantaged rural poor in Central and Southwestern Michigan. The progress report briefly describes seven small pilot scale programs which have been initiated. For example, a community Health Aide Program was instituted in conjunction with the Lansing Housing Commission. Since October 1970, 58 patients have been referred to the project nurse.(?)Plans for the future are geared more toward the Region's priorities rather than on categorical emphasis. Also, MSU-RMP is working with the C.H.P. 314-b Agency in an experimental Health Services Planning and Delivery System grant.

The MSU-RMP has been supported by MARMP since 1967. This application requests three additional years of support. The applicant originally estimated approximately $67,000 total unexpended funds for the current

year. This amount may change due to the recent budget compressions.

In its review of the request for continued support, the local Project Review Committee believed that the MSU has a greater potential for contributing to the RMP effort than was reflected in this application. Therefore, the Review Committee recommended to the RAG that the University completely restructure its request and identify a specific area upon which it could concentrate its efforts. The RAG concurred. If this request is funded, the funds will be held by the corporation pending an approvable program plan.

Requested Fifth Year (D.C.)	Requested Sixth Year (D.C.)
$170,000	$170,000

Project #14 - Wayne State University

Requested (D.C.) Fourth Year
$221,387

This program is currently supported at the $148,160 level. Three years of continued support are requested to enable WSU-RMP to increase the capacity of the Health Care Systems to provide expanded and more relevant care directed especially toward primary patient care. The primary thrust of the University program is directed toward the Metropolitan Detroit area. The WSU-RMP has participated with OEO, CHP and HUD in the design and implementation of a comprehensive health care (HMO) delivery model for Model City residents where family oriented care is being provided to an enrolled, prepaid population of 10,000 men, women and children on a capitation basis. The application proposed that this effort be expanded to include other defined population groups. Also, WSU-RMP have developed several other major projects which have been approved and are currently being funded. In fact, several of the professional staff, which are supported under the WSU-RMP planning office, are also listed (without compensation) as individual project directors. These WSU projects will be discussed individually later in this summary. The Wayne State University Subregional Planning Office was ranked number two priority in this application.

Requested Fifth Year	Requested Sixth Year
$276,800	$299,500

Project #15 - Zieger/Botsford Hospitals

Requested (D.C.) Fourth Year
$116,500

This program is currently supported during its third year at the $64,840 (D.C.) level. Continued three-year support is requested. Geographically

this is a two-pronged program aimed at the osteopathic physician (1900 D.O.'s in Michigan) in the Greater Detroit, Lansing-East Lansing area.

The objectives are:

1) To identify items of clinical behavior for specific diseases to be recorded and serve as an index of care.
2) To program the above for computer analysis.
3) Application in eight osteopathic and three medical hospitals to obtain base line data and comparative data on treatment received by the "poor" and "near poor".
4) To improve care through indicated intervention.
5) To evaluate progress through measurement of altered clinical behavior.

A self-administered survey-examination to determine physician knowledge involving some of the osteopathic physicians in Michigan was conducted under project support. (1700 examinations distributed - 31% completed). Physician knowledge gaps were identified and remedial educational programs based on these gaps have been or are being instituted and evaluated. The Subregional Planning Office is working closely with the Michigan State University RMP Office to involve the university medical hospitals in these activities. The budget request escalates almost 100% fourth year compared to the third year funding. The current request would add a new professional position (Evaluator-Statistician) and would allow for normal salary increases and provide $30,000 subcontract funds to be entered into with the Commission on Professional and Hospital Activities. This program was awarded a number three priority in the total application.

Fifth Year (D.C.) Request	Sixth Year (D.C.) Request
$123,072	$129,629

Staff in its review of the triennial application had the following concerns regarding the Subregional Planning Offices:

1) Are these in reality subregional planning offices or separate and independent units?
2) What are the relationships of the subregional planning offices to the central core staff?
3) Staff believes that some statement is indicated which will clearly clarify the relationships to RMP and to each other of the planning offices. Staff further noted that the University of Michigan subregional planning office is not requesting support in this upcoming triennium. It has been learned that the University of Michigan application was too meager to enable the Project Review Committee to make any determination. The RAG concurred and suggested that the University may wish to restructure its request which could

then be considered on its merit. Also, the RAG recommended that an amount of funds be retained in the corporation budget which could be available for any such program receiving RAG approval.

Requests for Continuation of Projects Within Approved Periods of Support

Project #17 - Stroke Base Center - Wayne State

Requested (D.C.) Fourth Year $26,865

This project is currently supported at the $16,000 (D.C.) level. As noted on the enclosed fiscal break-out sheet, funds for the Region's sixth year are requested which is beyond the approved period of support for this particular project. Continued support is requested to provide professional consultation to the cooperating stroke centers and stroke information program, assist in the design of professional educational opportunities to meet their needs, and be responsible for the overall evaluation of the Region's stroke program.

The Program was approved during June 1969 and funded during June 1970. A part of this was due to the relocation of the original Project Director (Dr. John Meyer). The progress reported thus far is in futuristic terms. An evaluation protocol has been developed which excludes surgical procedures and measures of patient status. The evaluation tool is to be tested at the Lapeer County General Hospital by a recently employed Record Analyst. In approving the project, the RAG conditioned the approval on the project including information on surgical procedures and measures of patient status. This project was awarded a priority ranking of sixth in the total application. It is related to program priority Category II - Prevention of Disease and its Complications.

Requested (D.C.) Fifth Year $33,980

Requested (D.C.) Sixth Year $38,293

Project #18 - Comprehensive Attack on the Problems of Stroke - Wayne State Univ.

Requested (D.C.) 4th Year $116,174

This project is currently supported at the $80,000 (D.C.) level. As noted on the enclosed fiscal breakout sheet, funds for the Region's sixth year are requested which is beyond the approved period of support for this project. The project was approved on 6/11/69 and funded on 7/11/70, under a new Project Director (Dr. John Gilroy rather than Dr. Meyer). Due to renovation and reorganization at Detroit General Hospital, opening of a 6-bed demonstration unit was delayed until 12/70. Progress is reported in terms of a multi-disciplinary conference which is being held weekly for those involved in the care of patients from the departments

of Neurology and Physical Medicine. This project is related for evaluation purposes to Project #17 - Stroke Base Center - Wayne State. The objectives of the program are to enable practicing physicians, R.N.'s L.P.N.'s, P.T.'s and Social Workers to gain the necessary knowledge, skills and attitudes to function optimally in the prevention and management of stroke patients. In the future years, the project hopes to involve these professionals from seven inner-city hospitals.

Personnel accounts for $112,224 of the total 4th year request of $116,174. As of February 1971 recruitment efforts were continuing for a nurse supervisor O.T., social worker and a pharmacy consultant. Also, the RAG in its review of the project, conditioned its approval on the submission of an approvable training program (course outline, class size, bibliography, etc.)

This project was awarded a priority ranking of fifteenth in the total application. It is related to Program Priority III - Prevent Disease and its Complications.

Requested Fifth Year	Requested Sixth Year
$128,000	$138,950

Project #19 - Stroke Demonstration Unit - Detroit Osteopathic Hospital

Requested (D.C.) Fourth Year
$99,990

This project is currently supported at the $84,775 (D.C.) level. Funds are requested for the Region's sixth year which is beyond the approved period of support for this project. The project was approved during June 1969 and funded during June 1970. A 16-bed stroke demonstration unit became operational on 9/15/70. At the time this application was prepared, 55 patients had been admitted to the unit - 48 with acute stroke and 7 with T.I.A. investigation.

Continued support is requested "to improve the quality and develop more uniform standards of care provided patients with stroke in Michigan by utilizing the center to train physicians and allied health professionals from participating hospitals." The project is receiving good cooperation from other Michigan osteopathic hospitals. This is one of the three funded stroke cooperating centers in the Region. (Detroit Osteopathic, Detroit General and Sparrow Hospitals). During its review of this request the Project Review Committee noted the apparent greater progress in this program as compared with the other two cooperating centers. The educational phase of the project is expected to be fully operational by March 1, 1971. For this reason, no information is available as to number and types of students, etc.

The Project Review Committee recommended approval subject to the programs submitting by May 1, 1971 to the MARMP Board of Directors, a formal course outline including educational goals for each of the disciplines involved. Detroit Osteopathic Hospital expects to maintain the unit and all project personnel as a regular cost of operation upon termination of RMP funding. Requests for personnel is $83,360 in the first year $99,990 request.

This project was voted a priority ranking of eleven out of the total application. It is related to Program Priority II - Increase the Delivery of Health Services.

Requested (D C) Fifth Year	Requested (D.C.) Sixth Year
$107,870	$107,870

Project #20 - Central Michigan Comprehensive Stroke Program

Requested (D.C.) 4th Year $72,564

The project is currently supported at $88,655 (D.C.) level. Funds for the Region's sixth year of support are requested which is beyond the approved period of support for this project. The project was approved during June 1969 and funded during June 1970. A 4-bed Stroke Demonstration Unit has been established adjoining the rehabilitation unit of the Sparrow Hospital. During the period 1/20/71 to 3/24/71, 18 patients were admitted to the unit. There were 4 deaths. A weekly multidisciplinary conference is held and written patient progress reports are sent regularly to attending physicians for modification of care or for additional diagnostic studies. A Stroke Committee has developed routine diagnostic, laboratory and nursing procedures and developed charts for graphic reporting of patient progress. Evaluation is being coordinated by the Wayne State University Stroke Base Center.

Continued support is requested for this activity with the hope that by demonstrating good patient care learning will follow by osmosis. This project was awarded a priority rating of eighteenth in the total application. It is related to Program Priority II - increase the delivery of health services

Requested (D.C.) Fifth Year	Requested (D.C.) Sixth Year
$78,451	$78,451

Project #21 - Stroke Education Program - Michigan Heart Association

Requested (D.C.)
Fourth Year
$58,950

This project was initiated during September 1970 and is currently supported at the $57,216 (D.C.) level. Two years of continued support is requested to provide a public education program regarding stroke risk factors. The objective of the project is to reduce the incidence and/or severity of premature stroke.

Radio and T.V. spot announcement scripts have been developed and will be produced during April 1971. The air target date is June 1971. Also, printed material for public distribution, speaker outlines and printed media material are being developed. Both the mass media and individual materials are aimed at providing public information regarding:

1) Predisposing stroke factors and their avoidance
2) Symptoms of incipient stroke so that medical advice is sought early enough to either avoid, postpone or modify an impending stroke. The concept was originally submitted as part of the Wayne State University stroke project.

Evaluation will consist of random sample interviews with the public and with selected groups of physicians. An out-of-state control community will be used. The University of Michigan Research Center is cooperating in the development of the evaluation instrument. Phase out plans and financial take-over of the activity are not firm.

The Project Review Committee raised a question regarding the $36,000 out of a total request of $59,000 which is requested for sub-contracts in view of their non specificity. If this project is funded this concern will be satisfied.

The project was voted a priority listing of seventeenth out of the total application. It is related to Priority Category #III - Prevent Disease and its Complications.

Requested (D.C.)
Fifth Year
$60,550

Project #26 - Continuing Education Program for Inner-city Hospitals - Wayne State University

Requested (D.C.) Fourth Year $97,337

This project is currently funded at the $80,219 (D.C.) level. The initial funding began on July 1, 1970. Funds for the Region's sixth year of support are requested which is beyond the approved period of support for this project. Continued support is requested to achieve the project's objective which is to improve care provided to patients with heart disease, cancer, stroke and related diseases in Detroit Inner-city Hospital. Full staffing has almost been accomplished with the exception of a medical school physician coordinator. Hypertension was identified as the first patient care problem. All hospital medical staffs (Detroit, Boulevard, Kirwood and Lakeside General Hospitals) have approved criterion practice for hypertension; actual practice data has been collected, reviewed and evaluated; initial intervention has been designed and implemented and post-intervention monitoring is in process. It is expected that two additional patient care problems will be defined and standards of care agreed on during the current year. Plans for the triennial period include the establishment of 12-15 patient care problem areas. Also, additional inner-city hospitals are to be brought into the project.

Personnel request for 71-72 is $88,000 of the total direct cost budget of $97,000.

A part of the evaluation methods are to analyze pre and post-intervention data.

Plans for continuing the program following withdrawal of RMP funds are not specified.

Requested (D.C.) Fifth Year $97,337

Requested Sixth Year $97,337

Project Continuations Beyond Approved Period of Support(Renewals)

Project #3 - Health Services in Six Michigan Counties - Data Collection-(formerly called E.C.H.O.) Michigan Department of Public Health

Requested Fourth Year $197,982

This project is currently supported at the $227,490 (D.C.) level. It was initially funded as a part of the Region's planning grant and has been supported for three years under the Region's operational phase. In the Region's operational phase, funding has come from various sources, but the initiating and primary source has been MARMP. Through June 30, 1970 MARMP has provided over 60% of the funds ($518,886). Two year RMP continued support is requested "to produce and stimulate the use of timely information on population, environment, health needs and services and to measure changeover time to develop the use of the extended vital statistics system."

Progress is reported in terms of vital statistics extension and health survey demonstration. According to the application, now that a basic methodology has been developed, continued RMP support is requested (50% first year - 25% second year - third year, none) for 2 years of a 3-year program to demonstrate the utilization of the data generated in six defined localities (Adrian, Detroit, Flint-Genesee County, Grand Rapids, Lansing and Muskeegan). The 1970-71 request had 11 objectives. The first nine concern refinement of statistical procedure, relating mortality and environmental data to geographic local dissemination of data, the use of non-professional community health analysts and alternative ways on how to finance the survey process. The remaining two objectives are related to MARMP.

1) To produce information on heart disease, cancer, stroke and related diseases as contributory causes of death in relationship to total causes of death.

2) To provide technical statistical consultation to MARMP and MARMP Projects.

The project is related to several federal programs: C.H.P. (A) (B) (D), Model cities, NCHSRD and OEO. In approving the request the RAG conditioned its approval upon assurance of availability of both local ($225,000) and state ($143,000) funds.

The project was voted a priority of twenty-one in the total application. It was considered to be related to Program Priority III - Prevent Disease and its Complications.

Requested (D.C.)
Fifth Year

$100,000

Sixth Year

None

RMP Staff in its review of the Triennial application, had great difficulty in trying to relate project #3 to the Region's priorities.

Project #4 - Model CCU - Michigan Heart Association

Requested (D.C.) Fourth Year
$146,900

The project is currently supported at the $103,000 level. The program was initially funded during September 1968. Three-year continued support is requested to: (1) offer physicians training in the management of acute coronary disease; (2) offer nurses training in patient management in coronary care units. Since September 1968 and through January 1971, this project conducted 12 community centered courses attended by 632 physicians from 149 hospitals and 34 community centered courses attended by 742 nurses from 135 hospitals, 73% of which had CCU's. It has developed a programmed instruction system for use by institutions wishing to train CCU nurses. All courses have been held in accordance with the proposed schedule. The physicians' courses were taught by 75% local faculty and the nursing courses by 100% local faculty.

The request for continued support is a RAG directed combination of the University of Michigan School of Nursing and the Michigan Heart Association effort to draw on a single program component based on the improvement of patient care.

Council policy as it relates to CCU's which was adopted at its November 9-10, 1970 meeting, is quoted:

"Coronary care units: Council affirmed that although coronary care units are now established community resources, Regional Medical Program funding units may be desirable when such units make important contributions to regionalized improvement in medical care, including overall efficiency and cost and when projects are planned to disengage from Regional Medical Program support promptly. To qualify for Regional Medical Program assistance, coronary care unit projects must also meet the following conditions: (a) An organizational structure and staff capable of implementing a high quality system must be present; (b) the mechanisms for entry into the system require development; and (c) RMP funding does not finance established technology, equipment, or patient service operations.

Training for coronary care units: Council requested RMPS to instruct all Regional Medical Programs having coronary care unit training projects to disengage Regional Medical Program funding at the end of their current project periods or within a reasonable period thereafter as noted above."

The program was voted a priority ranking of 20 in the total application. It was considered to be related to Program Priority IV - General Professional Continuing Education to improve the quality of treatment services.

Requested (D.C.) Fifth Year	Requested (D.C.) Sixth Year
$142,006	$150,042

Project #16R - Surveillance of Electronic Equipment
Michigan Heart Association

Requested (D.C.)
Fourth Year
$133,148

This project is currently supported at the $53,044 (d.c.) level. The project was initially funded for one year on May 1, 1969, through the Wayne State University. The July 1970 Council recommended approval for one additional year. During the operation of the project, it became clear to the Region that a key element in the MARMP goal of promoting replacement financing of projects would and could be served by collecting service fees from hospitals. This procedure conflicted with Wayne State University policy. Therefore, and by mutual consent, the project has now been transferred to the Michigan Heart Association. RAG approval of the transfer was based primarily on making the project self-supporting.

Three years continued support is requested in this application. The primary objective is to establish effective preventative maintenance practices and programs for electronic equipment in critical care areas. Since May 1969, and until the time this application was prepared, a total of 13 initial hospital surveys and two re-surveys have been completed. The progress report indicates this is far below the original estimate because of technical difficulties and the fiscal problem outlined above. The results of the program evidentally are receiving national publicity, i.e. national and regional meetings, seminars and publications.

Project personnel are continuing to work through the Intersociety Commission for Heart Disease Resources to develop guidelines for optimum use and maintenance for electronic equipment throughout the nation. Evaluation is proposed in terms of questionnaires being sent to participating hospitals to determine action on the recommendations of the team. The local reviewers obviously had difficulty in arriving at a recommendation. For example, the Project Review Committee members were unanimous in acknowledging the value of the program but believe that such activities might be more effective and appropriate for an agency capable of enforcement and long-term service. An amount of $100,374 of the first year of the three year triennial request of $133,148 is for personnel. If funded, this would add a second full-time engineer plus a ½-time secretary. This project was voted a priority listing of 22 out of the total application. It is related to Priority Category IV - General Professional Continuing Education to Improve the Quality of Treatment Services.

Requested (D.C.) Fifth Year
$133,148

Requested (D.C.) Sixth Year
$133,148

Project #22 - Cardiovascular Center - Mercy Hospital Benton Harbor

Requested (D.C.) Fourth Year
$16,530

This project is currently supported at the $28,920 (D.C.) level. The program was initially funded during October 1969. One terminal year support is requested. The project involves eight area hospitals. A modern cardiac catheterization and angiography laboratory has been established in the base hospital; a referral clinic has been established; a teaching program attended by 30 nurses has been com pleted with additional courses planned; CCU units (total 20 beds) have been established in seven of the eight participating hospitals; a seminar was held on "acute emergencies and their management" (attended by 50 M.D.s and 25 nurses); and in a three-month period, eleven persons were resuscitated by people trained in this program. Plans for the future are to expand and make more effective the work that has been developed. The project was voted a priority listing of seven out of this total application. It is related to Priority Category II - Increase the Delivery of Health Services.

No support requested for the fifth and sixth years of operation.

Project #25 - Western Michigan Medical Education Program - Blodgett Memorial Hospital, Grand Rapids

Requested (D.C.) Fourth Year
$86,050

This project is currently supported at the $73,429 (D.C.) level. It was initially funded (from carryover funds) during March 1970.

Three-years continuing support is requested. The objective of the program is to extend to physicians in smaller hospitals expert knowledge to improve the diagnosis and treatment of the cardiac patient. Using medical staff self-study methods, cardiology consultants from three medical schools have visited ten community hospitals (total 125 visits). The Kellogg Foundation is assisting three of the smaller hospitals in establishing CCUs. The project has provided reciprocal benefits and has made a measurable impact on the beginning of regionalization. Future plans are for expanded outreach activities to include five additional hospitals and adding new activities. (Arteriosclerotic Heart Disease) Detailed subjective and objective evaluation methods are utilized.

The 71-72 request of $86,050 includes $61,000 for personnel and $14,400 for consultants.

The project was voted a priority listing of ninth out of the total application. It is related to Priority Category II - Increase the Delivery of Health Services.

Requested (D.C.) Fifth Year
$91,550

Requested (D.C.) Sixth Year
$97,000

APPROVED PROJECTS NOT PREVIOUSLY FUNDED

Project #27 - Comprehensive Health Care for the Urban Poor - Wayne County General Hospital

Requested (D.C.) Fourth Year (1st Year Triennium) $505,269

This project grew out of a planning study which was supported by MARMP from June 1967 through August 1970 for $61,000. This period allowed the Region time to recast the original request following the recommendations of a technical site visit team. The revised project was approved during the July 1970 National Advisory Council.

In the period since this application was submitted, the Region has rebudgeted $69,941 (D.C.) to partially support the program through 8/31/71. The project was voted number one priority out of the total application. It is related to the Region's highest priority - immediate health service needs of the poor in the major metropolitan centers.

The program is being conducted in cooperation with O.E.O., the University of Michigan School of Public Health (for evaluation), the State Health Department and five voluntary health associations.

The objectives are to: (1) Demonstrate increased effectiveness of comprehensive health care compared with episodic care; (2) Improve patient care with available health professionals and to decrease costs by training sub-professional health workers.

Requested (D.C.) Fifth Year $454,574

Requested (D.C.) Sixth Year $477,459

Project #29 - Cooperating Stroke Center Detroit Memorial Hospital

Requested (D.C. Fourth Year (1st Year Triennium) $120,530

This project was approved by the November 1970 National Advisory Council. During the interim since this application was submitted, the Region has rebudgeted $39,811 (D.C.) to initiate and carry the program through 8/31/71. It was voted a priority rating of sixth out of the total application and is related to the Region's second highest priority - increase the delivery of health services.

The program adds a fourth major hospital to the Region's cooperative stroke program. It is to operate under the cooperative guidance of the Wayne State Stroke Base Center. In addition to providing continuing education for M.D.'s and paramedical personnel at Detroit Memorial, it will provide the same service in five other community hospitals. It

is to involve a specialty team, clinic facilities and a 25-bed stroke unit at Detroit Memorial. Teaching sessions are to be conducted at the participating hospitals. The project will involve the establishment of diagnostic procedures and evaluation criteria; will establish screening clinics and will strive for early patient transfer to rehabilitation care facilities or to home.

Requested (D.C.) Fifth Year	Requested (D.C.) Sixth Year
$120,880	$149,690

Project #30 - Southeastern Michigan Regional Cancer Program - Wayne State University

Requested (D.C.) Fourth Year (1st Year of Triennium) $220,720

This project was originally submitted to RMPS in January 1970. It was returned for some revision. The revised application was approved, at a reduced level, by the National Advisory Council during its February 1971 meeting. Currently it is not receiving any RMP funds. The project was voted a priority rating of fourth in the total application. It is related to the Region's second highest priority - increase the delivery of health services.

This is the Region's first cancer program. Its objectives, in cooperation with a model neighborhood program, are to:

(1) Improve cancer patient care and hospital facilities.
(2) Demonstrate feasibility of five small inner-city hospitals utilizing one medical social worker.

To accomplish these objectives the program is planned to:

(1) Provide inservice training to physicians whom other physicians look to for advice.
(2) Increase existing radiation therapy capability.
(3) Train in-service nurse educators.
(4) Evaluate the three-year impact of these activities.

Requested (D.C.) Fifth Year	Requested (D.C.) Sixth Year
$229,433	$251,609

Project #31 - Model Neighborhood Comprehensive Program Inc. - Community Health Service Coordinators (Developed by Wayne State University Staff)

Requested (D.C.) Fourth Year (1st Year Triennium) $207,353

This project was approved by the National Advisory Council during its February 1971 meeting. During the interim, since the time this application

was submitted, the Region has rebudgeted $16,000 (as stipend support) to support two trainees into the program. The project was voted a priority rating of eighth in the total application. The project is related to the Region's highest priority - immediate health service of the poor in the major metropolitan centers. The primary objective of the project is to demonstrate, test and evaluate the use of new personnel (Community Health Service Coordinators) who are to assist in providing comprehensive health care services to a defined, prepaid population. An amount of $161,172 is requested for personnel out of a first year request of $207,353 (D.C.). If funded, this project would interdigitate with Project #27 - Comprehensive Health Care for the Urban Poor. Also, the project appears to represent an excellent example of a cooperative effort between an RMP and a Model Cities Agency. Plans for gradual local takeover are described.

Requested (D.C.) Fifth Year	Requested (D.C.) Sixth Year
$196,665	$196,665

NEW PROJECTS

Project #32 - Lakeside Comprehensive Health Care for the Urban Poor - Michigan College of Osteopathic Medicine - Zieger/ Botsford Hospitals

Requested (D.C.) Fourth Year (1st Year Triennium) $160,000

This proposal requests three-year support to assist in the development of a comprehensive health care delivery system for a low income area. Its geographic scope will be the low income area of the city of Pontiac. The program is a part of a cooperative effort between the MARMP, O.E.O, CHP(b) and Vocational Rehabilitation. The program is presently in operation, on a limited basis, and is funded through the Michigan State University Department of Community Medicine, Pontiac Housing Commission and the O.E.O. (Headstart) program. The total first year budget is $646,700. An amount of $200,000 total costs is requested as MARMP's share. The remainder is to be provided from other sources. The primary objectives of the program are to:

(1) Provide an entry point into the health delivery system.
(2) Demonstrate the value of a three-level preventive and ambulatory program.
(3) Provide for continuity of care through two family practice teams.
(4) Develop an adequate pre-payment mechanism over the three-year period.

Personnel requests include a gamut of 24 full-time, three part-time personnel (physicians to typist/receptionists).

This proposal was voted a priority listing of tenth in this application. It is related to the Region's highest priority - immediate health service needs of the poor in the major metropolitan centers.

Requested (D.C.) Fifth Year	Requested (D.C.) Sixth Year
$200,000	$200,000

Project #33 - Comprehensive Stroke Day Care Center
Martin Place Hospital - East

Requested (D.C.)
Fourth Year
(1st Year Triennial)
$102,350

Three-year support is requested for this new proposal which is to become the fifth component of the MARMP stroke program. (Base center - Wayne State, Detroit General, Detroit Osteopathic, Detroit Memorial (not funded) and Sparrow Hospital in Lansing.)

Martin Place Hospital-East (269 beds) and Martin Place Hospital-West (154 beds) in Detroit have a common administration and each hospital has a four-bed acute stroke unit. They have a single medical staff of 219 osteopathic physicians which includes specialists in neurology, psychyiatry, neurosurgery, vascular and cardiosurgery and internal medicine.

The primary objective of the proposal is to reduce health care costs and aid in the return of the stroke patient. The proposed method to accomplish the objectives are to establish a day care center at Martin Place Hospital-East.

The program is specifically designed to reduce the health care costs of stroke patients and to more quickly re-integrate them in normal life. The center, when appropriate, will strive for a "day in the hospital, night at home" program.

A special modified bus, supported and staffed by the center, will be used to transport patients. Services to be provided will consist of a complex of medical and allied services which will be individually planned based upon the number of patient visits to the center.

The program is expected to become self-supporting through third-party payments.

The proposal was voted priority listing of fifth in this application. It is related to a program Priority Category III - prevention of disease and its complications.

Requested (D.C.) Fifth Year
$104,000

Requested (D.C.) Sixth Year
$112,177

RMPS/GRB
5/27/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

MICHIGAN REGIONAL MEDICAL PROGRAM
RM 00053 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: The Review Committee recommended that the Region be awarded $2,100,000 for each of three years including developmental component funds.

DIRECT COSTS ONLY

YEAR	REQUEST	RECOMMENDED
04	$3,338,631	$2,100,000
05	3,322,516	2,100,000
06	3,328,220	2,100,000
TOTAL	$9,989,367	$6,300,000

CRITIQUE: The recommendations of the June 9-10, 1971 site visit team were considered and recommended for approval. Since no Committee member participated in the site visit, two of the site visitors were present to highlight the team's findings and answer Committee reviewers' questions. The Committee agreed with the visitors that the Michigan RMP is a strong and viable program which has led to remarkable cooperation among the academic medical sectors, the providers and consumers of service. The Committee noted that the Region has assembled a small but cohesive central core staff which has demonstrated its competence and leadership. The Regional Advisory Group, which represents many of the health interests in the state and a wide geographic area, is effectively carrying out its responsibilities. The RAG is obviously a strong arm of the MARMP and is in control of the review and planning processes of the Region.

A major concern of the Reviewers was the resignation, effective 9/1/71, of the Program Coordinator. Dr. Heustis has been associated with the MARMP since early in its planning phase. Members of the site visit team had explored the anticipated results of this action with the search committee. They were advised that four qualified candidates are currently being considered. Further, the Region is administratively structured to permit any of these individuals to carry on the mission of the program with a minimum of interruption. The committee was assured that Dr. Heustis' resignation was for personal, rather than professional reasons.

A second concern was that while the Region's priorities are very well stated, and consistent with the mission and objectives of RMPS, their goals and objectives need to be explicitly stated, in terms of being quantifiable and related to a time frame for evaluation of progress and achievement. The reviewers learned that a 3-day retreat is planned for August 1971 to accomplish this. The reviewers noted that four of the Region's major activities proposed for the first year of the triennium are ranked under its number one priority--"Immediate Health Service needs of the poor (both black and white) in the major metropolitan centers and in designated areas inhabited by rural poor."

The Review Committee agreed that the Michigan program has demonstrated the capability and maturity to receive approval of a developmental component. The Region has a long history of prudent use of small amounts of funds to initiate, plan or study new and innovative ideas. During the triennial, plans are to utilize developmental funds to continue this function in relation to program priorities.

The Review Committee, as did the site visitors, believed that the Region should be encouraged to continue its efforts related to the amalgamation of core staff in the sub-regional planning offices.

The Committee acknowledged that the Region's review process meets the requirements for decentralization. The Reviewers agreed with the site visitors' recommendations and suggestions as outlined in the site visit team's report.

The Review Committee recommended for approval the level of support and the conditions developed by the site visit team: approval at a level of $2,100,000 for each of three years to enable the region to:

a) Support a developmental component. The Region requests $180,000 d.c. funds per year.

b) Continue core activities at their current level. All sub-regional planning offices are to be considered and supported as a part of core activity.

c) Provide sufficient funding to support all projects which have been rated as the Region's top ten activities.

d) Provide funding to renew Project #25 - Western Michigan Medical Education Program - Blodgett Memorial Hospital, Grand Rapids.

Neither the site visitors nor the Committee recommend renewal funding for the other projects beyond the approved support period. However, the Region should be allowed to allocate one year funding from within

the $2,100,000 to ensure orderly termination of RMP support. This action will require disengagement of RMP support for two projects that have already been funded for three-year periods - Project #3 - Data Collection - Department of Public Health and Project #4 - Coronary Care - Michigan Heart Association; and for Project #16 - Surveillance of Electronic Equipment, Michigan Heart Association (which has already been renewed once); and will require termination of RMP support for four stroke projects and Project #26 - Continuing Education Program for Inner-City Hospitals, Wayne State University, upon completion of the two remaining years of Council-approved support rather than three more years of support as requested.

Included in the recommended $2,100,000 level are funds to initiate Project #27 - Comprehensive Health Care for the Urban Poor - who reside in the immediate area of Wayne County General Hospital. The MARMP/RAG voted this project as the number one priority activity in the total application.

Dr. Hess was not present during the discussion of this application.

RMPS/GRB/7/13/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 23, 1971

Reply to Attn of:

Subject: Quick Report on Michigan Regional Medical Program Site Visit - June 9-10, 1971

To: Director, RMPS
THROUGH: Acting Deputy Director
Regional Medical Programs Service

Site Visit Team

Alexander M. McPhedran, M.D., Chairman
Emory University Clinic
Atlanta, Georgia

Robert W. Brown, M.D.
Coordinator
Kansas Regional Medical Program
Kansas City, Kansas

Jack H. Hall, M.D., Practicing Cardiologist
Director of Medical Education
Methodist Hospital
Indianapolis, Indiana

RMPS Staff

Joseph Jewell
Grants Review Branch

Jeanne L. Parks
Grants Review Branch

George Hinkle
Grants Management Branch

Eugene Piatek
Office of Program Planning and Evaluation

Elsa Nelson
Continuation Education and Training Branch

Maurice Ryan
Regional Representative

The visitors identified several areas of concern, but were in agreement that the MARMP is an energetic, effective Region with a well directed group of people who have developed maturity in the decision-making process and in developing a program to solve health care problems. The visitors were particularly impressed with the strength and competence demonstrated by the small, but cohesive central core staff and its capability in providing excellent leadership and direction to the program.

The Regional Advisory Group which represents many of the health interests in the state and a wide geographic area is quite effectively carrying out its responsibilities; it clearly demonstrated to the visitors that it is a strong arm of the MARMP; and it is in control over the review and planning process of the Region.

Through the activities of the Regional Advisory Group and its technical review committees, the Region apparently has engaged the interest of many physicians and osteopaths in the State and has involved the activities of the three medical schools and an emerging School of Osteopathy. It has also gained cooperative arrangements with some of the community and county hospitals. However, there was little evidence of active roles or involvement of the nursing or other health professions.

The Region has also made positive efforts toward shifting program planning and development from the earlier focus on the categorical diseases to attacking problems of the health care delivery system, as evidenced by the request for funds to support project #27 - Comprehensive Health Care for the Urban Poor, Wayne County Hospital, which is related to the Region's highest priority - immediate health service needs of the poor in the major metropolitan centers.

The Region's priorities are very well stated and are consistent, if not congruent, with the mission and objectives of RMP. The visitors expressed concern, however, that the Region had not given sufficient attention to explicitly stating program goals and objectives that might be quantifiable and related to a time frame for evaluation of progress and achievement. The visitors believed that the Region was well aware of the need for specificity in program goals and objectives and were advised that this would receive major attention during a 3-day retreat to be held in the near future. The need for an identifiable process in the area of evaluation was another concern of the site visit team and was discussed at great length with representatives of the Region. This appeared to be a somewhat sensitive matter, but the visitors got the impression that the Region is searching for ways to carry out its evaluation process.

A major concern was the impending resignation of the present program coordinator, and what effect this would have on the present program. The team realized that funding levels to be recommended for the next 3-year period would be administered under new leadership. The site visitors met with the search committee and were advised that currently four qualified applications are being considered. The team was also advised that, members of the committee believed that at this point in time, the MARMP is mature enough and so structured as to enable a new coordinator to assume and carry out the mission of the program without interruption.

The Region is currently funded for its third operational year, through 8/31/71, for $1,898,936 (d.c.).

The Region has requested $3,338,631 direct cost for its 4th year; $3,322,516 for its 5th year; and $3,328,220 for its 6th year. The site visitors recommend approval of the triennial application at a

level of $2,100,000 for each of the three years. The site visitors believe that this level will enable the Region to:

a) Support a developmental component.

b) Continue core activities at their current level. All subregional planning offices are to be considered and supported as a part of core activity.

c) Provide sufficient funding to support all projects which have been rated as the Region's top ten priority activities.

d) Provide funding to renew project #25 - Continuing Medical Education.

The site visitors do not recommend renewal funding for the other projects beyond the approved support period. However, the Region should be allowed to allocate one year funding from within the $2,100,000 to ensure orderly termination of RMP support. This action will require disengagement of RMP support for two projects that have already been funded for three-year periods - Project #3 - Data Collection - Department of Public Health and Project #4 - Coronary Care - Michigan Heart Association; and for Project #16 - Surveillance of Electronic Equipment, Michigan Heart Association (which has already been renewed once); and will require termination of RMP support for four stroke projects and Project #26 - Continuing Education Program for Inner-City Hospitals, Wayne State University, upon completion of the two remaining years of Council approved support in lieu of three more years of support as requested.

Jeanne L. Parks
Public Health Advisor
Grants Review Branch

SITE VISIT REPORT
MICHIGAN REGIONAL MEDICAL PROGRAM
June 9-10, 1971

The first day of the meeting was held at the Hospitality House, East Lansing. The second day, the group met in the Council Room at the Michigan State Medical Society in East Lansing.

Table of Contents

I. Site Visit Participants

A. Site Visitors

Alexander M. McPhedran, M.D. - Chairman
Emory University Clinic
Atlanta, Georgia

Robert W. Brown, M.D.
Consultant
Coordinator, Kansas Regional Medical Program
Kansas City, Kansas

Jack H. Hall, M.D.
Consultant
Methodist Hospital
Indianapolis, Indiana

B. Regional Medical Programs Service Staff

George Hinkle, Grants Management Branch
Joseph Jewell, Grants Review Branch
Miss Elsa Nelson, Continuing Education and Training Branch
Mrs. Jeanne Parks, Grants Review Branch
Eugene Piatek, Office of Program Planning and Evaluation
Maurice C. Ryan, Regional Office Representative

C. Staff, Michigan Regional Medical Program

Albert E. Heustis, M.D., Coordinator
Gaetane M. Laroeque, Ph.D., Associate Coordinator
Theodore Lopushinsky, Ph.D., Program Representative
Martin I. Pastor, Assistant Program Coordinator for Finance
David E. Eaton, Field Representative

D. Sub-Regional Planning Office Directors

Leonard Cohen, Ph.D. Zieger/Botsford Hospitals
Dr. George Suhrland and Mr. Jim Lyons, Michigan State University
Mr. Ralph Lewis, University of Michigan
Mr. Marvin Meltzer, Wayne State University

E. Representatives of the Michigan Region

Regional Advisory Group Members

Dr. Michael J. Brennan, Chairman, MRMP/RAC Michigan Cancer Foundation
4811 John R., Detroit, Michigan, 48201 (Michigan Cancer Foundation)

Miss Verna Jo Astley, R.N., Director of Nursing Service,
Butterworth Hospital 100 Michigan, N.E., Gd. Rapids, Michigan 49503
(Michigan Nurses Association)

Dr. Bernard Bercu, Wayne State University, Detroit, Michigan

Dr. Gerald H. Bonnette, Professor of Oral Surgery, School of Dentistry, University of Michigan, Ann Arbor, Michigan 48104 (Michigan State Dental Association)

Mr. Harold W. Byers, Director, Veterans Administration Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105 (Veterans Hospital)

* Dr. Dorothy Carnegie, 840 E. Mt. Hope, Lansing, Michigan 48910 (Michigan Association of Osteopathic Physicians and Surgeons) (President, Board of Directors, MARMP)

* Dr. Ethelene Crockett, 1327 Nicolet Place, Detroit, Michigan 48207 (Wolverine Medical Society)

* Dr. John Gronvall, Dean Medical School, University of Michigan, 1335 Catherine St., Ann Arbor, Michigan 48104 (University of Michigan)

Dr. Bonta Hiscoe, 2909 E. Grand River, Lansing, Michigan (Michigan State Medical Society)

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Professional Advisory Councils

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Dr. Robert P. Locey, Chairman, Proj. Director, Primary Care Study, 517 Ship St., Room 4, St. Joseph, Michigan (Chairman of Ambulatory Care PAC)

Dr. Yoshikazu Morita, 3535 W. 13 Mile Rd., Royal Oak, Michigan 48072 (Chairman of Kidney PAC)

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Program Directors and Others

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II. INTRODUCTION

The site visit was conducted following submission of the Michigan RMP's application for three years of continued funding. On August 31, 1971, the Region will have completed its initial 3-year operational period.

Under the new anniversary and award system, the purposes of the site visit were to: 1) review the Region's overall progress; 2) to examine in depth the experience and achievements of the ongoing program; 3) how this experience has (or will) modify program goals, objectives and priorities; 4) to consider the Region's prospects for the next three years and 5) then to arrive at a funding recommendation based on the intrinsic qualities of the program. The team met the evening before the meeting began and, based on the written information provided, agreed that the Michigan Regional Medical Program apparently had already reached a point of self-determination and decision-making capabilities that should permit them to have an established amount of money and to develop priorities in the spending of these funds according to the local needs.

III. CONCLUSIONS AND GENERAL IMPRESSIONS

The site visitors were in unanimous agreement that the MARMP is a viable region, and that it is doing an extremely effective job with a sophisticated awareness of the aims of the Regional Medical Program and have fostered exemplary cooperative arrangements in virtually every conceivable way as opportunity has allowed to discharge its responsibilities. In addition, the team was satisfied that there is adequate evidence of regionalization, with extensive cooperation with other community professional and consumer groups; and that the MARMP has a high level of competency and dedication in its operation. The team believed that the fulfillment of the National aims of the Regional Medical Programs is being developed to a high degree of excellence in Michigan.

Based on the various comments made by the broad variety of people who represented the Region, it was the opinion of members of the site visit team that this Regional Medical Program is already having a major impact in the improvement of the entire health care system in the State of Michigan. The team was impressed with the Region's singular determination to improve the health care of the people in Michigan and believed that RMP is evolving as the vehicle to do so.

The visitors were particularly impressed with the strength and competence demonstrated by the small, but cohesive central core staff and its capability in providing excellent leadership and direction to the program.

The Regional Advisory Group, which represents many of the health interests in the State and a wide geographic area, is quite effectively carrying out its responsibilities; it clearly demonstrated to the visitors that it is a strong arm of the MARMP; and it is in control over the review and planning process of the Region.

Through the activities of the Regional Advisory Group and its technical review committees, the Region has attracted the interest and encouraged the active participation of both the allopathic and osteopathic physicians in the State. It has also involved the activities of the three medical schools and an emerging School of Osteopathy. It has also gained cooperative arrangements with many of the community and county hospitals. While there was little evidence of active roles or involvement of the nursing or other health professions, the region recently employed a full-time nurse consultant who is to be based at Ferris State College, Big Rapids, Michigan. The Region has also made postive efforts toward shifting program planning and development from the earlier focus on the categorical diseases to attacking problems of the health care delivery system, as evidenced by the request for funds to support project #27 - Comprehensive Health Care for the Urban Poor, Wayne County Hospital, which is related to the Region's highest priority - immediate health service needs of the poor in the major metropolitan centers.

The Region's priorities are very well stated and are consistent, if not congruent, with the mission and objectives of RMPS. The visitors expressed concern, however, that the Region had not given sufficient attention to explicitly stating program goals and objectives that might be quantifiable and related to a time frame for evaluation of progress and achievement. The visitors believed that the Region was well aware of the need for specificity in program goals and objectives and were advised that this was the major topic to be discussed during a planned, 3-day retreat to be held during August 1971. The need for an identifiable process in the area of evaluation was another concern of the site visit team and was discussed at great length with representatives of the Region. This appeared to be a somewhat sensitive matter, but the visitors got the impression that the Region is searching for ways to carry out its evaluation process.

A major concern was the impending resignation of the present program coordinator, and what effect this would have on the present program. The team realized that funding levels to be recommended for the next 3-year period would be administered under new leadership. The site visitors met with the search committee and were advised that currently, four qualified applicants are being considered. The team was also advised that, members of the committee believed that at this point in time, the MARMP is mature enough and so structured as to enable a new coordinator to assume and carry out the mission of the program without interruption.

IV. REVIEW DETAILS

A. Goals, Objectives and Priorities

The Regional Advisory Group adopted the present program priorities during March 1970. Five major health priorities were adopted which appear to be substantively sound and address the Region's major health needs. For example, the first highest priority and its related objective is "to improve the immediate health service needs of the poor (both black and white) in the major metropolitan centers and in designated areas inhabited by rural poor." However, the Region's objectives and goal are not specific in terms of being quantifiable nor in reference to a time frame for evaluation of progress and achievement. The site visitors were advised that the Region was already aware of the need to strengthen its goals and objectives and have, in fact, scheduled a three-day retreat which will be directed primarily to identify specific goals and objectives related to the priorities and with a proposed time frame. The site visitors realized that when this application was in preparation, the national health goals and priorities had yet to be announced.

Members of the site visit team commended the Region on its foresightedness and were impressed that the Region recognized the necessity for establishing reasonable time-phased goals for the implementation of the established priorities and for the establishment for specific criteria by which the process and the accomplishment will be measured.

Representatives of the Region cited examples of how it plans to implement the newly approved program strategies and its priorities through the use of developmental funds. Specific ideas were cited to implement actions suggested by the Professional Advisory Councils as most important in improving the availability of quality health care service. For example, the securing of improvement of the care of patients with the four selected malignancies (hodgkins disease, carcinoma of the cervix, carcinoma of the uterus and carcinoma of the breast) selected by the Cancer Professional Advisory Council as being those in which the health of the people of the State would have the greatest chance of improvement through the application of existing knowledge. In addition, the developmental funds, could be used to quickly respond to new request within the Region's top three "program priorities"; in seeking ways to extend the process of regionalization to the northern part of Michigan's lower peninsula and to Michigan's northern peninsula; in supplementing University efforts by promoting the linking of larger community hospitals and their staffs to satellite institutions; in facilitating the callaborative working together of the four university medical schools in improving the accessibility and availability of health services in accordance with MARMP priorities; and in working with those who are interested and able to improve the effectiveness of existing health professionals and health-care services.

B. Organizational Effectiveness

It was obvious that the MARMP is made up of a well-directed group of people who have developed maturity in the decision-making process and

in developing a program to solve health care problems. The chairman of the RAG along with the entire Board of Directors were quite candid in accrediting the success of implementing the Region's program to the firm and adroit leadership of the Program Coordinator who has been successful in leading the Region "out of the wilderness". He is supported by an extremely small central core staff which is composed of 5 professionals, highly capable and well-qualified individuals. Since it's inception in June 1967, the Region has provided support to four subregional planning offices located in the three medical schools and selected osteopathic hospitals. While the subregional planning offices have been supported as separate operational projects, members of RMP staff of the various institutions were quick to admit that they were in reality, performing functions as extensions of core in their various institutions. Accepting this, the site visitors believed that the Core staff of the Region is actually composed of a broad range of both professional and discipline competence. The group of people who are working in the medical schools and their affiliated teaching hospitals provide the necessary credentials and are necessary and critical (considering that the Program Coordinator has a Public Health background) to capture the interest and support of academicians involved in the Region's program activities. In order to provide the Region with more flexibility in its core component, the site visitors recommended that an agreement be established whereby specific "core functions" which are to be carried out in the subregional planning offices are identified under the core budget allocation rather than as separate operational projects which is their current method of listing them in the application. It was the opinion of the site visitors that this recommendation will serve to separate core activities from operational activities while at the same time allowing additional financial flexibility in the core component.

The site visitors believed that the administrative functions and services provided by the grantee organization in this Region is commendable and perhaps could be used as a model for other regional medical programs. The grantee agency is a not-for-profit independent corporation which requests no direct costs.

The local review process in the Michigan Region was considered to be of excellent quality. Since the Region was established, they have had one application which was not approved at the federal level, Nuclear Medicine Technician Training Program. During the time that application was being prepared, Council established its policy with reference to support for this type of training.

Also, down through the years, approximately one half of project proposals which have been presented to the local review groups have received negative actions. The "not recommended" are not confined to any one disease or area of health care but rather cover a broad spectrum of both categorical and other types of proposals.

The MARMP/RAG currently is a 35-member body. Of this total, 5 are female, 3 are black. It was interesting to the team that 17 members attended the site visit meeting. Also, the corporation by-laws restrict consumer

representatives to six. While these positions are all currently filled, the Region outlined its past, almost futile efforts to locate consumers (with a small "c") who could or would make a contribution to the Region's program.

C. Involvement of Regional Resources

The site visitors spent quite a bit of time in trying to determine the involvement of the CHP agencies and the RMP. The "A" agency is presently located in the Governor's office where it is allocated a very low priority. The team was advised that any progress which had been achieved with the five funded "B" agencies in the state has been made on a direct relationship basis and has been made in spite of the "A" agency and not because of it. The CHP in the Detroit area where, one-half of the Region's population reside in a three-county area was described as a "mess!" While the Region currently has five funded CHP "B" Agencies, with minor exception, the RMP is, in fact, carrying our at least the CHP "A" agency mission throughout the State, partially by default. It is MARMP's intent to support the ultimate development of a strong Michigan CHP "A" agency at which time they will assume a more appropriate role for an RMP. Repeating for emphasis, it was obvious from the variety of talent present during the meeting that the Region has involved the activities of the three major schools of medicine and an emerging school of osteopathy. It has gained cooperative arrangements between these schools; between the osteopathic medical profession and the allopathic medical profession; is working with both community hospitals and county hospitals; and voluntary agencies, consumer and community groups. The Region indicated that it had lost some of its early categorical supporters in its insistence on program activities which did involve regional resources rather than single investigator institution-type activities.

The Region is currently actively involved in coordinative and collaborative efforts in the Detroit area (for example, assisting in an emerging Model Cities H.M.O.), with the Saginaw Hospital organization (a corporation), and with related health and planning programs in Grand Rapids, Flint, Lansing and Pontiac.

The team noted that with the possible exception of the currently funded coronary care program, the Region did not appear to be placing any great emphasis on involving the nursing and allied health professions. However, indications are that nursing has played an active role in the development and conduct of the MARMP program. Allied health is a major consideration in the development of programs to meet Michigan health needs. Conversely, the ability of the osteopathic physician (2,000 in Michigan) to work with the medical doctor in solving health problems throughout the state was amply demonstrated. In fact, and partially as a result of RMP involvement, hospital privileges are being exchanged. The team believed that almost anyone who is anything in the provision of or the planning for health services in lower Michigan has had some exposure to the Regional Medical Program, the Region is presently making a concerted effort to extend the availability and the types of specialty health care needed in the upper portions of the lower penninsula, Traverse City,

Grayling and points north. Incidentally, this area contains a number of remote Indian population areas.

However, these are discrete from reservation-type Indian settlements. Previously, because of limitations within the V.A. hospital system, there has been little formal relationship between the V.A. hospitals and MARMP. However, with recent revised allowances within the V.A. medical system, this is now being looked at for future incorporation as a resource toward responding to local health needs in selected medical scarcity areas.

Also, the visitors learned of the Regions beginning efforts to provide improvement in rural health care in some of the Regions 83 counties, three fourths of which are considered rural. The Michigan State University Subregional Planning Office is currently working in Cass County and the two counties surrounding it (total population - 250,000) to establish an H.M.O. without prepayment type activity. The program is funded conjointly with $125,000 of migrant health funds, $95,000 of CHP 314 e funds plus a public health service donated building. The university is to be responsible for the evaluation and appraisal of the total program.

D. Assessment of Need, Problems and Resources

The State of Michigan is believed to have one of the best and most complete data collections systems. Although funds have come from a variety of sources, the initiating and primary source of funding has been the MARMP.

The data collection efforts are now concentrating on demonstrating the utilization of data that has been generated in six defined localities - Detroit, Adrian, Flint-Genesee County, Grand Rapids, Lansing and Muskeegan.

Members of the site visit team were informed that the data generated is being utilized to a large extent by the Region through its various study groups, the Professional Advisory Councils, Project Review Committees, the Regional Advisory Group and a number of other agencies in the state, in establishing and changing the goals, objectives and priorities as they relate to the health care needs of the Region.

The visitors heard reports from representatives of the Region on the types of data which has collected and how this information is being utilized by the various groups in the Region. The data which has been collected provides information on health care and health needs, the availability of health manpower and data on the extent and manner of how various kinds of health services are being met in the State.

Representatives of the Region indicated that the most significant data collected to date was the data on Detroit which provided a current picture of the deterioration going on in the area, population shifts, shifts in social and medical needs etc. It was pointed out that while this kind of data is not particularly attractive to the politicians it serves to answer critical questions regarding the program required to

answer the health and social needs of a community. In addition, it has played a major role in obtaining funds from the Department of Housing and Urban Development for the development of a Model Cities Neighborhood Health Center in Detroit.

Although the site visitors believed that the data collection system is necessary and is providing useful information, they also believed that those individuals or agencies requesting information provided by the health data system, should be responsible for supporting it. The representatives of the Professional Advisory Councils which are advisory to the RAG and also serve as review bodies have been extremely effective in assessing the needs and problems of the Region relative to their particular specialty area. They have been actively establishing goals and objectives based on what is needed to upgrade the quality of care being provided in their respective areas. In addition, it was reported that an "articulated set" of written guideline and reports are in final stages of development relative to RMP efforts in specific areas. For example, a guideline establishing minimum criteria for the early detection, treatment and diagnosis of cancer, is being developed; a Regional Cooperative Stroke Education Program; Heart Disease Program Guideline; Guideline for the Preparation and Review of Proposals for Educational programs; Proposed Chronic Respiratory Disease Program Plan; and Charge to the Professional Advisory Council on Ambulatory Care.

E. Program Implementation and Accomplishments

As previously stated in this report, the site visitors believed the Core staff to be rather small in size but appears to be composed of highly capable and well-qualified individuals. It was agreed that, for the most part, the RMP assigned core type personnel in the Medical schools and Zieger/Botsford Hospitals have, or will in the near future, "turn the corner" and become more intimately involved in working toward MARMP priorities, goals and objectives. A case in point is Michigan State University. Due to a number of internal organizational type problems i.e., placement of RMP activities in the school, lack of new innovative approach, and the normal growing pains of a new consolidated total Health Science school, the MARMP/RAG disapproved the institution's request for continued funding. M.S.U. has been supported since the Region was established. In turning down the MSU Subregional Office continuation application, it was the RAG's intent to reorient the MSU effort toward the problems of rural health care and through using MSU's existing strengths as a land grant school, with an extension service, to begin to answer some of those very pressing problems of rural Michigan.

The area discussed by the RAG in which it was believed that MSU could best use its vast and unique resouces in making a real and needed contribution to improved health care of Michigan was "How can high quality care be delivered to the rural poor?" (This was not seen as precluding the University's responding to for instance, a specific request for help from the model cities areas within their geographic area of interest.) Within this broad theme it was believed that MSU could provide real

leadership in looking at the process of securing community involvement and participation within specific areas, in looking at needs and resources, and in assisting with the establishment of a system of "Comprehensive Health Care which would be acceptable to both providers and consumers. It was envisioned that the College of Human Medicine and other University resources might then develop programs to support this rather than the "vice-versa emphasis" seen in the past activities.

A good portion of the site visitors time was used in hearing testimony of how the collective core staffs had tried, sometime successfully, to coordinate with CHP agencies throughout the states. The visitors also learned the Region was involved in establishing and implementing programs with several other agencies such as housing commissions, O.E.O., Model Cities, State Official and voluntary health agencies. Two examples of these kinds of program activities are the Wayne County Central Hospital - Comprehensive Care for the Urban Poor Project (related to O.E.O.) which is currently approved - unfunded and Lake Side Comprehensive Health Care for the Poor which is a new proposal, in a housing project in Pontiac, Michigan. The latter program, if approved, is to be a conjoint activity which is related to O.E.O., CHP (b) and SRS (Vocational Rehabilitation).

The site visitors noted that the Region is currently requesting continued renewal or new support of 16 pure operational programs and a developmental component. Four of 16 projects are essentially for stroke patient - service type programs. It was noted that the 4 stroke projects had two remaining years of council approval. The application contained a request for one additional year of support beyond Council approval. The team recommends that these 4 programs be continued for the two-year approved period but that the request for 1 year renewal be denied.

F. Evaluation

The suggestion of the site visit team, during the feedback session, that the Region add an evaluator to the core staff, proved to be a sensitive point with the Region. It was pointed out by the Coordinator that Dr. Larocque, the full-time Associate Coordinator, has both the academic background and the experience credentials necessary to provide leadership in this area and it is the Region's belief that individuals must be employed and then given as much in-service education as possible to strengthen their skills. The Region also pointed out to the visitors that they have a close association with Dr. George Miller's evaluation workshops. The Region has also encouraged the use of evaluative expertise, and strength which are available from the universities, such as, Dr. Jason Hilliard, Dr. Katz, and others. However, it was reported that there were difficulties in utilizing the services available because of the tremendous demands on these individuals time. The Region also reinforced the fact that there is a nation-wide shortage of persons qualified to do evaluation. In addition, the cost of conducting ideal evaluation was discussed and whether an RMP could afford such costs. Dr. Larocque gave an example of a project with a total cost of $67,000 which was

submitted to one of the universities for an estimate of the cost of evaluating the activity. The price quoted was $100,000.

It was obvious to the members of the team that the monitoring and surveilliance of all activities is good. This opinion results from the performance of the Core staff, the many Professional Advisory Councils, the study groups, and especially the Regional Advisory Group. The Region's present evaluation strategy begins with the conception of an idea which while it may be considered adequate, is not ideal. For example, sufficient "evaluation handles" are incorporated into each proposal to allow the Region at any given time to extrapolate what is needed, what will be done, by when and possibly by whom. The site visitors recommended that with the increased attention now being given to evaluative efforts at the DHEW & HSMHA levels that a more systematic evaluation system would be in order. The need was seen to strengthen the evaluation capabilities of the Region which may take the form of additional staff assistance. This would serve to provide and give potential and prospective participants in the MARMP aid in the development of more specific program objectives and more specific evaluation criteria and methods. It was later learned that this recommendation is in line with the triennial plans for the Region. The recent addition of Theodore Lopuskinsky, Ph.D., who is a full-time Core staff member, may lead to more effective planning and evaluation in the future.

V. RATIONALE FOR FUNDING RECOMMENDATION

In consideration of the total presentation, the site visit team discussions and the responses to questions posed to representatives of the Michigan Regional Medical Program, the site visitors judged this Region to have achieved a very high level of organizational and program strength and maturity. Based on the Region's successful past experiences (combined with its future plans) in the prudent use of small amounts of funds for the planning, promotion and "seeding" of new ideas and concepts, the team believes that a developmental component should be approved for this Region.

The Region is currently funded for its third operational year, through 8/31/71 for $1,898,936 (d.c.).

The Region has requested $3,338,631 direct cost for its 4th year; $3,322,516 for its 5th year; and $3,328,220 for its 6th year.

The site visitors recommend approval of the triennial application at a level of $2,100,000 for each of the three years. The site visitors believe that this level will enable the Region to:

a) Support a developmental component.

b) Continue core activities at their current level. All subregional planning offices are to be considered and supported as a part of core activity.

c) Provide sufficient funding to support all projects which have been rated as the Region's top ten priority activities.

d) Provide funding to renew project #25 - Continuing Medical Education.

The site visitors do not recommend renewal funding for the other projects beyond the approved support period. However, the Region should be allowed to allocate one year funding from within the $2,100,000 to ensure orderly termination of RMP support. This action will require disengagement of RMP support for two projects that have already been funded for three-year periods - Project #3 - Data Collection - Department of Public Health and Project #4 - Coronary Care - Michigan Heart Association; and for Project #16 - Surveillance of Electronic Equipment, Michigan Heart Association (which has already been renewed once); and will require termination of RMP support for four stroke projects and Project #26 - Continuing Education Program for Inner-City Hospitals, Wayne State University, upon completion of the two remaining years of Council - approved support in lieu of three more years of support as requested.

Included in the recommended $2,100,000 level are funds to initiate project #27 - Comprehensive Health Care for the Urban Poor - who reside in the immediate area of Wayne County General Hospital. The MARMP/RAG voted this project as the number one priority activity in the total application.

It is currently in the approved/unfunded status. This project was initially submitted as a multiphasic screening program and was recommended for deferral to include a technical site visit, by the May 1969 Council. The revised application which was approved by the July 1970 Council expanded the scope of the project to the extent that the multiphasic screening aspects have been deemphasized. Staff and the site visitors review and discussions with representatives of the Region have established that this project no longer meets the criteria for classification as a "multiphasic screening project" as defined by the May 1971 NAC. Briefly, the overall objectives of the program are:

a) to demonstrate the increased effectiveness of the Comprehensive Health Service as compared to the traditional episodic care

b) to test the efficiency of the two health systems with respect to costs, physicians time, specific socio-economic and environmental factors contributing to the health needs of a medically indigent population, etc.

c) to test the feasibility of compensating for the shortage of physicians and nurses by training a new category of health workers to perform routinized types of procedures.

SUMMARY OF SUGGESTIONS AND RECOMMENDATIONS OF THE SITE VISIT TEAM

Sub-regional Planning Offices

The team recommends: 1) that a concrete method be established whereby MARMP staff supported in these offices will be identified with the MARMP and, more important, will be identified with programs and activities which are directly in line with and/or complement the goals, objectives and priorities as established by the Regional Advisory Group; 2) that the budgeting of Core personnel and functions which are carried out in these offices be completely separate from operational programs which may be carried on simultaneously in the institution or its affiliates and 3) that the Region's organizational chart be modified so as to show a line of authority between the appropriate individual in the central office and appropriate MARMP supported staff in each sub-regional office.

Program Visability/Public Relations

The team believed that the Region should give careful consideration as to how it might improve its image and visability both to its professional and lay constituency.

Comprehensive Health Planning

The team strongly suggests that the MARMP/RAG take the lead in an attempt to clarify the respective missions of these two agencies throughout Michigan. The picture was unclear as to the value of C.H.P to R.M.P.

Goals and Objectives

The team recommends that the Region address itself to redefining its long and short term goals and objectives in the sense of being quantifiable and related to a time frame for evaluation of progress and achievement in implementing its priorities.

Evaluation

The team recommends that the MARMP strengthen its efforts in the area of evaluation. It was suggested that this might be accomplished by the addition of qualified core staff to assist the individual who presently conducts the evaluation functions of the program.

Grant Administration

Because of its history of having relatively large unexpended balances in the face of unmet needs, the team recommends that the Region continue to establish and refine its mechanism to ensure the actual use of dollars allocated to MARMP participating institutions.

Data Collection

While the team understood the value to RMP (and others) for the continued collection of hard data, it was suggested that a greater emphasis might

be included as to what happens to the actual or potential patient. The team recommends that the MARMP withdraw as the primary fiscal support for the collection of data and that support for this activity be spread among the various agencies/institutions which utilize the results.

Core Staff

Because of a wide variation in the salary structure of institutional programs supported by the MARMP, the team suggests that the Region may wish to review its entire salary structure with the idea of developing a more equitable and fair level of support for MARMP affiliated personnel.

Recapitulation in Terms of RMPS Mission Statement and Review Criteria

A. Performance Criteria

1. The Region has established excellent priorities which are very well stated and which appear to be substantively sound and address the Region's major health needs. Long and short term goals have not been clearly stated. The site visit team recommended that the Region address itself to redefining its goals and objectives in terms of being quantifiable and related to a time frame for the implementation of its priorities. See the section on Goals, objectives and priorities, page 7.

2. The Region's previous activities have been successful in terms of the specific ends sought. These specific ends have been largely in activities that were categorical in nature. The Region is now making positive efforts toward shifting its program planning and development to attacking problems of the health care delivery system. See page 6.

3. The activities stimulated and initially supported by MARMP are for the most part still being supported by MARMP rather than being absorbed within the regular health care financing system. Although the success of some of these activities in promoting cooperative arrangements has been notable, the site visitors believed it might be too early to expect that they should have been discontinued. See page 14 - Rationale for Funding Recommendation.

Process Criteria

1. With regard to organizational effectiveness the MARMP is a strong and viable organization made up of a well-directed group of people who have been successful in the planning development and implementation of a program which addresses itself to solving health care problems. Refer to section on Organizational Effectiveness page 7 through 9.

2. With regard to the involvement of the health-related interests, the Region has a very strong inclusion of the allopathic and osteopathic physicians, through their involvement with the three medical schools and an emerging school of osteopathy. There is little evidence of an active role or involvement of the nursing and other health professions. However, the Region's triennial plans include the involvement of other health professionals. A

full-time nurse consultant has been employed and will be based at Ferris State College, Big Rapids, Michigan. See section on Involvement of Regional Resources, page 9 through 10.

3. The Region has five funded CHP "B" agencies. The "A" agency, located in the Governor's office is a very weak and ineffective program. The RMP is currently carrying out the CHP "A" Agency at which time they will assume a more appropriate role for an RMP. See section on Involvement of Regional Resource, page 9 through 10.

4. The MARMP has one of the best and most complete data collection systems, and is currently being utilized to a large extent by the Region in establishing and changing the goals, objectives and priorities as they relate to the health care needs of the Region. Refer to the section on assessment of Needs, Problems and Resources, pages 10 through 11.

5. The Region's evaluation process needs strengthening. The site visit team suggested that the Region might accomplish this by the addition of a qualified core staff member to assist the individual who presently conducts the evaluation functions of the program. See section on Evaluation, pages 12 through 13.

C. Program Criteria

1. The Region is rapidly changing its program emphasis from a purely categorical program to one which will reflect a provider action-plan of high priority needs and which are congruent with the overall mission and objectives of R.M.P. For example, the Region's top four priority activities are to increase the availability of care, enhancing its quality and making the organization of services and delivery of care more efficient. In addition, the seven activities listed under the Region's second highest priority (increase the delivery of health services) are exactly in line with the RMP mission.

2. With regard to increased utilization and effectiveness of community health facilities and manpower, the Region is making extensive inroads in the Model Cities Neighborhoods and in the future plans to institute both urban and rural health care delivery system, designed to use new and existing kinds of health professionals.

4. The Wayne County General Hospital project, which is currently approved, unfunded, is an excellent example of the Region's attempt to completely revamp the health care system to a large medically indigent population. The plan calls for health maintenance, disease prevention and early detection activities as a part of action plan.

5-8 One of the Region's new activities, Stroke Day Care Center, while categorical in nature, includes a plan to provide ambulatory care, out-patient care, diagnosis treatment, and rehabilitative services on a cost effective basis. The Region's "push" in the areas of Neighborhood Health Center and Model Cities efforts are based on primary care as opposed to inpatient care.

The Region is directing its efforts toward providing both primary and secondary care for the urban poor in Pontiac and Detroit. These two proposals alone should have immediate payoff in terms of accessibility, quality and cost moderation. The Lakeside Comprehensive Health Care project, a new proposal, will bring together the Michigan College of Osteopathic Medicine, MSU Department of Community Medicine, Pontiac Housing Commission and the O.E.O. Headstart program in a conjoint funding and provision of service effort.

9. The MARMP is highly supportive of other Federal efforts, as mentioned above, of their support of CHP, OEO and Model Cities Planning activities. The RAG believes the MARMP program priorities in obtaining requests which total in dollar value to approximately two times the amount of funds which are currently available to the Region.

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF ANNIVERSARY REVIEW AND AWARD GRANT APPLICATION
(A Privileged Communication)

NEW MEXICO REGIONAL MEDICAL PROGRAM
The University of New Mexico
Albuquerque, New Mexico 87106

RM 00034 8/71
July 1971 Review Committee

PROGRAM COORDINATOR: Reginald H. Fitz, M.D.

The region is currently funded at ~~$1,170,171~~ $1,045,765 (03 year) which includes $133,452 of carryover funds. The region has no committed funds for future years. The triennium application contains the following:

I. Developmental Component
II. Renewal of Core activities
III. Renewal of 9 ongoing projects; 3 continuing activities; 1 revised (new); and 1 approved/unfunded project (04 year)
IV. Termination of 2 projects (05 year)
V. Termination of 3 projects (06 year)

A site visit is scheduled for June 8-9, 1971. RMPS staff's preliminary review of the application has identified issues and concerns for the team's consideration and exploration with regional representatives. The review is a part of this summary.

FUNDING HISTORY
(Direct Costs Only)

Planning Stage

Grant Year	Period	Funded
01	10/1/66 - 9/30/67 (grant extended from 10/1/67 - 11/30/67)	$384,317
02	12/1/67 - 6/30/68 (7 months)	$252,379

Operational Program

01	7/1/68 - 6/30/69	$ 965,305
02	7/1/69 - 8/31/70 (14 mos.)	1,252,911
03	9/1/70 - 8/31/71	1,170,171

REGION New Mexico
CYCLE RM00034 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
* D00 - Developmental				91,200	91,200		91,200
#1 - Core		252,533			252,533	83,247	335,780
#1A - Registry		94,037			94,037	28,683	122,720
#2 - Cardiac Care Unit		36,282			36,282	8,108	44,390
#3 - Coronary Care Nurse Training		39,927			39,927	9,514	49,441
#4 - Unified Laboratory Sciences Training		49,950			49,950	16,887	66,837
#5 - Stroke and Rehabilitation		103,531			103,531	35,504	139,035
#6 - Emergency Med. Service		67,700			67,700	21,181	88,881
#7 - Continuing Education		24,983			24,983	4,118	29,101
#8 - Health Sciences Information Center		17,395			17,395	6,631	24,026
#9 - Pediatric Pulmonary Center		70,150			70,150	25,561	95,711
#10 - Cerdiopulmonary Evaluation Center	8,500				8,500	2,146	10,646
#14 - Remote Coronary Care	67,463				67,463	4,090	71,553
#15 - Streptococcal Throat Culture	24,950				24,950	3,783	28,733
#16 - (Formerly #12)Heart Sound & Mur. Sreeng.			23,302		23,302	6,717	30,019
#17 - (Formerly #13) Leukemia-Lymphoma				31,600	31,600	12,033	43,633
TOTAL	100,913	756,488	23,302	122,800	1,003,503	268,203	1,271,706

*Request amended to 3 years per telephone conversation by J. Salazar and the Region 5/4/71 - GRB-5/6/71

REGION New Mexico RM00034

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
D00- Developmental				91,200	91,200
#1 - Core		265,319			265,319
#1A		94,037			94,037
#2 -		———			———
#3 -		41,387			41,387
#4 -		52,540			52,540
#5 -		108,663			108,663
#6 -		70,880			70,880
#7 -		25,573			25,573
#8 -		21,955			21,955
#9 -		62,450			62,450
#10 -	———				———
#14 -	68,485				68,485
#15 -	25,498				25,498
#16 -			24,274		24,274
#17 -				33,342	33,342
TOTAL	93,983	742,804	24,274	124,542	985,603

REGION New Mexico RM00034
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
DOO-Developmental				91,200	91,200	273,600
#1 - Core		278,873			278,873	796,725
#1A -		89,886			89,886	277,960
#2 -		-------			------	36,282
#3 -		42,934			42,934	124,248
#4 -		55,286			55,286	157,776
#5 -		114,103			114,103	326,297
#6 -		74,251			74,251	212,831
#7 -		26,198			26,198	76,754
#8 -		23,188			23,188	62,538
#9 -		55,864			55,864	188,464
#10 -	———				———	8,500
#14 -	———				———	135,948
#15 -	———				———	50,448
#16 -			———		———	47,576
#17 -				35,188	35,188	100,130
TOTAL		760,583		126,388	886,971	2,876,077

GEOGRAPHY AND DEMOGRAPHY

The region is coterminous with the state, with some established patient flow patterns into Colorado and Texas. The population numbers a little over one million one thousand, with 66% urban based. The median age is 22.8; 90% white, 2% Negro and 6% Spanish American and Indian.

There is one School of Medicine located at the University of New Mexico in Albuquerque, and three Schools of Nursing, all of which are based at the University of New Mexico. There are 44 hospitals, mostly short-term, non-federal with approximately 4,262 beds. As of 1967 there were 970 active M.D.s and D.O.s and 2,511 actively employed graduate nurses, with 1,095 inactive. There are also 712 employed licensed practical nurses.

HISTORY OF REGIONAL DEVELOPMENT

The University of New Mexico School of Medicine was designated by the Governor to plan and operate a Regional Medical Program, and a planning grant application was submitted to DRMP on July 1, 1966. Planning was to be carried out by disease-oriented committees, set up by the Regional Advisory Group. The same approach was envisaged for the Evaluation and Continuing Education Committees. The Dean of the School of Medicine was appointed RMP Director, as well as Chairman of the Executive Committee of the RAG.

The initial planning grant in the amount of $449,736 was awarded for the period of October 1, 1966 to November 30, 1967. Seven-month planning funds in the amount of $108,048 were made for the second-year planning continuation (December 1, 1967 to June 30, 1968). This phasing was due to the Region's submission of its first operational request, which was disapproved by the National Advisory Council in May 1967.

The Progress Report submitted with the 02 continuation application indicated very slow progress in planning, and also that considerable confusion existed among NM/RMP personnel concerning goals and methods for meeting the needs of the state in the categorical diseases. Dr. Fitz continued to act as Dean of the Medical School, Coordinator of the RMP and Chairman of the Executive Committee of RAG.

An Associate Director was appointed on June 1, 1967 and DRMP staff became aware of some increase in NM/RMP activity. The RAG met only twice during the first year, and descriptions of planning activities for the 02 year were vague and seemed to be operational in nature. No justification for expenditures of 01 year funds was included.

Staff review of the continuation planning application was uniformly critical and a decision was reached to extend the 01 grant for 60 days, during which time the grantee was asked to justify expended grant funds, and completely revise its proposed budget (66% above the 01 year level).

A major criticism of the application was the over-commitment of Dr. Fitz, the Coordinator. In October 1967 the Director and Associate Director for Operations, DRMP, discussed the administrative problems with the Coordinator and the continuation application was subsequently approved in November 1967.

A four-part operational application was submitted in April 1967, and requested support for (1) a Medical Information Network for Albuquerque hospitals; (2) Itinerant Cardiac Clinics; (3) CCU Training Program and (4) Rheumatic Fever Registry. Disapproval of the request was voted by Council, based upon poorly planned projects which seemed unrelated to the original planning grant, inadequate conceptualization of an RMP, weak evaluation procedures, and lack of involvement of organizations and agencies outside the Medical School. The region was urged to submit a new application.

An improved application was submitted in December 1967, described as "Phase I" program with five operational projects, although descriptions of future phases were not included.

The Review Committee (January 11-12, 1968) identified weaknesses similar to those observed in the original operational application and recommended deferral and a site visit for the purpose of exploring, with NM/RMP personnel, ways and means of determining the real needs of the region with appropriate translation into a unified, comprehensive proposal with a truly regional orientation.

The reviewers believed that the application would have been more comprehensive as Phase I, if Phase II had accompanied it. There were many weaknesses readily apparent which had been identified in the previous proposal.

Prior to the Site visit of April 8 and 9, 1968, the NM/RMP submitted a "phase I Supplement", which included a number of changes in the proposal.

The site team explored with the region the ways and means of moving from planning into an operational phase. The team also attempted to reach a better understanding of regional needs and resources. Seven projects were reviewed with the program personnel who were articulate and responsive to questions and discussions concerning their implementation.

Also, the team, because of the changes in the administrative structure of the Medical School and the NM/RMP, discussed with the Core staff, as well as the Chairman of the RAG, the concerns and organizational and administrative complexities. The team was impressed with the competency of this individual, but the discussion with the Coordinator did not clarify where the program "control" was. The program did not seem to focus on major problem areas and failed to provide for continuity in planning, evaluation and a natural transition into operational projects.

The site team had difficulty in separating the Regional Medical Program as an entity from activities of the medical school.

The seven projects* reviewed were:

#1 - Model Coronary Care Unit
#2 - Training Course in Coronary Care Nursing
#3 - Laboratory Sciences in Allied Health Professions
#4 - NMRMP Stroke Program
#5 - Emergency Health Services (Related diseases)
#6 - Educational Programs
#7 - Health Information & Communication

The National Advisory Council of May 27-29, 1968, recommended approval in a reduced amount, and a grant was made, effective July 1, 1968, in the amount of $965,305 (D.C.), for Core activities and seven projects, one of which was from earmarked funds for a Pediatric Pulmonary Center, in Lovelace Clinic (Project #8).

During the first operational year the region submitted two supplemental projects, #10 - Cardiopulmonary Laboratory at St. Vincent's Hospital in Santa Fe and #11 - Rural-Urban Linkage for Improved Health Services (Estancia). Both were viewed favorably by Committee and Council, although the Estancia program was funded by NCHSR&D. Project #10 was funded from unexpended 01 monies, in the amount of $14,963.

The Progress Report for the first year indicated some organizational improvements, with a notable shift away from the medical school orientation. The Region identified $355,612 in unspent balances, and was granted $1,252,911 (D.C.) for a fourteen month period. This amount represented 90% of the previously approved level for projects, and Core at 100%. Authorization was also granted to continue the two projects that were funded from carryover in the 01 year.

Project #12 - Heart Sound & Murmur Screening for N.M. School Children was reviewed at the February/March 1970 cycle and was returned for revision. Submitted for the July/August 1970 cycle was a three-part supplement for three new programs: #13 - Leukemia - Lymphoma Program; #14 - Monitoring of Decentralized Coronary Care Unit; and #15 - Streptococcal Throat Program. Project #14 was presented to staff in March 1970 as a request for rebudgeting of funds to support a pilot phase. Because the proposal involved many technical and clinical complexities, and indeed presented a new dimension to the N.M. program, it was agreed by staff that approval of rebudgeting to implement this study before submission to the Review Committee and National Advisory Council was inappropriate.

Reviewers of the Leukemia - Lymphoma (#13) program returned it for clarification of the personnel budget, its relationship to the overall regional cancer program and a statement concerning the therapeutic and clinical backup.

*With subsequent applications, all projects have been renumbered.

The continuation application for the 03 year requested:

Core and 9 projects	$1,053,537
Carryover balances	174,902
	$1,228,439

The carryover request was to fund for one year projects 12, 13, 14, 15, all of which were pending Council recommended revisions and to permit the region to place $44,000 in escrow for three pilot studies in kidney disease planning, expansion of project #5 and multiphasic screening for Indians and Spanish Americans.

Staff discussed at length the advisability of allowing Dr. Fitz to utilize unspent balances for continuing pilot activities which would expire (and whose staff had threatened to resign without a year's salary commitment). Staff thought that commitment of one year's funds from carryover balances to continue, salaries of physicians who inaugurated the pilot studies would circumvent Committee/Council authority since Council had returned them for revision. The region had submitted new protocols for #12 and #13 with the continuation request. There was agreement by staff and approval by the Director, RMPS of the following:

--Approval for <u>one year only</u> (with last 6 months restricted) pending a revision to be reviewed at January/Feburary cycle as components of the Anniversary Review application for:

#12 - Heart Sound and Murmur	$16,000
#13 - Leukemia-Lymphoma	24,675
	$40,675

--Approval for <u>one year only</u>, with updated projects to be submitted as components of A/R request:

#14 - Monitoring of CCUs	$68,127
#15 - Strep Throat Culture	22,100
	$90,227

--Disapproval of "escrow" carryover ($44,000)

Total Direct Cost amount of carryover - $130,902

Staff agreed that the region needed assistance and encouragement to spell out details of a "regional design" in the forthcoming Anniversary Review package. There was further agreement that a program site visit was urgently needed.

Staff was unable to get a real feeling about progress in the region, an almost complete turnover of Core staff was noted, as well as Dr. Fitz'expressed intention to leave from time to time. Also discussed was the region's inability to budget its funds well with

a recurring balance at the end of each year. The RAG seemingly does not concern itself with the region's administrative affairs. The region included revised By-laws, but staff noted the RAG continues with limited representation, i. e. one Spanish American.

The continuation award for the third operational year was made, effective September 1, 1970 for twelve months with direct cost amount of $1,170,171. This award carried the restrictions for projects referred to above.

The region submitted a revision of the Heart Sound and Murmur Screening Program, now re-numbered as #16. The reviewers were impressed with the revised program, which appeared to have improved with additional planning. The involvement of the Heart Association was commended, as well as the interest of the Department of Public Health which will take over the program eventually.

THE NM/RMP ORGANIZATION

The Regional Advisory Group is comprised of 41 members, with an eight-member Executive Committee, all but one of whom, are physicians. The Executive Committee serves as the nominating committee for the election of officers and new members of RAG. It reviews all applications for technical and fiscal soundness and recommends in writing all applications presented to the full body of RAG for approval. It frequently meets on a weekly basis.

There are also categorical committees of RAG--Cancer, Heart, Stroke, Continuing Education, Kidney Disease and Cardiopulmonary, all relating to projects.

The full RAG meets quarterly, approximately three weeks prior to the RMPS deadline for application submission. Review procedures were modified in October 1970 to include review by State and Areawide Comprehensive Health Planning agencies. The review procedures will be revised and updated prior to September 1, 1971, and will apparently be correlated with priorities and criteria for funding.

REGIONAL GOALS

The basic strategy for the accomplishment of NM/RMP goals lies in the cooperative relationships that have evolved between the Regional Medical Program, Comprehensive Health Planning Agencies, the medical profession, community hospitals, and the University of New Mexico School of Medicine and other institutions of higher education in the state.

The region sees the relationships referred to above as permitting a flexibility and capability for program development relating to manpower training, the logistics of health care delivery, qualitative aspects of medical care, and the pooling of health service information appropriate for health planning in the agencies

and organizations with health planning responsibilities. The next Triennium will utilize the region's categorical projects and supportive resources at the Core staff and project levels to coordinate and complement the basis on which to move toward the achievement of its goals.

DEVELOPMENTAL COMPONENT

First Year $91,200 Second Year $91,200 Third Year $91,200

The NM/RMP RAG has approved four activities to be implemented under such a component:

1. Management of renal disease in New Mexico. A 3-year developmental and demonstration will request approximately $150,000. An NM/RMP Renal Disease Planning Committee was formed in July 1970. Establishment of satellite dialysis centers and home dialysis training programs are the preferred activity areas.

2. In-service Educational Program: Local Community Hospital Involvement. Expansion of the Presbyterian Hospital Center in Albuquerque so that it may serve such a function for smaller hospitals in other areas.

3. NM/RMP and Model Cities Involvement. The Santa Fe Model Cities Program, in conjunction with the North Central New Mexico Comprehensive Health Planning Council, has developed a preliminary proposal to provide locally situated health maintenance services to residents of the Santa Fe Model Neighborhood Area.

4. Training new Types of Allied Health Manpower. NM/RMP has been asked to assume the catalytic role in establishing training programs for "physician assistant" equivalents. The University of New Mexico School of Nursing is examining potential resources which could be linked to establish a curriculum and other quidelines for a "nurse practioner" program. Such training, on a pilot basis, is currently being conducted by the Department of Epidemiology and Community Medicine (Estancia Project). Also, the Bataan Memorial Hospital in Albuquerque and the Presbyterian Medical Services of the Southwest, Inc., in Santa Fe, have also expressed interest in developing a cooperative arrangement to establish this type of training program.

The region anticipates that it will eventually submit all of the four proposals outlined above as operational projects. In addition, early planning is expected to get underway in the area of hypertensive disease.

The review process for developmental component proposals will be the same as for other operational project applications. A preliminary

proposal will be reviewed by the Director and Core staff to determine the general feasibility and merit of the proposal. If the proposal receives approval in a preliminary review by the Executive Committee, the proposal originators and Core staff will develop a course of action to prepare a formal project application. An ad hoc advisory committee may assist in this task, if necessary.

When the application is completed, it will be forwarded to the appropriate Professional Advisory Committee (e.g. Cancer) for technical review. The Executive Committee will then consider all recommendations and make its own critique and return it to orgniators for the final version. The Director will then submit the completed application, together with documentation that the review process has been followed, to the RAG for approval. Before this last step, appropriate areawide and/or state Comprehensive Health Planning authority will be obtained. The application process may be interrupted for revisions at any step along the way. If a decision is made at any level that the proposal is not feasible or acceptable, the initiator may request, a special review by the RMP Executive Committee.

Administrative procedures for the allocation of such funds will be in accord with existing fiscal management procedures employed by the University of New Mexico, the grantee.

PRESENT APPLICATION	Fourth Year Request
Core	$94,037

The most important area of Core activity for the next Triennium will be to 1) upgrade the State's health care delivery system by employing RMP resources to supplement various existing capabilities within smaller community hospitals; 2) provide basic and upgrading training capabilities to meet New Mexico's ancillary health manpower needs; 3) coordinate NM/RMP activities with State and areawide Comprehensive Health Planning agencies and with Model Cities programs in Santa Fe and Albuquerque to develop a health information system capable of clearly defining New Mexico's health needs; 4) lend support to the possible development of an experimental health services planning and delivery system project in the Albuquerque area; and 5) cooperate in exploring the potential for health maintenance organizations and area health education centers in New Mexico.

The New Mexico State Planning Office, Comprehensive Health Planning, in collaboration with NM/RMP, developed the multi-agency development of a State Health Information System for New Mexico. The system has not matured beyond a relatively informal structure due to restricted funds.

The region is supporting the salary of one Health Planner working with the State CHP Agency. This salary will be assumed by the State Planning Office beginning July 1, 1971.

The Mid-Rio Grande Health Planning Council, Inc., was a member of the initial inter-agency group, together with NM/RMP and other agencies, that attempted to develop a State Health Information System for New Mexico. Cooperative arrangements still exist among these bodies and the Mid-Rio Grande HPC and NMRMP share health data resources (personnel and processing capabilities) in current efforts to utilize the Health Planning Council's Patient Origin Study and to refine inputs to the community health profiles.

The Director and Core staff undertook a primary role in the development of an organizational structure entitled "The Albuquerque Area Health Coalition" which was developed in order to become the applicant organization for an Experimental Health Services Planning and Delivery Systems Program. This organization, functioning within the Middle Rio Grande Health Planning Council umbrella, and with the assistance of RMP and HPC staffs, developed the proposal submitted to the National Center for Health Services Research and Development. The region provided staff for the development of the Northern New Mexico Comprehensive Health Planning Agency "NORCHAP" to facilitate its transition from organizational to planning status.

The region will assist during the coming Triennium in developing CHP agencies in the four planning districts of the state where such organizations have not yet developed.

Fifth year - $265,319 Sixth year - $278,873

Project 1-A - NMRMP Registry Program - Fourth Year Request $94,037

Funds are requested for three additional years to provide (1) data handling capability; (2) follow-up of medical care for more than 5,000 registered cancer patients; (3) tumor registry services for 45-50 hospitals; (4) data on cancer incidence, morbidity, mortality, stage of disease at diagnosis, treatment, survivial, etc.; and (5) regular reports to more than 1,000 physicians.

About eight more hospitals will be added for a complete statewide network. Interested hospitals will develop appropriate clinical activities to meet requirements of American College of Surgeons. It is hoped that the registry services will be supported entirely by local hospitals or other sources by July 1974, with NM/RMP continuing to fund other parts of the data handling.

Fifth year - $94,037 Sixth year - $89,886

Project 1-B - Health Information Mini System

This project is terminating on August 31, 1971. The system was instrumental in examining internal health information capabilities and needs of the NM/RMP. It focused on the development of health information from census data, the promotion of appropriate use of

such information, and the continuation of efforts to develop a plan and necessary inter-agency cooperation to implement the developmental phases of a State Health Information System.

Project 2 - Model Cardiac Care Unit — Fourth Year Request $36,282

This program is requesting renewal for one additional year, with the Bernalillo County Medical Center assuming the major financial responsibility by August 31, 1972. The CCU is a home base for many activities of the CCU Nurses Training Project (#3) and serves as a central monitoring and teaching unit for the Remote Monitoring Project (#14). NM/RMP support of the project for the requested fourth year is limited to professional salaries, which assures teaching resources and facilities for both projects #3 and #14.

Project 3 - Coronary Care Nurses Training Project — Fourth Year Request $39,927

The project emphasizes the relationship between training of personnel in cardiovascular care and their functions in the Central Monitoring Units and remote stations. It will continue the four-week course and accelerate the teaching of personnel who will be working in the Remote Stations (one-week courses).

The Remote Monitoring Project will establish eight Central Units and 23 remote units to provide quality care in local facilities. The plan encompasses approximately one-half of the small hospitals in New Mexico. To this end, this project will train 21 registered nurses for the central monitoring units and 73 nurses to work in the remote units. Also, a six-week course to train monitoring technicians is planned, and will correlate activities of the CCU Project and the CMU Remote Project.

Fifth year - $41,387 Sixth year - $42,934

Project 4 - Unified Laboratory Sciences Training Program — Fourth Year Request $49,950

Three additional years are requested for this project, which addresses the lack of training facilities, supporting personnel and great distances to provide continuing education for laboratory personnel in an essentially rural population. In addition to present staff, a medical technology educator will be recruited and it is planned to direct some attention toward specialized laboratory orientation or training for other categories of personnel such as cancer recognition and management, heart disease management, kidney diseases, disorders of blood-forming tissues, etc.

Fifth Year - $108,663 Sixth Year - $55,286

Project 5 - Stroke and Rehabilitation Project

Fourth Year Request $103,531

The goal of this project aims at setting up a definite structure of personnel with suitable rehabilitation skills in various regional community hospitals and smaller satellite centers around the state. It is hoped to bring expert stroke and rehabilitation consultation to medical and allied health personnel in selected urban and rural communities.

Major urban centers with satellite rural communities within New Mexico have been selected as target areas for this project. This will provide the setting for formal educational programs presented in the urban center, with a home base in Albuquerque.

The training of substitute specialists in rehabilitation will be an important new component of this project and will foster subregionalization. These specialists will bring new rehabilitation services to rural and urban communities, with RNs and LPNs trained in basic rehabilitation nursing techniques and some in occupational and physical therapy.

As physicians, urban community health leaders and substitute specialists gain expertise and capability in planning for patients, a reduction in project activity will begin. It is anticipated that at least five of the subregions will be self-sufficient by the end of the triennium.

Fifth Year - $108,663 Sixth Year - $114,103

Project 6 - Emergency Medical Services Project

Fourth Year Request $67,700

An additional three years support is requested to continue educational programs designed to improve the knowledge and delivery of skills of physicians, allied health professionals and related occupations.

The curricula of educational programs have been developed and tested over the past two years. Also, a pilot project will be developed for Rio Arriba County based at the Espanola Hospital with mobile components at Chama and Tierra Amarilla. Cooperative working arrangements have been established with the hospital, the State Highway Traffic Safety Commission, the Medical Association, and the Rio Arriba County Commissioners to implement the program.

A school for Emergency Medical Technicians developed from the RMP Training program for ambulance personnel. Training requires three months and curriculum was prepared by Dunlap Associates.

Other aspects of the program include radio communications, categorization of hospital emergency departments, expansion of first-aid training and evaluation of educational programs--pre-test, post-test, demonstration of learned skills, attitudes, cost trainee ratio, reciprocating benefit, attendance, student evaluation, etc.

Fifth Year - $70,880 Sixth Year: $74,251

Project #7 - Continuing Education Program — Fourth Year Request $24,983

Three additional years are requested to provide support for opportunities for health professionals, working in institutional settings and private practice, to update skills and knowledge.

Circuit programs have fostered the development of workshops and other types of programs for allied health personnel in outlying areas. For instance, the Stroke Rehabilitation Team has been involved as well as the Coronary Care Nurses Training and Pediatric Pulmonary Center programs.

The program is viewed as a continuing activity, particularly the circuit riding program, which provides presentations that are timely and convenient to remote practitioners. One important spin-off effect is the organization of workshops by local people, utilizing local resources and facilities.

Another principal thrust of the project will be the presentation of symposia and seminars in Albuquerque. The staff with cooperation of Core, will guide and coordinate other RMP programs for close interaction with program goals.

Fifth year: $25,573 Sixth Year: $26,198

Project 8 - Health Sciences Information Center — Fourth Year Request $17,395

This request is for three additional years, and the region states that it does not expect it to terminate as long as RMP exists. However, aspects of the project that are not demonstrating impact will be phased out during 1972 and 1973.

By means of a WATS telephone service, literature and bibliographic searches are requested. The project assists smaller community hospitals in upgrading health and medical information for local libraries. The Library of the Medical Sciences of the University of New Mexico provides reference services and has absorbed some of the overload from the project. The Dial Access audio-tapes will not be emphasized during the coming year and the WATS telephone service will become a function of RMP Core staff, although the project and Library staff will continue to house the equipment and provide an answering service.

Fifth Year $21,955 Sixth Year - $23,188

Project 9 - Pediatric Pulmonary Center — Fourth Year Request $70,150

The request will fund an additional, three year support but on a diminishing scale. The funds provide a comprehensive health center for all children with chronic pulmonary disease.

The Pulmonary Center is housed in the Bataan Rehabilitation Center with associate laboratory facilities in the Lovelace Foundation and teaching facilities in the Bataan Hospital-Lovelace Foundation Medical Center. The staff will be decreased from 15 to 13 for the next three-year period. The budget requested for the fifth year will be 80% of the present year and further decreased to 72% and 66% during the following two years. Other sources of funding have been located through the National Cystic Fibrosis Research Foundation and fellow-ships are being requested. Training and educational programs will continue as presently set for externs, residents, fellows and student nurses. In addition, community visitation training programs are planned to continue with visitations to 4 major and 2 smaller communities.

Fifth Year - $62,450 Sixth Year -$55,864

Project #10 - Cardiopulmonary Evaluation Center — Fourth Year Request $8,500

For the final year of RMP support, the program will expand its activities into exercise testing and will continue sponsoring lectures and other educational activities for physicians and nurses in northern New Mexico. The New Mexico Division of Vocational Rehabilitation will buy some necessary equipment to assist in expansion of laboratory capabilities. The primary activity will continue to be the provision of cardiopulmonary evaluation services, and responsibility for continuing the Center will be fully assumed by St. Vincent Hospital after August 31, 1972.

Project #16 - Heart Sound and Murmur Screening Program — Fourth Year Request $23,302

This project (formerly #12) was initiated originally with funds from 02 year balances as a pilot program for six months only. Committee/Council reviewed a revised protocol in January/February 1971, and approved without funds for three years. The region now requests funds at a reduced level to continue this activity for two more years, with emphasis shifting from kindergarten groups to third grade children in Title I schools and fourth and tenth grades in rural and pueblo or reservation settings. Plans are underway to reach children in the Navjo reservation area this year. An additional computer is requested which will give them three PhonoCardioScan computers. Project activities will be coordinated with those of the Streptococcal Throat Culture Program (#15) and will continue to work closely with the NM/RMP Registry Program to refine registry procedures to track New Mexico children with organic heart disease.

Fifth Year - $24,274 Sixth Year - 0 -

Project #17 - Leukemia-Lymphoma Program — Fourth Year Request $31,600

This program (formerly #13) will mobilize and coordinate physicians and facilities throughout the state to provide the most current effective investigative and therapeutic tools in a more uniform manner. During the pilot phase (first year) 21 physicians, mostly private practitioners, committed their support to this program. Groups have been established in chemotherapy, radiotherapy, infectious disease

and blood services. Protocols developed by expert chemotherapists were established to provide a more uniform approach to therapy.

The blood services group will develop more effective means of providing the intensive platelet transfusion support, and an oncology patient review conference will be established. This will coordinate activities between these various groups and utilize the expertise of physicians with major interests in cancer, including the surgeon, the pathologist, the oncology nurse and the social worker. Training for oncology nurses will be undertaken and teaching programs will be developed for major hospitals. A central information bank will be actively followed.

During the last two years of this Triennium, the project will seek support from the Cancer Memorial Research Fund, the New Mexico Leukemia Lymphoma Society, Inc., and the National Cancer Institute. One NCI grant has already been approved.

Fifth Year: $33,342 Sixth Year: $35,188

Project #14 - Remote Coronary Care Project — Fourth Year Request $67,463

This project was approved by Council in July 1970 for three years without additional funds. It was implemented from 02 balances for one year only. The present application requests two years funding. At present the University Heights Hospital, Albuquerque, and the Cibola General Hospital in Grants (70 miles away) are tied into the Bernalillo County Medical Center by remote monitoring. Since April 1971, Los Almos Hospital is monitored by Bataan Memorial Hospital in Albuquerque, and the latter hospital will now become a central monitoring point for hospitals in Santa Rosa (120 miles) and Tucumcari (160 miles). During the first year it is anticipated that eight small community hospitals will be incorporated into 3 networks for remote monitoring. A training program for monitoring technicians is ongoing in coordination with other heart disease projects.

The second and third years of the program will establish units in Las Cruces, Santa Fe, Clovis, Farmington and Raton. When this is accomplished, nearly one-half of the 52 small hospitals in the state (90% of the state's general hospital system) will be able to provide quality care for acute heart patients. The central monitoring and its remote stations will be used as a nucleus for continuing educational programs for physicians and nurses, as well as a regional information center, data collecting unit, etc.

Fifth Year: $68,385 Sixth Year: - 0 -

Project #15 - Streptococcal Throat Culture Program — Fourth Year Request $24,950

As a companion to project #14 above, this program was similarly inaugurated, and requests two years support. The program will be extended to southern New Mexico by mid-june 1971

and the physicians' office program will move into northern New Mexico by early August 1971. Physicians receive reports at two month intervals and further refinement of the reporting procedure is expected. The New Mexico Heart Association is co-sponsor of this program.

Fifth Year - $25,498 Sixth Year - 0 -

RMPS/GRB 6/4/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: May 24, 1971

Reply to Attn of:

Subject: Staff Review of the New Mexico (RM-34) Triennial Application May 10, 1971.

To: Harold Margulies, M.D.
Director, RMPS

Through: Chairman of the Month

Chief, Grants Review Branch

Chief, Grants Management Branch

Acting Chief, Regional Development Branch

Staff in attendance: Jessie F. Salazar, Grants Review Branch
Rodney Mercker, Grants Management Branch
Cecilia C. Conrath, Continuing Education and Training Branch
Joan Ensor, Program Planning and Evaluation
Michael Posta, Regional Development Branch
Joseph Ott, Office of Systems Management

Staff review dealt with overall program issues, and was based upon an awareness that a site visit (the first in three years) is scheduled for June 8-9, 1971. From the general discussion, a list of impressions and concerns emerged. It is hoped that clarification and a better understanding of the NM/RMP can be gained by the site visit team. Miss Conrath, who will participate, was a member of a visiting team organized by the Experimental Health Systems on April 1. Mr. Mercker was a participant in the RMPS Management Assessment visit on May 5-7, 1971.

It was generally agreed that the NM/RMP is a "one man program." There appears to be a lack of communication not only among staff, but particularly from Core staff to project staff and to community hospitals.

The Nurse Coordinator is believed to be imaginative and competent, but is apparently stymied in implementation of allied health training programs due to the Coordinator's reluctance to delegate any responsibility in these areas.

Dr. Oseasohn, who was responsible for much creative planning in the early days of the program, has left the RMP to head up the Medical School

Department of Community Medicine. Dr. Oseasohn's departure has left a gap in the planning aspects of the NM/RMP as well as continuing program evaluation. There is some evidence of individual activities, or portions of projects being evaluated, but no real data on program evaluation.

The operational projects all appear to be provider-oriented, with very little, if any, consumer representation. Core staff is quite aware of existing minority problems, yet the application does not indicate that the NM/RMP (as a program objective) is giving any attention to such problems.

A very high percentage (over 50%) of the population pays for its own health services. New Mexico is probably the only state in the union that does not cover at least one-half of its population through group health insurance.

There is some evidence of a reluctance on the part of the NM/RMP to turn away from the categorical (heart, cancer, stroke) approach. The Cooreinator differentiates Core staff as "categorical" and "administrative."

Staff believes that Comprehensive Health Planning involvement by the NM/RMP is a plus. An RMP Health Planner is stationed in the Santa Fe CHP Office, and his salary will be picked up by CHP beginning July 1. He has been assisting in the development of "interim councils" in four districts throughout the state. There is an Area Health Coalition in Albuquerque, which is the applicant organization for the Experimental Health Services and Delivery Systems.

The New Mexico Comprehensive Health Planning Council (NORCHAP) was assisted in its formation as a 314 (b) agency by the Coordinator of NM/RMP, Dr. Fitz. Mr. Thomas I. Harnish, the Executive Director, of the Presbyterian Medical Services of the Southwest, Inc., which is the sponsor of NORCHAP, is a member of the RAG. It was noted that even though there is a lot of planning talent in the Albuquerque area, no real leader in the existing agencies has emerged. There is a tendency to organize a new agency about every six months, or whenever a new program appears on the horizon. There was no real feeling, either in the application, or in staff awareness, as to the involvement of the State Department of Health in health planning.

The RAG has been broadened to include some minorities and lay people, although the Executive Committee (mainly physicians) is believed to be the power group (and decision-making) of this body. Program activities are largely medical school centered and provider oriented rather than patient (people) oriented. Staff is of the opinion that New Mexico clings to the "colonialism" of the past, with no apparent attention given to ancient communication problems between its "Anglo" population and the Spanish American and Indian citizens. Of the 41 member RAG, 37 are males. The region does not seem to be making any attempt at sub-regionalization.

It was noted that there have been no statewide conferences in promoting physicians assistants. Staff felt this is significant for an area with such acute manpower problems. Also, there was no indication of involvement by the Bureau of Indian Affairs in RMP health planning.

Bernalillo County Hospital is the only hospital in Albuquerque providing out-patient services, or services for indigent patients. This is the teaching hospital for the Medical School. This pointed to the observation that there is a great deal of emphasis on the Presbyterian Hospital Services and it was noted that a number of RAG members are representatives of that institution.

While staff did not deal in depth with the request for Developmental funds, questions were raised as to how the various components fit into a total package. The site team should explore the region's plan for approving Developmental funds, and the reasons for such broad areas they propose.

The Form 16 for projects 3, 4 and 9 request stipends which are believed to be in conflict with Council policy.

The Kidney Disease RMPS staff have visited the NM/RMP with a view to attaining some knowledge of local management resources for renal disease. It has been reported that the Dr. Condon (a lady physician) with the Veterans Hospital who was named by Dr. Fitz as the person responsible for planning a kidney program in New Mexico, has left the VA Hospital and moved to Iowa. The visiting team needs to explore new kidney plans.

NM/RMP seems to have "dropped the ball" relative to the Estancia Project, which received much national acclaim, planned under RMP auspices and funded by NCHSR&D. The original plan proposed to use this project as a pilot for replication in other parts of the state.

There was some opinion that the region may be tending to "drop the ball" in the planning for Health Services Planning and Delivery Systems as well. Dr. Fitz appears to view the RMP as a broker, utilizing RMP funds to generate the interest, then once the program is underway, moves on to greener pastures. This is not believed to be completely negative, but staff thinks that the program suffers from a lack of a feeling of continuity or cohesiveness in planning.

Previous fiscal and budgeting problems appear to have been corrected. The region has a history of large carry-over balances. The Grants Management Branch reports that this should not be a problem this year or in the future. The region has submitted a budget request based on the Dr. Vernon Wilson letter of April 7, 1971 which limited the support for this region at $912,313 based on it present funding level, will be needed for the Triennium. This was discussed by GRB and GMB with Dr. Fitz, who will submit an alternative plan, for an expanded request. The present budget request is unrealistic, should additional funds become available.

Equipment and computer costs requests need exploration by the site team. There are some existing federal sources that may be able to provide these more economically.

In summary, the RMPS staff found the application well written and adequate in its presentation. It raises many questions, however, (not alleviated by the new format) and concerns outlined in the foregoing which need to be explored in greater depth by the site visit team.

Jessie F. Salazar
Public Health Advisor
Grants Review Branch

Action by Director _____

Initials _____

Date 6/1/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

NEW MEXICO REGIONAL MEDICAL PROGRAM
RM 00034 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

Recommendation: Award of $850,000 for one year only; disapproval of Developmental Component. Specific conditions of this recommendation are outlined at the end of this Critique.

Year		Request	Recommended Funding
04	Developmental Component	$ 91,200	-0-
	Core 9 ongoing 3 continuing 1 revised (new) 1 approved/unfunded	912,303	$850,000
Total		$1,003,503	$850,000

Critique: The Chairman of the site visit team reported on the visit made on June 8-9, 1971. The secondary reviewer was also an *ad hoc* member of the Review Committee for this cycle. He supplied additional details concerning the conclusions and recommendations of the team.

The Review Committee heard a brief history of regional development and was reminded that this was the first program visit since April 1968. Immediate problems facing the current team were: inability of the NM/RMP to project its expenditures so that year after year it has been faced with unexpended balances, and the lack of committed funds for future years.

Although the region's goals are re-stated in the present application, they are not accompanied by specific objectives or priorities. Nor are the proposed operational activities identified as to goals they are implementing. Undoubtedly existing deficiencies in numbers and distribution of health personnel and facilities has conditioned the region's goals (with emphasis on improvement of access to and quality of health services, disease prevention, and correcting the health manpower shortage). While these are unquestionably reasonable and relevant, (considering the general assessment of New Mexico as a "have not" region) and seem to be congruent with national priorities, their implementation appears less successful.

Core staff is still organized around the categorical diseases, with Assistant Coordinators responsible for a group of projects in these areas. This emphasis appears to inhibit the region's attempts to pursue its primary goals, its objectives of sub-regionalization, and to link together all of the planning and projects into an integrated program. The Coordinator referred to this as a "vestigial categorical structure." Core staff has been actively involved with other federal agencies, especially Comprehensive Health Planning. It is also involved in developing community organization and planning in the Four Corners area. Staff would like to assist in developing Area Health Education Centers, but there does not appear to be this expertise on Core staff at present. It was reported that planning for such centers is being explored by the Dean's office and not by NM/RMP staff.

The region has apparently not considered how the Emergency Health Personnel Act might be implemented in New Mexico, although there was an indication that this could become a future function of NM/RMP. This might be the source of physicians for the Model Cities activities in Albuquerque, Santa Fe and Rio Arriba County.

The reviewers received the impression that the NM/RMP sees itself in the role of "broker" of RMP funds. However, once the RMP funds are allocated for the various activities such as Model Cities, there does not appear to be much coordination of effort or follow-up on the part of Core staff.

While the NM/RMP has enjoyed close cooperation with both A and B agencies of CHP, and Model Cities, there is an absence of a firm program of action. These agencies are eager to participate in RMP affairs and would like to organize a Neighborhood Health Center. There was uncertainty, however, about the source of necessary funds.

The Committee was impressed to learn that the NM/RMP has excellent relationships with other health agencies in the state.. There are some town/gown problems with the State Medical Society, but the RAG, through its Executive Committee, appears to have credibility, at least in the Albuquerque and Santa Fe areas. Although decentralization, regionalization and peripheral dissemination are stated major objectives (by the RAG) for the future, the representation from peripheral areas is minimal. The RAG does represent well the areas where care is available, as it also represents some areas of need. It would appear, however, that more RAG input as to other local needs would seem desirable, and possible, if active representation can be found for other high need areas. The RAG appears to function more as a "board of approval" rather than an active policy-making body.

There is little evidence of capability on the part of Core staff in evaluation procedures, and this segment of the NM/RMP needs attention and strengthening. Although there is adequate staff to begin some planning in this direction, no formal plan or strategy was presented.

The Review Committee recalled that in initial stages there was an excess dependency on the resources of NM/RMP on the part of the

developing Medical School. There now appears to be a clear separation of the grantee and administrative responsibilities.

A number of the operational activities seem to be proceeding well. The Emergency Medical Services Project (#6) enjoys impressive leadership. This program seems particularly appropriate to New Mexico. Based in Española, it exhibits adequate resources, interest and environment for the development of a subregional center, which could serve a large geographic area in the north of the state.

The Tumor Registry Project (#1A) has been successful in abstracting records from hospitals representing 90% of the region's beds, but is not being used as part of the leukemia-lymphoma program (#17) to plan an overall cancer program, or to link it with the continuing education programs in cancer.

The Health Information Mini-System (#1B) was disappointing to the reviewers in that it has not led directly to operational activities. Rather, opportunities for action seem to have been by-passed.

Another concern about operational activities in general was that most of the projects begun three years ago are requesting additional three year funding, with no apparent plan for phasing out support in order to create turn-around money.

There was agreement that the prognosis for the NM/RMP is positive. There seems to be a good climate at the present time for a reorganization under new and stronger leadership. While certain inconsistencies do exist between the region's goals and its operations, it was recognized that the turn-around process in a state with such limited resources will be slower. The Review Committee commended the efforts of the recent site visit which took place in an exceedingly candid atmosphere, with expressions of good will on the part of all concerned. The Committee agreed that it is important to proceed as soon as possible in the unification and strengthening of Core staff under new leadership. Also, the appointment of the new Coordinator, Dr. James R. Gay, following the site visit as the result of the immediate naming of a Search Committee by the Executive Committee of RAG, was endorsed by the reviewers. The former Coordinator, Dr. Reginald Fitz, will serve as a consultant to the NM/RMP on an interim basis, for an orderly transition of the region's leadership.

There was discussion of the possible jeopardy in which the Medical School may be placed if the NM/RMP should withdraw its investment. Continuing mutual support is essential, therefore, for an effective re-orientation and reorganization of the RMP. Committee noted that the Dean had expressed his intention to the site team to phase out as rapidly as possible the Medical School dependency. There was agreement that extraordinary opportunities, as well as problems exist, with a wide spectrum of "haves" and "have nots." About 25% of the population is Spanish-American, Indian or Mexican-American, and thus far the region has not given specific attention to the health needs of these minorities.

In considering the request for a Developmental Component, the reviewers agreed that the region has not demonstrated the necessary maturity or organizational development to administer such funds. Also, the triennium application under review was believed to be about one year premature. Committee expressed the hope that reports issuing from the present review need to be strengthening, candid and supportive. The Review Committee endorsed and unanimously approved the conclusions and recommendations of the site visit team.

RMPS/GRB/7/14/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 25, 1971

Reply to Attn of:

Subject: Mini Site Visit Report of the New Mexico Regional Medical Program, June 8-9, 1971

To: Director
Regional Medical Programs Service

Through: Acting Deputy Director
Regional Medical Programs Service

List of Participants: Sister Ann Josephine, Chairman
Mr. Arthur M. Rogers
John Gramlich, M.D.
Morton C. Creditor, M.D.
Anthony L. Komaroff, M.D.
George E. Schreiner, M.D.
Mr. Cleveland Chambliss
Mrs. Jessie F. Salazar

I met with Sister Ann Josephine in Albuquerque at 11 a.m. on June 7, at her request in order to brief her on the program, and particularly with reference to the issues and concerns we had previously identified, and with which you are familiar. Actually, some of the issues turned out to be more sensitive than we had anticipated. At the outset, I would like to record that much of the sensitive areas of the site visit were skillfully guided and channelled into what will, hopefully, result in a "positive and constructive message" (Dean Stone's description). Sister brought to the Chairmanship of the team a superb leadership as well as a sympathetic understanding and awareness of the strengths and weaknesses of the New Mexico Regional Medical Program.

Dr. Fitz is leaving the program in September to join the Commonwealth Fund.

The site visit team found the MNRMP goals to be reasonable and relevant, considering the general assessment of New Mexico as a "have not" region. It was unclear however as to whether goals or objectives are the result of a specific assessment of needs, problems and resources. Certainly they are congruent with national priorities, but are being implemented less successfully.

Core staff is still organized around the categorical diseases, with Assistant Coordinators responsible for a group of projects in categorical disease areas. The site visitors believed that this emphasis inhibits the region's attempts to pursue its primary

non-categorical goals, its objective of subregionalization, and to link together all of the planning and projects into an integrated program. The regional representatives referred to this as a "vestigial categorical structure," yet appears not to have attempted to divest itself of this approach.

The Core staff (particularly the Director) has been involved with other Federal Health Agencies, especially CHP, since the beginning of the NM/RMP. NM/RMP has paid the salaries of one community planner to work with the A agency, and to help plan for the establishment of B agencies. Another RMP staff man is delegated full-time to work with the B agency in Santa Fe (NORCHAP) and with the Santa Fe Model Cities. Since the A agency staff consists of four people and the B agency staff of three, the RMP contribution is substantial. RMP is involved with developing community organization and planning in the "Four Corners" area of the state. The site team felt that this aspect of the core staff activity in program implementation is commendable.

The region would like to assist in developing Area Health Education Centers, but the team could identify no one on the core staff competent to pursue this task. The only possibility thus far is at the New Mexico State University in Las Cruces. This possibility has been explored by the Dean's office, but not by RMP staff.

There was no evidence that the region has considered how the Emergency Health Personnel Act might be implemented in New Mexico, although there was an indication that this could become a function of RMP. Apparently no thought has been given to the possibility that the Emergency Health Personnel Act might help supply physicians for the Model Cities activities in Albuquerque, Santa Fe and Rio Arriba County.

The site visitors had very little time to evaluate individual project activities. We were disappointed that the Health Information Mini System has not directly led to operational activities. Rather, opportunities for action seem to have been by-passed. Another concern was that most of projects begun three years ago are requesting additional three-years funding. This seems to not be in keeping with the policy of phasing out support in order to create turn around money. On the other hand, the team realized that New Mexico is a region of limited resources with fewer possibilities for financial support from other sources. The individual project activities are apparently uncoordinated. Rather, they seem to be a group of "good deeds" rather than a cohesive program. For instance, the cancer registry which has been successful in abstracting records from hospitals with 90% of the region's beds, is not being used as part of the Leukemia-Lymphoma program to plan an overall cancer program or, to link it with the continuing education program in cancer.

The Emergency Medical Services Project, under the vigorous leadership of Dr. Hendryson is impressive. This program seems particularly

fact that
appropriate in view of the/mortality from accidents is greater than mortality from any of the categorical diseases in New Mexico. This Espanola-based program exhibits the appropriate resources and environment for the development of a subregional concept. It seems likely that Espanola will be able to serve as a regional center for a large geographic area in the northern area of the state.

The New Mexico Regional Advisory Group appears to represent well the areas where care is available. It represents some areas of need, but more RAG input as to other local needs would seem desirable and possible if active representation could be found for the other high need areas. Nineteen members were added to the RAG in December 1970, twelve from Albuquerque, four from Santa Fe and one each from Espanola, Las Vegas and Carlsbad. It appears that this change was intended to increase the number rather than extending representation. Throughout the site visit presentation it was clear that policy is made and controlled in the Core staff and Executive Committee of the RAG. The team believes that the RAG is in fact a "board of approval" rather than a body organized for active participation in policy making. The program has good credibility and an understanding relationship with the Medical Society.

There was little evidence of capability in evaluation and this segment of the program certainly needs attention and strengthening. There is no formal evaluation plan or strategy, although there is adequate staff to begin to plan in this direction.

Although there appears to be a clear separation of the grantee and administrative responsibilities the site team was aware that in the initial stages of the program an excess dependency of the Medical School on the resources of NM/RMP existed. Dean Stone acknowledges this and stated his intention to phase out this dependency as quickly as possible.

Conclusions and Recommendations of the site visit team:

1. The region should be complimented on the good relationships that exist between the NM/RMP and other professional groups, and the Dean for the Medical School support of the NM/RMP. The team was cognizant of the possible jeopardy to the Medical School by a severe cut-back to the program.

2. It was agreed that another year will be required to prepare an appropriate triennium document which would be capable of approval and implementation. The NM/RMP has not demonstrated the program maturity for a Developmental Component.

3. Core staff is in great need of strengthening.

4. Funding in the amount of $850,000 for one year only is recommended in order to allow the region to establish a plan of action which will emphasize a more positive approach to a viable RMP.

5. A Search Committee should be appointed as soon as possible to find a new Program Coordinator.

6. The membership of the Executive Committee of RAG needs better representation and orientation for its role in policy guidance of the program.

7. Except through indirect means (through CHP and Model Cities outreach) the NM/RMP appears to not have addressed the specific health needs of minorities.

8. The "constructive, positive message" which was the plea from Dean Stone to the site visitors and his to-the-point criticisms of the program in general require careful and serious consideration.

Jessie F. Salazar
Public Health Advisor
Grants Review Branch

D R A F T

SITE VISIT REPORT
NEW MEXICO REGIONAL MEDICAL PROGRAM
June 8-9,1971

Sites visited were:
Albuquerque and Santa Fe

I. Site Visit Participants:

Sister Ann Josephine, Chairman; Member of Review Committee; Administrator Holy Cross Hospital, Salt Lake City, Utah

George E. Schreiner, M.D., Member of National Advisory Council; Chief, Nephrology Section, Georgetown University Hospital, Washington D.C.

Anthony L. Komaroff, M.D., Beth Israel Hospital, Boston, Massachusetts

Morton C. Creditor, M.D., Coordinator, Illinois RMP, Chicago, Illinois

Arthur M. Rogers, Chairman of RAG of Connecticut RMP, Scovill Manufacturing Company, Waterbury, Connecticut

John Gramlich, M.D., (Mountain States - WICHE), Practicing Physician, Cheyenne, Wyoming

RMPS Staff:

Jessie F. Salazar, Public Health Advisor, Grants Review Branch

Cleveland R. Chambliss, Office of Organizational Liaison

New Mexico RMP Staff:

Reginald H. Fitz, M.D., Program Coordinator
William Weeks, Assistant to the Director for Administration
Loyal L. Conrath, M.D., Assistant to the Director for Heart
A.G. Greenhouse, M.D., Assistant to the Director for Stroke
Charles R. Key, M.D., Assistant to the Director for Cancer
I.E. Hendryson, M.D., Assistant to the Director for Related Disease
Dudley Griffith, Assistant to the Director for Planning and Evaluation
Mary Pozorski, Nursing Education Specialist
Elizabeth Barnett, Paramedical Education Specialist
Anthony Mares, Ph.D., Health Planner
Helen Potter, Health Information Coordinator
Gar Elison, Information Services Officer

Regional Advisory Group:

Hugh B. Woodward, M.D., Chairman, Executive Committee; Medical Director, Mountain Bell Telephone Company
Robert S. Stone, M.D., Executive Committee; Dean, University of New Mexico School of Medicine

Regional Advisory Group (cont.)

Vaun T. Floyd,M.D., Executive Committee; President Elect-New Mexico Medical Society, N.M. Cancer Society and N.M. Heart Association
Mr. Richard Heim, Executive Director, New Mexico Health and Social Services Department, Santa Fe, New Mexico
Alonzo C. Atencio, Ph.D., Assistant Dean/Student Affairs and Assistant Professor/Biochemistry, University of New Mexico
Mr. Sidney Hertzmark, Hertzmark-Parnegg Realtors, Albuquerque, New Mexico
Mr. George Olson, Director, State Comprehensive Health Planning Council Santa Fe, New Mexico
Bruce D. Storrs, M.D., Executive Committee; Director, Health and Social Services Dept. (Medical Services Division) Santa Fe, New Mexico
Julius L. Wilson, M.D., Private Practice, Santa Fe, New Mexico

Others

Mr. George Olson, Director, State Planning Office, CHP Division
Mr. John Glass, Director, NorCHaP
Mr. Thomas I. Harnish, Executive Director, Presbyterian Medical Services of the Southwest, Inc.
Mr. Roger Brumley, Santa Fe Model Cities Staff Liaison for NorCHaP
Mr. Rudolf Pendall, Executive Director, Mid-Rio Grande Health Planning Council
Eva Wallen, M.D., Director, Health Unit, Bernalillo County, Albuquerque
Mr. Jeff Meyer, Health Planner, Albuquerque Model Cities Program

II. BACKGROUND INFORMATION

This was the first program site visit to New Mexico Regional Medical Program since April 8-9, 1968, when a site team explored with the region ways and means of moving from a planning into operational status.

The current visiting team was charged with an evaluation of the program generally, and especially:

.. the region's readiness for a developmental component;
.. the experience and achievements of ongoing programs;
.. regional goals, objectives and priorities
.. involvement of health interests throughout the region;
.. the roles of Coordinator, Core staff and the RAG and its committees;
.. status of the regionalization concept;
.. organization and process of the technical review of programs;
.. the region's evaluation processes;
.. the decision-making methodology;
.. an examination of the region's interrelationships with other health planning agencies.

The team met on the evening of June 7, 1971, to discuss the application in general, and the concerns and issues previously identified by staff and members of the team. It was recognized that there was a great deal to be covered in the two days allotted for the visit, and that some of the areas might prove to be quite sensitive.

III. REVIEW DETAILS

A. Goals, Objectives and Priorities

The recognition that New Mexico is a "have-not" Region, with deficiencies in both the absolute numbers and distribution of health personnel and facilities, has conditioned the Region's goals from the outset. The goals remain pretty much unchanged: Emphasis is on the improvement of access to and quality of health services, disease prevention, correcting the manpower shortage, and lastly the categorical disease.

Restatement of these goals is found in a letter from the RAG to the Director, RMPS. None of the goals is accompanied by specific objectives or priorities, nor are the proposed operational activities identified as to the goals they are implementing. In another part of the RAG letter, a series of new objectives are listed, which will be discussed subsequently.

The site visit team felt that the goals were reasonable and relevant, considering the general assessment of New Mexico as a "have-not" Region. It was less clear whether any goals or objectives had been born out of a more specific assessment of the needs, problems, and resources of the Region.

The team felt that the goals and objectives were congruent with national priorities as stated, but were being implemented less successfully.

Spokesmen for the medical school, medical society, state department of health, and other federal agencies all acknowledged their agreement with the general goals of the program. Implementation of specific objectives to carry out these goals had proceeded slowly enough to raise the question whether the established health forces in the Region really supported these goals; there was no hard evidence to justify this skepticism, however.

The Region appeared torn between its rhetorical emphasis on broad, non-categorical activities, and what appeared to be its actual continuing strong emphasis on the categorical diseases. The Core staff is still structured around the categorical diseases, with assistant coordinators for each disease area. Each assistant coordinator has responsibility for a group of projects in his categorical disease area. The site visitors felt that this emphasis on the categorical diseases inhibited the Region's attempts to pursue its primary non-categorical goals, to pursue its objective of subregionalization, and to link together all

of the planning and projects into an integrated program. Futhermore, the Region seemed to realize this dilemma: It described as "vestigial" its persisting structure oriented toward the categorical diseases. Yet the Region had not chosen to divest itself of this "vestigial" structure. Perhaps this was because many on the Core staff had been chosen for their competance in the categorical diseases, and held medical school appointments, and thus could neither be easily replaced nor asked to accept non-categorical planning and organizational responsibilities.

Some of these responsibilities were among the new objectives outlined in the current application. The objectives were all fully congruent with current Federal priorities. They include: 1) The development of new types of allied health manpower; 2) The development of area health education centers as proposed by the Carnegie Commission report; 3) Implementation of the Emergency Health Personnel Act; and 4) The development of Health Maintenance Organizations. The site team felt that these objectives had been chosen more because of signals from Washington than from a spontaneous interest arising in the Region. As will be discussed later in the site visit report, little thought had apparently been given as to how these objectives would be pursued and implemented.

B. Organizational Effectiveness

1. Coordinator

A major defect of the program is the failure on the part of the Coordinator to exercise a leadership role. He failed to provide clear understanding of the operational framework within which the program goals and objectives were to be accomplished. He cannot be identified with a particular strategy which gives "character" to NMRMP. It is the feeling of the site visit team that he has similarly failed to characterize NMRMP to his constituency.

On the other hand, Dr. Fitz appears to have developed excellent personal relationships with CHP agencies and medical society, but this may well be related to lack of the usual pressure exerted by agressive RMP leadership.

Dr. Robert Stone, Dean of the University of New Mexico School of Medicine, the grantee agency, inferred some lack of confidence in the leadership ability of the Coordinator.

2. Core Staff

The core staff is small and their effectiveness is difficult to assess in the absence of an understandable programmatic framework. In other words, individual functional effectiveness can't be evaluated if the functions are not well defined and organized.

The competency of core staff was difficult to judge. The background and competency of a few were well demonstrated in terms of specific

targeted responsibility (e.g. for tumor registry, health information system and categorical activity) but one sensed a lack of cohesiveness associated with good management.

The fact that the management assessment team criticized certain auditing lapses on the part of the grantee, lapses which in fact do not exist, suggests a wide hiatus in terms of grantee-staff administrative relationships.

There is little evidence of capability in evaluation or at least use of the capability if such exists.

The categorization of core staff is highly artificial and based on admittedly "vestigial" categorical (heart, cancer, stroke) considerations.

One member of core staff who is obviously a plus is Dr. I. E. Hendryson. He is creative, understanding and well-organized.

C. Assessment of Needs, Problems and Resources

Although there is a stated commitment to subregionalization and change in program direction, there is little evidence of intent to modify staff composition and responsibility in acknowledgement of new program directions.

The core staff, particularly the Director, have been admirably involved with other federal health agencies--especially CHP--since the beginning of the NM/RMP. RMP has paid the salaries of one staff man ("community planner") to work with the A agency and to help plan for the establishment of B agencies. Another RMP staff member is designated full-time to work with the B agency in Santa Fe (NORCHAP) and with the Santa Fe Model Cities Program. Since the A agency staff consists of four people, and the B agency staff of three, the RMP contribution is substantial. The RMP representative is involved also with developing community organization and planning in the Four Corners area of the State (described elsewhere in this report). The site team commended the NM/RMP on this aspect of Core staff activities in program implementation.

Several questions clouded the evaluation of program implementation. It appears that the NM/RMP has not decided whether it should serve as a "doer", directly instigating activities, or, as a "broker" to encourage others to do so. It seems that the NM/RMP is playing mainly the "broker" role. This raised two questions: (1) Is the RMP an active broker, perceiving opportunities to bring disparate groups together, or, is it a passive broker, available only if other health groups, on their own initiative, sought RMP assistance? It appeared to the site team that NM/RMP has been too passive in the broker role. (2) Is the NM/RMP seen as an independent organization whose staff has special planning and implementing resources, or is it seen merely as another source of dollars which other health agencies could tap? It appeared to the visitors that the RMP has been viewed by the Medical School, Medical Society, State Department of Health, etc., as a source of funds. The team recognized the problems of creating a sophisticated and independent organization in a "have-not" region, but felt that the RMP leadership has not done enough to develop such an organization.

The visiting team was concerned by a disparity between the region's stated new objectives and its readiness to pursue those objectives. For instance, it was stated that the continuing education function would be enhanced by recent legislation making New Mexico the second state to require continuing education for physician relicensure. Yet, there was no indication as to the role NM/RMP might play in assisting the State Medical Society to develop these mandated continuing education activities.

The Region indicated a strong interest in the development of new types of allied health personnel. Indeed, the NM/RMP directly supported the initial development of a nurse-practitioner program in Estancia. This program was subsequently funded by the National Center for Health Services R&D. There was no evidence that staff of the NM/RMP is currently involved in seeking other opportunities to expand the use of this model for health care delivery. NM/RMP supports 50% of a secretary's salary to assist the Hospital Association in its physician assistant (MEDHIC) program. However, overall, RMP's efforts in experimenting with the development of new types of health personnel are only token at this point.

The Region expressed an intention to assist with the development of Health Maintenance Organizations. The site visitors could not identify anyone on Core staff with the kind of expertise and available time necessary to stimulate interest in, and plan for HMOs. The Dean specificially doubted the capacity of RMP to help develop HMOs. In fact, the only HMO in New Mexico which has been seriously considered thus far is the joint venture of the Lovelace Clinic and Presbyterian Medical Services; NM/RMP has not been involved in the planning.

The Region stated that they would like to help develop Area Health Education Centers, as recommended by the Carnegie Commission. Again, the site visitors could identify no one on the Core staff who could pursue this task. The only possibility thus far is the Las Cruces (New Mexico State University) area, and this possibility has been explored by the Dean's office, and not by RMP staff.

The site team found no evidence that the Region had considered how the Emergency Health Personnel Act might be implemented in New Mexico, despite their indication that this could become a function of RMP. In the proposed Model Cities activities in Albuquerque and Santa Fe, and in the Emergency Health Care proposal for Rio Arriba County, apparently no thought has been given to the possibility that the Emergency Health Personnel Act might help supply physicians.

The visitors were concerned about the approach that New Mexico RMP has taken in stimulating an application for an Experimental Health Systems grant from the National Center for HSR&D. The RAG specifically rejected direct RMP leadership of this effort, and chose to form a new planning body--the Albuquerque Area Health Coalition. Thus, although RMP had participated in the development of an Experimental Health Systems proposal (consistent with its recently developed objectives) it did so in an indirect and possibly ineffectual manner.

Although the Region claimed to place a high priority on the development of a program in kidney diseases, the only progress in this direction was to form a committee twelve months ago which has "not developed any plans to the point of maturation." In fact, no plans of any sort were described to the site visitors, and it appeared that none of the four nephrologists in the Region has been seriously involved. The site team believed that opportunities do exist for preliminary planning for a renal program, and noted the especially critical needs in the Four Corners area as one place to begin.

1. Grantee Organization

The grantee organization provides adequate support, in fact some unrecognized as noted above. Although there appears to be a clear separation of grantee and administrative responsibility, there was developed at the beginning an excess dependency of the medical school upon the resources of NM/RMP. This is acknowledged by the Dean who promises to phase out this dependency as quickly as possible (but not abruptly) and who acknowledges that the school has greater obligation to RMP in return for the investment.

Early-on the New Mexico University School of Medicine took vigorous note of the need to separate its policies and philosophies from the NM/RMP, in spite of the heavy dependence of the NM/RMP on the Medical School for professional resource people. In fact, the lack of strong leadership by the RAG Executive Committee is likely the result of a conscientious attempt to avoid an appearance of co-opting the NM/RMP by a single major interest. In 1968, Dean Stone criticized "too much Medical School involvement."

It is the feeling of the present site visit team that reinvolvement in the RAG by key Medical School people would strengthen RAG leadership. Certainly in the selection of a new Coordinator for NM/RMP the Medical School should be closely involved.

2. Regional Advisory Group

The New Mexico Regional Advisory Group currently consists of 41 members. 24 are located at Albuquerque, 7 in Santa Fe, and one each from ten other locations. The group well represents the areas where care is available and represents some areas of need, but more Regional Advisory Group input as to other local needs would seem desirable and possible if active representation could be found for the other high need areas. Appointment is initiated as a result of individual expression of interest and there has been little apparent attempt to seek out members in an effort to create appropriate balance.

Nineteen members were added to the Regional Advisory Group in December 1970. 12 reside in Albuquerque, 4 in Santa Fe, and one each in Española, Las Vegas, and Carlsbad, so it would appear that this change in the membership was intended to increase its size rather than for the prime purpose of extending representation.

The Executive Committee, which is obviously the key policy making group which wields the power, is inappropriately constituted in that all of the members but one are physicians. In the RAG itself there is little representation from the allied health professions other than physicians and nurses. Participation by institutions of higher education is limited to the University of New Mexico, there being no other colleges or junior colleges participating.

The present Chairman has served in this capacity since the beginning of the program. The site visitors noted that although the By-Laws provide for rotating Chairmanship with an election each year, there appears to be a reluctance on the part of the membership to elect a new chairman.

Throughout the site visit presentation it seemed clear that policy was made and controlled in the staff and Executive Committee. There was little reference to the Advisory Group in any of the presentations or discussions. One would conclude that the Regional Advisory Group is in fact a board for approval rather than one for active participation in policy making.

As the New Mexico RMP goes forward to programming, it would seem necessary for the Regional Advisory Group to take a stronger role in the policy discussions of the program. An evaluation of the contribution expected of each member of the Regional Advisory Group could lead to moving the group in this direction and if necessary, to some change in the makeup of the group.

Wide use of interlocking board memberships appears to have established good working relationships with other related health planning agencies and should continue. Reciprocal involvement on the NM/RMP RAG is not so apparent. There is no OEO representative; there is one Community Action Program member on the present RAG. The absence of a representative of the Bureau of Indian Affairs is striking. In the selection of a new Coordinator, his ability to achieve broader delegation of responsibilities and to activate representation of presently uninvolved health agencies and ethnic groups should be considered.

The RAG, through its Executive Committee, appears to have policy control over the program and seems to have credibility, at least in the Alburquerque and Santa Fe areas. The team had very little opportunity to assess the perceptions of other areas of the state. It was noted that although decentralization, regionalization and peripheral dissemination is stated as a major objective of the future, the representation from the peripheral areas is minimal. Also, there is a

technical review structure and process outlined in the application. However, it appeared to the team that very little objectivity is used in such review since the approval of activities does not seem to be consistent with the priorities as stated by the RAG itself.

D. Involvement of Regional Resources

The NM/RMP seems to be quite effective in its support of other health-related interests, institutions and professions in New Mexico. It has been particularly active at the planning level and it is anticipated that this activity will contribute to achieving regional goals. Presumably effectuation of ongoing projects of significance should be forthcoming.

Comfortable relationships have been established with practicing physicians, and organized medicine in New Mexico seems to look favorably on NM/RMP as a whole.

Community hospitals are well-represented, but because of the population distribution, they are predominantly from Bernalillo County (Albuquerque).

A Meson beam facility is being built at Los Alamos. It is anticipated that the facility will be finished by 1973. The possible application of a Meson beam for delivering radiotherapy at specified depths has therapeutic implications which are being pursued by the NM/RMP Cancer Coordinator.

There seems to be amicable association with other health agencies, especially at the planning level. However, little direction has been achieved toward interesting other agencies in taking over projects as part of a planned phase-out. NM/RMP has developed good cooperation with other planning groups--i.e. assignment of a Core staff employee to CHP in Santa Fe seems to be useful at the planning level. Consumer and community groups have not yet been extensively involved in the RMP. The Española project may prove to be an outstanding exception.

Some support of New Mexico political power structure seems to have been received through the State Health Department. However, there was no evidence of close working relationships at the program level.

In terms of subregionalization, much was said about future intentions, although up until now, RMP program activity has been virtually limited to Albuquerque and Santa Fe. There appears to be some disagreement between the Coordinator and the Dean concerning the most logical targets of initial subregionalization attempts. There is no evidence as yet of participation by people in the proposed subregions in the planning for such regionalization, except in Santa Fe.

Part of the site team visited the Española Hospital, which is about 23 miles northwest of Santa Fe, to look at the Emergency Medical Services program, under the direction of Dr. Hendryson. It appears that the resources are appropriate and the individuals involved in this institution are ready and anxious to cooperate in the

development of a subregional concept. It appeared to the visiting team that Espanola will be able to serve as the regional center for a large geograhic area in the northern region of the State. Further, there seemed to be a genuine understanding on the part of those with whom this was discussed, of the organizational needs and requirements.

E. Program Implementation and Accomplishments

1. Core Activities have been covered under Organizational Effectiveness, page 4.

2. Project Activities and Evaluation

The site visitors had very little time to evaluate the individual project activities, and our comments here will be necessarily brief.

The site visitors felt that the planning effort (the Health Information Mini-System) had not directly led to operational activities. Rather, opportunities for action that fit the general goals and objectives of the program had been "grabbed up" -- there was no evidence that the Region had used its planning data to specify areas of greatest need, and then instituted operational activities to meet these needs. The site team realized that this type of approach had characterized many RMPs, and were hesitant to be too critical on this point.

Most of the project activities seemed appropriate to the Region's apparent and stated goals and objectives -- dealing with improved access to health care, disease prevention, and particularly the manpower shortage.

Most of the projects appeared to strengthen linkages among the Region's health institutions.

There is little evidence of capability on the part of Core staff in evaluation procedures, and the team noted that this segment of the New Mexico program needs attention and strengthening. Although there is adequate staff to begin some planning in this direction, no formal plan or strategy was presented.

The site team was bothered by the fact that almost all of the projects which had begun three years ago were requesting an additional three years funding. This seemed not in keeping with the policy of phasing out support for given activities as soon as possible, in order to create "turn-around money." On the other hand, the team realized that New Mexico was a region of limited resources where the health sector was less liable to be able to pick up and financially support RMP-initiated activities. Nevertheless, it was felt that more support from non-RMP resources could be found for those projects which clearly provided services to community health facilities, such as the Stroke and Rehabilitation Project, and the Unified Laboratory Science Training Program.

The site visitors felt that the individual project activities were not as well integrated as they might have been. They appeared to be "a group of good deeds" rather than the implementing arms of a cohesive program. For instance, the cancer registry has been successful in abstracting records from hospitals with 90% of the Region's beds, and yet the registry data were apparently not being used as part of the Leukemia-Lymphoma program, to plan an overall cancer program, or to tie into a continuing education program in cancer. As another example, the three coronary care projects were described in the application as separate activities; despite assurances of their integration by the heart disease coordinator, evidence in support of that assurance was lacking. It was felt that the three projects should be combined, with probable savings in both quality and cost. As one example of meaningful integration, the site team was pleased to note the intention to coordinate the streptococcal throat screening and phonocardiogram screening programs.

One project which site visitors found very impressive was the Emergency Medical Services project. Under the vigorous leadership of Dr. Hendryson, this project has completely surveyed emergency medical services in the Region, has led to the establishment of a Governor's Advisory Commission on Emergency Medical Care, and has trained 400 ambulance attendants and essentially all of the state highway patrolmen in basic emergency medical care procedures. This project seemed particularly appropriate in view of the fact that mortality from accidents is greater than mortality from any of the categorical diseases in New Mexico, and emergency care is greatly complicated by widely dispersed health personnel and facilities.

It is difficult to see the New Mexico RMP as a unit. It exists as a number of separate projects not yet tied into a composite whole. Assessment of the overall program and evaluation of projects must wait on the establishment of a system of program and detail evaluation.

There was no evidence of any feedback mechanism relating to program and project evaluation of the Regional Advisory Group.

IV. Conclusions and Recommendations of the Site Visit Team

1. The region should be complimented on the good relationships that exist between the NM/RMP and other professional groups, and the Dean for the Medical School support of the NM/RMP. The team was cognizant of the possible jeopardy to the Medical School by a severe cut-back to the program.

Although there appears to be a clear separation of the grantee and administrative responsibilities, the site team was aware that in the initial stages of the program an excess dependency of the Medical School on the resources of NM/RMP existed. Dean Stone acknowledges this and stated his intention to phase out this dependency as quickly as possible.

2. It was agreed that another year will be required to prepare an appropriate triennium document which would be capable of approval and implementation. The NM/RMP has not demonstrated the program maturity of a Developmental Component.

3. Core staff is in great need of strengthening.

4. Funding in the amount of $850,000 for one year only is recommended in order to allow the region to establish a plan of action which will emphasize a more positive approach to a viable RMP.

5. A Search Committee should be appointed as soon as possible to find a new Program Coordinator.

6. The membership of the Executive Committee of RAG needs better representation and orientation for its role in policy guidance of the program. Consideration should be given to some modification in its leadership and direction in order that this body can more adequately represent and steer the larger body.

7. Except through indirect means (through CHP and Model Cities outreach) the NM/RMP appears to not have addressed the specific health needs of minorities.

8. Finally, the team was disappointed at the lack of progress in the kidney disease area. It is believed that opportunities do exist for preliminary planning for a renal program, and the consultants noted the especially critical needs in the Four Corners area as one place to begin. The team's recommendation for this component of the program is that an amount of $30,000 be specifically earmarked for this health problem.

RMPS/7/27/71

(A Privileged Communication)

REGIONAL MEDICAL PROGRAMS SERVICE

"910" Application
(Special Action)

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

NATIONAL KIDNEY FOUNDATION
315 Park Avenue, South
New York, New York 10010

Project Director: Edward J. Mitchell

Requested Program Period	01 8/1/71-7/31/72	02 8/1/72-7/31/73	03 8/1/73-7/31/74	Total
Direct Costs	$367,010	$350,170	$341,870	$1,059,050
Indirect Costs	-0-	-0-	-0-	-0-
TOTAL	$367,010	$350,170	$341,870	$1,059,050

(Although RMPS has a backlog of "910" applications, this is the first and only one being presented to Council. This particular proposal was entered into the review process since RMPS already had the mechanism to provide the technical review required, specifically the Ad Hoc Panel on Renal Disease. In a June 1971 review, the Panel unequivocally recommended that the proposal not be supported. Because of the negative Panel review, RMPS is asking Council for its recommendation. No purpose would be served by not informing the Kidney Foundation of the results of the review.)

The Application - "Kidney Donor Program"

The National Kidney Foundation requests support for a three-year program to increase the number of cadaveric anatomical gifts for kidney transplantation. An intensive public and professional education program based upon the uniform donor card is proposed. The anticipated effect of this program will be both an increase in the number of kidneys donated and a decrease in the waiting time and the financial burden of chronic and pre-transplant dialysis.

The project is divided into two areas of concentration: the first is a national project which is an expansion and development of the existing public and professional program of the National Kidney Foundation; the second is a local pilot project in a state or major metropolitan area and is designed for a more controlled and intensive effort than is proposed on the national level.

Of the $367,010 requested from RMPS for the first year 28.6% is for personnel; 7.4% for consultant services; 2.5% for equipment; 2.6% for supplies; 3.2% for travel; 55.5% for "other." The major "other" costs are Postage and Shipping, Building Occupancy, and Printed and Audio-visual Materials.

Critique of the Ad Hoc Panel on Renal Disease:

The Panel found this proprosal to be without innovation and believed it represented essentially the continuation of established National Kidney Foundation activity. The procedures are not clearly defined nor is the process for evaluation, such as pre- and post-publicity action, spelled out. The proposal misses an important point in not being directed at the identification of the population who should be worked with in specific areas to procure organs which come available. The Panel believed that much of this work is being performed on the Regional level, and that the Foundation would be well advised to coordinate or cooperate with Regional activities. It was recognized that the Foundation and its affiliates might perform an intermediary role where applications are known to be under development. It seems that the Foundation could effectively accomplish munch of its task, without Federal funds, by coordinating its funding with its affiliated chapters.

Recommendation: The Panel recommended that the "Kidney Donor Program" not be supported.

RMPS/GRB/7/19/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 17, 1971

Reply to Attn of:

Subject: Pre-Triennial Assessment

To: The Reviewers of the Northern New England RMP

The Northern New England RMP is entering its third operational year during which it will be preparing its triennial application. This Region has pursued a data collection and analysis approach to program development unique among most RMPs. Concomitant with this approach has been an unusually small number of operational projects. The Region has not submitted any projects since its initial operational application (which contained four) was reviewed two years ago. Even were the supplemental proposal (project #6) included in this application to be approved and funded, the Region would still have only three ongoing operational projects. Projects #2, Progressive Coronary Care, and #4, Project in Continuing Education, will be in their last year. Applications from this Region have experienced continuing difficulty in review at the national level since the Program's planning days. It has not always explained its systems approach well, nor justified its requests for funds as completely as it should have.

In staff's review of the application in May 1971, they were similarly unable to get a grasp of what the Region had accomplished and what its future plans might be. Regional goals, objectives and strategy seemed to be absent from the RAG report. While the application forms did not ask for an explanation of the data base, staff was disappointed that the Region did not take the opportunity to describe its program or to discuss possible implementation of the technical site visit recommendations in December 1970.

For these reasons, when staff reviewed the application they recommended to the Director, RMPS, that Committee and Council be requested to assess its program approach before the Region began preparation of its three year look. Additional information was requested from the Region. The memo containing staff's review and recommendations can be found at the end of the summary.

In conclusion, staff would like some guidance on how to work with this Region while it is preparing its triennial application.

Dona E. Houseal

Dona E. Houseal
Public Health Advisor
Grants Review Branch

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY GRANT APPLICATION
(A Privileged Communication)

Northern New England RMP
University of Vermont
College of Medicine
25 Colchester Avenue
Burlington, Vermont 05401

RM 00003 8/71
July 1971 Review Committee

Program Coordinator: John E. Wennberg, M. D.

This Region is currently funded at ~~$670,677~~ $590,196 (direct costs) for its second operational year which ends August 31, 1971. The application includes a request of $971,708 for continuation of core and two projects (staff action only) and a new project dealing with kidney disease (Committee and Council action required). A breakout chart identifying the components follows.

FUNDING HISTORY
Planning

Grant Year	Period	Funded (d.c.o.)
01	7/1/66-6/30/67	$208,807
02	7/1/67-6/30/68	577,775
03	7/1/68-4/30/69	459,581

Operational Program

Grant Year	Period	Funded (d.c.o.)
01	5/1/69-8/31/70	$915,703
02	9/1/70-8/31/71	670,677
03	Future Commitment	590,196 1/

1/ This amount is reduced from the ~~committed~~ level of $670,677 as a result of RMPS funding cuts.

GEOGRAPHY AND DEMOGRAPHY

Although the Northern New England RMP was originally envisioned to include New Hampshire, Maine and Vermont, this Region now encompasses only the State of Vermont and three northeastern New York Counties. The population of this total area is 595,700. The State of Vermont has one medical school - the University of Vermont College of Medicine at Burlington. There are also five professional nursing schools, three practical nurse training and four allied health schools.

Vermont is served by 621 active physicians, 31 of whom are osteopaths. There are 1,836 active and 955 inactive nurses. 956 licensed practical nurses are presently actively employed. In addition to a V. A. Hospital, there are 20 hospitals with a total 1,961 bed capacity.

ORGANIZATIONAL STRUCTURE AND PROCESSES

Comprehensive Health Planning have been merged into a 32-member group during the past year. The new relationship between these organizations is described in a subsequent section.

The Regional Advisory Board component of the Joint Board has 25 voting members, including seven consumers. The purposes of the RAB are to advise and guide the RMP in its planning and operational programs; to be actively involved in developing regional objectives; and to be continually concerned with the relevance and effectiveness of the RMP's programs to its objectives.

A Study Committee of the RAB serves as an Executive Committee to the RAB. Its seven members review and make recommendations on proposed programs to the RAB, monitor funded programs, ratify candidates for disease management committees and function as the Regional Health Management Committee of the State Health Planning Council of CHP.

This Region has organized disease management committees to both manage clinical activities and recommend investment of resources for a delineated number of specific health care problems, usually in a particular categorical disease area. Membership of the committees includes physicians, nurses, hospital administratiors and representatives of other health interests. More specifically, such groups are charged by the Advisory Board with:

1. Accountability for the establishment of the standards and guidelines for the clinical management of preventive, early detection and therapeutic and rehabilitative services within the region.

2. Responsibility for making operational decisions on the allocation of health systems resources under their control and influencing decisions on resources that are not directly under their control.

3. Responsibility for establishing a quality control information system and exercising audit functions for the disease area under their purview.

An operational disease management program for coronary artery disease and cancer currently exist. There are plans to develop similar programs in respiratory disease, stroke, and kidney disease, as well as maternal and child problems, trauma services and infectious disease. Six Intersociety Task Groups in Heart Disease have also been formed to read and review Intersociety Reports on Heart Disease, review data from Vermont and make recommendations for programs to the Coronary Care Management Committees.

In the area of continuing education, a management committee has also been formed. It is assisted at the community level by seven Local Educational Councils.

CORE

Core staff's primary sphere of activity appears to be the data system. Its

accomplishments during the past year included working with the disease management reports, completing data base development, establishing outlets for data, and completing a study of primary care in Cavendish, Vermont. Other efforts included work to achieve the merger of the CHP and RMP Advisory Boards and providing organizational support to disease management groups and CHP "b" agencies.

Its plans for next year are listed as follows: 1) provide basic planning data to develop the State Health Plan, 2) provide organizational support to develop disease management committees in respiratory disease and kidney disease; 3) provide organizational and technical support to developing CHP "b" agencies; 4) develop new Phase II reports on major health problems; and 5) continue to update the data base.

The staff includes 17 members with expertise in administration, medical coding, systems analysis, survey research, urban planning, education, library work, mathematics, social work, engineering and medicine. All but two are full time.

Core staff has completed reports on cancer, respiratory disease, end-stage kidney disease, stroke, prepared plans of medical care, and primary care management in rural practice.

Core staff will be funded at approximately a $389,157 level during the 03 year.

THE DATA SYSTEM

The NNE RMP has a comprehensive, population-based information system containing: 1) hospital, nursing home and home health agency abstracts for all institutions within Vermont and neighboring portions of New York and New Hampshire; 2) health manpower and facility inventories for a similar area; 3) corresponding demographic data; and 4) survey research capability. According to the RMP, this data base permits the establishment of population based utilization, disease, admission, procedure and mortality rates on a small geographic base. Differences between individual institutions can therefore be observed. It also permits cross tabulations with physician characteristics, estimations of per capita resource investments including personnel, dollars and facilities.

In addition to the special reports in particular categorical areas, the Region is providing data to CHP for its planning uses and to the State Medical Society for its Peer Review organization. Other users include the Connecticut Valley Compact, the Northern Counties Comprehensive Health Planning Council, Planned Parenthood of Vermont, the Vermont Hospital Association and two HMO activities (in Abnaki and Black River).

RMP-CHP RELATIONSHIPS

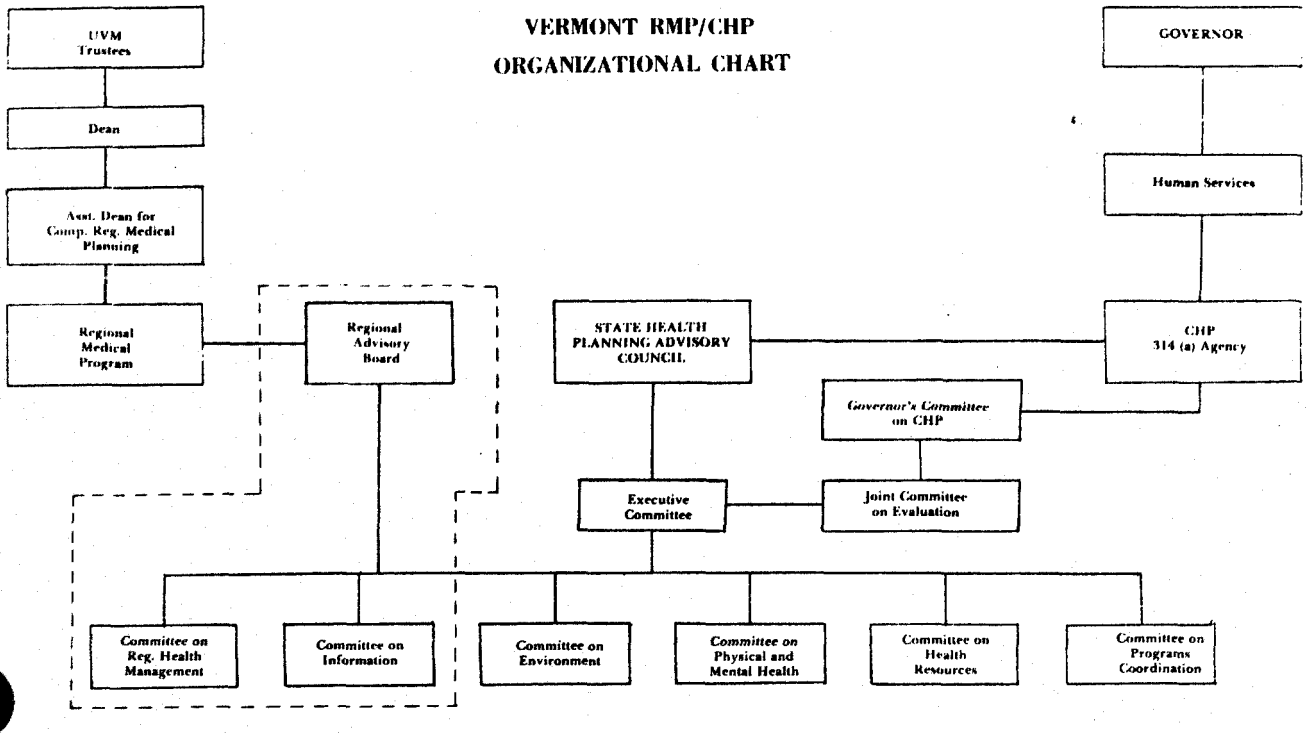
During the past year the RMP Regional Advisory Group effected a merger with Vermont's State Health Planning Advisory Council (CHP A Council) to form a new State Health Planning Advisory Council (SHPAC). On December 9, 1970,

the organizaing meeting of the combined RMP-CHP Boards was held. The merged board has retained within it the Regional Advisory Board (RAB) membership and its ability to function as a separate board when necessary. On the other hand, some RMP Board members are not full voting CHP Board members. Members from the RAB serve on all six of the Council's standing committees. In addition, in order to retain continuity in decision making, the Study Committee of the RMP has been retained intact as the Committee on Regional Health Management for the State Health Planning Advisory Council.

With regard to RMP-CHP staff cooperation, the two staffs are collaborating on development and implementation of the data base. One interesting note is the fact that Mr. David Miller, the CHP A Agency Director, is organizationally above RMP by virtue of his position of assistant dean at the Medical School.

A recent NNE RMP newsletter discusses the differences between RMP and CHP in the following way:

> The purpose of the Regional Medical Program is to develop regional disease management programs. The purpose of the Comprehensive Health Planning Program is to create planning councils to analyze problems, set priorities, and establish plans concerning the most comprehensive aspects of health. Without the Regional Medical Program, Comprehensive Health Planning lacks sufficient specific resources for technical skills in problem definition, program design, and program evaluation. The Regional Medical Program, with its University base, provides a technical skills resource which can respond rapidly and efficiently to the needs of Comprehensive Health Planning for technical assistance. This can be done either with the Regional Medical Program resources or by using the Program as a technical advisor in evaluating other technical resources.
>
> Without Comprehensive Health Planning, the Regional Medical Program lacks context. Comprehensive Health Planning provides local and State level planning organizations. Through these organizations, it expects to achieve a planning process which will determine the problems, the priorities, and the actions necessary to achieve comprehensive health. The Regional Medical Program's information and technical skills can be used most constructively in support of this planning process. Comprehensive Health Planning, therefore, provides the mechanism for deciding whether or not the Regional Medical Program's proposed alternatives are feasible solutions either in terms of public acceptance or interagency cooperation.



REGIONAL DEVELOPMENT PLANNING PROGRAM

Planning for regional medical programs in Vermont began in June 1965 with the appointment by the Governor of an Advisory Board for Health Programs. Early planning efforts appeared to center in the University and were directed by Dr. Robert Slater, then Dean of the Medical School.

Early in the planning process, a systems approach to definition and analyses of needs was outlined. The engineering assistance of TRW was contracted to develop, in collaberation with the professional health personnel of the University Medical Center, alternative organizational patterns within which the most effective use of professional talent could be made. Particular attention was paid to development of basic models of patient care. Since national reviewers had questions about the practicality of such an approach to the complex problems in medical programs, a national ad hoc committee of systems analysts was convened and developed guidelines for Regions who wished to take the systems approach. Funds for the TRW contract were omitted in the initial planning award. Progress was slow because of change in direction (Dr. Robert Coon replaced Dr. Slater) and the lack of Core staff. With the change in Coordinator, the Region did not veer from its original emphasis on systems analyses. Although some of the systems analysis proposals were

deleted from the original application, an attempt was made to include similar services by making use of University resources. Closer relationships were developed with the College of Engineering, bioengineering personnel and management engineering groups. A supplemental request for $62,000 to support a survey of heart disease in Chittendon County was submitted during the first planning year. Since the proposal represented a first attempt to relate baseline data to treatment, approval was recommended and the study funded at a reduced amount.

Planning during the 02 year continued to emphasize the systems analysis framework: a supplement was submitted requesting additional Core staff positions, a subcontract for systems engineering consultation (TRW), service charges for a Professional Activity Study (PAS) and additional personnel time from the College of Technology. The overall plan behind this request was to develop a Model of Patient Care by a Committee which would define objectives, identify evaluation criteria, review progress and make recommendations to the RMP Core group. This Committee was a forerunner of the Disease Management Groups described below. Because of the need for more information about such an approach, a site visit was held in July 1967 to review the merits of the application and to assess the systems capability. The visitors found the systems capability modest but with the involvement of the University resources in technology, etc., they thought that it would expand. Reviewers agreed with the visitors that the planning request, with the exception of the systems subcontract with TRW and some of the bioengineering positions, should be supported.

Dr. John Wennberg, a young physician with expertise in preventive medicine and public health, succeeded Dr. Coon as Coordinator in May 1967. With Dr. Wennberg's appointment came somewhat of a change from the long-range planning described above to short-term project development. The Region embarked on certain planning activities, some of which later evolved into operational proposals. These studies included the heart inventory, the PAS study and the systems contract with TRW (mentioned earlier), as well as coronary care, emergency care, and health professions education studies, a regional cancer project and a hospital-shared data processing system. The RMP participated in the development of the Connecticut Valley Health Compact, whose overall goal was to examine the possibilities for the provision of total health care in the subregion. Many of these studies, however, showed the continuing importance of the systems approach to problem solving and planning in the Region's conceptual strategy. During its third planning year, the Region requested and was granted approval to rebudget funds for a data information study to be performed under contract with IBM. The study planned to develop the basic plans and operating methods for a shared data processing system which could be accepted by all hospitals in the Region.

OPERATIONAL PROGRAM

The Region's operational application, including renewal of core and four projects was submitted in mid-1968. The projects included:

#2 Progressive Coronary Care
#3 Emergency Health Care
#4 Continuing Education for the Health Professions
#5 Evaluation Protocol for Emergency Health Services

A pre-operational site visit was held in October 1968. The visitors noted the Region's slow rate of maturity and the lack of RAG involvement in the decision-making process. They were also concerned by the lack of medical society involvement in generating program ideas, the absence of a clearly defined conceptual strategy, and apparent irrelevance of the operational projects to the immediate categorical health needs of Vermont. On this basis, Council deferred the application for additional information and clarification. The revised submission was reviewed again in early 1969 and approved. Core was approved at a reduced level with reservations. Reviewers noted the continuing emphasis on systems engineering and analysis. They questioned the desirability of such influence in the operational project managers, who seemed to stand outside of the medical activities proposed, and they stated that there should be no further significant increase in Core staff support until the Region had demonstrated the effectiveness of the staff currently employed and the existence of a plan pertinent to Regional Medical Programs. Project #3 was not supported because of Council consideration in mobile coronary care units and part of the program of project #5 was consolidated into Core. Until this cycle (July-August 1971) the Region has submitted no further project applications, although staff learned that over 40 proposals have been in the local review process. In May 1970 when the Region submitted its continuation request for 02 year support, staff found the progress reporting so sketchy, the future plans so nebulous and the financial reporting so unjustified, that the application was deemed unreviewable. There was also considerable discussion about the Region's first year of operational experience resembling its planning experience, i.e., concentrating on problem identification, epidemiologic studies, data analysis, etc. There appeared to be no clear-cut operational plan of action. The Region submitted a revised application, which was approved with the staff recommendation of a site visit. Such a visit would investigate: 1) whether the Region actually has systems analysis capabilities, 2) whether the Region's strategy and its incorporation into the CHP planning structure was consistent with RMP goals and also evolving a Regional Medical Program, and 3) whether there has been any major reallocation of regional resources.

A staff consultative site visit was made in early December 1970. The recommendations are too numerous to repeat here, but the general advice seemed to be that although the major emphasis on data acquisition and analysis strategies was reasonable, perhaps some of the Region's resources should be allocated to RMP activities which would give the RMP some visibility in the Region. The data techniques had been used effectively in some instances, but some plans for utilization, including a systemmatic data utilization strategy, should now be developed. Particular attention should be paid to problems encountered in preparing or "marketing" the data for specific organizations. In addition, the Region should broaden the base of understanding of the data system among regional groups and perhaps add someone not integrally involved with the program and with expertise in preventive medicine and public health to the Study Committee of the RAG. Although in the early planning days, there was evidence of support from the Medical School and the State Health Department, the December 1970 staff visitors reported problems in communications with members of these institutions. The relationship with the practicing community was also a question.

The continuation application for the 03 year submitted in May 1970 did not speak to many of these points. Staff, therefore, thought that in light of

the concerns of earlier reviewers and the criticisms of the site visitors, it would be prudent to bring the program before Committee and Council for an assessment of their approach before the Region began to prepare their triennial application.

Project #6 Northern New England RMP
Kidney Proposal

Requested First Year
$126,740

This proposal would establish a program to control chronic renal disease in the patient service areas of the major teaching hospitals serving Vermont and portions of New Hampshire and upper New York State. At the present time, there are no centers providing chronic dialysis or kidney transplantation in Vermont or New Hampshire. Decreasing ability to place patients from these two states in outside programs is becoming critical. A chronic renal home dialysis and transplantation program is to be established at the Medical Center of Vermont in Burlington. Coordinated development plans have been established with the Dartmouth Medical School in Hanover, New Hampshire. A home dialysis training program (24 patients a year) and a kidney transplant program (10-24 patients a year) would be instituted. The transplant capability would be coordinated with the Tri-State RMP proposed New England Kidney Program and the Interhospital Organ Bank. Evaluation will include assessment of access, quality of care and cost.

Other sources of funding have been identified, and funds have been received from the Vocational Rehabilitation Agency and the State of Vermont. State monies were obtained after passage of specific legislation pertaining to the treatment of end-stage renal disease.

A Kidney Disease Management Committee has been established to analyze the status of the health system, and to define priority problems and an operational program by the application of health systems performance criteria. The Kidney Committee will be responsible to the Advisory Board (RAG) for solving priority problems, establishing standards and guidelines for the performance of the program and monitoring resources. They will also serve as a focus for determination of further resource investment options.

Second Year
$117,404

Third Year
$137,368

REVISED 6/11/71

REGION Northern New England
CYCLE RM 00003 8/71

BREAKOUT OF REQUEST 03 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
#1 - CORE	$389,157				$389,157	$181,751	$570,908
#2 - Progressive Coronary Care	119,999				119,999	39,340	159,339
#4 - Project in Continuing Education	81,040				81,040	18,759	99,799
#6 - Kidney Program				126,740	126,740	30,816	157,556
TOTAL	$590,196			126,740	$716,936	$270,666	$987,602

REGION_____

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
#1	--				--
#2	--				--
#4	--				--
#6				117,404	117,404
TOTAL				117,404	117,404

REGION_____

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
#1	--					$389,157
#2	--					119,999
#4	--					81,040
#6				137,368	137,368	381,512
TOTAL				137,368	137,368	971,708

GRB 6/11/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 3, 1971

Reply to Attn of:

Subject: Staff Review of the Anniversary Application from the Northern New England RMP, RM 00003-03, May 12, 1971

To: Harold Margulies, M.D.
Director, RMPS

Through: Acting Deputy Director, RMPS

Chief, Grants Review Branch

Chief, Grants Management Branch

Acting Chief, Regional Development Branch

Staff met to review the Northern New England RMP's AR application, which included a request for continuation of core and two projects. A supplemental project in kidney disease is expected after June 1. Since progress appears adequate, staff recommends approval of the $830,046 (total costs) continuation request.

The Northern New England Region is unique among RMP's and for several reasons. One is its relationship with Comprehensive Health Planning. A second is its almost exclusive investment in the data planning and analysis approach to program. As a result of this commitment, a third feature which sets this program apart from many others is the small number of projects--this Region has not had an application before Committee and Council since its initial operation review. Each of these points was considered during staff review of the application.

RMPS Staff present at the meeting included:

Spencer Colburn, Regional Development Branch
Tom Rice, M.D., Continuing Education and Training Branch
Teresa Schoen, Office of Program Planning and Evaluation
Loren Hellickson, Office of Systems Management
Gene Nelson, Office of Program Planning and Evaluation
Charles Barnes, Grants Management Branch
William McKenna, Regional Office Representative, DHEW Region I
Dona Houseal, Grants Review Branch

I. Direction of the Program - Core and the RAG

The Coordinator and his staff provide the control and program direction for the NNERMP. A Joint Board of RMP-CHP now serves as the NNERMP Regional Advisory Group. Since it has only met two times, staff thought it might be premature to evaluate its decision-making or priority setting abilities. At this point, there is not much evidence of either. The RAG report does not even outline Regional goals, objectives, priorities

- Director, RMPS

or strategy for addressing these, although one paragraph in the Core section (form #8) describes what could be considered as the Region's operational objectives for the coming year. These include providing basic planning data to develop the State Health Plan, providing organizational support to further develop disease management groups, providing organizational and technical support to developing CHP "b" agencies, developing new Phase II reports on major health problems and continuing to update the data base.

The very general discussion of the data base in the RAG report also raised doubts about the Group's complete understanding of or commitment to this emphasis. A Study Committee, which serves as an Executive Committee to the Board, seems to provide more direction than the RAG, but it also appears reactive to Dr. Wennberg.

The December 1970 site visit team made several recommendations which they thought might broaden the base of understanding about the data system approach among regional groups: 1) a member of the Study Committee should be an ex-officio member of each management committee to keep the Study Committee appraised of its activities; and 2) the Study Committee should add a member with expertise in preventive medicine and public health, who is not a member of Core staff, to provide an independent assessment of the data base. The present application shows no evidence that these have been implemented.

With regard to RMP-CHP staff cooperation, the two staffs are collaborating on development and implementation of the data base. Along this line, it is hoped that the head of the state CHP program, Mr. David Miller, may be able to provide some necessary administrative and public relations backup to the RMP. Parenthetically, staff noted with interest that Mr. Miller is also an assistant dean at the Medical School, which places him organizationally above RMP.

II. <u>The Data Base</u>

Staff's discussion of the data base related primarily to the comments of the December site visit report and to personal knowledge of it through special reports and visits and conversations with the Region. For the second year in a row, the application provides insufficient information on the program. The data system itself, including from what sources the data is collected and how it is put together, is not explained for reviewers.

At the time of the December site visit, the team found great potential existed for use of the system, but no plans for its implementation had been delineated. Although staff learned that the Region is now finding users (such as the Medical Society for medical audit purposes), they still have not spelled out a utilization strategy, including other potential users, an implementation schedule, controls on the use of the data and the like. Staff also had additional questions relating to

- Director, RMPS

what data would be supplied to what users and the system's use of other data resources in the Region. Finally, they wished to see some indication of how the Region had met the recommendations of the December site visit. They though that, in order for the Region to give an adequate account of its program plan to Committee and Council, the Region should submit additional material, including a description of the data base and the strategy for its utilization.

III. Question of Need for RMP Involvement in Activities Other Than The Data Base

While there was a consensus among staff about the need for more information regarding the data studies, staff was divided as to the desirability of the Region's continuing to invest all its efforts in the data planning and analysis approach with so few other visible activities in the Region. As noted earlier, the Region would have only two projects ongoing during their 03 year.

The Region has had numerous proposals in its review process, but has held back even the better ones, apparently because the RMP had not yet fully developed its review criteria or the data base. Certain staff members indicated that in view of the lessening availability of funds and the mixed success of many Regions going the project route, the data analysis approach was entirely appropriate for this RMP. In contrast with many other RMP's, this one, they argued, was not haphazardly developing projects, but was actually trying to provide data for the Region to determine its needs before developing project proposals.

Other staff members, however, expressed their concern about the program's visibility in the Region, as well as the desirability of RMP being the sole support of a resource which has a potential benefit for so many agencies. These staff were apprehensive that the stymying of all projects in review, coupled with possible misunderstanding or ignorance of the data approach on the part of many in the Region, would not only inhibit visibility of the program, but might also alienate some interested groups or individuals. There was evidence from conversations with the heads of the State Health Department and the University's Department of Community Medicine at the last site visit that this was occurring. While not encouraging the Region to begin submitting larger numbers of projects, staff felt that there were probably certain high priority activities which could be uncertaken at the present with Core or project funding without waiting for a complete data collection and analysis of Regional needs. These staff also suggested that the Region might consider: 1) the addition of a health planner to Core staff who could assist with the implementation of the data base results in the medical community and 2) alternate ways of financing the data collection and analysis resource. (Some people in the Region have already suggested the establishment of a nopprofit corporation with responsibility for the pooling of data collections.)

4 - Director, RMPS

Recommendations

1. Approval of the $830,046 total costs continuation request for Core and Project #2 Progressive Coronary Care, and #4 Project in Continuing Education.

2. a) The Region submit an expanded RAG report with emphases on goals, objectives, priorities and strategy; b) the Region consider expanding the memberships of the committees as described above.

3. The Region should submit additional information its data base for Committee and Council review. This information should include: a) a description of the data base with emphasis on goals, objectives, priorities, utilization strategy and controls on dissemination and b) a progress report on and response to the recommendations of the December 1970 site visit.

4. In view of staff's discussion regarding the proper role of RMP in N.N.E., they believe the most appropriate course would be to refer the present application with some additional materials to Review Committee and Council, not for an action on funding, but to give the Region, the benefit of the reviewers' thinking about the appropriateness of this approach prior to the Region's preparation of their triennial application.

Dona E. Houseal

Dona E. Houseal
Public Health Advisor
Grants Review Branch

Action by Director Approval

Initials [illegible]

Date 6/15/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

NORTHERN NEW ENGLAND REGIONAL MEDICAL PROGRAM
RM 00003 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: The Committee recommended that this application which requests supplemental support for Project #6, NNE RMP Kidney Proposal, be supported as follows: $55,290 for the 01 year; $37,900 for the 02; and $25,400 for the 03 year.

An outline of the Region's request for their 03 year and staff and Committee recommendations follows:

	Request	Recommendation
Continuation of Core and 2 Projects (Staff Action)	$590,196	$590,196
Project #6 (Committee Action)	126,740	55,290
TOTAL	$716,936	$645,486

In addition, for reasons outlined in the staff summary, Staff requested guidance from Committee on how to work with the Region as it prepares its triennial application. These comments are discussed below.

CRITIQUE: Committee responded to Staff's sense of uneasiness over the Northern New England RMP, whose unique program thrust (data collection and analysis) and poorly prepared applications have consistently given staff difficulty in assessing the Region's progress and program plans.

The reviewers identified six features of the NNE Program which were probable causes of this uncertainty:

1. The unique history of the program in which the systems analysis approach (with few projects) prevailed;

2. The absence of a good set of goals, objectives and priorities;

3. With the only two operational projects due to phase out this year, the difficulty of assessing what the Region has done;

4. In addition, the lack of information on what the NNE RMP is doing for the health care problems of Vermont;

5. The lack of a data utilization strategy; and

6. An apparent communications problem between the Coordinator and both the Regional Advisory Group and the health providers of the Region.

Reviewers also had concerns about the operation being primarily the creature of the Coordinator, and the extent to which existing data bases within the Region were incorporated in the system.

Despite these problems, Committee was impressed with the competence of Core staff, who appear to have the capability for developing a meaningful data system. They noted that the data base was a factor in the selection of Vermont for an Experimental Health Services Planning and Delivery Systems contract from NCHSRD.

In discussing what advice to give staff in working with the Region, Committee was first concerned with the lack of a defined strategy for utilization of the data. Although the capabilities and interests on Core staff may be more oriented to collection and analysis, reviewers stressed the importance of outlining plans for using the data. Committee recommended, therefore, that RMPS staff encourage the NNE RMP to seek assistance with development of a utilization strategy from 1) the technical experts at the December 1970 site visit, and 2) groups specializing in utilization of knowledge, such as the Center for Research in Utilization of Scientific Knowledge in Ann Arbor, Michigan.

Another recommendation to the Region was to improve the presentation of information about the program in the application. For example, reviewers could not determine from a list of twelve agencies, described as users of data output, just what information they were using and for what purpose. Since the application format does not lend itself to an adequate description of the program, the Region needs to reinforce the requested material with supplemental information regarding the data system, its utilization strategy, spinoff effects, endorsement of the program by other institutions and agencies, and the like.

The issue of RMP-CHP relationships was discussed. While the lines of program responsibility for the two agencies have not been defined, it appeared to some that RMP seemed to have taken on the responsibilities of a CHP "A" Agency. Committee felt it important, therefore, that in their triennial application the NNE RMP delineate the responsibilities of and relationship between the two agencies.

The last issue discussed was the overall question of the Region's ability to move in a new direction, i.e., toward the improvement in the Vermont health care delivery system. While its primary efforts

to date have been the collection and analysis of data, it is now beginning to offer the output to various agencies and organizations who influence the delivery of health care in Vermont. As long as the Region can demonstrate that RMP goals are being carried out, either by the Vermont RMP itself or by the RMP catalyzing other agencies, the reviewers stated that they were not concerned by either the almost exclusive investment in the data analysis approach or the small number of project activities. Committee believed that the results of such a unique approach, which the Region has pursued from its early days, should provide valuable experience for many other Regions.

The Ad Hoc Kidney Disease Control Panel reviewed Project #6, the NNE RMP Kidney Proposal. The Panel members determined that a need for the capability in Vermont existed and found the staff well-qualified. The Panel recommended that "the trained talent in Vermont be utilized to develop a program which can later be evaluated in its relationship to the Tri-State Region, and in the size and quality of the activities initiated." They also requested the opportunity to review the second year continuation application to determine the project's progress and its relation with the proposed Tri-State RMP Kidney Program.

Committee concurred with the Panel's comments and the reduced funding recommendation of $55,290 for the 01 year; $37,900 for the 02; and $25,400 for the 03 year.

RMPS/GRB
7/19/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

Rochester Regional Medical Program
University of Rochester Medical
Center
260 Crittenden Boulevard
Rochester, New York 14620

RM 00025 8/71
July 1971 Review Committee

Program Coordinator: Ralph C. Parker, Jr., M.D.

The Rochester Regional Medical Program currently is in its 03 operational year. The original 03 budget period was extended, so the 03 year represents an 18-month budget period for which the direct cost award was $1,451,951 (equivalent to an annualized figure of ~~$967,967~~). 895,000
The indirect costs for the 18-month period were $501,418, an overall indirect cost rate of 35%. The current budget period ends August 31, 1971. This Triennial application requests support for:

I. Developmental Component funding for 3 years.
II. Renewal support for core and 12 ongoing projects -- core for three years and the individual projects for varying lengths of time from one to three years.
III. Initiation of six new projects in the first year of the Triennium (04 Operational Year) and three new projects in the 2nd and 3rd years of the Triennium (05 and 06 operational years). These last three projects will include many of the activities currently being conducted under eight of the ongoing projects through their merger into more comprehensive groupings.

The Region requests $1,514,081 direct costs for its fourth year of operation, $1,478,419 for the fifth, and $1,559,790 for the sixth. The chart on page 3 compares the actual funding levels for the first three operational years with the request for the coming Triennium, and breakout charts identifying the components for each of the three years are included as pages 17 through 19 of this summary.

Staff review of this application has identified certain areas of concern in which the site visitors, Committee, and Council reviewers may be interested. These concerns are listed briefly below, and elaborated upon in the memorandum attached to this summary.

1. Problems in core staffing and apparent lack of administrative leadership.

2. Questions about the review and decision-making process and the locus of responsibility in certain crucial areas: e.g. allocation of funds, determination of priorities, etc.

3. Apparent lack of subregionalization.

4. General concerns regarding whether the Region has developed a program (as opposed to individual project activities), the amount and quality of evaluation, and the relationship of program goals to RRMP activities.

5. University-RMP and CHP/RMP relationships.

FUNDING HISTORY

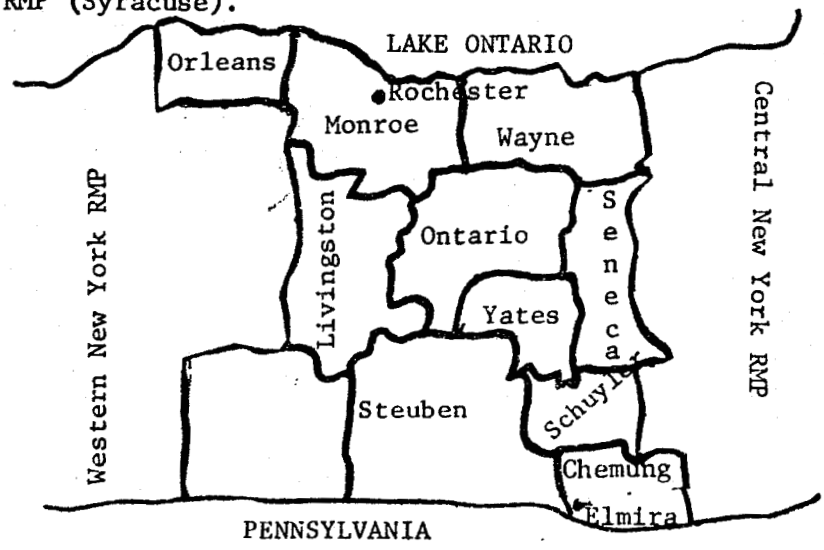
(Planning Phase)

Grant Year	Period	Funded (direct costs)
01	10/66-10/67 (13 mos.)	$246,394
02	11/67-2/68 (4 mos.)	$72,752

(Operational Stage)

01	3/68 - 2/69	$841,296
02	3/69 - 2/70	$1,008,164
03	3/70 - 8/71 (18 mos.)	$1,451,951

GEOGRAPHY AND DEMOGRAPHY: The Rochester Regional Medical Program is composed of ten counties in the western portion of New York State. It is bordered on the west by the Western New York RMP (Buffalo) and on the east by the Central New York RMP (Syracuse).



The map on page 4 shows the geographic relationship to the Rochester Regional Medical Program to the other five RMPs in New York.

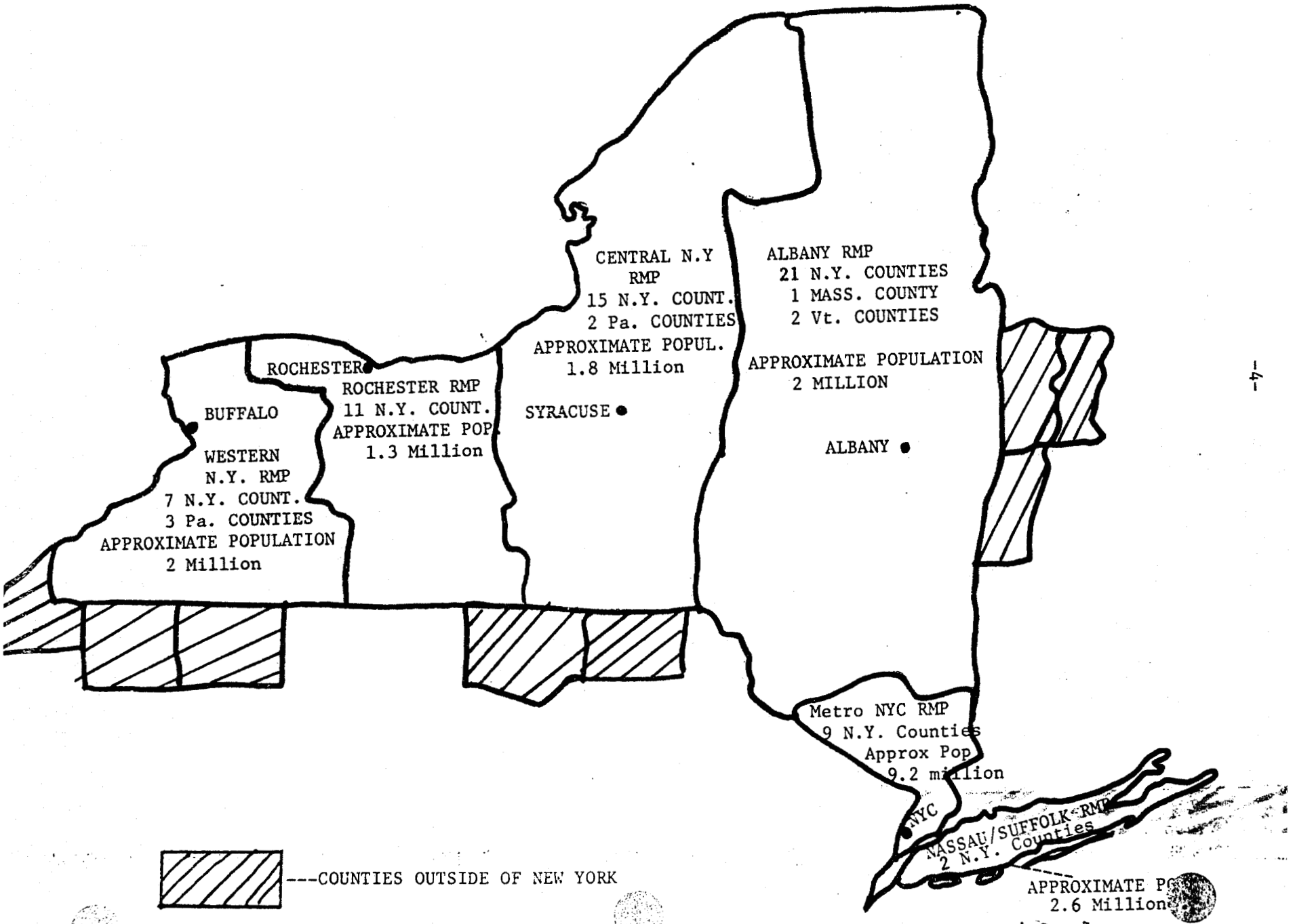
The approximate population served by this Region is 1.3 million, and the area contains the University of Rochester School of Medicine and Dentistry, eight professional nursing schools and three for practical nurse training, nine schools of technology and 27 short-term hospitals containing 4,258 beds. There are, in addition, approximately 2,049 active physicians and 5,589 active nurses in the Region.

ROCHESTER REGIONAL MEDICAL PROGRAM
Comparison of 01-03 year funding
and 04-06 year request

PROJECT	FUNDED			REQUESTED		
	01	02	03 (18 months)	04	05	06
Core	244,805	303,908	436,392	352,542	377,766	404,059
#1 - Reconstruction & Equipping of Learning Center	26,400	--	--	--	--	--
#2 - Postgraduate Trng. in Cardiology	83,857	77,026	110,609	74,453	74,791	merged with #28
#3 - Myocardial Infarction Registry	21,180	8,770	10,954	--	--	--
#4 - Regional Coagulation Laboratory	69,420	45,123	65,589	20,000	--	--
#6 - CCU Training - Nurses	71,339	62,074	83,396	56,396	57,034	merged with #29
#7 - Early Disease Detection Unit	202,232*	263,789	383,713	266,103	215,554	164,918
#8 - CE in Cerebrovascular Disease	30,911*	40,010	53,624	Merged with project #2		merged with #28
#9 - Cancer Clearinghouse	19,542*	22,500	32,310	23,218	merged with project #27	
#10- Statistical & Evaluation Unit	71,610*	58,440	83,920	71,918	78,076	84,554
#11A-Telephone EKG Consultation	--	30,051*	43,152	4,002	--	--
#13 - Decentralized Cancer Education		36,933*	53,018	14,958	16,131	merged with #28
#14 - Development of Stroke Team		20,701*	27,710	merged with project number 26		
#15 -Neurologic & Rehab. Nursing		9,078*	13,036	29,598	30,509	merged with #29
#16 -Phys. Trng. Chronic Renal Disease		6,119*	9,720	7,460	8,147	merged with #28
#17- Chronic Renal Disease Nursing		3,115*	11,029	24,386	25,452	merged with #29
#18-Diabetes Education Program		20,527*	33,779	31,367	33,234	merged with #28 & 29
#21 -Regional Organ Procurement Sharing Transplant				107,129	68,442	72,844
#22- Community Research & Teaching				77,979	82,598	merged with #28
#23- Family Counselor Program				18,440	19,643	22,920
#24- Consultation Service Rural Pract.				50,210	54,452	58,920
#25- Health Education & Advocacy				62,072	66,047	70,248
#26- Chronic Neuromuscular Dis. Team				121,850	130,680	140,059
#27- General Clearinghouse					39,863	45,080
#28- Comprehensive Postgrad. Ed. Phys.						216,572
#29- Comprehensive Postgrad. Ed. Nurses						179,616
Developmental Component				100,000	100,000	100,000
TOTAL	841,296	1,008,164	1,451,951	1,514,081	1,478,419	1,559,790

* for 8 or 9 month periods

IN NEW YORK


CENTRAL N.Y
RMP
15 N.Y. COUNT.
2 Pa. COUNTIES
APPROXIMATE POPUL.
1.8 Million
ALBANY RMP
21 N.Y. COUNTIES
1 MASS. COUNTY
2 Vt. COUNTIES
APPROXIMATE POPULATION
2 MILLION
ROCHESTER
ROCHESTER RMP
11 N.Y. COUNT.
APPROXIMATE POP.
1.3 Million
BUFFALO
WESTERN
N.Y. RMP
7 N.Y. COUNT.
3 Pa. COUNTIES
APPROXIMATE POPULATION
2 Million
SYRACUSE
ALBANY
Metro NYC RMP
9 N.Y. Counties
Approx Pop
9.2 million
NYC
NASSAU/SUFFOLK RMP
2 N.Y. Counties
APPROXIMATE P
2.6 Million
---COUNTIES OUTSIDE OF NEW YORK

HISTORY: The initial planning period for the Rochester Regional Medical Program began in October 1966. By that time, Dr. Ralph Parker, the former Medical Director of the Rochester Regional Hospital Council, had been appointed Coordinator and Mr. Frank Hamlin, past President of the Hospital Council, had been appointed Chairman of the Regional Advisory Group. These appointments were considered particularly auspicious since the Hospital Council is an organization which practiced regionalization well in advance of the concept's embodiment in PL 89-239. The Committee and Council were impressed with the history of cooperation among the components of the medical community in the Region.

When the RRMP applied for operational status in early 1968, staff and national reviewers emphasized Dr. Parker's difficulty in recruiting full-time staff (he was the only full-time person for the first nine months) and the lack of administrative personnel involved in the program. Despite this problem, site visitors and Committee/Council reviewers thought the Region to be well-established with good university and community support, and ready to inaugurate an operational program. Since each of the five project proposals in the original operational application, however, addressed some aspect of heart disease, the reviewers indicated that the Region needed to give attention to the development of a balanced program.

Over the next couple years as project proposals were reviewed by Committee and Council and as continuation requests were assessed by RMPS staff, the initial optimism about this Region began to wane. In fact, uneven progress in the RRMP prompted a staff reduction of the 02 year commitment. There appeared to be a growing concentration of activities in Rochester (and the University Medical Center in particular) at the expense of peripheral involvement. The laissez-faire administration of the Coordinator, the low rate of expenditures, and the continued dearth of full-time professional staff were seen as problems as well. The Rochester RMP appeared to lack influence on the health care system. Consequently, a site visit was conducted in April 1970 for the dual purpose of investigating the validity of reviewers' concerns and providing guidance to the Region.

In general, the site team found that many of the individual projects were strong and many were promoting regionalization. The Regional Medical Program itself, however, was beset by the suspected difficulties. Of prime importance were the administrative deficits of the Coordinator and the passive character of the Regional Advisory Group which had relegated problems regarding program and priorities to others. In a general feedback session and in special individual consultations with the Coordinator and with the RAG Chairman, the site visitors emphasized the necessity of Dr. Parker's obtaining strong administrative backup and of the assumption by the Regional Advisory Group of its proper role.

REGIONAL GOALS AND PRIORITIES: The application explains that the original planning grant application of the Rochester Regional Medical Program outlined the following five goals:

1. To make health services and facilities of highest quality more generally available throughout the area.

2. To improve communication between the medical and nursing faculty and other health care personnel with special knowledge and skills and the staff members of all hospitals, nursing homes,and other patient care facilities.

3. To determine ways in which nurses, social case workers, technologists and other medical aides can contribute maximally in the provision of health services by supplementing the activities of our limited physician manpower pool.

4. To provide optimal programs of advanced training of physicians and nurses to meet the requirements for increasingly complex medical care.

5. To develop programs of continuing education in which physicians nurses and paramedical personnel will be active participants.

Recently the Statistical and Evaluation Unit conducted a survey of the Regional Advisory Group, from which priority ratings were determined. In addition to a ranking of ongoing activities, which will be discussed later in this summary, the survey produced priority ratings along two other axes.

1. Target populations -- inner-city residents, rural residents, migrant workers, etc.

2. Project functions -- organization and delivery of ambulatory services; manpower development; administration of health services; organization and delivery of chronic inpatient, home health, and rehabilitation services; preventive services; health education; organization and delivery of emergency services; and organization and delivery of acute inpatient services.

REGIONAL ADVISORY GROUP: The RAG gradually has been expanded to represent a greater diversity of interests. There presently are 35 members, including 17 physicians, three nurses, and nine public representatives. Half of the members are from outside the immediate Rochester vicinity. Mr. Hamlin remains chairman. Although the Region refused to complete the Equal Employment Opportunity form on the grounds that New York State law prohibits

racial or ethnic classification, phone conversations with Dr. Parker indicate that two RAG members are black.

The former Planning Committee, which had great influence on program direction and which was University-dominated, has been replaced by a nine-member (plus two advisory members) Executive Committee of the RAG. The Chairman of the Executive Committee is the Chairman of the University Department of Preventive Medicine and Community Health.

There are, in addition to the RAG and its Executive Committee, three Study Committees: Heart Disease, Cancer, and Stroke. The application does not explain the review process, so it is unclear what the roles of the various committees are and their relationships to and interaction with the RAG, the Executive Committee, and the core staff.

APPLICATION COMPONENTS

I. Developmental Component — Requested 04 Year $100,000

Three-year developmental component funding is requested. These monies will be used to carry out short projects in general or categorical areas of primary health service but without financing actual patient care. Since RRMP may be receiving an OEO grant for the training of allied health personnel for an inner-city health care network to be established by Neighborhood Health Centers, Inc., developmental activities will focus on problems of rural residents, migrant workers and the homebound chronically ill adult. Activities are expected to center around the organization and delivery of ambulatory services and manpower development.

Priorities and objectives for developmental funding will be established by the RAG. Expenditures of less than $5,000 appear to require only the approval of theCoordinator, with sums in excess of that amount needing Executive Committee sanction.

05 Year: $100,000 06 Year: $100,000

II. Renewal Support for Core and Twelve Ongoing Projects

Requested 04 Year $352,542

Core: The full-time professional staff of the Rochester Regional Medical Program consists of the Coordinator, the Nurse Coordinator, and two Nurse Specialists. There are, in addition, five Program Directors of Health Services, Heart Disease, Cancer, Stroke, and Renal Disease, ranging from 27% to 71% time, and part-time systems analyst and research bibliographer. During the Winter of 1970, Dr. Parker brought on an Assistant Coordinator, a young man who had recently received his M.P.H. This individual, however, resigned this month (May 1971)and Dr. Parker is recruiting a new Assistant Coordinator. The four other professional vacancies on core staff are for a Nurse Specialist in cancer, and three people to work on a physicians' assistant program.

The Region sees some of the most significant core accomplishments during the past year as its work with the Genesee Region Health Planning Council (the CHP "b" agency), particularly in the planning of an ambulatory rural health center, developing plans for the emergency department of a small community hospital, planning for health services in a rural area, developing a migrant workers' health program, and developing programs for the training of nurse practitioners and physicians' assistants. During the past year nine percent of the core budget was allocated to planning and feasibility studies. There are no core-supported central regional services. The application states that the most important areas of core activity during the next year will be to continue planning for rural health care, to help start allied health personnel training programs, to participate with the CHP "b" agency in an experimental health services planning and delivery systems project, and to identify other unmet health care needs. In the area of consultation, community relations and liaison activities, the application explains that limitations on core time prohibit the seeking of new activities. When present activities demand less time, "other problems will be looked for."

05 Year: $377,766 06 Year: $404,059

ONGOING PROJECTS: All ongoing projects have been given priority rankings by the Regional Advisory Group and are presented in this summary in their priority order.

Project #7 - Early Disease Detection Unit (Priority 1) — Requested 04 Year $266,103

Support is requested for the fourth, fifth, and sixth years of this activity. It is hoped that after that time the project will have achieved economic independence . During 1970, 7,306 patients were screened (in the central unit at Strong Memorial Hospital and in the mobile unit), and activities were expanded to serve some ambulatory aged, rural and inner-city residents, and high-risk cardiac groups in industry. In addition, a number of evaluative studies were performed. It is planned that during the Triennium, a satellite screening unit will be developed in a rural area and further liaison will be established with new ambulatory care centers in Rochester, thereby supporting primary health care for rural and urban disadvantaged and providing for the collaboration of the screening program with the health care system. The May 1971 Council, in examining multiphasic health testing as a regional medical program activity, concluded that RMPS should withhold funding from any new multiphasic health testing projects, but that intensive efforts should be made to gather and evaluate the experience that will be gained in the projects already funded.

05 Year: $215,554 06 Year: $164,918

Project #2 - Physicians' Postgraduate Trianing in Cardiology (Priority 2) Two additional years of support are requested for the fourth and fifth years of this activity. In its sixth year it will be incorporated into the proposed Project #28 - Comprehensive Postgraduate Education for Physicians. Past activities of this project (including circuit clinics, visiting professorships, individual and telephone consultations, demonstrations, workshops) are said to have reached more physicians, hospitals, and consumers than any other RRMP activity. Interest has gone beyond cardiology to include sessions on pulmonary and renal problems, etc. Future activities will include three-day intensive courses, expansion of the circuit clinics from six to nine locations, increasing the content of other sessions and providing for some hospital sponsorship, presenting workshops, and establishing a cardiology self-instruction room at the Medical Center. The project will address itself as well to the needs outside of the hospital.

Requested 04 year $74,453

05 Year: $74,791

06 Year: Merge with Project #28

Project #6 - Cardiovascular Nursing (Priority 3) This project has been in operation since 1968, and 04 and 05 year renewal support is requested. In the 06 year, it will be merged into proposed Project #29 - Comprehensive Continuing Education Courses for Nurses. This activity has trained 229 nurses in coronary care and related functions, many of whom now are conducting programs in their home hospitals. Future plans call for the continued development of this regional educational center through cooperative arrangements with community agencies and adjacent RMPs. Courses for nurses will cover the areas of episodic nursing, coronary nursing, pulmonary nursing, and continuity of care for the cardiac patient, as well as courses for instructors. Plans call for the gradual transition to community support when possible.

Requested 04 Year $56,396

05 Year: $57,034

06 Year: Merge with Project #29

Project #14 - Development of a Stroke Team (Priority 4) It is proposed that these activities be incorporated with those of new Project #26 - A Chronic Neuromuscular Disease Team Program.

Project #15 - Neurologic and Rehabilitative Nursing (Priority 5) This project is requesting support for its third and fourth years of operation. It then (in the third year of the Triennium) will be incorporated into proposed Project #29 - Comprehensive Continuing Education Courses for Nurses. Its objectives are to develop a philosophy of rehabilitation for nursing practice, demonstrate the interdisciplinary team approach to patient care, and develop and test educational media. Intensive courses in rehabilitative nursing have been developed and conducted, along with supportive activities. These courses have been directed primarily toward nurses in leadership position

Requested 04 Year $29,598

Future activities will concentrate on reaching nurses in the outlying northern counties. It also is planned to incorporate into the stroke rehabilitation teaching, instruction in the various clinical areas of diabetes, chronic renal, and neuromuscular disease. Planning will be done for the preparation of adult health practitioners to fill gaps in the care of chronically ill in areas with a scarcity of health professionals.

05 Year: $30,509 06 Year: Merge with Project #29

Project #16 - Physician Training in Chronic Renal Disease (Priority 6) This project has received RMP funding since 1969 and is requesting money for two more years, after which time it will merge with proposed Project #28 - Comprehensive Postgraduate Education for Physicians. In an effort to coordinate and improve the care of patients with chronic renal disease, during the past year nine visits have been made to hospitals and medical groups for presentations and discussions of the treatment of patients with renal disease. Activities planned for the next two years are not discussed.

Requested 04 Year $7,460

05 Year: $8,147 06 Year: Merge with Project #28

Project #8 - Continuing Education for Physicians in Cerebrovascular Disease (Priority 7) This project has been supported since 1968 and will terminate at the end of the current budget period. Its activities will meld into Project #2 - Postgraduate Cardiology Training Program for Physicians - for the first two years of the Triennium (04 and 05 years) and then be incorporated, along with Project #2, into the proposed Project #28 - Comprehensive Postgraduate Education for Physicians.

Project #13 - Decentralized Cancer Education (Priority 8) Third and fourth year support is being asked for this project which is planned for incorporation into proposed Project #28 - Comprehensive Postgraduate Education for Physicians - in the 3rd year of the Triennium. The objectives are to increase the availability of the most advanced knowledge and techniques for cancer diagnosis and treatment at area hospitals. An education and service unit has been established at Highland Hospital and teaching activities have been carried out at area hospitals.

Requested 04 Year $14,958

05 Year: $16,131 06 Year: Merge with Project #28

Project #18 - Diabetes Mellitus; A Program for The Education of Paramedical and Medical Resource Personnel (Priority 9) Two years' additional support is requested for this project which was initiated in 1969, after which time it will be merged into proposed Project #'s 28 and 29, Comprehensive Continuing Education for physicians and nurses. Past activities have been

Requested 04 Year $31,367

concentrated in the areas of continuing education for nurses, demonstration projects in patient education and expanded roles for nurses, and the development of instructional media. During the coming two years project activities will include continued efforts in the training of diabetes nurse specialists (some in locations other than Rochester), implementation of community-based educational programs, physician education, continued definition of the nurse practitioner role, and continued development and testing of instructional media.

05 Year: $33,234 06 Year: Merge with Project #'s 28 and 29

Project #17 - Chronic Renal Disease Nursing (Priority 10) Requested 04 Year $24,386

This project originally was funded in 1969 and the Triennial application requests third and fourth year funding. In the third year of the Triennium (06 year) these activities will be included in proposed Project #28, a comprehensive nursing education proposal. The application explains that because of reduced funding and the lack of a nurse specialist, activities have been limited. However, there has been periodic consultation, a collection of teaching materials has been started, a two-day conference for public health nurses was conducted, and a regional survey of resources, needs, and problems was conducted in conjunction with the CHP b agency. A nurse specialist was appointed in March 1971 to work as a member of a team to plan an interdisciplinary and regional program of care. A communication network among established units and nurses will be initiated, educational programs will be developed, a standard approach to care will be established, self-instructional materials for patients and nurses will be produced, and public information activities will be carried out.

05 Year: $25,452 06 Year: Merge with Project #29

Project #10 - Statistical and Evaluation Unit (Priority 11) Requested 04 Year $71,918

This unit, which has been operational since 1968, is expected to be maintained by RMP support for life since it performs functions critical to the core staff: i.e., data collection and assessment, project evaluation, and program evaluation.

05 Year: $78,076 06 Year: $84,554

Project #11A - Telephone EKG Consultation (Priority 12) Requested 04 Year $4,002

This project has been funded since June 1969 and is asking for only one more year of support. It originally was a portion of a three-part proposal: Part B of the original proposal

for Transmission of EKGs for Remote Computer Analysis was approved/unfunded, and Part C - Regional Arrhythmia Detection Service Utilizing Dynamic EKG Monitoring - was disapproved at the national level. There apparently are now (or will be in the near future) three receiving stations (two in Rochester and one in Elmira) and two transmitting hospitals (in Sodus and Hornell). Although the network is presently used primarily for emergency consultation, ultimately routine EKGs will be sent.

Project #9 - Cancer Clearinghouse (Priority 13) This activity has received three years of support, one more is requested, and then in the second and third years of the comming Triennium it will become part of proposed Project #27 - General Clearinghouse. In the 21-month period between March 1969 and December 1970 the Clearinghouse received 550 calls. As a result, 65 patients were referred for consultation at the University of Rochester Medical Center and 25 were seen in their home communities. In addition, cancer teaching programs and conferences are being presented. Some problems which have been encountered include the apparent lack of awareness of the service and the difficulty in arranging consultation for patients unable to travel. Next year's plans are not discussed.

Requested 04 Year
$23,218

05 Year: Merge with Project #27

06 Year: Merge with Project #27

Project #4 - Regional Coagulation Laboratory (Priority 14) Only one additional year's support is requested for this project which was initiated at the beginning of this Region's operational phase in 1968. During the past three years, 55 health personnel technicians have been trained and the Center has served as the primary diagnostic and therapeutic center for patients with hemmorrhagic or thrombotic disorders. Next year's plans are not discussed nor is mention made of future support mechanisms for this activity.

Requested 04 Year
$20,000

Project #3 - Myocardial Infarct Registry (Priority 15) No further support is requested for this project which has received three years of RMP financing. Whether it will continue under other financial auspices is not explained.

III. Initiation of New Projects (Six in the first year of the Triennium, one in the second, and two in the third)

FIRST YEAR (04 Yr.) INITIATION

Project #21 - Regional Organ Procurement, Sharing, Transplantation This request is for funding from Kidney Disease earmarked funds. The application makes clear that if no special funda are available, the proposal is not to be considered for support.

Requested 04 Year
$107,129

The objective is to coordinate all resources for the purpose of treating patients with end-stage renal disease by transplantation, and in order to do this the existing resources of the Region must be supplemented. Specifically, the project will establish a treatment care facility for transplantation in the Rochester area, support a tissue typing laboratory to meet the needs of the American component of SONY-West, and support the coordinating center for kidney procurement and organ sharing in the American component of SONY-West.

05 Year: $68,442 06 Year: $72,844

Requested 04 Year

Project #22 - Development of a Community Research and Teaching Faculty for Ongoing Postgraduate Medical Education $77,979

The purpose of this project is to develop the research and teaching potential of traditional practices by implementing a data-collection and record-keeping system which will permit a practicing doctor to review his practice experience according to many variables: age/sex incidence, treatment success, etc. Ten primary care practices have indicated an interest in participating and it is hoped that as others are informed they, too, will want to participate. The program is planned for two phases: 1) setting up the systems in the individual doctors' offices, and 2) collecting and making use of the information for postgraduate education and research. After two years of support, this project will be incorporated into proposed Project #28 - Comprehensive Postgraduate Education for Physicians - in the third year of the Triennium.

05 Year: $82,598 06 Year: Merge with project #28

Requested 04 Year

Project #23 - Family Counselor Program. Mature non-professional women will be selected for training as family counselors for children with chronic physical illnesses and their families and assisting the physician with their management. It is hoped that through this program the high rate of psycho/sociologic problems experienced by these children will be diminished and that physicians will be free to apply their time and energies to other aspects of the patients' needs. Each trainee will receive an initial 30-40 hours of education, bolstered by monthly meetings during the first year of the program. $18,440

05 Year: $19,643 06 Year: $22,920

Requested 04 Year

Project #24 - Consultation Service for Rural Practitioners and Communities This project aims at the improvement of rural health care delivery through assistance to rural communities and practitioners in the form of: manpower training $50,210

and continuing education related to local needs, and analyses and education regarding administrative practices. The consulting service will: analyze the content of practices to determine possible improvements in the efficient use of resources and where new manpower roles can be instituted; provide the facilities for recruitment and education of new manpower; relate the functions of the individual practitioner wih the health care needs of the community; evaluate the results of changes instituted in individual practices.

05 Year: $54,452 06 Year: $58,920

Project #25 - Health Education and Advocacy — Requested 04 Year $62,072

In an effort to fill the gap between inner-city patients with chronic diseases and the providers of health services, the proposed project will train patient-workers as health education advocates. Diabetes has been selected as the initial target disease, but as the program evolves similar techniques will be utilized for other chronic diseases. The initial pilot project will recruit and train 15 diabetics in an eight-week program. It is projected that approximately 300 patients will be involved.

05 Year: $66,047 06 Year: $70,248

Project #26 - A Chronic Neuromuscular Diasease Team Program — Requested 04 Year $121,850

This proposal describes plans for 1) prevention and after-care planning for stroke patients, and 2) utilization of existing health care facilities. Patients with potential and accomplished neuromuscular disease who are potentially salvageable for more independent living will be indentified in any of five stages of illness: 1) during evaluation at the Early Disease Detection Unit- Project #7, 2) during acute hospitalization, 3) at point of discharge from acute hospital, 4) at point of admission to chronic disease institution, and 5) when established at home. Patients will be seen by the Chronic Neuromuscular Disease Team, recommendations will be made as to their management and care, and the team will document the faults of the health care system at each of the five stages and report them to appropriate groups and health care workers. Evaluation techniques are described. The activities presently carried out under Project #14 - Development of a Stroke Team - will be merged with this proposal.

05 Year: $130,680 06 Year: $140,059

SECOND YEAR (05 Yr.) INITIATION

Project #27 - General Clearinghouse — Requested 04 Year -0-

The purpose of this project is to improve health care delivery by facilitating consultation in all categories of disease. It will include the activities of ongoing Project #9 - Cancer Clearinghouse. Present staff will be used to expand the clearinghouse, the present panel of clinical experts will expand to cover a variety of medical areas, and the types of questions asked will be analyzed to determine areas for continuing education programs.

05 Year: $39,863 06 Year: $45,080

THIRD YEAR (06 Yr.) INITIATION

Project #28 - Comprehensive Postgraduate Education for Physicians. This proposal incorporates the activities currently carried out under the following projects: — Requested 04 Year -0-

#2 - Postgraduate Training in Cardiology
#8 - Continuing Education in Cerebrovascular Disease
#13 - Decentralized Cancer Education
#16 - Physicians Training in Chronic Renal Disease
#18 - Diabetes Education Program

and the activities proposed in a new project which will run the first two years of the Triennium before incorporation:

#22 - Community Research and Teaching

Continuing Education programs will be developed which include all clinical areas and will be divided between intramural programs in the Rochester teaching hospitals and teaching clinics in the hospitals outside of Rochester.

05 Year: $0 06 Year: $216,572

Project #29 - Comprehensive Continuing Education Program for Nurses This proposal incorporates the activities currently carried on under the following projects: — Requested 04 Year -0-

#6 - CCU Training for Nurses
#15 - Neurologic and Rehabilitation Nursing
#17 - Chronic Renal Disease Nursing
#18 - Diabetes Education Program

The proposed program will consist of three major components: A) planning and organizational development, B) continuing education, and C) demonstrations. It is explained that the merger of discrete categorical activities into a unified program will facilitate the achievement of a common goal, promote flexibility in assignment of staff and funds, increase the ability to respond to changing goals and needs, and simplify administrative and organizational activities.

05 Year: $0 06 Year: $179,616

GRB/RMPS 6/7/71

REGION Rochester
CYCLE RM 00025 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
DOC-Developmental				100,000	100,000 1/		100,000
Core Component		352,542			352,542	167,857	520,399
#2-Postgraduate Training Program for Physicians		74,453			74,453	24,263	98,716
#4-Reg. Coagulation Lab.		20,000			20,000	7,731	27,731
#6-Cardiovascular Nursing		56,396			56,396	15,684	72,080
#7-Early Disease Detection		266,103			266,103	52,864	318,967
#9-Cancer Clearinghouse		23,218			23,218	8,250	31,468
#10-Statistical & Eval. Unit		71,918			71,918	34,980	106,898
#11A-Telephone EKG Consult.		4,002			4,002	2,070	6,072
#13-Decentral. Cancer Ed.		14,958			14,958	5,060	20,018
#15-Neurologic & Rehab. Nurs.		29,598			29,598	8,880	38,478
#16-Physician Trng. in Chronic Renal Disease		7,460			7,460	3,762	11,222
#17-Chronic Renal Disease Nursing		24,386			24,386	9,360	33,746
#18-Diabetes Mellitus-Program for Education		31,367			31,367	14,044	45,411
#21-Regional Organ Procurement-Sharing Trans.				107,129	107,129	31,001	138,130
#22-Comm. Research &Teach.				77,979	77,979	35,340	113,319
#23-Family Counselor Prog.				18,440	18,440	8,400	26,840
#24-Consultation Service For Rural Practitioners				50,210	50,210	24,300	74,510
#25-Health Education and Advocacy				62,072	62,072	25,066	87,138
#26-Chronic Neuromuscular Disease Team				121,850	121,850	60,000	181,850
#27-General Clearinghouse				2/	--	--	--
#28-Comprehensive Post-graduate Ed. for Physicians				3/	--	--	--
#29-Comprehensive Post-graduate Ed. for Nurses				3/	--	--	--
TOTAL		976,401		537,680	1,514,081	538,912	2,052,993

1/ request amended to 3 yrs. per letter from coordinator to E. Faatz
2/ requested for 05 and 06 year only
3/ request 06 year only

REGION Rochester

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
DOO- Developmental				100,000 1/	100,000
Core Component		377,766			377,766
#2		74,791			74,791
#4		--			--
#6		57,034			57,034
#7		215,554			215,554
#9		--			--
#10		78,076			78,076
#11A		--			--
#13		16,131			16,131
#15		30,509			30,509
#16		8,147			8,147
#17		25,452			25,452
#18		33,234			33,234
#21				68,442	68,442
#22				82,598	82,598
#23				19,643	19,643
#24				54,452	54,452
#25				66,047	66,047
#26				130,680	130,680
#27				39,863	39,863
#28				--	--
#29				--	--
TOTAL		916,694	--	561,725	1,478,419

1/ Request amended to 3 yrs. per letter from coordinator to Eileen Faatz

REGION Rochester

BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
DCO-Developmental				100,000 1/	100,000	300,000
Core Component		404,059			404,059	1,134,367
#2		--			--	149,244
#4		--			--	20,000
#6		--			--	113,430
#7		164,918			164,918	646,575
#9		--			--	23,218
#10		84,554			84,554	234,548
#11A		--			--	4,002
#13		--			--	31,089
#15		--			--	60,107
#16		--			--	15,607
#17		--			--	49,838
#18		--			--	64,601
#21				72,844	72,844	248,415
#22				--	--	160,577
#23				22,920	22,920	61,003
#24				58,920	58,920	163,582
#25				70,248	70,248	198,367
#26				140,059	140,059	392,589
#27				45,080	45,080	84,943
#28				216,572	216,572	216,572
#29				179,616	179,616	179,616
TOTAL		653,531	--	906,259	1,559,790	4,552,290

1/ request amended to 3 yrs. per letter from coordinator to Eileen Faatz

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 2, 1971

eply to Attn of:

Subject: Staff Review of the Rochester Regional Medical Program Triennial Application and Identification of Issues for Site Visitors

To:

Director
Regional Medical Programs Service

Through: Acting Deputy Director
Regional Medical Programs Service

Staff met on Monday, May 17, to review the Rochester application. Although it was noted that the University-dominated Planning Committee which hitherto had almost complete control of the program had been replaced by an Executive Committee of the RAG and that the RAG had been diversified along many lines, the areas of concern far outnumbered the commendable aspects of the program. Discussion revolved around the following topics:

Core

1. Who provides the administrative and program direction for this Region?

    a. The Coordinator appears to be the only staff person in an administrative capacity.

    b. Do the roles of the program directors provide for their input into overall program direction or are they concerned only with project direction?

    c. The "Chart of Program Relationships" on page 38 of the application presents an embroglio of communication and responsibility channels that appear to confuse rather than enhance these processes.

    d. Is there any person on core staff who deals with fiscal control and accountability?

2. How active is the core staff in initiating activities. Does it merely respond to requests?

Review and Decision-making Process

1. What is the review process? Does it provide for technical review?

2. What are the respective roles of the RAG and the Executive Committee? How are the members appointed?

3. Who determines priorities and on what basis?

4. Who allocates funds and on what basis?

5. What is the genesis of the projects which are being proposed in triennial application.

Subregionalization

1. Is there any? What mechanisms exist for the RAG to become aware of local concerns, needs, and proposals for solution? The site team a year ago urged that the approximately 35 regional physicians with University appointments assume some RMP responsibilities for subregionalization. Has anything been done in this regard?

Goals and Program Direction

1. Has RRMP actually developed a program approach or does the merging of individual projects into more comprehensive units during the second and third years of the Triennium represent its program approach?

2. Are the goals of the Rochester Regional Medical Program operational? Are they related to ongoing and planned activities? Do the new proposed projects further the Region's goals?

3. What evaluation has been conducted and/or planned, and how do the evaluation results affect the direction of the Rochester program? What is the Statistical and Evaluation Unit doing in this regard?

4. Although there are three full-time nurses on core staff and numerous projects in the area of continuing education for nurses, the RRMP appears not to have developed an allied health thrust. Where in the RMP does responsibility lie for leadership and coordination of the continuing education and manpower components with regard to allied health personnel?

Relationships

1. What is the relationship between the Rochester RMP and CHP agency?

2. What is the relationship between the RMP and the University? Is it symbiotic or does the University play the predominant and controlling role?

The following staff participated in the review of the Rochester application:

A. Burt Kline - Regional Development Branch
Larry Witte - Program Planning and Evaluation
Jerry Stolov - Kidney Disease Control
Julia Kula - Continuing Education and Training Branch
Lee Teets - Grants Management Branch
Tom Simonds - Grants Management Branch
Eileen Faatz - Grants Review Branch
Spencer Colburn - Regional Development Branch

Eileen I. Faatz
Public Health Advisor
Grants Review Branch

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

ROCHESTER REGIONAL MEDICAL PROGRAM
RM 00025 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION:

Year	Request (Direct Costs)	Recommendation (Direct Costs)
04	$1,514,081	$800,000
05	$1,478,419	-0-
06	$1,559,790	-0-

The Review Committee agreed with the site team in recommending approval of one year's further funding at the reduced level of $800,000 with a follow-up site visit in a year to check the Region's progress with regard to the site visitors' recommendations. The only specific disapproval is for developmental component funding. The award is to be allocated at the Region's discretion among core, ongoing, and proposed activities with the clear understanding, however, that:

1. This will be the final year of support for Coronary Care raining and the Early Disease Detection Unit (multiphasic screening) to allow phase-out and data analysis support.

2. The Region will have flexibility in budget rearrangement to build its core staff, develop a revised form of Regional leadership, strengthen the management processes, formalize the review process and effect other changes recommended by the site team.

3. Although the kidney project is excluded from funding within the $800,000 level, if earmarked funds become available there is no objection to an increased award to permit funding of this activity. This project, however, did receive an unfavorable review from the Ad Hoc Kidney Panel.

CRITIQUE: The Committee noted that this year it was seeing essentially the same problems in Rochester that were identified by a site team a year ago and by a management assessment team in the interim. These revolve around the continued inadequate program leadership, a poorly organized and staffed core, and an under-utilized Regional Advisory Group. There was this time, however, a new and optimistic dimension to the Committee's and the site visitors' view of the Rochester Regional Medical Program -- the Region has begun a significant process of change. And although it is only perhaps a quarter of the way through, the Committee hoped that the momentum [illegible] sufficient to complete the evolutionary process.

Perhaps the most important difference in the program is the diversification of the RAG and the recent creation of an interested and active Executive Committee of the RAG. It was agreed that in the Executive Committee rests the leadership potential for bringing this Region out of the doldrums. It already has identified many problems and possible solutions. One of the key areas of concern discussed by the Executive Committee is the inadequate review and decision-making process, and the group realizes that a more complete review process must be established, that the RAG must assume program-direction responsibility, and that a formal technical review system must be devised. Another hopeful sign is that the Region has embarked on its first attempts at objective and priority setting, and although the mechanisms need smoothing, the objectives appear to be a reasonable first step. The program is not yet, however, more than a group of disparate projects. This is another area in which the Executive Committee is working -- the integration of goals and objectives into a coordinated program approach with attendant priorities for determining activities. There are also the positive factors of the program's being well thought of throughout the area, having brougnt about good regionalization, having an excellent and enthusiastic nursing staff, and having developed some interesting project activities. But most good accomplishments appear to be a result more of serendipity than planning.

The relationship between the RRMP and the Medical School is good, and the school is very supportive of the efforts of the Executive Committee. Likewise, RRMP and CHP seem to get along well -- there is governing board membership overlap, there are collaborative endeavors, and the RMP is using (and will more in the future) CHP county committees are sources for local ideas and needs.

Problems continue in core staffing and administrative leadership. Dr. Parker still has no deputy (as has been recommended to him numerous times) and provides little program direction to core staff. Although Dr. Parker is effective on a one-to-one basis and is well liked throughout the Region, his administrative abilities are limited and his own passivity appears to permeate and characterize the core approach. The Review Committee relied on the site team's perception that, after discussing the matter with the visitors, the Executive Committee clearly understands the necessity for restructuring the core to provide for its assumption of administrative, financial management, planning and evaluation, and certain program development responsibilities and to release core staff from day-to-day project direction duties. It agreed that there appear to be good people on core who suffer from lack of direction but are anxious to become coordinated and program oriented.

The Triennial application under review by the Committee requested for the 04 year developmental component funding, renewal of core and 12 ongoing projects, and initiation of six new activities. The attached chart compares past funding of the program with the current request. Although the Region obviously lacks the maturity required for a developmental award, and the Ad Hoc Kidney Panel recommended disapproval of the kidney proposal on the basis of its being out

of date, the Committee agreed with the site team that with these two exceptions any of the application's proposals were reasonable candidates for support from $800,000 recommended award. The $800,000 recommended level represents reductions from the current year's annualized level of approximately $895,000 (after the cut) and the request level of $1,514,081, and was considered by the Committee to be an amount sufficient to provide for a core allocation adequate to accomplish the recommended changes. At the same time, it will force the Region to make choices among various combinations of activities for support during the coming year.

Northern New York Regional Medical Programs

One point that arose repeatedly during the two-day meeting was that three of the four RMPs in northern New York had submitted Triennial applications for this review cycle, had been site visited, and all found to have basic problems in terms of the quality and direction of the programs. The three RMPs are Albany, Central New York (Syracuse), and Rochester. The fourth RMP, Western New York (Buffalo), was reviewed by October/November 1970 Committee and Council. There was some sentiment on the Review Committee that serious thought should be given to combining these three, or possibly four Regions, and that this would represent a better use of limited dollars and perhaps combine the strengths of the various programs. It was recognized at the same time that, politically, any combination of these Regions would be quite difficult. Also, since each of the three Regions being reviewed this cycle was seen as being at a turning point in its development, with some hope for resolution of its problems during the coming year, the reigning attitude was that now would be an inopportune time to suggest any combined superstructure without giving the programs another year to iron out their own difficulties. The Committee also saw the need for more data before considering any possible merger.

RMPS/GRB
7/16/71

ROCHESTER REGIONAL MEDICAL PROGRAM
Comparison of 01-03 year funding
and 04-06 year request

PROJECT	FUNDED			REQUESTED		
	01	02	03 (18 months)	04	05	06
Core	244,805	303,908	436,392	352,542	377,766	404,059
#1 - Reconstruction & Equipping of Learning Center	26,400	--	--	--	--	--
#2 - Postgraduate Trng. in Cardiology	83,857	77,026	110,609	74,453	74,791	merged with #28
#3 - Myocardial Infarction Registry	21,180	8,770	10,954	--	--	--
#4 - Regional Coagulation Laboratory	69,420	45,123	65,589	20,000	--	--
#6 - CCU Training - Nurses	71,339	62,074	83,396	56,396	57,034	merged with #29
#7 - Early Disease Detection Unit	202,232*	263,789	383,713	266,103	215,554	164,918
#8 - CE in Cerebrovascular Disease	30,911*	40,010	53,624	Merged with project #2		merged with #28
#9 - Cancer Clearinghouse	19,542*	22,500	32,310	23,218	merged with project #27	
#10- Statistical & Evaluation Unit	71,610*	58,440	83,920	71,918	78,076	84,554
#11A-Telephone EKG Consultation	--	30,051*	43,152	4,002	--	--
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#14 - Development of Stroke Team		20,701*	27,710	merged with project number 26		
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#21 -Regional Organ Procurement Sharing Transplant				107,129	68,442	72,844
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#23- Family Counselor Program				18,440	19,643	22,920
#24- Consultation Service Rural Pract.				50,210	54,452	58,920
#25- Health Education & Advocacy				62,072	66,047	70,248
#26- Chronic Neuromuscular Dis. Team				121,850	130,680	140,059
#27- General Clearinghouse					39,863	45,080
#28- Comprehensive Postgrad. Ed. Phys.						216,572
#29- Comprehensive Postgrad. Ed. Nurses						179,616
Developmental Component				100,000	100,000	100,000
TOTAL	$41,296	1,008,164	1,451,951	1,514,081	1,478,419	1,559,790

* for 8 or 9 month periods

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: June 29, 1971

Reply to Attn of:

Subject: Quick Report on the Rochester Regional Medical Program Site Visit June 24-25, 1971 (Rochester, New York)

To:

Director, RMPS
Through: Acting Deputy Director
Regional Medical Programs Service

I. Site Visit Team

Alexander M. Schmidt, M.D. (Chairman Site Visit Team)
Dean, Abraham Lincoln School of Medicine
University of Illinois College of Medicine
Chicago, Illinois

Robert Lawton
Deputy Director
Tri-State Regional Medical Program
Medical Care and Education Foundation, Inc.
Boston, Massachusetts

Richard J. Cross, M.D.
Professor of Medicine
Assistant Dean
Rutgers Medical School
New Brunswick, New Jersey
Also
Chairman of New Jersey RMP
Regional Advisory Group

Richard Haglund
Associate Coordinator for Administration
Intermountain Regional Medical Program
Salt Lake City, Utah

RMPS STAFF

Eileen Faatz
Grants Review Branch

Julia Kula
Continuing Education

Burt Kline
Regional Development Branch

Spencer Colburn
Regional Development Branch

Robert Shaw
Regional Representative
DHEW Region II
New York, New York

II. BACKGROUND: This visit was viewed by the site team as the third in a sequence of visits which evidence the growing concern on the part of staff, Committee, and Council reviewers about the Rochester Regional Medical Program. The first in the trio of visits was approximately a year ago, in April 1970, and was prompted by the apparent concentration of activities in Rochester, the laissez-faire administration of the Coordinator, the low rate of expenditures, and the continuing dearth of full-time professional staff. That visit, and the subsequent Management Assessment visit in November 1970, resulted in recommendations to the Region that the Regional Advisory Group assume its responsibilities for program direction and that the program hire a strong Deputy for the Coordinator and provide administrative assistance to the program. Staff review of the current triennial application highlighted problem areas consistent with past reviews. The purpose of this visit then, was to determine what efforts and progress had been made in ameliorating the Region's chronic problems.

III. GENERAL IMPRESSIONS: The general conclusion of the site team was that initial rehabilitation therapy has begun and that the Region has potential for assuming an active and productive role. But much remains to be done.

The happiest change that has come about is the diversification of the Regional Advisory Group and the creation of an interested and active Executive Committee of the RAG. It is in the Executive Committee that the site team saw the leadership for bringing this RMP out of the doldrums. It has been meeting weekly since its creation a few months ago and can provide the dynamism necessary for change. Although the program is well thought of throughout the area, has brought about good regionalization, and has developed some interesting projects (particularly in the spheres of cardiology and nurses' continuing education), it does not yet hang together as a program. It is more a conglomeration of individual projects. There are many factors that contribute to this lack of a coordinated program, primarily:

1. Continued problems in core staffing and lack of administrative leadership. The Coordinator still has no deputy and provides little program direction to the core staff. The site team recommended a restructuring of core staff to provide for its assumption of administrative, financial management, planning and evaluation, and certain program development responsibilities and to release core staff from day-to-day project direction duties. There are some very good people on core who suffer from lack of direction.

2. Lack of integration of goals and objectives into a coordinated program approach with attendant priorities for determining program activities. Progress is beginning in the Executive Committee (with help from the Statistical and Evaluation Unit) and should spread to the Regional Advisory Group.

3. The inadequate review and decision-making process. The Executive Committee already had identified this as a key problem and is working on solutions, to include the assumption of program-direction responsibility by the RAG, development of a more complete review process, a formal technical review procedure, and the restructuring of the current committees on heart disease, cancer, and stroke into less categorical groupings with relevance to program objectives.

Although it might have been rather discouraging for this site team to be replaying the same feedback tape which the Region presumably heard on the two previous visits, there was a definite note of optimism which had been absent before. This time something will be done--the Executive Committee will take the ball and carry it. It was in this happy frame of mind that the team arrived at the following recommendation.

IV. RECOMMENDATION: Approval of one year's further funding at the reduced level of $800,000 with a follow-up site visit in a year to check the Region's progress with regard to the site visitors' recommendations. The only specific disapproval is for developmental component funding. The award is to be allocated at the Region's discretion among core, ongoing, and proposed activities with the clear understanding, however, that:

1. This will be the final year of support for coronary care training and the Early Disease Detection Unit (multiphasic screening) to allow phase-out and data analysis support.

2. The Region will have flexibility in budget rearrangement to build its core staff, develop a revised form of Regional leadership, strengthen the management processes, formalize the review process, and effect other changes recommended by the site team.

3. Although the kidney project is excluded from funding within the $800,000 level, if earmarked funds become available the site team has no objections to an increased award to permit funding of this activity.

The $800,000 recommended level represents reductions from the current year's annualized level of approximately $895,000 (after the cut) and the requested level of $1,514,081 and was considered by the team to be an amount sufficient to provide for a core allocation adequate to accomplish the recommended changes. At the same time, it will force the Region to make choices among various combinations of activities for support during the coming year.

Eileen I. Faatz
Public Health Advisor
Grants Review Branch

Attachment: Comparison of 01-03 yr. funding with 04 & 06 yr. request.

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TOTAL	841,296	1,008,164	1,451,951	1,514,081	1,478,419	1,559,790

* for 8 or 9 month periods

DRAFT-1

SITE VISIT REPORT
ROCHESTER REGIONAL MEDICAL PROGRAM
June 24-25, 1971

A. Site Visit Participants:

Alexander M. Schmidt, M.D., Chairman; Member of Review Committee; Dean, Abraham Lincoln School of Medicine, University of Illinois College of Medicine, Chicago, Illinois

Robert Lawton, Deputy Director, Tri-State Regional Medical Program, Medical Care and Education Foundation, Inc., Boston, Massachusetts

Richard J. Cross, M.D., Professor of Medicine, Assistant Dean, Rutgers Medical School, New Brunswick, New Jersey; Chairman of New Jersey RMP Regional Advisory Group

Richard Haglund, Associate Coordinator for Administration, Intermountain RMP, Salt Lake City, Utah

RMPS STAFF:

Eileen Faatz, Public Health Advisor, Grants Review Branch

Julia Kula, Continuing Education and Training Branch

Burt Kline, Operations Officer, Regional Development Branch

Spencer Colburn, Operations Officer, Regional Development Branch

Robert Shaw, Regional Representative, DHEW Region II

B. Regional Participants

Regional Advisory Group and Executive Committee

Mr. Frank Hamlin, Chairman of the RAG
Dr. Robert Berg, Chairman of Executive Committee (Dept. Prev. Medicine)
Mr. Peter Warter, Executive Committee (Xerox Corp.)
Dr. Wendell Ames, RAG (Dept. Health)
Mr. Walter Wenkert, RAG (CHP b Director)
Mrs. Janet Mance, R.N., RAG (NYS Nurses Association)
Miss Rita Chisholm, R.N., RAG (U. Rochester School of Nursing)
Mr. Arnold Jerome, Exec. Committee (Hospital Administrator, Elmira)
Dr. James Norton, Exec. Committee (Private practice, Montour Falls)
Dr. Christopher Parnall, Jr., Exec. Committee (Hosp. Administrator, Rochester)
Mr. David Stewart, Executive Committee (Blue Cross)
Dr. Willis Weeden, Exec. Committee (Private Practice, Canandaigua)
Dr. Wayne Templer, RAG (Private Practice, Corning)

Regional Medical Program Staff

Dr. Ralph C. Parker, Jr., Program Coordinator
Dr. Barbara Bates, Director, Health Services Program & EDDU Proj. Director
Dr. Thomas Cardillo, Director, Heart Disease Program
Dr. Gaetano F. Molinari, Director, Stroke Program
Dr. William Gavett, System Analyst
Dr. Arthur Jacobs, Direct of Statistical and Evaluation Unit
Dr. Mary Sears, Cancer Projects
Miss Edith Olson, Coordinator, Nursing Activities
Miss Janet Long, Specialist, Rehabilitation Nursing
Miss Rose Pinneo, Specialist, Cardiovascular Nursing
Mrs. Maria Smith, Diabetes Project Nursing
Dr. Eugene Farley, Project Director for Proposal for Community Research & Teaching
Mrs. Ginny Hansen, Nurse Specialist on Core
Dr. Barry Pless, Project Director for Proposal for Family Counselor Program
Ms. Naomi Chamberlain, Proj. Director for Proposal for Health Advocacy
Dr. Robert Breckenridge, Project Director, Coagulation Laboratory
Dr. Robert Jones, Staff of Proposed Chronic Neuromuscular Disease Team

Other Participants

Dr. J. Lowell Orbison, Dean of Medical School
Dr. Lawrence Young, Chairman of Dept. of Medicine
Ms. Eleanor Hall, Director of University Nursing Education
Mr. Donald Irish, Medical Society
Mr. Richard Hufnail, University Financial Officer
Mr. Peter Norman, Northern Livingston Health Center
Mr. Darwin Farber, Neighborhood Health Centers, Inc.
Mr. Norbert Temple, Rochester Regional Hospital Council
Dr. Robert Easley, Genesee Valley Heart Association
Ms. Pulling, Genessee Valley Heart Association

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(3a)

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Developmental Component				100,000	100,000	100,000
TOTAL	841,296	1,008,164	1,451,951	1,514,081	1,478,419	1,559,790

* for 8 or 9 month periods

has no objection to an increased award to permit funding of this activity.

IV. REVIEW DETAILS

A. Goals, Objectives and Priorities

Findings: The goals of the Rochester Regional Medical Program remain as stated in the original planning grant, and include improving the availability of quality health services, improving communications between and among health personnel and institutions, determining uses for new allied health manpower, and providing continuing education and training for physicians and nurses. The important recent change revolves around the RAG determination of priority ratings along three axes:

1. Target populations: ten population groups have been ranked in priority order. Heading the lest are inner city residents, rural residents, and migrant workers.

2. Ongoing activities: a rank order list of all presently operational projects has been compiled, although this list does not include new projects proposed for funding.

3. Project function: perhaps the most meaningful listing developed is that showing the relative priorities among various project functions:

- organization and delivery or ambulatory services
- manpower development
- administration of health services
- organization and delivery of chronic inpatient, home health and rehabilitation services
- preventive services
- health education
- organization and delivery of emergency services

The statements of target population and project function were developed by the Statistical and Evaluation Unit, and the priority determinations resulted from a simple survey questionnaire which requested ranking assignments from each RAG member. The lists as they appear are composite ratings. Even in that respect they are imperfect because the questionnaire drew only a fifty percent response rate from RAG members -- or only approximately 15 returns. Furthermore, the three prioritized lists have not been integrated to elicit congruence among the three sets of priorities nor to develop specific objectives for the future. No method had been developed to relate the priorities to the determination of activities to be supported.

Although the Statistical and Evaluation Unit has done some survey work (primarily attitudinal) and has developed a data book (discussed in a later section of this report), most needs assessment appears to be more the result of perceived needs gained through informal personal contacts made throughout the region than based on actual data analysis.

Comments: The site visitors saw the Region as being in the preliminary stages of evolution toward the development of a set of workable and operationally valid objectives, based on actual regional needs, developed in priority order by the Regional Advisory Group, and a factor in determining regional activities. Much work needs yet to be done. Nevertheless, even though more by accident than design, the present stated goals and priority project functions represent a reasonable first cut in this evolution.

B. Organizational Effectiveness:

Coordinator and Core Staff

Findings: The Coordinator has not been successful in developing and maintaining a strong sense of program direction and cohesion or an effectively functioning core staff. Dr. Parker is a kindly and well-liked gentleman who lacks administrative and management skills. In response to the urgings of both April 1970 site visitors and the November 1970 management team that the Coordinator have a deputy to carry the administrative burden, Dr. Parker in the Winter of 1970 brought on as Assistant Coordinator a young man who recently had received his M.P.H. This individual, however, resigned in May 1971 and another young man with similar background has been chosen to replace him, starting in July.

The core staff currently consists of Dr. Parker and eight categorically-oriented people who also are project directors. These are people who in other Regional Medical Programs would be included on individual project budgets rather than core. Although the core appears to be a very talented group, in the absence of direction from the Coordinator, its loyalities and interests seem to lie more with the individual projects and the Medical School than with the Rochester RMP. Dr. Bates, for instance, who organizationally is Head of the Health Services Program on core staff is interested only in certain areas of health services - specifically, the Early Disease Detection Unit (for which she is project director) and nurse practitioner training. She also is working for the Medical School and running the outpatient department.

There are many areas in core left uncovered:

1. Administration and management - Dr. Parker is the only person with administrative responsibilities.

2. Financial capabilities - project accounts are kept primarily by project directors and a core secretary reconciles them monthly with a University print-out; the fiscal management services provided by the University are not appropriate to the needs of the program; nobody has the responsibility for reviewing expenditure reports or suggesting fund reallocation; the project directors develop budgets and Dr. Parker reviews them.

3. Planning and evaluation - the Statistical and Evaluation Unit is budgeted as a separate project and generally left to pursue its own interests.

4. Program development - in the absence of direction the core staff has concerned itself little with what the RRMP is, should be, or might become.

Comments: The site visitors believed this Region has a phantom core staff. It has no practice in thinking of itself as RMP - it is not dedicated to building a cohesive program. In a core group discussion of possible uses of developmental component funds the staff seemed to be exchanging ideas and discussing the future of the program for the first time. Each is used to doing his own thing without consulting others and although some of these individual efforts are very good, they likely are things these people would be doing without RMP anyway and are not the product of either coordination or leadership. The site team saw this combination of a Coordinator

who fails to provide leadership and a staff whose loyalties lie elsewhere as potentially devastating. It was very encouraging, though, to see the obvious willingness of the staff members to lower their categorical sights and become program oriented. The team stressed the necessity for restructuring the core to provide both for administrative competence and a formalization of the program aspects, and offered some specific suggestions along these lines:

1. It was suggested, first of all, in the feedback session that the Executive Committee take on the job of overseeing the reorganization of core staff. It is a group which has an interest in doing this and is, itself, acting as a substitute core with regard to thinking in terms of a coordinated program. It also was suggested that the Executive Committee consider bringing in a consultant to look at core staff organization and function.

2. Dr. Parker must have an associate or deputy to relieve him of the necessity of carrying the entire administrative burden. He can no longer be all things to all people.

3. Some business and financial management expertise must be added to core.

4. The functions of the Statistical and Evaluation Unit should become a part of core and evaluation expertise must become an integral part of program planning.

5. Core staff must be released from day-to-day project routine and become involved with the program aspects of the RMP, implementing the policies of the RAG and developing an understanding of the potential and opportunity of RMP. As stated before, core is now spread out and functioning with many hats, but it has shown a distinct eagerness to serve the core staff function of building an RMP.

Grantee Organization:

Findings & Comments: The relationship of the University of Rochester Medical School to the Rochester Regional Medical Program has raised some questions in the past. The site visitors, though, found the relationship to be sound and beneficial to both parties. The University has been good to RMP. It has on occasion provided matching funds for RMP activities, it supplies considerable administrative and fiscal assistance, and the Dean spends a lot of time on RMP affairs. The University does not hold a tight rein on dollar management. It is very supportive of the new and active Executive Committee of the RAG which is struggling to fashion a coordinated program, and it appears not to have any designs to dominate and affords the program a considerable degree of freedom. The Medical School feels a responsibility for core staff - most have tenure - and in the event of a disaster befalling the RMP, most probably would be transferred to the University payroll. The only cautionary advice from the site team was that in the area of personnel development of core staff, the coming year is a critical one, and the University must balance any concerns about the future of RMP and the fate of its staff with the realities and necessity of increasing certain competencies on the staff.

Regional Advisory Group:

Findings: The Regional Advisory Group gradually has been expanded to represent a greater diversity of interests. There presently are 35 members, including 17 physicians, three nurses, and nine public representatives. Two RAG members are Black. Half

the members are from outside the immediate Rochester vicinity.

A nine-member Executive Committee of the RAG recently has been formed, and appears to offer hope for salvation. In the months since its creation it has been meeting weekly, and the minutes of these meetings reveal that it has been grappling with problems vital to this RMP. The Executive Committee consists of two University representatives, two public representatives, two hospital administrators, two regional physicians, and a Blue Cross representative. Parenthetically, the nurses are worried that they are not represented on the Executive Committee. The three leaders of the Committee appear to be: Dr. Berg the Chairman, and Head of the Department of Preventive Medicine and Community Health; Mr. Hamlin, the Chairman of the RAG; and Mr. Warter, Vice President for Research at the Xerox Corporation. It is Mr. Warter who seems to be the driving force behind the move for change -- he certainly is the idea man and the most vociferous of the three. He was named to the RAG at the suggestion of Dr. Saward, Associate Dean for Extramural Affairs (and himself a member of the Executive Committee although out of the country at the time of the visit) and when he learned of the Executive Committee's existence, Mr. Warter requested membership. The three representatives stated that they welcomed the opportunity to talk to the site visitors, first to explain what they had been doing and second to receive guidance and advice. Both purposes were accomplished.

The present review process is nominal, at best. In preparation for this Triennial application, a letter was circularized explaining that the RRMP was accepting project proposals for inclusion in its

annual application. Each proposal was reviewed by the Executive Committee and then by the full Regional Advisory Group. Although the RAG receives the proposals on those projects for which the Executive Committee recommends approval, it receives only project summaries of those for which disapproval has been recommended. The attendant technical review procedures are presently very unorganized and used only sporadically. At present, the Coordinator and the core staff play a large role in what technical assessment there is. The Executive Committee realizes this is all wrong and is gathering its collective thoughts on possible solutions. Although it's not clear exactly what procedures will emerge, some preliminary planning has been done. For instance, the entire study committee structure is being reorganized. The present categorical committees on heart disease, cancer, and stroke are being phased out to be replaced by groups with more relevance to the program. Some early thoughts on the types of committees which are needed include: long-range goals and priorities, communications and public relations, by-laws and membership, finances and budget, evaluation, continuing education, and health services delivery. It is hoped that in the process of regrouping, the services and interest of the members on the now defunct categorical committees can be retained. It is planned that the new committees will play a substantial role in program development and idea generation. It is the present thought that technical review will be provided on a ad hoc basis.

Comments: The site team thought the RAG as presently constituted was representative of regional interests, but urged the Region to add members of the CHP county committees (discussed in the

next section of this report) as interested people are identified. The RAG obviously has abdicated any program directing position and must, during the coming year, assume its proper responsibilities. The Executive Committee knows this and plans to pave the way by developing guidelines and procedures for the RAG, and the site team thought they probably could do it. The Executive Committee itself is a promising group which is on the right track and will act on the advice of the site team. The Committee realizes that initially it will be appropriating for itself an undue amount of power, but as functions and procedures are formalized, the Executive Committee plans to delegate responsibilities to core and the RAG and its committees. The site team thought this to be a reasonable approach. The Committee was urged to develop a sound review process on two levels: (1) technical merit and (2) the fit of the activity with local and national goals. Although the site team saw an ad hoc system of technical review as one way of doing things, it expressed the hope that the Region consider other mechanisms which might require less supervision.

Subregionalization

Findings: The Rochester program has decided against establishing any sort of formal subregional structure for a number of reasons:

1. The Region is a small one and no point is more than 2½ hours driving distance.

2. The core and project staff travel throughout the Region extensively and sound out perceived needs, at least, on an informal basis.

3. There is neither enough time nor money to invest in establishing such structures.

4. The CHP b agency has established a network of county committees with which RMP has informal liaison. There are presently on the RAG seven people with overlapping RMP/CHP memberships, and as particularly interested individuals from the CHP county committees emerge and are identified, RMP will tap them for RAG membership.

Comments: The site team believed that subregionalization could be achieved by the method the Region described, and urged a formalization of relationships between RRMP and CHP and its county committees.

C. INVOLVEMENT OF REGIONAL RESOURCES

The Rochester Regional Medical Program is known, well-liked, and used by many individuals and agencies throughout the Region

Dr. Parker's esteem with the physicians is manifest in his recent election to the presidency of the county medical society. There was much evidence that the regional physicians look to the RMP for help. Much of this was brought about through the good rapport established through the regional continuing education activities and the friendly way in which RMP staff will respond to pleas and go into communities and assist in analyzing and solving problems. Many area physicians now, because of RMP, are excited about physicians' assistants, and will look to the RMP for what they want to do in this area. The program is cooperating with and helping communities in the delivery of care through an analysis of emergency room utilization, supporting the Medical Society's Monroe Plan (modeled on the San Joachim Valley Plan), promoting the development of the North Livingston Health Center - a rural ambulatory prepaid health care center - and involvement with a

recently-funded Blue Cross/Shield prepaid health care model. There was testimony to indicate RMP's substantial role in promoting facility utilization analysis - for instance, in Elmira, two community hospitals with cobalt facilities combined them in one institution. And the words of praise came from the administrator of the hospital which relinquished its capability.

Relationships with CHP are proceeding apace. There is collaboration in studies (for instance the data book and a study of emergency departments in city hospitals) and the seven overlapping RAG/CHP memberships. Mr. Wenkert, the CHP b director, has a rather large staff of mostly generalists, and he looks to RMP for some technical assistance. The two groups orginally had collaborated on an experimental health services delivery application, but when it was drastically reduced to become no more than an HMO, CHP became the lead agency. It probably will look to RMP, though, for evaluation expertise. In general, then, CHP/RMP relationships are reasonably good, but need formalization. Mr. Wenkert also stated that he would find it easier to work with RMP if he were sure of its goals and the direction it intended to take.

The Region appears to have worked out reasonably good but informal relationships with many local agencies such as the heart association and the regional hospital council. It also is quite interested and active in the Genesee Regional Educational Alliance for Health Personnel.

Comments: The site team credits the RRMP with turning the ten-county area into a region which is now established and viable. It has managed to relate the University to the communities for the first time, primarily through its continuing education activities and interesting

the university in the problems of providing medical care. It has brought about good communication between physicians and nurses and between town and gown. The site team felt that the impact of RMP on the communities is substantial.

The Region, however, has shown considerable timidity in its use of regional resources. The area health organizations are coming to RMP for assistance, but the RMP, in turn, is not bold in exacting similar requests of these other groups. The program is not strong in the initiation and promotion of activities. It is very strong, though, in providing assistance and responding to requests.

D. ASSESSMENT OF NEEDS, PROBLEMS, AND RESOURCES

Findings: The Statistical and Evaluation Unit is budgeted and treated as a separate project. It relies primarily on its own interests and requests from others (CHP, project directors) to guide the direction of its activities. It has worked on some interesting studies (e.g. emergency room utilization), has conducted attitudinal surveys, and has worked with the Executive Committee in the first phases of developing an objectives and priority setting mechanism. There is a recently produced regional data book (in conjunction with CHP) which contains a compilation of statistics but little analysis. The activities of the Unit are not comprehensive. The core and project staff, through their numerous informal contacts throughout the Region, have gained an idea of perceived needs, but the RRMP has not yet started planning based on data analysis. Interestingly enough, the Region's objectives are reasonable - even though perhaps accidentally. However, core and operational activities do not reflect systematic programming based on assessment.

Comments: The activities of the Statistical and Evaluation Unit must become core functions and responsive to the necessity of data analysis as a basis for determining program direction.

E. PROGRAM IMPLEMENTATION AND ACCOMPLISHMENTS

Findings: It would be difficult to discuss core and project activities separately since, like the staff, the activities overlap. Generally speaking, core activities have been confined to responding and reacting to requests rather than aggressively initiating activities. But they are available to the people in the Region and have fostered a great good feeling through their helpfulness. There are four divisions into which most ongoing and proposed project activities fit, and core is being reorganized along those lines: medical continuing education; nursing continuing education; health services; and evaluation, management services, etc.

Medical Continuing Education

Ongoing projects for which 04 year funding is requested:

Postgraduate Training in Cardiology

Cancer Clearinghouse

Telephone EKG Consultation

Decentralized Cancer Education

Physicians' Training in Chronic Renal Disease

Diabetes Education Program

New Proposals for which 04 year funding is requested:

Community Research and Teaching

Many of the ongoing continuing education activities are planned for merger into a larger overall multicategorical physicians' postgraduate education program in the 06 year. Generally speaking, the activities carried out in the field of medical continuing education are casual and unstructured. An adequate job of late 60's vintage continuing education is being accomplished, with cardiology standing out particularly. The process of regionalization is being furthered through informal consultations, circuit riding, and bedside teaching activities in community hospitals. The Region expects pending recertification requirements to have a major impact on its continuing education activities. Unfortunately, there is no evidence that the continuing education project directors/core staff have ever met together to discuss the future of the continuing education program and how it can become part of and foster a restructured health service system.

Nursing Continuing Education:

Ongoing projects for which 04 year funding is requested:

CCU Training for Nurses

Neurologic and Rehabilitation Nursing

Chronic Renal Disease Nursing

Diabetes Education Program

No new proposals in the area of nursing continuing education are presented for 04 year funding. However, in the 06 year, all of the ongoing projects are proposed for merger in a multicategorical comprehensive program for postgraduate education for nurses.

This group of activities is possibly the best of the RRMP program. The nurses are energetic, dedicated, and well-known throughout the Region. Largely through their efforts, there now apparently is an unusually free dialogue between physicians and nurses. They are building bridges out to the rest of the region and between and among community hospitals. They are excited about the new roles they see developing for nurses. Although they are speaking in terms of career ladders upward from the diploma level, they have not yet looked at the bottom rung and the LPN with an eye toward upward mobility. The nurses, too, expect upcoming recertification requirements to impact on their program. They are apprehensive that the Executive Committee does not contain nursing representation, but they seem amenable and willing to pursue the new look in core responsibilities.

Health Services:

Ongoing activities for which 04 year funding is requested:

Early Disease Detection Unit

Proposed new activities for 04 year funding:

Family Counselor Program

Health Education and Advocacy

Physicians' Assistants Planning (through core)

Early Disease Detection Unit is entering its fourth year of operation, and since the site visit a year ago Dr. Bates has been working on evaluation. She feels she is not in a position to evaluate the effect of screening on the community and has been concentrating on how the physicians to whom patients are referred react. The

results have been rather discouraging in some instances. For example, 250 patients with poor hearing were referred from the unit and in only three instances was something done about it.

The three new proposed projects all were interesting but the site visitors could not see that they resulted from any health services programming effort. They were, rather, activities that came along and received RAG approval. If there really were a functioning core unit on health services, instead of just a box on an organizational chart, elements of these proposals might be integrated, perhaps with EDDU, and a program based on objectives could be derived.

Evaluation, Management Services, Etc.:

Ongong projects for which 04 year funding is requested:

Regional Coagulation Laboratory

Statistical and Evaluation Unit

New proposals for which 04 year funding is requested:

Regional Organ Procurement, Sharing and Transplantation

Consultation for Rural Practitioners

Chronic Neuromuscular Disease Team

The projects in this category represent a mixed bag of activities which did not fit into the other three categories. The Statistical and Evaluation Unit should, of course, become a part of core.

Comments: The site team found a group of miscellaneous projects occasionally related to an unstructured program. The overall quality of these activities is uneven, with nursing and

cardiology continuing education winning high marks for success. The strength of the program to date appears to lie in its consultation and education activities and the availability of the staff to give assistance throughout the region. One project is being phased out and two others are slated for withdrawal of RMP support next year. But without clear objectives and priorities, it is rather difficult for the Region to make these determinations.

One apparent problem for which the site team found no solution (primarily because the problem never was articulated and the sources never brought out) revolves around the status of cancer activities in the Rochester Regional Medical Program. There has been evidence for some time that cancer has been getting short shrift, but the visitors did not find out why and Dr. Hall, the program director for cancer, was out of town during the site visit.

F. EVALUATION

Findings: For the most part, project evaluation seems to be left up to the individual project directors (with varying degrees of sophistication and success), but Dr. Jacobs, Director of the Statistical and Evaluation Unit, has been giving some assistance in terms of comparing cost with units of output. Program evaluation has not developed - and there is no program to evaluate. Dr. Jacobs is suffering from lack of direction and not understanding what his role is supposed to be. He doesn't know whether he's line or staff and, in the absence of guidance, has been following his own interests and instincts, which seem to revolve around evaluation as a research activity more than as an applied discipline.

The studies that have been done by his group seem not to be used by anyone.

Comment: The Statistical and Evaluation Unit must be transferred to core staff and be provided guidance as to the directions its activities should take.

V. RATIONALE FOR FUNDING RECOMMENDATION

The $800,000 recommended level represents reductions from the current year's annualized level of approximately $895,000 (after the cut) and the requested level of $1,514,081, and was considered by the team to be an amount sufficient to provide for a core allocation adequate to accomplish the recommended changes. At the same time, it will force the Region to make choices among various combinations of activities for support during the coming year.

VI. RECAPITULATION IN TERMS OF RMPS MISSION STATEMENT REVIEW CRITERIA

I. PERFORMANCE

1. Goals, Objectives, and Priorities. The site visitors saw the Region as being in the preliminary stages of evolution toward the development of a set of workable and operationally valid objectives, based on actual regional needs, developed in priority order by the Regional Advisory Group, and a factor in determining regional activities. Much work needs yet to be done. Nevertheless, even though more by accident than design, the present stated goals and priority project functions represent a reasonable first cut in this evolution.

See pp. 4 and 5.

2. Accomplishments and Implementation. The site team found a group of miscellaneous projects occasionally related to an unstructured program. The overall quality of these activities is uneven, with nursing and cardiology continuing education winning high marks for success. The strength of the program to date appears to lie in its consultation and education activities and the availability of the staff to give assistance throughout the region. See pp. 16-20

3. Continued Support. One project is being phased out and two others are slated for withdrawal of RMP support next year. But without clear objectives and priorities, it is rather difficult for the Region to make these determinations.

II. PROCESS

1. Organizational Viability and Effectiveness. This Region combines a Coordinator who fails to provide leadership with a core staff which is not accustomed to think in program terms. The site team stressed the necessity for restructuring the core to provide both for administrative competence and a formalization of the program aspects. The RAG has been, to date, a rather passive assembly, but with the advent of the new Executive Committee of the RAG there is great and encouraging potential for change. See pp. 6-12

2. Participation. The site team credits the RRMP with turning the ten-county area into a region which is now established and viable. It has managed to relate the University to the communities for the first time and has brought about good communication between

physicians and nurses and between town and gown. It was felt that the impact of RRMP on the communities is substantial. The Region however, has shown considerable timidity in its use of regional resources. The area health organizations are coming to RMP for assistance, but the RMP, in turn, is not bold in exacting similar requests of these other groups. The program is not strong in the initiation and promotion of activities. It is very strong, though, in providing assistance and responding to requests. See pp. 13-15

3. Local Planning. The RRMP is pursuing subregionalization through its informal relationships with CHP b agency county committees. This seemed reasonable to the site team, but it urged a formalization of relationships. See pp. 12-13

4. Assessment of Needs and Resources. The core and project staff, through their numerous informal contacts throughout the Region, have gained an idea of perceived needs, but the RRMP has not yet started planning based on data analysis. See pp. 15-16

5. Management and Evaluation. In the absence of a real program, any program evaluation is out of the question. Project evaluation is sporadic as to quality. See pp. 20-21

III. PROGRAM

1. Action Plan. The program has just made the first cut in what it thinks its needs are. It does not yet know what its overall mission is, so it hasn't evolved to the point where a provider-action plan could be expected. The Region is working on it, though, and is conscious of the necessity.

2. Dissemination of Knowledge. The Region is getting at this through its continuing education and multiphasic screening activities. The area of manpower is a priority item. The Region has been involved in a model prepaid health care system sponsored by Blue Cross/Shield which has just been funded and is planning to study general practitioners' practice arrangements. The site team would give the Region at least an average rating.

3. Utilization Manpower and Facilities. The Region has done some work along these lines including working with communities on forgiveness loans for medical students; planning for nurse practitioners and physicians extenders programs; and a study of emergency room utilization throughout the Region.

4. Prevention. The Regions primary activity in prevention is its Early Disease Detection Unit.

5. Ambulatory Care. The extent to which the RRMP becomes involved will depend on the development and direction of its manpower program to a significant degree. Ambulatory care is listed as a high priority item. The RRMP was involved in the initiation of the North Livingston Health Center - a rural prepaid health care center.

6. Continuity of Care. It is the stroke people in the program who seem primarily concerned in this area and some of the education programs are dealing with secondary care.

7. Short-Term Payoff. Outside of the involvement in the Blue Cross/Shield prepaid plan (cost moderation), the Early Disease

Detection Unit (access), and the Region's continuing education programs (quality), the site visitors could not determine much activity. It has been modest or slow on picking up on the HMO concept. Generally, the Region is leaving this for others and is not initiating much itself.

8. Regionalization. Quite a good job has been done. Community hospitals, with RRMP advice, are getting together on facility utilization; the physicians and nurses are communicating well; and much of the town/gown conflict has been ameliorated.

9. Other Funding. The site team felt that the Rochester RMP probably was being tapped for funds more often than it was tapping others. This was seen as part of the Region's syndrome of letting people come to it rather than going out and stirring up activity.

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Privileged Communication)

Texas Regional Medical Program
4200 North Lamar Blvd., Suite 200
Austin, Texas

RM 00007 8/71
July 1971 Review Committee

Program Coordinator: Charles B. McCall, M.D.

This Region is currently funded at $1,708,040 (dc) for its third operational year which terminates August 31, 1971. Of this amount $549,344 represents unspent second-year funds reauthorized as carryover into the third year. The Region currently receives indirect costs of approximately 30% of direct costs. These figures represent the current funding level of the 03 year after the 12% budget reduction was imposed in April 1971.

The Texas RMP submits a Triennium Application that proposes:

I. Developmental Component for three years.

II. Core and two new projects for three years.

III. Initiation of one approved/unfunded project.

IV. Eight continuation projects for one year; two projects for two years.

V. Two renewal projects for one year.

VI. Specific request for "Earmarked" Kidney Disease Program Funds for three years.

The Region requests $1,714,244 (dc) for its initial year of its Triennium. An amount of $120,000 is requested for the developmental Component which represents 10% of the current 03 year's funding level (minus carryover of $549,344). The Region expects the committed funding level to be increased after the current review cycle and projects increased amounts for the Developmental Component for its second and third years of the new Triennium. The breakout chart identifying the Components for each of the three years is found on the next page of this synopsis.

This Region is scheduled for a site visit on June 29-30, 1971. The staff's preliminary review of the application has identified several issues which may be pursued by the site visit team. These are included in Section C of the staff review appended to this Summary.

Geography and Demography

The Texas Regional Medical Program covers the State's 267,000 square miles and 254 counties. Its approximate 11 million citizens reside in areas ranging from heavily populated urban, industrialized cities to those of

2nd Revision (6/7/71)

REGION Texas

CYCLE RM 00007 8/71

BREAKOUT OF REQUEST 04 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
#21A-Core (Coord. Office)	(692,343*)				(692,343)	(74,536)	(766,879)
#21B-Core (Planning for R.D.)				(20,000)	(20,000)	(780)	(20,780)
#21C-Core (Feas. of Pastex)				(4,000)	(4,000)	(483)	(4,483)
Total Core	692,343*			24,000	716,343	75,799	792,142
D00 - Developmental **				120,000	120,000	--	120,000
#54 - Project GRO				75,000	75,000	10,290	85,290
#36-Serial Control System	9,001				9,001	1,666	10,667
#55-Electrical Hazards				75,000	75,000	3,120	78,120
#8-Statewide Cancer Registry	108,000				108,000	42,486	150,486
#35-Reduce Complications During Radiotherapy	35,000				35,000	16,460	51,460
(#46A-Maxillofacial Services)	(34,878)				(34,878)	(9,622)	(44,500)
(#46B-Maxillofacial Services)	(30,062)				(30,062)	(19,907)	(49,969)
(#46C-Maxillofacial Services)	(35,060)				(35,060)	(9,952)	(45,012)
#46 - TOTAL	100,000				100,000	39,481	139,481
#45-Rehabilitation Mgt.	55,000				55,000	10,727	65,727
#37-Hlth. Careers Personnel Program	77,000				77,000	11,664	88,664
#6-Medical Physics		20,000			20,000	11,034	31,034
#51-Inhalation Therapy			$26,900		26,900	2,275	29,175
#20-Eradication of Cervical Cancer	20,000				20,000	9,801	29,801
#38-Dial Access Tele. Analys.		17,000			17,000	5,313	22,313
(#14A-Stroke Demonstration)	(63,419)				(63,419)	(19,296)	(82,715)
(#14B-Stroke Demonstration)	(36,581)				(36,581)	(5,706)	(42,287)
#14- TOTAL	100,000				100,000	25,002	125,002
#16-Reg. Rehab. -Wharton	20,000				20,000	4,255	24,255
(#17A-Reg. Rehab.-New Braunf)	(5,444)				(5,444)	(3,129)	(8,573)
(#17B-Reg. Rehab.)	(14,556)				(14,556)	(1,643)	(16,199)
#17 - TOTAL	20,000				20,000	4,772	24,772
#50-Control Hypertension and Renal Disease			120,000*		120,000	24,119	144,119
*Growth Funding					----	----	----
*see page 17 of the Summary for additional comments							
TOTAL	1,236,344	37,000	146,900	294,000	1,714,244	298,264	2,012,508

*05 & 06 years of request are Continuation Beyond Approved Period of Support.

**Request amended to 3 years per telephone conversation by M. Posta and the Region 5/12/71

GRB-6/7/71

REVISED (6/7/71)

REGION Texas
BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
#21A - Core		(803,219*)			(803,219)
#21B - Core		--			--
#21C - Core		--			--
Total Core		803,219*			803,219
Developmental				170,000	170,000
#54				75,000	75,000
#36	--				--
#55				56,000	56,000
#8	75,650				75,650
#35	--				--
#46A	--				--
#46B					
#46C					
#46 - Total					
#45					
#37					
#6					
#51			26,500		26,500
#20					
#38					
#14A	(63,419)				(63,419)
#14B	(36,581)				(36,581)
#14 - Total	100,000				100,000
#16					
#17A					
#17B					
#17 - Total					
#50				124,300*	124,300
*Growth Funding				451,850	451,850
*see page 17 of the Summary for additional comments					
TOTAL	175,650	$803,219	$26,500	877,150	1,882,519

*05 & 06 years of request are Continuation Beyond Approved Period of Support

REVISED -(6/7/71)

REGION Texas
BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)		
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
(#21A - Core)		(866,853*)			(866,853*)	(2,362,415)
(#21B - Core)		--			--	(20,000)
(#21C - Core)						(4,000)
#21 - Total		866,853*			866,853*	2,386,415
Developmental				185,000	185,000	425,000
#54				75,000	75,000	225,000
#36						9,001
#55				27,000	27,000	158,000
#8						183,650
#35						35,000
(#46A)						(34,878)
(#46B)						(30,062)
(#46C)						(35,060)
#46 Total						100,000
#45						55,000
#37						77,000
#6						20,000
#51						53,400
#20						20,000
#38						17,000
(#14A)						(126,838)
(#14B)						(73,162)
#14 - Total						(200,000)
#16						20,000
(#17A)						(5,444)
(#17B)						(14,556)
#17 - Total						20,000
#50				128,800*	128,800	373,100
*Growth Funding				753,000	753,000	1,204,850
*see page 17 of the summary for additional comments						
TOTAL		$866,853*		1,168,800	$2,035,653	5,632,416

*05 & 06 years of request are Continuation Beyond Approved Period of Support

-1-c-

primarily agricultural and sparsely populated. Two of the counties have more than one million residents, while several have less than 5,000 persons.

Although endowed with outstanding health educational facilities, composed of five medical schools, three dental schools, three schools of pharmacy, 51 professional and 153 practical nurse training schools, and ample allied health facilities, the majority of the counties do not have adequate health services according to the Texas State Health Department.

There are 490 short term community hospitals with 44,587 beds. Almost 60% of the hospitals are less than 50 bed facilities. Two hundred, twenty-six of the total 565 hospitals are accredited and approximately 25 are medical school affiliated. The Region contains two categorical research centers - M. D. Anderson (cancer) at Houston, and the Cardiovascular Research Center (heart) at Baylor. There are 11,279 practicing physicians in Texas (106 per 100,000 population) made up of 31% general practitioners, 21% medical specialists and 33% surgical.

FUNDING HISTORY
(Direct Costs Only)

Planning

Grant Year	Period	Amount Funded
01	7/66-6/67	$ 969,541
02	7/67-6/68	1,039,295

Operational

01	7/68-9/69	1,615,000
02	10/69-9/70	2,220,891 1/
03	10/70-8/71 2/	1,708,040 3/

1/ Included $444,178 Carryover from 01 year.
2/ Award for 11 months at request of RMPS to accommodate anniversary review scheduling.
3/ Included $549,344 Carryover from 02 year; also, includes 12% budget reduction placed on Texas FY 1971 appropriation.

Regional Development

In December, 1965, various academic, State and private health representatives met to discuss the potentials of the then newly enacted legislation calling for Regional Medical Programs. A State Coordinating Committee was formed which later became the Regional Advisory Group. After first attempting to establish three separate Regions, the applicants compromised on three subregions in North Texas, South Texas, and the Gulf Coast. Seven schools in the Houston area represented the Gulf Coast subregion, while the UTSW in Dallas represented the Northern subregion and UT San Antonio

represented the Southern subregion. The University of Texas at Austin was designated the applicant organization, while the Texas Medical Center in Houston was designated the fiscal agent. In June 1970, the fiscal agency was transferred to the Office of the Comptroller of the University of Texas System in Austin.

The initial planning grant was awarded in July 1966, but progress, including staff recruitment was relatively slow. Baylor (Houston) reported some progress in planning for an Allied Health Training Program and in starting a Cancer Registry; San Antonio reported resistance problems with private practitioners; while Southwestern (Dallas) reported good progress in surveying resources and personnel needs in the categorical diseases. Dr. C. LeMaistre was serving as Program Coordinator in Austin, and Dr. Spencer Thompson was appointed Associate Coordinator and was stationed in Galveston.

During the second planning grant year, staffs from the various institutions began joint planning meetings, task forces were created in the categorical diseases, the RAG began to develop its Review Process and the Texas Council of Health Science Libraries was created. This planning group submitted its initial operational application which led to a site visit conducted in June 1968.

The major concern of the site visitors was the apparent lack of central direction and coordination of the program. This was illustrated by the uneven progress made in the development of the nine subregional planning units and by the fact that operational proposals appeared to be "based on institutional interests and strengths with very little regard for community needs and goals - either regionwide or local - and only a few demonstrated evidence of true cooperative arrangements or unilateral peripheral involvement." The site team observed that the Regional Advisory Group, though under strong leadership, had not been active in the identification of program goals and the development of program plans. The RAG was weak in its representation of minority groups, consumers, allied health professions, and the practicing community.

Because of these apparent shortcomings, Council recommended a one-year approval of the Texas operational application, including continued planning support, with future funding contingent upon demonstrated improvement in the areas mentioned by the site visit reviewers. Accordingly, a one-year operational award was issued on July 1, 1968, in the amount of $1,615,000 (d.c.o.). These funds were divided evenly between operational and planning activities. This combined package included fourteen operational projects and a number of planning efforts which included core support and support for the nine institutional planning units.

A subsequent site visit was held in April 1969 to judge the progress made in fulfilling the conditions laid down the year before as necessary for further funding; that is, strengthening central administration and expanding the RAG. The reviewers were well satisfied that these requirements

were being met; a new coordinator, Dr. Charles McCall, had been appointed and had presented his plans for tightening up the organization. The RAG was expanded to include nine new interested groups.

On that basis, an 02 year operational award was made, but since RMPS still considered the Region in probationary status as far as managerial direction was concerned, support for the 12 new approved projects was not included in the calculation of supplemental funds or of the commitment for the next year (03). Instead, the Region was awarded funds at the 01 year level. Consequently, ten of the new projects were funded from carryover to keep the Region from stagnating.

When the Region applied for 03 year continuation, the financial bind in which it found itself was apparent. From an 02 year operating budget of $2,220,891, TRMP dropped to an 03 level of $1,400,000. This substantial decrease resulted from a combination of the Core's reduction because of the phasing out of the institutional planning bases and the Region's use of carryover to initiate a number of activities during the 02 year. In reviewing the application, staff emphasized that this fiscal disarray was not the fault of TRMP; rather, it was due to circumstances and past Division practice. Staff review further emphasized that Dr. McCall's plan appeared to be working: The planning bases were phased out by January 1970 (except for development of a subregional office in Houston) and for the first time the Region had a multidisciplinary core staff in Austin. Functional differentiations between the RAG and the core staff had been delineated. The RAG had adopted a set of by-laws and seemed to be involved in program development. Five task forces, with primary review responsibilities, had been made agents of the RAG rather than of the Coordinator. Financial management procedures had been altered with RMPS assistance. Planning and evaluation functions had been consolidated in the Coordinator's office.Close relationships between TRMP and the Texas Hospital Association and a formal working arrangement with CHP had been initiated. Subregionalization was being actively pursued.

Because of the progress the Region had made during the 02 year, and because of the promise it showed for the future, the 03 year award was made for $1,866,044. This figure included $549,344 in carryover funding to permit the Region to retain the momentum it had built up. The funding history, attached on the last page of this summary, lists the projects currently supported. It reflects a 12% budget reduction imposed on the Texas RMP in April 1971.

Organizational Structure and Processes

The grantee institution, the University of Texas System, is a consortium of 17 state-supported educational institutions. Medical, Dental, Biomedical Sciences and Nursing Schools are represented. Eleven of the 50 member Regional Advisory Group are from the respective schools representing the

grantee. It should be emphasized that these 11 members represent their respective schools and have not represented the grantee. According to the recent RMPS Assessment visit, no attempt to monopolize funding strategy has taken place. The grantee's fiscal agent has provided outstanding services to the RMP by providing annual audits on the various program components, exerting equipment control and purchasing good excess equipment available from an updated inventory maintained by the Comptroller's office.

Both the RAG and its 17 member Executive Committee are highly provider-oriented and appear to be well balanced geographically. Five minority members are noted on the RAG. Allied Health representation appears to be lacking in both the RAG and Executive Committee, but might be more prevalent in the newly created Program Development and Evaluation standing committees of the RAG or confined to the 14 member Standing Task Force on Allied Health Programs. The site visitors may wish to pursue this question.

The five standing Task Forces on Heart, Cancer, Stroke, Allied Health Programs and Continuing Education and Biomedical Communications each met three times and made recommendations to the RAG through the Program Development Committee regarding program direction and content. Each maintains an inventory and awareness of Regional resources in their respective program elements.

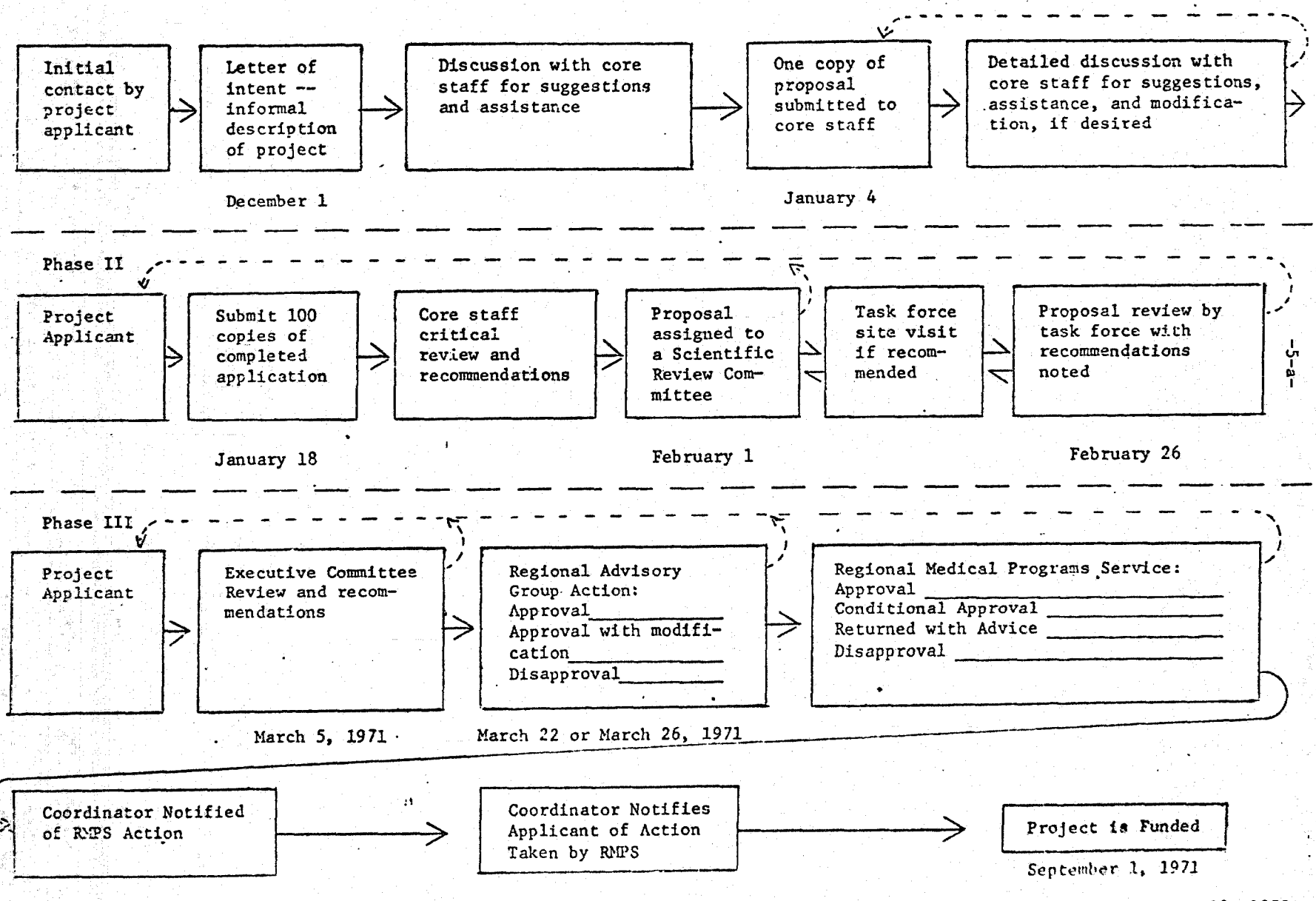
The review process has been established and appears to be working well. A chart depicting the various phases and deadline dates for the subject application is found on the next page.

Regional Objectives

The long range objectives established to meet the needs of Texas, as endorsed by the RAG, include: 1) the improved delivery of technical skills and service through prevention, detection, treatment, and rehabilitation; 2) the development of programs designed to meet the real health manpower needs; 3) to serve as an agent/broker for information that will achieve insight into the real health problems; 4) to promote innovative approaches to the improved availability of health care; and 5) continuing education. During the past year, the full membership of the RAG has decided to reexamine its present project approach and pursue a "total program" direction. However, a transition period will be needed whereby two critical concerns will have to be met: 1) ongoing activities (projects, services, etc.) must continue as planned, and 2) the shift to the new orientation must be positive but smooth. To achieve an organized gradual change to programmatic emphasis, the application states that "a three-phase integrated approach has been implemented. Each segment of the existing program is being carefully scrutinized. Priorities are being assigned to program objectives and strategies. Programs are being divided into work plans so that each step toward the established goal can be estimated, measured, and documented for later evaluation. In the three years allocated to the accomplishment of

REGIONAL MEDICAL PROGRAM OF TEXAS

PROPOSAL REVIEW PROCESS



full transition from project to program orientation, RMPT will meet its current obligations and build an operational base through which the health professional can respond to the real health needs of Texas."

Operational emphasis for 1971-72 will center around the continuation of selected 1970-71 activities and the development of the first phase of the long-range plan. The RAG and staff will be responsive to community needs, cognizant of the magnitude of individual problems, and ready to assist those who want to contribute to solutions. An organization to meet these demands has been developed in recent months. Its key features are:

1. Subregional offices have been opened in East Texas, far West Texas, South Texas, and the upper Texas Coast. An office is planned for the Panhandle/Permian Basin area this year.

2. RAG has appointed a Program Development Committee to advise on program areas, content, and priority. Staff is working closely with this broadly representative group.

3. The program development function has been separated from evaluation to provide emphasis in these critical transition years.

4. Education has been organizationally separated from Professional Programs to accommodate the potential shift in emphasis between areas as programmatic emphasis becomes clearer.

Present Application

Developmental Component

The Region requests developmental funds of $120,000 for the initial year of the Triennium and hopes to increase this total with an expectant higher commitment level for the second and third years. Examples of how these funds will be used include:

1. Community hospital linkage
2. Rural health care
3. Subregionalization especially on the Mexican-American border
4. Catalyst function for the encouragement and growth of high-quality care outside the urban Medical Centers
5. Extending the resources of Coronary Care over areas not having these services.

In addition, the Region states that the Grass-Roots Organization (Project GRO) has the potential of creating an entire series of spin-offfs which will further stimulate catalytic activities on the part of RAG and Core staff. This project, while essentially moving into action through education, provides a flexible format for the introduction and testing of innovative, new approaches to health care delivery.

An abbreviated review process has been designed for the effective administration of developmental funds. For maximum flexibility, in situations where timeliness is critical, the Coordinator has been delegated the authority by the Regional Advisory Group to commit up to $5,000 to any single unique activity. He must report such action to the Executive Committee at its next regular meeting following such action. Authority for commitments in excess of $5,000, but less than $15,000, has been delegated to the Executive Committee based on the majority vote of a quorum of the entire committee. All commitments in excess of $15,000 must be submitted for approval of the Regional Advisory Group.

Second Year- $170,000 Third Year - $185,000

CORE Requested First Year-$716,343

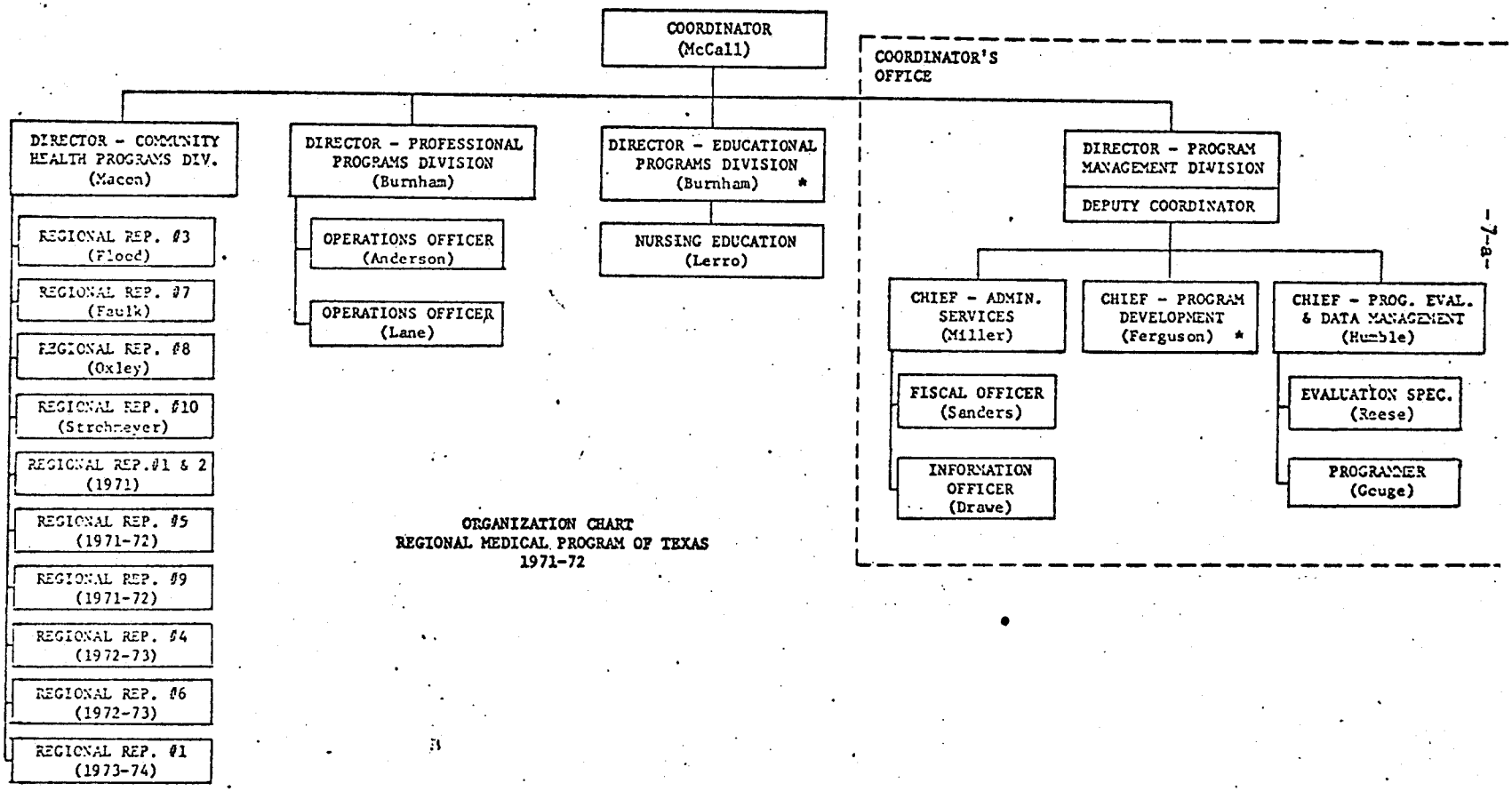
The request for Core personnel for the initial year of the Triennium is $497,794 which calls for 21 full time professionals and appropriate secretarial and clerical assistance. This compares to the original 01 year of $666,501 which supported staff for the nine institutional bases.

Five professional positions are now vacant, three of which are Regional representatives who will be expected to man the subregional areas operating out of the Director's office of the Community Health Programs Division. The other two vacancies include a Director of Educational Programs and a Chief of Program Development. Subregional offices are operative in four of the ten designated district areas of Texas, and other planning areas are scheduled to be manned during the coming year.

Since Dr. McCall's appointment as Coordinator in June 1969, the Core staff has been increased with capable and enthusiastic employees. The Region has established a viable program under its Division of Evaluation and Data Management, the Division of Professional Programs, the Division of Educational Programs, and its Division of Community Health Programs. Each of the Divisions has outlined measurable objectives for the coming year. Since June 1970, the staff has been augmented by the addition of a nurse, a business graduate, an economist, a hospital administrator, a former voluntary health agency executive, a mathematician, and a former pharmaceutical representative. An organization chart depicting the Core staff is found on the next page.

Three planning studies and two of the proposed new project activities will be administered under the supervision of Core staff. They include a data bank, a study to determine the feasibility of PASTEX (Texas Hospital participation in the Professional Activity Study /PAS/), a plan for a Regional Comprehensive Renal Disease Program, Project GRO, and an Electrical Hazards Project.

Numerous cooperative arrangements have been established by the TRMP. They can be found on pages 120-132 of the application.



ORGANIZATION CHART
REGIONAL MEDICAL PROGRAM OF TEXAS
1971-72

*These functions are being conducted by the individuals shown. The positions will be filled as qualified individuals can be recruited in 1971-72.

The total amount requested for Core activities is $716,343, exclusive of developmental component request. It includes:

Salaries	$497,794
Equipment	5,670
Supplies	8,100
Travel	56,400
Space Rent	49,809
Publication	25,800
Consultant	4,000
Communication	27,970
Computer	12,000
Feasibility	4,000
Planning for Renal Disease	20,000
Other	4,800
Total	$716,343 First Year Request of new Triennium

Second Year Request $803,219 Third Year Request $866,853

PROJECTS

Ten of the 16 project activity requests are scheduled for one more year of funding; three are scheduled for two more years and three projects are scheduled for three years of RMPS assistance. The new proposed projects have received funding priorities of #1, #3 and #10 by the Regional Advisory Group. These will be described first with the continuation projects described later in order of their funding priority. Project #50, a specific request for earmarked Kidney Program funds, described on Page 18 of this report, was submitted after this summary was started.

New Project Proposals:

Project #54 - GRO (Priority #1) First Year Request $75,000

This proposal, to be administered by Core staff, was developed from interest generated at the community level. Local cooperative planning groups were established which has led to the request for a local Coordinator of Health Services Resources. The project proposes to:

1. Organize several small community hospitals into three larger groups which would represent 32 hospitals with a bed capacity of 1,500. The three groups would consist of West Cross Timbers Council, Mid Trinity Valley Council and Northeast Texas Advisory Group.

2. Once organized, the three groups would arrange for educational teams from medical schools to visit their localities and offer training to physicians and allied health personnel.

An amount of $75,000 for each of three years is requested for salaries and expenses. By the end of the third year of RMP support, six self-supporting group programs involving 60 hospitals with health professionals delivering services associated with a 3,000 bed capacity are forecast.

Second Year Request $75,000 Third Year Request $75,000

Project #55 - Electrical Hazards (Priority #3) First Year Request $75,000

This three year proposal, to be administered by Core staff, has established the following objectives:

1. To provide hospitals and their administrative and professional staffs with information on hazards associated with medical electronic instrumentation.

2. To demonstrate methods for meeting the need to provide appropriate expertise and consultation to hospitals concerning potential and existing hazards in their critical care areas.

3. To determine health manpower needs in medical electronics.

4. To provide hospital personnel with pertinent data about the safe use and care of specific electrical equipment in critical care areas.

5. To determine a practical methodology for regular monitoring and surveillance of critical care areas.

The Texas Medical Association is a strong supporter of the proposal and assisted in its preparation. The Michigan RMP, currently funding a similar program was visited prior to the initiation of this application.

Second Year Request $56,000 Third Year Request $27,000

Project #51 - Helping Hospitals Organize and Strengthen Inhalation Therapy Patient Care Programs (Priority #10)

First Year Request $26,900

This project, which requests $26,900 for the first of two scheduled years, was approved by the February 1971 Council. It is the same project, except for georgraphic coverage, as #4 of the same title which was operational between July 1968 and September 1970. During the previous operating phase, the activity was administered by the Methodist Hospital. When support resumes, the Texas Hospital Association will be the sponsoring Agency.

Objectives Include:

1. To foster improvement of patient care by assisting interested hospitals in developing allied health personnel in inhalation therapy.

2. To establish relationships between those hospitals interested in organizing inhalation therapy departments and several key hospitals having outstanding inhalation therapy departments.

3. To provide basic knowledge of inhalation therapy, the organization and management of the unit, and the development of selected inhalation therapy trainees and others through a two-day institute.

4. To develop selected inhalation therapy trainees by providing their clinical resources for training in a two-week clinical setting.

5. To assist hospitals in organizing inhalation therapy departments by providing an inhalation therapy manual designed and developed specifically as a reference and guide in organizing and managing such a unit.

6. To continue to provide consultation and guidance in the development of personnel and/or facilities to those hospitals participating in the inhalation therapy training program.

Second Year request $26,500

Continuation Projects:

Project #36 - Interregional Cooperative Serial Control System (Priority #2)

This library project was supported this past year at a level of $28,001. It is scheduled for one more year of RMP support at $9,001 and should be self-supporting thereafter. The major objective for 1971-72 is to expand and improve the biomedical serial data base which was created during the first two years. A listing, entitled TALON (Texas, Arkansas, Louisiana, Oklahoma and New Mexico) Union list (meaning "union" of literature) has been published. The list includes 9,436 titles; a supplement containing 3,000 changes has been completed. A second edition of TALON will be published in July 1971.

Project #8 - Statewide Cancer Registry System (Priority #4)

This project was renewed and supported this past year for $87,123. It is scheduled for two more years of support at levels of $108,000 and $75,650, respectively. The following objectives are planned for 1971-72:

1. Test alternative methods of data collection and organization.

2. Develop a series of information subsystems for processing data.

3. Compile sample reports of several types appropriate to the purposes of a Cancer Information service.

This project was site visited by a technical team in August 1970. Its sponsor is the UT School of Public Health, Houston.

Although organizational progress was considered satisfactory, the site visit team may wish to explore progress in the study area (Health Planning area #9) and plans for statewide implementation.

Project #35 - Reduce Complications Following Radiotherapy (Priority #5)

This project, sponsored by the UT Dental Branch at Houston, was supported last year at a level of $38,566. Continued support for one additional year is requested for $35,000 to demonstrate effective methods of patient management and to emphasize the need for oral care of head and neck cancer. Progress denotes the project team conducted 14 meetings attended by 807 dentists, radiotherapists, radiologists, and head and neck surgeons. Seven hundred other individuals from other Regions also attended. The project published and distributed "Refresher Course" booklets concerning the various aspects of oral care for the head and neck patient and effectively demonstrated improved patient care through the development of a systematized program.

Project #46 - Expansion of Maxillofacial Prosthetic Services (Priority #6)

This project, sponsored by Baylor College of Dentistry, was supported last year at a level of $106,217. Continued support for one additional year is requested at $100,000 to (1) expand service and maxillofacial prosthetic services to three million persons as well as those residing in other areas of the Region; (2) continue the implementation of training programs for dentists and technicians to serve on head and neck cancer teams; and (3) increase patient care capabilities to a level of 400 patients per year.

According to the Region, the project has made reasonable progress in that it has significantly strengthened cooperative relationships and in doing so has implemented full prosthetic treatment of patients needing removable intra-oral and extra-oral appliances, has recruited three dentists for the training program and has increased its monthly treatment capacity from 33 to 40 patients. From September to December 1970, there were 234 patient visits, 52 appliances were delivered and 71 professional consultations were administered. The bulk of the funding requested is to be used for salaries and stipends.

Project #45 - Rehabilitation Management Through Coordinated Community Action - St. Elizabeth's Hospital (Priority #7)

This project, cosponsored by Baylor University and St. Elizabeth's Hospital in Houston, was supported last year at a level of $91,723. Support for one additional year is requested for $55,000, which will be used primarily for salaries. To date, the project has received three years' assistance. NAC approved it for four years.

The activity is geared to provide rehabilitation management for patients residing in the low income area of Houston. Progress denotes full implementation with 13 staff members and additional assistance from various community agencies. The project has initiated a plan to treat indigent patients and has developed an instrument to establish the nature and extent of residual physical impairment. The team provides medical evaluation, physical and occupational therapy, psychological evaluation and therapy, social work assistance, special therapy, vocational training, and financial assistance on an in and out patient basis. The project hopes to receive future support from other Federal sources when RMP funding is phased out in August 1972.

Project #37 - Health Careers Personnel Program (Priority #8)

This project, based in South Texas, was supported last year at a level of $65,762. Support for one additional year is requested for $77,000 to be used for salaries of project personnel and for travel. The primary objective for next year includes an intensive effort earmarked towards recruitment of Black and Mexican-American students to the health field. This activity is planned on a statewide basis with more concentrated efforts placed in the Houston-Galveston area, especially since the hospital association in this area has requested such.

The applicant notes that after a relatively slow start, considerable activity has been generated during the last five months of 1970. The Regional Project Director, based in South Texas, has addressed 6,589 secondary school students in assemblies, arranged hospital tours, and made visits to homes of interested students. The Black field representative has been active in counseling and recruiting in predominantly Negro schools. A plan for evaluating data gathered from the project is currently being formulated. The telephone counseling service has not been as effective as was originally anticipated but efforts will be continued to develop, analyze and test this service next year.

Project #6 - Medical Physics in a Regional Center (Priority #9)

This project, conducted at M. D. Anderson Hospital and Tumor Clinic, was supported last year at a level of $45,000. Renewal support is requested for one year at $20,000 which will be used to cover the salary of a physicist and his travel expenses. The project is expected to be self-

supporting by 1972. Plans call for a minimum of 15 site visits to various hospitals to establish dosimetry standards which will enable medical physicists to communicate more effectively with physicians.

Progress denotes that the State's medical physicists have formed their own organization, have conducted two workshops to promote the standardization of procedures, have developed a regional calibration facility, have made available thermo-luminescent dosimeters, on a weekly basis, for verification of exposure rate of therapy machines between calibrations and have provided other service activities within this subspeciality for 22 States and six foreign countries.

Project #20 - Eradication of Cervical Cancer in South Texas (Priority #11)

This project, conducted at the Medical School in San Antonio (UT) was supported last year at a level of $86,700. Support is requested for $20,000 for one additional year primarily to evaluate the data on hand for the purpose of defining an appropriate role of the computer in cervical cancer screening programs. This activity has provided for cytologic screening of a high-risk population in South Texas and has demonstrated the importance of a computer assisted records program. Since 1968, an average of 40,000 smears have been taken in 33 South Texas Counties. Follow-up has been made effective by the cyclic computer reminder system. Nurses and LVN's have been taught to administer the smear technique. Previous support has been received through 314(e) funds. Additional plans for next year are outlined on page 152 of the application.

Project #38 - Dial Access Telephonic Analysis: Medical Consultation Service (Priority #12)

This project, conducted at M. D. Anderson Hospital and Tumor Clinic, was supported last year for $19,963. Renewal support is requested for one year in the amount of $17,000 which will be used to update 100 tapes which are made available to physicians as an aid in the management of cancer patients. The system employed renders toll-free telephone calls of six to eight minute tape recordings of the most recent diagnostic and therapeutic information on specific neoplastic disease problems and situations.

Through December 1970, the project has serviced 2,339 physicians who have telephoned for information. Brochures have been mailed to 13,000 physicians and dentists throughout Texas. Louisiana physicians have recently begun to use the service. The program has been endorsed by the Texas Academy of General Practice; and an exhibit has been prepared and displayed at the National Osteopathic Association's Tenth International Cancer Conference.

Project #14 - Stroke Demonstration Unit (Priority #13)

This project sponsored by the Neurological Department of University of Texas Medical School at Dallas (Southwestern) was supported last year for $141,045. Two additional years of support are requested; $100,000 for each year. Objectives include the training of 100 or more nurses and LVN's per year in formal on-site workshops, one-day conferences for post graduate education for M.D.'s, two-week courses for family practice physicians, six-month fellowship programs for practicing physicians, evaluation of course content, and plans to evaluate the economics of operating stroke units for the benefit of smaller hospitals.

Progress through December 1970, denotes that the project has developed a special 22-bed stroke unit facility and has assembled a multi-disciplinary team of health specialists who have demonstrated to North Texas health professionals the latest techniques of RX and rehabilitation for stroke patients. Other factors include: (1) the addition of two beds to the intensive care unit; (2) 25 nurses have participated in the 5½ day training program; and (3) only two of 25 expected physicians have attended the one-day conferences. An evaluation of the nurse workshop program has been initiated.

Project #16 - Regional Rehabilitation Through Community Action - Wharton, Texas (Priority #14)

This project, cosponsored by Baylor and two community hospitals in Wharton, was supported in the amount of $67,708 this past year. One additional year of support is requested for $20,000 to make available complete rehabilitative services, provide training programs for hospital administrators, physicians and allied health personnel, develop a program which can become operationally independent and demonstrate the feasibility of providing services of this kind to other communities.

Progress denotes that 641 patients were given services during the reporting period, the size of the facility was increased by 8,000 square feet, program and patient evaluation, data collection and patient follow-up was made available, and the project has established a regional center for the improvement and enhancement of patient care to a community where this kind of service had not been previously available. Texas RMP has supported this project for three years.

Project #17 - Regional Rehabilitation Through Coordinated Community Action - Bihl Center, New Braunfels, Texas (Priority #15)

This project is cosponsored by the Department of Physical Medicine, University of Texas Medical School at San Antonio, and the Bihl Rehabilitation Center which services a three-county area. RMP support, in the amount of $46,185 was made available this past year. One more year's support is

requested for $20,000. After then, the New Braunfels Hospital is expected to continue the operation of the model program of the Bihl Center.

During the reporting period, 175 patients were treated which is fewer than expected. The decrease in anticipated admissions was caused, in part, by the difficulty in obtaining medicare funds. Forty formal instructional presentations were made to hospital and nursing home staffs. There were 30 training sessions for LVN's, attended by 150 persons. Patients are beginning to pay for services which will assist the self-supporting objective. Texas RMP has supported this project for three years.

Terminating Projects

Eight project activities and two Core supported feasibility studies will terminate with the close of this, the 03 year. Project activities include:

1 - Areawide Total Respiratory Care

The project provided respiratory care in twelve counties surrounding Houston and utilized the San Jacinto TB and RD Association facilities as back-up support to the sponsoring agency at Baylor University. It is anticipated that respiratory intensive care units will continue through local funding now that RMP support has been withdrawn.

2 - Annual Clinical Conference

This project, funded at $11,520 this past year, presented the 15th Annual Clinical Conference on "Progress in the Rehabilitation of the Cancer Patient" in Houston. Attendance totaled 372, including 52 persons from 25 other States and three foreign countries. M. D. Anderson Hospital and Tumor Institute was the sponsor for the past two years.

3 - A Beginning Program of CE for OT's

This project has been funded for two years at approximately $24,000 each year. It has created interest in stimulating Continuing Education for Occupational Therapists. By July of 1970, 140 of the estimated 400 OT's in Texas had been located and interviewed. Six one-day workshops along with the Annual TOTA Convention were held in Galveston in April 1971. Other workshops are scheduled. A new proposal with more innovative approaches to Continuing Education is being considered. Other sources of funding will be explored.

4 - Extending Coronary Care Nursing Training to Community Hospitals

This program has had considerable success in that 107 nurses had been trained in five hospitals, including one ghetto hospital in a predominantly Black area in Houston during the first year of operation. Only two hospitals had been planned originally which, together would have trained 20 nurses. Additionally, physician interest was stimulated leading to the training of 30 Black physicians. During the second year, five rural hospitals were conducting the program for 75 nurses. One group of ten hospitals and another comprised of nine hospitals have requested TRMP assistance in pursuing this kind of activity in the immediate future.

5 - Medical Genetics of Tumors

This program has identified a number of high risk families. Progress noted on page 164 of the Triennium Application is noteworthy. A plan for continuation is not indicated.

6 - Long Distance Telephonic Consultation

This project may have served to demonstrate the lack of interest on the part of physicians for continuing education opportunities utilizing what was considered to be a unique project designed to provide free consultative services via telephone to physicians within a one hundred mile radius of Dallas. Only three to four percent of those physicians eligible (1,441) actually used the services.

7 - Regional Consultation Services - Radio Therapy

Significant progress is noted in that 17,800 patients were treated with mega-voltage irradiation therapy at the M. D. Anderson Hospital since 1968, Hermann Hospital had had a total of 522 external beam irradiations and 39 interstitial irradiation new patients, and St. Joseph's had 355 external and 30 intracavitary irradiation new patients. Improved techniques, evaluation of equipment of advanced design and a system for the centralization of data which provides for access, retrieval and analysis were noted as further progress.

8 - Regional Rehabilitation Program - Kilgore, Texas

Progress has been considered above average. The program will be continued with local support.

Terminating Core Studies

The two terminating feasibility studies supported by Core included (1) the development of a physical therapy unit at the Uvalde Hospital which accomplished its objective; and (2) a study to determine the feasibility for developing an innovative training and educational program directed at correcting critical manpower deficiencies which the current educational system has been unable to alleviate. Although the need has been well documented in the area of training anesthesiology technologists, it is too early for the Region to forecast prospective results in establishing a program similiar to those now conducted at Case Western Reserve and Emory Universities. Since RMPS no longer will support this kind of activity, other Federal support will be sought if the educational system chooses to pursue this need.

Request for "Growth Funding"

In the addendum material submitted by the Region, projected "growth funding" is requested for the second and third years of the Triennium. The budget request includes $451,850 for the second year with the assumption that adequate numbers of good proposals will be submitted to the National Advisory Council one year from now. These proposals are expected to be generated from the Developmental Component activities. Budget projections have been made for each of the Program entities which include Community Health, Professional, and Educational Programs in an effort to determine a resource level for planning and development purposes. The RAG is specifying program priorities against which these potential resources can be budgeted. An amount of $753,000 is projected for the final year of the Triennium.

The Region stresses that Program emphasis will continue to shift from education to demonstration of health services and community action-based efforts. Education is expected to seek a level at which the TRMP can disseminate knowledge and assist cooperative education efforts without duplicating those services already being provided.

The RAG and its Committees have established the policy to concentrate on the development of community health demonstrations and will plan to implement them as soon as economically feasible.

Specific Request for "Earmarked" Kidney Disease Funds

Project #50 - Control of Hypertension and Chronic Renal Disease

First Year Request $120,000

This project activity is a resubmission for specific consideration for funding from those sources assumed to be earmarked for kidney disease proposals. It is understood that the request will not compete with other proposals in the application. Funding will not be implemented unless the total budget request, including this activity, will be funded to the Texas RMP.

The project was reviewed by the Kidney Disease ad hoc Panel in January 1971 and was referred to Council for a decision regarding the maximum length of time which RMP support could be obligated or projected. A specific answer has not yet been obtained, although the Region has been advised that funds, presently allocated to the TRMP, could be used for a short duration until other support could be found. In essence, this project has been considered as approved for one year only. The present request calls for three years of RMP support.

The project had been supported three years by the National Center for Chronic Disease Control and one year by the Moody Foundation. It is scheduled for seven more years of operation before final results of the study can be considered to be conclusive.

The target population in the study includes children who entered the primary school system four years ago. The same children will be followed for an eleven year duration.

The project has been designed to demonstrate:

1. That reduction in the number of future cases of hypertension and chronic renal disease can best be accomplished by early detection and appropriate therapy during the presymptomatic stages.

2. That since the presymptomatic stage for hypertension and chronic renal disease occurs early in life, school-age children comprise the ideal target population.

3. That incorporation into existing school health programs will provide the most feasible and acceptable system for delivery and early detection to that target population.

4. Developing predictors of hypertension and chronic renal disease.

5. Investigating community responses to a program for this control.

Second Year Request $124,300 Third Year Request $128,800

TEXAS REGIONAL MEDICAL PROGRAM

Projects Funded During 03 Year

Sept. 1, 1970-Aug. 31, 1971

NO.	TITLE	CURRENT BUDGET	BUDGET REDUCTION	AMENDED BUDGET
	Coordinator's Office (Including two feasibility studies $27,335)	$ 696,222	$ 96,085	$ 600,137
20	Eradication of Cervical Cancer in So. Texas	90,000	3,300	86,700
17	Reg. Rehab., UTSAMS - New Braunfels	48,000	1,815	46,185
46	Maxillofacial Prosthetic Services	110,287	4,070	106,217
16	Reg. Rehab., Baylor-Wharton	72,068	4,360	67,708
14	Stroke Demonstration Unit	151,000	9,955	141,045
35	Reduce Complications Following Radioth.	40,986	2,420	38,566
46	Rehab. Mgmt., Baylor-St. Elizabeth's	100,000	8,277	91,723
8	Statewide Cancer Registry	105,300	18,177	87,123
36	Library - Serial Control System	28,610	609	28,001
37	Health Careers	66,862	1,100	65,762
1	Medical Genetics	14,000	1,430	12,570
4	Cont. Ed. for Occupational Therapists	24,311	1,485	22,826
31	Long Distance Telephone Consultation	20,000	605	19,395
18	Reg. Rehab., UTSWMS - Kilgore	47,000	1,951	45,049
33	Coronary Care Nurse Training	64,915	2,365	62,550
39	Annual Clinical Conference	11,520	0	11,520
6	Medical Physics	45,000	0	45,000
38	Dial Access Telephonic Consultation	19,963	0	19,963
5	Regional Consultation, Radiotherapy	30,000	0	30,000
15	Community Respiratory Care	80,000	0	80,000
		$1,866,044	$158,004	$1,708,040

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: May 21, 1971

Reply to Attn of:

Subject: Staff Review, Triennium Application, Texas Regional Medical Program
May 14, 1971

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

THROUGH: Sam O. Gilmer, Jr., Acting Chief
Regional Development Branch, RMPS

Mrs. Sarah J. Silsbee, Chief
Grants Review Branch, RMPS

Gerald Gardell, Chief
Grants Management Branch, RMPS

Persons attending: Eileen Faatz, Grants Review Branch
Carol Larson, Continuing Education & Training
Charles Barnes, Grants Management Branch
Lee Teets, Grants Management Branch
Harold O'Flaherty, Planning & Evaluation Branch
Thomas Simonds, Management Assessment
Michael J. Posta, Regional Development Branch

A. Background

The Texas RMP is currently funded at $1,708,040 (d.c.) for its 03 operational year which terminates August 31, 1971. Of this amount $549,344 represents unspent second year funds reauthorized as carryover into the third year. Indirect costs approximate 30% of the above mentioned direct costs. These figures represent the current funding level of the 03 year after the 12% budget reduction was imposed in April 1971.

The subject Triennium Application requests:

1. Developmental Component for three years
2. Core and two new projects for three years
3. The initiation of one approved but not yet funded project
4. Eight continuation projects for one year; two projects for two years.
5. Two renewal projects for one year.
6. Specific request for "earmarked" Kidney Disease Program funds for one year.

The Region requests $1,714,244 (dc) for its initial year of its second Triennium. An amount of $120,000 is requested for the developmental Component which represents 10% of the current 03 year's funding level (minus carryover of $549,344). The Region expects the committed funding level to be increased after the current review cycle and projects increased amounts for the Developmental Component for its second and third years of the new Triennium.

B. Purpose of the Review

Since the Region is scheduled for a site visit on June 29-30, 1971, staff centered its discussion on issues which might be pursued by the visitors. Although a specific funding recommendation was not attempted, there was unanimous concern regarding the relatively low funding level forecast for Texas. To date, this Region has yet to be given a funding base which would allow for adequate future planning and development. Instead, carryover funds have been granted on a year to year basis. This problem was discussed at the Type 5 meeting last year, but since the Region was headed into its 03 year, carryover again was recommended by staff and received your approval. The April 1971, decision to fund RMP's on the basis of its "book commitments" has again placed financial pressures on this Region. Staff suggests that Texas be given special funding consideration for its new Triennial, assuming the site visitors' recommendations are favorable.

C. General Impressions

Staff members, particularly those who have visited the Region, are most impressed with the Program Coordinator and his enthusiastic and qualified Core staff. Recent staff visits concerning evaluation activities and management assessment reiterate the progress being made by the Region, especially in the overall direction and in its Core-centered activities.

There was some concern expressed relating to the Triennium application in that 11 of the 15 project activities requested are to be continued for one more year. This factor led to the question as to whether Texas is really ready for a Triennium Review. The application clearly states that a transition year is needed before new "1970 philosophy" can be implemented in its support of project activities. Aside from two new project proposals, to be administered by Core staff, there is very little basis upon which a funding recommendation can be made over a three-year period.

D. Issues Raised for the Site Visitors' Consideration

1. The grantee, the University of Texas System is a consortium of 17 State-supported educational institutions. Eleven members, representing its various schools, serve on the 50-man RAC and seven

serve on the 17-man Executive Committee. Staff is satisfied that the grantee does not monopolize funding strategy but the site visitors might wish to further investigate this possibility and suggest that the RAG and its Executive Committee reduce the number of grantee members to the extent feasible.

2. Consumer and Allied Health representation are lacking in both RAG and in the Executive Committee. Can these apparent shortcomings be alleviated in the near future?

3. There was some speculation that the Executive Committee was the only group given the responsibility of ranking the project activities by funding priorities. Since this Committee is primarily provider-oriented, staff asked a) how is the Executive Committee appointed; b) why can't the full RAG determine funding priority?

4. How does the RAG justify its position with respect to the fact that the vast majority of projects will be operational for one year only; where and how will the Program move in the future?

5. From a recent evaluation meeting in Texas, at the request of RMPS, staff noted that only one-fourth of the ongoing projects are being monitored. Can this ratio be improved? Will the RAG members be involved in the monitoring process?

6. The application does not address the topic of priority setting. What can be expected in the near future, especially if the developmental component request is approved?

7. The application does not contain a copy of the By-Laws. A copy will be obtained for each of the site visitors prior to the meeting.

8. From the Organization Chart on page 92 of the application and the general discussion concerning it, there was some question as to the reason for both a Division of Professional Programs and a Division of Educational Programs. Perhaps the site visitors might wish to further explore the etiology of this development. More specifically, what are the criteria for achieving program balance in these two areas? (See Figure 13, page 74 of the application.)

9. Although a number of good cooperative arrangements have been developed, response from the CHP agencies, relative to the review of this application, do not seem to indicate strong ties. This factor might be pursued further by the site visitors with particular reference to the "B" agencies already funded and those now in the planning phase.

10. Equal employment opportunity among minority groups appears to be evident in the projects funded, but is lacking within Core. Perhaps this point should be emphasized as a function of the Administrative Service Division and inserted into its operational objectives found on page 88 of the application.

D. Recommendation to the Director, RMPS

With your approval, this report will be included for the site visitors' information and will be attached to the yellow Summary Sheet made available to members of the Review Committee.

MJP

Michael J. Posta
Operations Officer
Regional Development Branch

Approved ___

Disapproved ___

Date 6/20/71

Harold Margulies, M.D.
Director, RMPS

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

TEXAS REGIONAL MEDICAL PROGRAM
RM 00007 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: Approval for two years only of the Texas Regional Medical Program at a funding level of $1,590,000, including the use of developmental funding.

DIRECT COST ONLY

YEAR	REQUEST	RECOMMENDED
04	$1,714,244	$1,590,000
05	1,882,519	1,590,000
06	2,035,653	-0-
TOTAL	$5,632,416	$3,180,000

CRITIQUE: The findings of the June 29-30, 1971, site visit were presented to the Committee by Dr. George E. Miller, former member of the Review Committee. The principal discussants were the primary and secondary reviewers who were members of the Review Committee itself. Dr. Miller presented the team's findings in the context of the past history of the Texas Regional Medical Program. He reminded the Committee that the program had begun initially with the intention of creating three Regions which were finally merged into a single statewide region with three subregions. He said the interrelationships in the early days were illustrated by the fact that the grantee was the University of Texas, Austin Campus, and the fiscal agent was the Texas Medical Center, with institutional planning staffs in each of the University of Texas medical schools, Baylor and M.D. Anderson Hospital. He recounted that after two years of planning, the site visitors studying the Region's application for operational funds, reported that the program seems to represent a loose confederation of special interests rather than a Regional Medical Program. The strong institutional interests did not adequately represent minorities, consumers, allied health professions or the practicing community. At the time of a site visit one year later in 1969, significant progress had been made in strengthening the central administration, largely through the appointment of a new full-time coordinator, who was establishing a central organization in Austin and planning to phase out the institutional planning units. Dr. Miller reported that by 1970 the strong central administration had been established and the University of Texas system had been named both grantee and fiscal agent.

The site visitors were much impressed by what they encountered in Texas in 1971. The visit was carefully planned, superbly organized and nicely run by the Coordinator and his Core staff. There was excellent and easily understood documentation of each presentation. In synthesizing their ideas and responding to the site visitors' questions, the Core staff gave evidence of high professional quality. It was also impressive to the team to have the Chairman of the Regional Advisory Group (a former president of the Texas Medical Association) not only present throughout the visit but an active and well-informed contributor to the discussion. Other significant Regional Advisory Group members were also present, some throughout the entire meeting.

The team found evidence that working relationships between the staff and the Regional Advisory Group were excellent and the Regional Advisory Group exercises significant influence in the policy and direction of the program. In addition, a number of individuals representing academic institutions, professional associations, comprehensive health planning groups, public and voluntary health agencies, individual practitioners, task forces and advisory groups had come from all over Texas to give supporting testimony to the site visitors about the importance of this program to the health services system of the state.

The team concluded that the Coordinator had managed an impressive shift from the institutional focus of the past to provider and community focus. The program has won enthusiastic and widespread support in most quarters including not only the medical professions but other health providers as well. The team found that the parochial interest which appeared to impede the initial development of the program are rapidly receding. It was also evident that the program is rapidly extending into a series of subregional organizational centers. This is to be the major thrust of the next program phase. Four of the ten health subregions in Texas are now covered by full-time Core staff members who are indigenous workers with impressive understanding of their local problems. A fifth subregional representative would have been appointed except for the budget cutback.

Despite evidence of significant progress, the site visitors found that at the decision-making level, the organization still appears over-balanced by physicians. Twenty-nine of 50 RAG members are physicians as are 12 of the 17 Executive Committee members. The only health professionals on the RAG are three dentists and two nurses. There are no other health professions represented on the Executive Committee. A previous management assessment visit felt that the grantee (University of Texas system) was overly represented on the RAG, but the strong and persuasive response from the Chancellor indicated that only two such persons represented the system while the others represented individual health education and health service institutions within the system. The team believes there is sufficient justification for this arrangement. Although important steps in securing minority representation on the RAG have been taken, additional efforts seem desirable to the team. In the

four major subcommittees there are no minorities represented and this certainly requires correcting. Site visitors also noted a paucity of minority groups on the Core staff.

While it is evident that the Coordinator and the RAG are giving serious attention to delivery problems in low service high demand areas, they still seemed to the team like ad hoc arrangements at this point in time. A program development committee of the RAG is working on the establishment and priorities and critieria but these are not yet available in other than the most general terms. A good review system has been established. It is difficult to decide which programs deserve support and which do not. The team felt there is no question but what progress has been made in this direction. The system has not yet been codified. The team found this of special concern in the face of the triennium proposal in which phase out of present project would make $450,000 available for future program development during the second year and $750,000 during the third year. The array of projects identified for funding during the next year were considered largely pedestrian and routine and represent the original program approach which is now being phased out. In the area of assessment of regional needs and problems, the team had some feeling that the process was more a central academic review than a peripheral involvement and input - a theoretical rather than a programmatic approach. The Core staff theoreticians are excellent but will need increased input from the emerging subregional organization and staff. Dr. Miller reported that program accomplishments thus far are rather modest; in fact, some of the projects (such as the Cancer Registry) are described by technical reviewers as little short of disaster. Nonetheless, there is perceptible achievement in at least one project (the about to be terminated coronary care nursing training); the outcome has been dramatic, not only in the involved institutions but also in their impact upon other institutions. The team did not look at individual projects as such.

An evaluation committee has been established in the RAG, headed by Dr. Stanley Olson, with technical assistance of a widely respected senior social psychologist at the University of Houston. The only significant evaluation effort thus far has been directed toward the above-mentioned coronary nursing training program. The team reported anecdotal evaluation by practicing physicians present at the site visit which were quite expressive of their understanding and appreciation of the program offerings. Dr. Miller summed up the site visitors conclusions as "well satisfied that very significant progress has been made in the Regional Medical Program of Texas and that extraordinary attitudinal and organizational changes have occurred under the leadership of Dr. McCall. The program offers high promise of substantial impact upon access to and delivery of health service in the Texas Region. The team feels it deserves strong support." The team recommended, however, that the Region not be provided three-year funding as requested in the absence of substantive program plans for the second and third year of the triennium. The team did feel that the developmental funding was well justified by the review

system developed, the Core staff available and the strong RAG. The team recommended that the Region be awarded $1,590,000 for each of two years including the requested $120,000 developmental component, with the understanding that there will be further program review at the end of the first year at which time they may wish to again submit a triennial application.

The Committee discussion following Dr. Miller's presentation was spirited. The Committee reviewers, having had the benefit only of the application, were somewhat skeptical about program progress and critical of the project proposals included in the application. However, Dr. Miller re-emphasized the team's feeling that significant changes had occurred in the RMP of Texas, changes that had resulted from earlier site visit recommendations such as the change from the institutional focus to the program focus.

The team concluded that the power structure behind and involved in the Regional Medical Program was impressive and was in a position to effect the change in program direction they are embarked on. Dr. Miller explained that it was with the help of the knowledgeable people on the RAG, that the Coordinator had been able to function in the positive fashion in which he had.

The Committee voted to accept the site visit recommendations which included funding at $1,590,000 for two years, including the developmental component. A site visit will be made in one year to see how the Region is progressing in its subregional program development, in including allied health professions on decision-making bodies, in adding representatives of the 25% minority population of the Texas Regional Medical Program on decision-making and other committees and in helping them play a construcitve role in program development.

Dr. Brindley was not present at the discussion of this application.

RMPS/GRB
7/15/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: July 6, 1971

Reply to Attn of:

Subject: Quick Report of Texas Site Visit, June 29-30, 1971

To: Director
Regional Medical Programs Service

THROUGH: Acting Deputy Director
Regional Medical Programs Service

The following consultants took part in the Texas site visit:

George Miller, M.D., Chairman
Alfred Popma, M.D., Mountain States Director, former Council member
Joseph Smith, M.D., Practicing Cardiologist, Connecticut RAG member
I. Jay Brightman, M.D., Coordinator, New York Metropolitan RMP

Staff members on the team were: Michael Posta, Regional Development Branch, who prepared all the site visit materials; Miss Carol Larson, Continuing Education and Training Branch; Harold O'Flaherty, Program Planning and Evaluation; Dale Robertson, DHEW Region VI, Dallas; and Mrs. Judy Silsbee, Grants Review Branch.

The meeting took place in the Texas RMP offices in Austin. Working staff of the Texas RMP were the primary spokesmen for the Region with members of the Executive Committee, RAG, Task Forces and the Coordinator participating as the need arose for clarification of their commitment and involvement in the process described by staff.

This mention of agenda format is significant as an indicator of the changes that have taken place in Texas. Three years ago when the Texas RMP first requested operational status, or even two years ago when a site visit reported that the Texas program would no longer require a yearly surveillance by Council, the agenda had to be presented by institutional representatives, either of the Core staff or categorical projects. There was no one spokesman for the Texas program because the program represented a loose confederation of competing institutional interests.

There has been remarkable progress in the past two years. The concentration on institutional interests and needs has given way to a concentration on the health needs of Texas without sacrificing the support and commitment of the educational institutions. There are

still strong proponents for the categorical medical center approach in Texas, but these interests have been neutralized by the support for a program emphasizing the needs of community hospitals and practicing physicians, backed by the resources of medical centers.

The attention of the Texas RMP is now focused on sub-regionalization. Ten areas, coterminous with CHP boundaries, have been designated for RMP development. Four of the areas are now staffed: the El Paso area, the Lower Rio Grande area, East Texas and Houston. The subregional staff are a remarkable group of people, with only one type of experience in common - firsthand knowledge of their areas. The El Paso representative, Mrs. Maria Elena Flood, is a Mexican-American, mother of eight, who has worked for years in hospitals and clinics in the area; she has no educational background but she has knowledge of the health needs and health resources in the area. Sister Strohmeyer, a former surgical nurse with graduate training in public health, has on-site experience with the problems and frustrations of the migrant workers and Chicanos of the Lower Rio Grande. Mr. Faulk, a former voluntary health association employee, is a native East Texan who not only speaks the East Texas dialect but understands the pace necessary to get down to business. The newest subregional staff member, Mr. Oxley, has been a drug representative in the Houston area for a number of years. The Region had hoped to employ another staff to work in the Lubbock area, but RMPS budget reductions made it impossible. However, Dr. McCall, the Coordinator, explained that plans for the Lubbock staff call for close association with the developing medical school (whose parent university is Texas Tech rather than the University of Texas), in contrast to the other staff.

While subregional staffing has been underway only for the past year, the shift toward subregional emphasis has been evolving since Dr. McCall became Coordinator two years ago. The central staff, recruited for the most part and developed by Dr. McCall, have been responding to local community interests in imaginative ways. For example, the coronary care training project staff amassed for a group of Black hospitals in Houston, has been providing consultation and training to several groups of small hospitals in rural areas, including an East Texas combination of predominatly white staffs. The proposed project, GRO, which was rated the highest priority by the RAG, has grown out of central staff efforts to provide specialized help in in-service education for small rural hospitals. By assisting several hospitals to form a corporation for joint purchasing and other services, the central staff has enabled the hospitals to develop funds from the resulting savings for in-service training. In turn, the medical institutions have been persuaded to provide training manpower for this purpose.

The team became convinced that the Regional Advisory Group has actively participated in the changes of the Texas program, and has provided

guidance to the staff at critical junctures. As an example, last Fall when the staff proposed a management approach to planning based on non-categorical programmatic objectives, the Executive Committee urged staff to test out the theoretical approach with practicing physicians and community hospitals before approaching the total RAG with the idea. The positive local response resulted in the appointment of RAG committees on Program Development and Evaluation.

The staff works well with the RAG and Task Forces, providing data and materials needed for policy.

The team was particularly interested to see how the staff provided data and other information for the new RAG committees on Program Development and Evaluation, and the receptiveness of these groups to staff contributions.

Another area of progress in the Texas RMP is the involvement and participation of practicing physicians at both the decision-making level and at the level of those on-going projects which the physicians feel help them with patient care. The Texas Medical Association, through both its physician officials and executive staff, is an active supporter of the Regional Medical Program. The fact that this has not always been the case is significant.

The team determined that a number of other key health groups, including CHP, the State Health Department, the nursing association, the hospital association and voluntary health agencies support the program. It seems that the Regional Medical Program has provided a forum in which occasionally dissenting groups could work together.

There are several areas that still need attention in Texas. The team recommends that the 1972 site visit pay particular attention to progress in the following areas:

1. The establishment of priorities under the new program direction.

   Texas is just turning its program around from one based on categorical and institutional focus to one based on subregional health care needs. It has made significant progress in reaching the turn-around, but it is still soon to see what the changes will mean in terms of priorities in funding.

   The review system that has been developed seems a good one, but it can't be tested until the priorities are established.

The approach to regional planning through objectives is conceptually very sound, but it needs translation into subregional activities based on priorities.

The team is confident that the Texas RAG and core staff will establish priorities meaningful for Texas within the next few months; but the 1972 site visit team will be in a position to judge the accuracy of their prediction.

2. Translation of interest in subregional development into specific programmatic goals.

Texas has recruited an imaginative group of subregional staff members, well-versed in local health needs and resources, but these staff need a great deal of help and support from the central staff and the RAG in developing subregional goals, objectives and specific activities. The team felt that one obvious suggestion was the development of local advisory groups, either in conjunction with CHP (b) agencies or under RMP auspices when that is not possible.

The team knows the Region must progress in this area by the time of the 1972 application and site visit because it is upon the subregional program development that the Region has staked its hopes for future funding.

The developmental funding recommended by the team should help in this development.

3. Increase of representation from allied health groups on major policy making bodies, including the Regional Advisory Group.

The Texas RAG is heavily represented by physicians in one capacity or another. Texas feels the physicians involvement has been a factor in acceptance of and involvement in the program and the team agrees that this has been important.

Texas feels that the involvement of allied health representatives on committees and task forces is critical, but the team urged them to place allied health representatives who have servedably in these capacities on decision-making bodies.

Several members of the Executive Committee stated they would be held accountable for changes in the representation.

4. Increase of representation from minority groups on major policy-making bodies.

Texas is committed to tackling health care needs of the poor - Chicanos and Blacks in the cities and migrant workers on the farms. There is representation from professional members of these groups, but the team urged the Coordinator to provide an opportunity for non-professional to become involved in the Texas RMP soon enough to be constructive in their participation. The team also suggested that a conscious effort on the part of the staff and RAG to allow their constructive contributions at the RAG level.

The Coordinator implied that this particular recommendation might be harder to achieve than the others but agreed to try.

Recommendation: The site visit team recommends that the Texas RMP be provided $1,590,000 direct costs for each of the two years to include developmental funding, with the understanding that:

1) A site visit will be made within the next year to study specific program activities to be proposed to implement the new focus on subregionalization and

2) Texas may elect to request triennial funding in 1972 when its three-year program plans are more specific.

This was a compromise evolved by the site team. The team was so impressed with the progress made in Texas that its inclination was to recommend three year level funding for the Program in the confidence that the RAG and the Core staff would use the funds in imaginative ways to help the most pressing health needs of the subregions.

But in the absence of either established priorities or specific activities proposed for the second and third years of requested funding, the team did not feel it could recommend three-year funding.

Hence, the compromise which in the team's mind will acknowledge the progress in Texas and provide motivation for accelerating the next phases of program development.

Sarah J. Silsbee

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN OPERATIONAL SUPPLEMENT GRANT APPLICATION
(A Privileged Communication)

TRI-STATE REGIONAL MEDICAL PROGRAM
Medical Care and Education Foundation Inc.
Two Center Plaza, Room 400
Boston, Massachusetts 02108

RM 00062 8/71
April 1971 Review Committee
May 1971 Council
August 1971 Council

ORIGINAL REQUEST 1/

Requested Program Period	01 6/1/71-5/31/72	02 6/1/72-5/31/73	03 6/1/73-5/31/74	Total
Direct Costs	$463,292	$368,595	$381,513	$1,213,400
Indirect Costs	-0-	-0-	-0-	-0-
TOTAL	$463,292	$368,595	$381,513	$1,213,400

REVISED REQUEST (See "Background" Below)

Program Period	9/1/71-8/31/72	9/1/72-8/31/73	9/1/73-8/31/74	Total
Direct Costs	$466,764	$369,880	$345,730	$1,182,374
Indirect Costs	-0-	-0-	-0-	-0-
TOTAL	$466,764	$369,880	$345,730	$1,182,374

1/ (The Summary of the original proposal is attached--pages 6 to 10)

History: In November 1970, Council reviewed the Region's total program and its Triennial application, and concurred with the favorable report of an October 1970 site visit. Council concluded that the Region had developed the capacity for self-determination; had set realistic, timely and acceptable goals and objectives; and had adequate decision-making processes as well as management and evaluation capabilities. Although the Council approved direct cost level of funding for the Region's Triennial application during the next three years is $2,261,685, $2,015,591 and $2,043,035, RMPS fiscal restraints will only permit funding and commitment for these periods at $1,817,632, $1,882,485 and $1,882,485.

Background: This application contains a single proposal which is a modified version of Project #13, New England Regional Kidney Program (NERKPRO). The original proposal was reviewed in April 1971 by both the Review Committee and the Ad Hoc Panel on Renal Disease. Since the two groups met simultaneously, the Committee did not have access to the Panel's recommendations. The Committee, however, was impressed with the proposal from a program point of view and recommended that additional funds be made available for NERKPRO, subject to a satisfactory technical review by the Ad Hoc Renal Panel.

In May Council concurred with the Panel's recommendation of deferral with a site visit. There were serious reservations as to whether the appropriate individuals within the six states had had ample opportunity to review the proposal in its final form to determine the degree of collaboration and cooperation that would be required; 2) the budget seemed extremely excessive; 3) the extent of participation by the Board of Governors could not be clearly determined; and 4) due to the magnitude of the program, further detailed evaluation of its many facets seemed warranted.

A site visit was made on May 24, 1971 by members of the Renal Panel and RMPS staff. The team was impressed with the support of the proposal by the NERKPRO Scientific Advisory Committee (Providers) and members of the Advisory Groups (third-party carriers).

Since the November 1970 submission of the proposal to RMPS, a number of important changes had occurred, including the decision of Connecticut to cooperate only in the Inter-Hospital Organ Bank of NERKPRO.

The team was concerned that the proposal as originally written did not clearly reflect the procedures of plans for the critical segments of the program, especially the expansion of transplant services. The greatest need existing in the New England Area is a significant increase in the number of cadaveric kidneys being procured. Further, the team believed that the RMP should: 1) reexamine the need for satellite tissue typing facilities; 2) reevaluate the educational programs proposed, including technical brochures and films; and 3) absorb the registry as part of the Inter-Hospital Organ Bank.

It was obvious that the proposal had stimulated a substantial amount of interest among providers and third-party carriers in New England. Considerable time and effort had gone into the development of the proposal. The site visit team recommended further deferral pending receipt and review of a revised proposal by the site visit team prior to the August 1971 Council meeting. The visitors believed that any other action could very well slow down, if not completely stop, the momentum and interest which has been generated during the last two years.

Present Application: This revision of the original proposal more specifically restates its goals and provides a clearer definition of method.

Goals and Objectives (Restated)

1. The goal of NERKPRO is to assure that no patient with end-stage kidney disease will die from lack of necessary services.

2. The long-range objective is to furnish to transplant units an adequate supply of cadaveric organs to satisfy patient needs, and to assist in developing mechanisms for funding of services to patients.

3. The intermediary objective is to develop an organization in the five-state region (Massachusetts, Maine, New Hampshire, Vermont and Rhode Island) which will procure the cadaveric organs needed for transplantation, and to identify the main problems in funding so that programs can be developed to solve them.

As originally stated, the goal was to establish the New England Regional Kidney Program to assure that no person will die of kidney failure because of a lack of funds, or lack of a plan to be treated on knowledge of what is available.

In the original proposal, support was requested for the training of: 1) Dialysis Nurses; 2) Transplant Nurses; 3) Dialysis Technicians; and 4) Tissue Typing Technicians and for continuing education: 1) Nurse Consultants in Dialysis and Transplantation were to be available for any program in the region to assist with specific problems, demonstrate new techniques to remote centers, and act as advisors to areas starting new programs; 2) An annual two-day workshop on new developments in dialysis and transplantation was to be held for nephrologists, transplant surgeons, immunologists, nurses and technicians; 3) short (up to two weeks) individual training courses to update skills will be sponsored.

The revised proposal eliminates the training program for technicians, nurses and physicians, as suggested by the site visit team. Also, eliminated is the request for funds for audiovisual teaching materials since film production is expensive and films along with brochures have limited usefulness.

The originally requested support for the registry is eliminated. The RMP states that registeries are records kept in a particular format for purpose of future reference and research. They should be an integral part of the organ bank and funding desk and do not require separate budgeting.

Originally it was planned to establish three IOB tissue typing satellite laboratories. The NERKPRO Executive Committee has decided that each region will make its own judgement on the necessity for tissue typing. The request for support for satellite tissue typing is eliminated in the revised proposal.

New Items Proposed in Revised Proposal

Procurement Physicians: As suggested by the site visit team, it is proposed to use the services of physicians at the level of assistant professor in a university hospital to increase the supply of cadaveric organs. Seven members of active transplant centers in the New England region will be selected by the Executive Committee of NERKPRO. Support is requested for 50% time of each physician. One procurement physician will be located in each of the following: Maine; Burlington, Vermont; Providence, Rhode Island; Massachusetts General Hospital, Boston; Boston City Hospital; Peter Bent Brigham Hospital, Boston; and Boston University - V.A. It will be the function of these physicians to formulate and initiate programs for the procurement of cadaveric organs from hospitals in their area. A detailed description, their functions are presented on pages 16-18 of the revised application.

Local Coordinators: To reinforce the physicians working at the professional level would be a counterpart among the laity. Support is requested for 5 full-time local coordinators whoes main purpose would be the education of the public in the importance of donating organs, and in directing the attention of the public and lawmakers to their duty in supporting programs dealing with kidney disease. A coordinator would be located in Maine, Massachusetts, Rhode Island, New Hampshire, and Vermont. A coordinator's job description is given on pages 20-21 of the revised proposal.

July 16, 1971 Review of Revised Proposal by Site Visit Team:

In their review of the revised proposal July 16, 1971, the site visitors were favorably impressed with the revised application. Its positive reflection of most of the recommendations proposed at the May 24 site visit results in a realistic program which can be achieved.

Recommendation: The site visitors recommend approval of the Tri-State NERKPRO application (Project #13) with a modified budget. The proposed budget is considered extravagant in some aspects, and it does not reflect as direct a decremental RMPS funding schedule as the site visitors would prefer and believe to be practical with growing potential sources of future funds. The site visitors consider the application from Vermont to be complementary to the NERKPRO program. Should Council also approve the application from Northern New England (Vermont), the site visitors have recommended deletion of several positions from NERKPRO application which would be duplicative in the overall Tri-State operation.

With these modifications, the site visitors recommend that the NERKPRO be approved with a first year budget approximating $308,000*, with the succeeding two years reflecting a 30 percent reduction in personnel costs from the first year. The recommended budget estimates are:

	01*	02*	03*
Personnel	$257,766	$172,000	$86,000
Other	50,234	33,000	33,000
TOTAL	$308,000	$205,000	$119,000

* Excludes Vermont positions

RMPS/GRB/7/20/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN OPERATIONAL SUPPLEMENT GRANT APPLICATION
(A Privileged Communication)

TRI-STATE REGIONAL MEDICAL PROGRAM
Medical Care and Education Foundation Inc.
Two Center Plaza, Room 400
Boston, Massachusetts 02108

RM 00062 5/71
April 1971 Review Committee

ORIGINAL PROPOSAL

Requested Program Period	01 6/1/71-5/31/72	02 6/1/72-5/31/73	03 6/1/73-5/31/74	Total
Direct Costs	$463,292	$368,595	$381,513	$1,213,400
Indirect Costs	-0-	-0-	-0-	-0-
Total	$463,292	$368,595	$381,513	$1,213,400

History: In November 1970, Council reviewed the Region's total program and its Triennial application, and concurred with the favorable report of an October 1970 site visit. Council concluded that the Region had developed the capacity for self-determination; had set realistic, timely and acceptable goals and objectives; and had adequate decision-making processes as well as management and evaluation capabilities. Although the Council approved level of funding for the Region's Triennial application during the next three years is $2,261,685, $2,015,591 and $2,043,035, RMPS fiscal restraints will only permit $1,722,474 funding and commitment for these periods.

Present Application: The application contains one kidney disease project, which is also to be reviewed by an RMPS Ad Hoc Panel on Renal Disease on April 14-15, 1971.

Project #13 New England Regional Kidney Program
Submitted by the Tri-State RMP, this three-year project proposes to establish the New England Regional Kidney Program (NERKPRO) to assure that no person will die of kidney failure because of a lack of funds, or lack of a plan to be treated on knowledge of what is available. The proposal is in three parts.

Part I - A general introduction documenting need and resources.

As a result of a recent series of meetings sponsored by the Tri-State RMP, a group of leading nephrologists and other interested persons joined to develop NERKPRO. (See Apendix X: Minutes of NERKPRO Meetings - Durham, New Hampshire; pp. 107-138). There is general agreement that NERKPRO must meet several basic

needs: 1) a present need for more cadaver organs; 2) the need for larger pools of prospective donors and prospective recipients; 3) professional training programs are needed for physicians, nurses and technicians in the fields of hemodialysis, organ harvesting, organ transplantation, and tissue typing.

Boston and New Haven are major transplant centers, and others are in the process of being developed in the region. Transplant centers are also centers for professional education and training in kidney disease. In addition, Boston is the location of the Interhospital Organ Bank (IOB), a clearinghouse for matching cadaver organs with potential recipients.

NEW ENGLAND FACILITIES FOR END-STAGE KIDNEY DISEASE

Central Support:

Interhospital Organ Bank
Massachusetts General Hospital
Boston, Massachusetts

Dialysis Units:

Boston

Boston City Hospital
Lemuel Shattuck Hospital
Massachusetts General Hospital
Peter Bent Brigham Hospital
University Hospital
Veterans Administration Hospital
St. Elizabeth's Hospital

Other Massachusetts

Babcock Street Unit, Brookline
Lakeville Hospital, Lakeville
North Shore Regional Dialysis Unit, Beverly
Springfield Hospital, Springfield
St. Joseph's Hospital, Lowell
Worcester Memorial Hospital, Worcester

Maine

Maine Medical Center, Portland

Connecticut

Yale-New Haven Hosp., New Haven
Hartford Hospital, Hartford
Veterans Administration Hosp., West Haven
Bridgeport Hospital, Bridgeport
St. Vincent's Hosp., Bridgeport
Danbury Hospital, Danbury
Waterbury Hospital, Waterbury
Hospital of St. Raphael, New Haven

Transplant Centers:

Operative

Boston City Hospital
Harvard and B.U. Services
Massachusetts General Hospital
Peter Bent Brigham Hospital
University Hospital
Veteran Administration Hospital

Yale-New Haven Hospital

Part 2 - An application for funds to finance regionalization of the operations of the Inter-hospital Organ Bank.

Reorganization of the IOB is a major component in the development of the NERKPRO program. The "bank", a non-profit organization, is actually a center for information, expertise, the performance of technical functions (tissue typing), and administration of organ allocation. Major functions of the IOB include: 1) Education and information efforts, primarily with physicians, to encourage the "harvesting" of cadaver organs suitable for transplantation; 2) Operation of a central office: (a) serving as a communication center through which information on organ availability, suitability, and demand can be exchanged, (b) maintenance of a central registry of persons awaiting transplant and of potential donors, and (c) administration of a system for determining the allocation of cadavar organs available among the patients awaiting transplant, using information determined by central serotyping laboratory; and 3) operation of a central serotyping laboratory.

The IOB is currently supported under a contract from the Kidney Disease Control Program, RMPS, and funds from the Massachusetts Department of Health. The IOB has begun charging fees for serotyping, and is negotiating with third party payers to make these and related costs reimbursable. The IOB is in the process of expanding the field of operation to serve the entire New England region. Financial assistance is needed to support the IOB during this transitional stage when: (1) the IOB is expanding its physical capacities, geographic coverage, and training activities, (2) support from the Kidney Disease Program, RMPS is being phased out, and (3) income from fee-for-services is not yet sufficient to support these operations on a full or regular basis. (Pages 47-53 of the application describe steps to be taken to facilitate expansion of the IOB.)

A total of approximately $166,000 is requested for the first year support of the IOB as follows: $128,289 personnel; $22,524 supplies; $15,300 equipment.

Part 3 - Describes the steps to be taken in developing the remainder of the program components so that at the end of the grant period, a coordinated regional program will exist.

The development of the program will be administered by George L. Bailey, M.D. with the advice of NERKPRO, its Scientific Advisory Committee and other committees. In addition to the IOB, other program elements will be developed as follows:

Development of Programs and Standard Setting: NERKPRO through its Scientific Advisory and other committees will offer advice to any group contemplating development of a kidney program (Pages 28-29).

Professional Training: Is discussed on pages 29-35 of the application. The applicant notes that present RMPS guidelines exclude the support of physicians fellowships. If funding becomes available, a fellowship training program in nephrology or transplant surgery would be implemented. Support is requested for the training of: (1) Dialysis Nurses, (2) Transplant Nurses, (3) Dialysis Technicians, and (4) Tissue Typing Technicians.

Continuing Education: (1) Nurse Consultants in Dialysis and Transplantation will be available for any program in the region to assist with specific problems, demonstrate new techniques to remote centers, and act as advisors to areas starting new programs. (2) An annual two-day workshop on new developments in dialysis and transplantation will be held for nephrologists, transplant surgeons, immunologists, nurses, and technicians. (3) Short (up to two weeks) individual training courses to update skills will be sponsored.

Organ Procurement: Lay and Physician Education: As presented on pages 33-35, this would involve: (1) Training organ harvesting teams, (2) educating the general public to increase their willingness to be donors and recipients, and (3) increasing the awareness of the physician in general practice concerning the desirability and practicability of treating end-stage kidney disease.

The Funding Desk (Pages 36-43): This desk would serve three basic functions: (1) Serve as a clearinghouse for information concerning presently available sources of financing; (2) collect data on third-party payer experience with reimbursement for kidney disease and other catastrophic conditions, and would develop proposals for more systematic funding of these conditions; (3) undertake special investigations into the impact of prospective changes likely to effect financing of end stage kidney disease over the next few years.

Registry of NERKPRO (Pages 44-46)

The registry functions would include:

1. Maintenance of an up-to-date registry of all potential cadaveric transplant recipients in order to provide the necessary information for the equitable sharing of cadaver organs.

2. Registration of all live related donor transplants for purposes of follow-up on success rate, funding profile, statistics, etc.

3. Registration of all dialysis patients indicating whether center, satellite or home; source of funding; location; etc.

4. Registration of every physician, nurse, or technician trained in dialysis, transplantation or tissue typing in New England.

5. Registration of every dialysis and transplantation facility noting their patient capacity, training capacity and costs.

A total of approximately $297,000 is requested for this part of NERKPRO (does not include IOB costs) as follows: $74,829-personnel; $5,000-consultants; $7,360-furniture; $16,000-travel; $142,200-training and continuing education; $19,270-rent and telephone; $11,020-postage and special transportation; and $21,500-computer time and fees for harvesting organs.

The Appendices of the application contain copies of 52 letters of support and participation; by-laws, rosters and other information for the IOB; Teaching Protocol for Twin-Coil Machine Dialysis; Funding of Renal Patients in New England; Minutes of NERKPRO meeting; and curriculum vitae of key personnel.

RMPS/GRB 3/9/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF ANNIVERSARY REVIEW AND AWARD GRANT APPLICATION
(A Privileged Communication)

Virginia Regional Medical Program
700 East Main Street
Richmond, Virginia 23219

RM 00049 8/71
July 1971 Review Committee

Program Coordinator: Eugene R. Perez, M.D.

The region currently in its second year of operation, is funded at a level of $673,037 direct cost. In addition, the region has received $63,718 of indirect costs which represents an average indirect cost rate of 9.4 percent. On 3/1/71 the VRMP broke away from their grantee, The Medical College of Virginia and has become a corporate body. The region will be submitting its anniversary review application in the November 1971 review cycle.

The region has requested in this supplemental application $795,155 for three years support of Project #13 - A Comprehensive Program for the Control of End Stage Kidney Disease in Virginia. The sponsor is the Medical College of Virginia and the project director is David H. Hume, M.D.

Project #13 - A Comprehensive Program for the Control of End Stage Kidney Disease in Virginia. This proposal was initially submitted as Project #12-Procurement of Cadaver Kidneys for Transplantation in the February 1971 review cycle. Based on the technical deficiences identified by the RMPS Ad Hoc Panel on Renal Disease the Council deferred action in order to obtain additional information relative to commitment of cooperating institutions, definition of budget and clarification of objectives and methodology.

	First Year Request
	$251,341

In follow up to Council's recommendation a site visit to the Virginia RMP was conducted by staff on April 9, 1971. The concerns expressed by Council were discussed with representatives of the VRMP and the two medical schools of Virginia. As a result of this meeting the VRMP has established a categorical committee on dialysis and organ procurement.

This proposal is a comprehensive approach to provide services to patients with end stage renal disease. It is expected that this program will increase the dialysis capability in the region, provide training, improve the availability of cadaver organs for transplants and develop a state-wide public education program in all aspects of kidney disease.

Second Year: $264,149 Third Year: $279,665

GRB 6/11/71

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION
OF JULY 1971 REVIEW COMMITTEE

VIRGINIA REGIONAL MEDICAL PROGRAM
RM 00049 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

Recommendation: Approval with reduced budget. Recommended that RMPS staff visit the project to clarify the capacity and relationship of existing dialysis facilities and negotiate RMPS support on the basis of concepts expressed in the review and contained in renal disease application guidelines. The basis for patient selection, support for continuity of unit operations, and MCV backup should be specifically identified. It is suggested that no equipment or supplies be funded, but only personnel; i.e., 3 nurses (one more than requested), janitorial, and physician to assist handling the non-paying patients in the new limited care unit for paying patients. The following recommended level of funding represents what staff should use as a basis for negotiation.

	Recommended Funding (direct costs)		
	01	02	03
Physician (33%)	10,000	6,000	--
Three Nurses	28,883	20,000	12,000
Custodial (part-time)	1,000	1,000	1,000
Estimated Total Direct	39,833	27,000	13,000

Critique: The Committee concurred with the conclusion of the Ad Hoc Panel on Renal Disease and noted that the Panel was impressed with both the scope and the problems represented in the Virignia renal disease program. It generally agreed with the concepts presented in the application.

While computer costs related to cross-matching were considered reasonable, it appeared that they should be deleted from the application. This would hopefully establish a trend to halt piecemeal requests for computers, which would more properly be proposed for regional, or multi-regional application. A recommendation was made to the KDCP relative to possible continued contract funding for computer use in tissue typing development. Consideration was given to the need of the Region to begin charging for some "service" portions of tissue typing work. This is underscored by the absence of Title XIX support in Virginia, augering for development of local sources of funds.

The request for organ procurement program appeared too high and suggests a request for support for capabilities which already exist. The KDCP is funding a cadaver organ procurement project over three years, the third year recently negotiated at $109,000. The proposed fees ($100) for private physicians as organ procurers appeared reasonable but administrative physician salaries were considered appropriate for support only on a decremental basis, toward encouraging development of other sources of support. It was suggested that these physicians costs be included at successive levels of the requested rate for the first year, at 50% in the second year, and excluded from grant support in the third year. A decremental Federal support pattern should be brought to the Region's attention.

The Panel report states that the demonstration of a new type of satellite facility was not appropriate for grant support. It also was persuaded to question wheter increased home dialysis training might not be better accomplished by expanding existing facilities at Richmond and Charlottesville. Doubt was expressed on the suitability of developing patient self-dialysis to be performed in the satellitedialysis units. The proposed increase in dialysis patients was questioned in view of the expressed objective to increase transplantation. While basic problems were recognized with respect to Charlottesville, Richmond and the Norfolk area, the proposals in the application will not resolve Regional problems of cooperation and coordination of facilities.

The request to fund professional and paramedical personnel training through the satellite units rather than developing patient home training was considered inappropriate. Reviewers felt the Federal support responsibility lay in providing for those items which could not be recouped through other sources. To accomplish this it was recommended that support for personnel and urging that supply costs of indigent patients be met through charges levied on paying patients.

The request to fund a second satellite unit for indigent patients, while another unit is now being opened for paying patients, was considered extravagant. It is felt that one unit could serve both populations, with support.

RMPS/GRB/7/16/71

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY OF AN ANNIVERSARY TRIENNIUM GRANT APPLICATION
(A Priveleged Communication)

Wisconsin Regional Medical Program
110 East Wisconsin Avenue
Milwaukee, Wisconsin 53202

RM 00037-05 8/71
July 1971 Review Committee

Program Coordinator: John S. Hirschboeck, M.D.

This Region is currently funded at $1,554,640 (direct costs) for its fourth operational year ending August 31, 1971. The Region currently receives indirect costs of $300,488 which is 19.3 percent of the direct cost of the award. The Region submits a triennial application that requests:

I. A Developmental Component
II. Renewal of Core activities
III. The continuation of four ongoing activities
IV. The renewal of three activities
V. The implementation of four Council approved/unfunded activities
VI. The implementation of five new activities

The Region requests $1,917,076 D.C. for its fifth year of operation, $1,509,777 for its sixth year and $1,084,858 for its seventh year. A breakout chart identifying the components for each of the three years follows on pages 2-4. This Region was site visited in December 1970 in relation to its developmental request. Because of this, another site visit to the WRMP was not scheduled at this time. Staff, during its preliminary review of the application, noted that the Region has made considerable progress in the areas of program planning, developing objective methods of its evaluation procedures, and is now shifting its emphasis toward program development rather than the solicitation and encouragement of independent projects, as in the past.

It was further noted that the Region has begun to strengthen and expand its subregionalization efforts and is moving toward further development of collaborative relationships with the areawide health planning agencies in the Region. The Region is also in the process of expanding the present three-member corporation, the governing body of WRMP, to a total of nine.

Staff in its review also expressed concern regarding the following:

1. Lack of racial minorities represented on core and project staff.
2. Inadequate representation from the black community on the RAG.
3. Lack of evidence regarding sources of future funding for certain project activities upon termination of RMPS funding.
4. Lack of information regarding income generated from project activity.

REGION Wisconsin
CYCLE RM 00037 8/71

BREAKOUT OF REQUEST 05 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)			
IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREV. FUNDED	NEW, NOT PREV. APPROVED	1st YEAR DIRECT COSTS	INDIRECT COSTS	TOTAL
Core		495,675			495,675	80,570	576,245
00-Developmental				140,000	140,000	60,000	200,000
#5B-Dial Access-Library Service - Nurses	18,600				18,600	4,364	22,964
#5C-Single Concept Films Project	15,500				15,500	5,940	21,440
#6-Radiology		95,200			95,200	39,144	134,344
#12-Uterine Cytology		50,820			50,820	17,765	68,585
#13A-Inactive Nurse			66,500		66,500	21,175	87,675
#15-Comprehen. Renal	469,234				469,234	79,726	548,960
#16-Medical Library		1,525			1,525	--	1,525
#17-Nurse Utilization	130,890				130,890	43,300	174,190
#18A-Medical College of Wisconsin Manpower			57,965		57,965	9,025	66,990
#22-Community-Oriented Rehabilitation			54,341		54,341	--	54,341
#23-Cardiac Intensive Care Nursing			97,177		97,177	15,246	112,423
#24- CARE				28,945	28,945	3,300	32,245
#25-Unassigned							
#26-Nurse Associates				116,901	116,901	50,325	167,226
#27-Unassigned							
#28-Diagnosis & Therapy Criteria Review				23,000	23,000	9,625	32,625
#29-Unassigned							
#30-North Central Out-reach				12,862	12,862	--	12,862
#31-South Side Health Contact Center				41,941	41,941	--	41,941
	[illegible]	643,220	[illegible],983	363,649	1,917,076	439,505	2,35[illegible]81

REGION Wisconsin

BREAKOUT OF REQUEST 06 PROGRAM PERIOD

(Support Codes)	(5)	(2)	(3)	(1)	
IDENTIFICATION OF COMPONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	2nd YEAR DIRECT COSTS
Core		531,973			531,973
00- Developmental				140,000	140,000
#5B					
#5C					
#6					
#12					
#13A					
#15	469,234				469,234
#16					
#17					
#18A			57,965		57,965
#22			57,428		57,428
#23			83,007		83,007
#24				28,945	28,945
#25 Unassigned					
#26				118,225	118,225
#27 Unassigned					
#28				23,000	23,000
#29 Unassigned					
#30				--	--
#31				--	--
	469,234	531,973	198,400	310,170	1,509,777

REGION Wisconsin

BREAKOUT OF REQUEST 07 PROGRAM PERIOD

upport Codes)	(5)	(2)	(3)	(1)		
TIFICATION OF ONENT	CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT	CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT	APPROVED, NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3rd YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
e		571,700			571,700	1,599,348
Developmental				140,000	140,000	420,000
3						18,600
						15,500
						95,200
2						50,820
3A						66,500
5						938,468
6						1,525
7						130,890
8A			57,965		57,965	173,895
2			62,016		62,016	173,785
23			83,007		83,007	263,191
24				28,945	28,945	86,835
25 Unassigned						
26				118,225	118,225	353,351
27 Unassigned						
28				23,000	23,000	69,000
29 Unassigned						
30				--	--	12,862
31				--	--	41,941
			302,988	310,170	1,084,858	4,51[illegible]

FUNDING HISTORY

PLANNING STAGE

Grant Year	Period	Funded (d.c.)
01	9/1/66-8/31/67	$319,458

OPERATIONAL PROGRAM

Grant Year	Period	Council Approved	Funded (d.c.)
01	9/1/67-8/31/68	$539,366	Core 415,093 Proj.183,773
02	9/1/68-8/31/69	1,365,463	Core 438,974 Proj.723,707
03	9/1/69-8/31/70	1,338,194	Core 438,974 Proj.800,536
04 *	9/1/70-8/31/71	1,794,257	Core 411,689 Proj.1,142,951

* Reflects 12% reduction imposed on all RMPS programs.

Geography and Demography: The boundaries of the Wisconsin Region are coincident with those of the State. The University of Wisconsin Medical School sphere of medical care influence includes parts of Minnesota, Iowa and Illinois; similarly, the Marquette University School of Medicine has medical care influence in the Michigan peninsula and part of Illinois. The population is approximately 4.5 million with over 50% residing in the six metropolitan areas of Duluth-Superior, Green Bay, Kenosha, Madison, Milwaukee and Racine. About 66% of the population is urban and 96% white. The median age is approximately 29.4 years.

The Region has two medical schools - the Medical College of Wisconsin in Milwaukee with an enrollment of approximately 416 (88 graduates) and the University of Wisconsin Medical School in Madison with an enrollment of 409 (92 graduates). There is one school of pharmacy, a dental school, 25 professional nursing schools (10 of which are based at colleges and universities), 12 practical nurse training institutes, 3 schools of cytotechnology, 35 schools of medical technology, 30 schools of radiology technology and 2 schools of physical therapy.

Hospital facilities include two V.A. hospitals, 8 long-term hospitals, 158 short-term hospitals, 353 nursing homes and 65 long-term care units with a combined total of 55,278 beds.

The Region has 4,700 active (non-Federal) medical physicians and osteopaths, 14,084 actively employed nurses and 3,996 LPN's.

Regional Development In April 1965, both the University of Wisconsin and Marquette University submitted separate applications which were considered by the National Advisory Council on Regional Medical Programs, and were deferred with the suggestion that a revised application be submitted. It was further suggested that cooperative arrangements would be enhanced through closer collaborative efforts between the two medical schools. During the interim between April 1965 and July 1966, the Wisconsin Regional Medical Program, Inc., was formed as a collaborative venture by the Marquette School of Medicine and the University of Wisconsin. The corporation is controlled by the Presidents of Marquette University and the University of Wisconsin. Management of the Corporation is vested in a 9-member Board of Directors with a broader representation which includes the State Medical Society of Wisconsin, the Wisconsin Hospital Association and consumer interests. Dr. John S. Hirschboeck was elected secretary and appointed Regional Program Coordinator who is appointed by the Board of Directors. The Program Coordinator is directly responsible to the President of the corporation. The Board of Directors also appoints the Regional Advisory Committee and its chairman.

In July 1966, the Wisconsin Regional Medical Program, Inc. submitted a revised 2-year planning grant application which was reviewed and approved by Council for the period September 1, 1966 - August 31, 1968. After one year of planning activities 9/1/66 - 8/31/67, the second year planning grant was merged with the first year operational grant. The Region became operational following a preoperational site visit in July 1967. The second year (9/1/67 - 8/31/68) ward provided continued support for Core planning and administration, plus support for three feasibility studies (two in dial access tape libraries, and one for single concept films). In addition, funds were provided to support three operational projects. These were in Uterine Cancer Therapy, Pulmonary Thromboembolism and Cancer Chemotherapy for adults.

During its third year, 9/1/68-8/31/69 (second operational), the Region received approval for the renewal support of Core planning and administration. Also during this period the Region submitted a request for the support of nine new operational projects contained in two separate applications. A site visit was held during November 11-12, 1968 to review these projects and to review the regionalization process as it was developing in the Region. In general, the visitors were satisfied with the development of the Region but expressed the following concerns:

1) Role and composition of the RAG. It was suggested that this group take a more vigorous role in the identification of regional goals. It was believed that the addition of more consumers would add strength to this group.

2) Role of assistant coordinators in the medical schools.

3) The Region's emphasis on the engineering approach to planning. It was believed that this activity should be augmented by the addition of other groups such as epidemiology, preventive medicine, etc.

4) The fragmentation of the continuing education efforts. Seven of the 9 projects were recommended for funding.

During the fourth year, 9/1/69-8/31/70 (third operational) the Region received approval for the following projects: a Comprehensive Program in Renal Disease; Cardiopulmonary Resuscitation Project; Medical Library Service; Nurse Utilization Demonstration Unit; and two years renewal support for Dial Access Library Service for Physicians; and three years renewal support for Dial Access Library Service for Nurses and Single Concept Films Project.

In August 1970, staff reviewed a request from the Region for the fourth operational year, 9/1/70-8/31/71. The request was for the continued support of Core ($438,974) and twelve ongoing projects. The request was comprised of the total committed support of $965,444 and carryover in the amount of $60,704 as partial support for two approved projects; #16 - Medical Library Service and #17 - Nurse Utilization Demonstration Unit. Approval of continued support in the amount requested for the fourth year was recommended.

A site visit was conducted on December 11-12, 1970 to assess the Region's readiness to utilize developmental funds requested in an application, submitted during October 1970; to review the overall program progress of the Region; and to evaluate project and core activities in terms of their relationships to overall program goals and objectives. The site visitors agreed that the WRMP has demonstrated that it has the machinery, expertise and local autonomy to successfully and prudently administer and use a developmental component, and recommended that that developmental component be awarded for approximately $160,000 for one year. The site visitors also recommended that the Region should:

1) Continue its sub-regionalization efforts. The establishment of an "RMP" desk in selected CHP Regions, Assignment or appointment of a part-time community coordinator in the Marshfield Clinic and the University Extension Service were seen as possible solutions.

2) Expand and augment the three-man corporation (perhaps to a total of nine) which might include representatives of the State Medical Society, Hospital Association, etc.

3) Exert more effort to give the Region more professional as well as lay visibility.

4) Strengthen the core staff especially in the area of an Assistant or Associate Program Coordinator to back up the Coordinator to assist in the day-to-day management of the program.

5) Take concrete steps to overcome the lack of objective evaluation methods in the Region.

The Review Committee considered the Developmental Component request from the WRMP during its January 1971 meeting. In spite of the site visitors positive recommendations on the request for developmental funds, members of the Review Committee believed that action on this request should be deferred with advice to the Region to incorporate the proposal for developmental funds with their triennial application.

The following chart shows the Region's funding at the time this application was developed; the level of funding for the continuing life of ongoing projects and specific new and previously approved activities.

Core and Projects for Triennium (Direct Costs)

	Present Funding	1st Year	2nd Year	3rd Year
Core	$ 411,689	$ 495,675	$ 531,973	$ 571,700
Developmental Component	-0-	140,000	140,000	140,000
Projects				
Ongoing Projects, Continuation and/or Renewals	1,142,951	1,277,444	469,234	-0-
Approved Projects (Not Initiated)		275,983	198,400	202,988
New Projects		223,649	170,170	170,170
TOTALS	$1,554,640	$1,917,076	$1,509,777	$1,084,858

Organizational Structure & Processes

Board of Directors - The Wisconsin RMP, Inc., is controlled by the presidents of the Medical College of Wisconsin and the University of Wisconsin. At present there are only three members of the corporation, but will soon be expanded to a total of nine. Management of the corporation is vested in an elected nine-member Board of Directors (who are not members of the RAG).

Regional Advisory Group - The RAG adopted several amendments to its bylaws on September 24, 1970, to take into account its expanding role in guiding the activities of WRMP:

1) Increased the size of membership (47 members) to assure a broader representation of various health professions, organizations, and agencies and of members of the public.

2) Allowed for a maximum term of six years instead of the previous three years to provide for rotation of membership with a sufficient continuity for carrying out the program successfully. The RAG has a strong role in policy direction and guidance and a strong input into the review process of the WRMP. Since the RAG makes its policy decision within the framework that "the ultimate purpose of all activities of the WRMP shall be the promotion of the health of all people in the Region," its strategy has been to work with a number of groups in the state, such as, the State and County Medical Societies, the Nursing League and Nursing Association of Wisconsin, the Wisconsin Hospital Association, State Dental Society, Association of Osteopathic Physicians and Surgeons, Blue Cross-Blue Shield, Kidney Foundation and the voluntary health agencies. Agency cooperation includes all of the universities, the school of nursing and the Marshfield and Gundersen Clinic Foundations. The WRMP has also worked very closely with the Bureau of Comprehensive Planning since its inception. The RAG is proposing further development of functional liaison with areawide health planning agencies, by forming a WRMP field service with a representative in each of the areawide health planning agencies.

Sub-Committees - The Regional Advisory Group, on December 3, 1970, approved the following changes in its sub-committee structure:

Steering Committee, formerly the Planning Committee, is charged with the responsibility of (1) recommending goals and objectives to the RAG; (2) recommending ways to implement the goals and objectives; (3) identifying areas which can and should be developed; and (4) recommending charges to other RAG sub-committees, including the formation

of new committees; the elimination of non-functioning committees; and the changes in committee responsibilities.

Review & Evaluation Committee formerly the Project Review Committee, has the responsibility of recommending to the RAG: (1) approval or disapproval of applications for WRMP funding, including budgetary changes; (2) discontinuation of projects or portions of projects prior to scheduled termination; (3) establishment of evaluation procedures which are to be carried out by the Evaluation Director with the help of WRMP Staff and the Project Staff. This committee also prepares periodic and terminal reports regarding the progress of WRMP projects and programs for the RAG.

Continuing Education Committee which replaces the earlier Council on Continuing Education is responsible for: (1) recommending to the RAG and the Steering Committee goals for the educational programs and projects of WRMP; (2) advising the RAG & Steering Committee regarding the development and coordination of continuing education resources in Wisconsin; (3) advising the project staff and core staff regarding continuing education needs, purposes, and methodology for programs and projects conducted by WRMP; (4) providing (when possible) for the coordination of continuing education activities conducted by voluntary health agencies, professional societies and educational institutions.

Council for the Allied Health Profession: (1) provides a forum for discussion of problems in health care delivery and professional education as they apply to the allied health professions and to health care in general; (2) recommends to the RAG appropriate participation of the allied health professions in WRMP programs and projects; (3) stimulates the development of continuing education activities for the allied health professions as they relate to WRMP goals; and (4) fosters programs which improve interprofessional educational activities and interprofessional collaboration.

Program Priorities

On September 24, 1970, the Regional Advisory Group identified and approved high priority program priorities for WRMP as follows:

A. The planning and promotion of an improved coronary artery disease care system for the Region.

B. The planning and development of innovations in health care delivery and manpower utilization.

C. The planning and development of improved hospital emergency care and improved transportation of the sick and injured.

D. The planning and development of innovations to improve long-term patient care, including home care and nursing home care.

E. The planning and development of means by which education can be brought to those health professionals who are not presently served.

F. The planning and development of continuing education which is designed to develop proficiency in using new knowledge or new technology.

G. The planning and development of improved health care for isolated rural residents.

H. The planning and development of improved health care services for the poor and those who find it difficult to enter the health care system.

I. The promotion of further involvement of health profession schools and their faculties in RMP activities.

Review Process

After a proposal is identified and submitted, staff will analyze and translate it into an "Issue Paper" in line with the planning model and goals of WRMP. The written analysis is then reviewed by the Executive Committee of the RAG for a priority decision regarding allotment of staff time and effort for the future development of the proposal. Once it is decided that the proposed merits further consideration, it is developed and reviewed by appropriate study groups on subcommittees of the RAG and by appropriate areawide comprehensive planning agencies (when reaction might be contributory). It is then prepared with a budget for final review by the Project Review and Evaluation Committee (formerly named Project Review Committee) which assigns priority, and then by the Regional Advisory Group itself.

Evaluation

The Region's evaluation efforts are described in this application in three different stages: during planning and development of projects; during the process of formulating objectives and after the activity is completed. An evaluation team, consisting of two Review and Evaluation Committee members, two Regional Advisory Group members, a staff person and the evaluation director, conducts evaluation reviews at least twice a year. When a project becomes operational, the project director makes periodic progress reports to the evaluation director and annual reports to the Regional Advisory Group, through the evaluation director. The Project Review and Evaluation Committee provides feedback to the project directors and suggests or requests changes if the progress proves unsatisfactory. All projects are required to have an evaluation component and in some cases the project staff is primarily responsible for accomplishment of

the work. In other cases the review by the Review and Evaluation Committee may suggest that parts of the evaluation would best be carried out by the core staff. Outside consultants are also called in to evaluate proposals and projects.

The Project Directors are responsible for providing a final report to the RAG through the Project Review and Evaluation Committee. This report provides information valuable to future planning by analysis of the strength and weakness of results related to the procedures and assists agencies in deciding on adoption of the procedures into ongoing programs. The following standards are used in evaluation:

(a) Goals and objectives as determined by the RAG and program areas chosen to achieve them on the basis of highest priority.

(b) The degree to which WRMP programs are able to provide additional services and more efficiently use existing manpower.

(c) The degree to which WRMP can design new and coordinate existing projects to form programs to meet the priorities of the Regional Advisory Group.

(d) The degree of professional and lay acceptance of the programs.

(e) The ability of projects to become self sustaining, cost-effectiveness measures where appropriate, improved distribution of services, and improved utilizaton of existing services and facilities will be measured.

Present Application

The Developmental Component

The Region requests $140,000 (d.c.o.) for development funds for each of three years.

Within the broad scope of policy and goals it has adopted, the WRMP states that it is committed to the planning and development of programs which will improve the health care services within the Region. To improve the efficiency of the total planning and operational effort, developmental funds will be used to initiate and test the feasibility of proposed projects prior to their development into more permanent projects or programs. The Regional Advisory Group has recommended that developmental funds be made available for feasibility studies and program development in the areas of high priority program interests described under "Program Priorities." The following proposals are currently under consideration for support by the Developmental Component:

1. The preparation of a manual and visual aids for the University of Wisconsin Extension Library Service to be used in carrying out the continuation of WRMP Medical Library Project No. 16. The University of Wisconsin Extension will continue the project under its own sponsorship.

2. Plan the organization and implementation of a Comprehensive Cancer Therapy Program for Southeastern Wisconsin in collaboration with the Comprehensive Health Planning Agency of Southeastern Wisconsin, The Southeastern Wisconsin Medical Center, Inc., and the Medical College of Wisconsin.

3. Prepare a manual for high school counselors to assist them in health career guidance in collaboration with the Wisconsin Hospital Association.

4. Plan and organize a health care delivery program for the residents of Menomonee County (formerly the Menomonee Indian Reservation) in collaboration with the Northeastern Wisconsin Health Planning Council.

5. Assist six hospitals in Metropolitan Milwaukee in developing a pilot quality control system for laboratory services.

The review mechanism described under "Organizational Structure and Processes" will apply to the developmental component as well.

Core Central Core activity is presently supported at $411,689 in the Region's fourth operational year. This amount supports a staff of 20 full and part-time personnel. One existing professional position is vacant (Director of Fiscal Management). This application requests five new professional positions in the first year of the triennium, an Associate Coordinator for Program Development as recommended by the December 1970 site visit team, an Assistant Coordinator, Medical College of Wisconsin and three liaison representatives to provide functional liaison with the areawide Health Planning Agencies.

Requested (d.c.)
Fourth Year
(1st year of triennium)
$495,675

The application describes a core staff who is now moving into the areas of program development, planning and in evaluating the operational effectiveness of the Region. The application also describes two panning studies which were conducted during the previous year, generated with assistance from the core staff. The fifth year requests continued support for one core-supported planning study - Southside Health Contact Center, and one feasibility study - North Central Wisconsin Outreach. Also, during the next year (1st year of triennium), the core staff will collaborate with the Wisconsin Bureau of Comprehensive Health Planning and the Community Health Planning Service

of the APHA in the planning and development of a Comprehensive Health Service demonstration.

Two of the five new projects included in this application are "outgrowths" of either planning or feasibility studies conducted with core funds.

Requested Sixth Year	Requested Seventh Year
$531,973	$571,700

Requests for Continuation of Projects Within Approved Periods of Support

Project #5-B Dial Access Library Service for Nurses - University of Wisconsin - One additional year is requested (Fifth period) to provide continued support for the development of library tapes and to provide prompt, convenient dissemination of information to nurses. The program, used also by inservice coordinators and instructors in nursing schools has created better understanding of patients' conditions and has provided confidence to nurses in isolated practice settings. Over 32,000 calls have been accepted in a 28-month period. Future use of the library program will also include service to the allied health workers. It is anticipated that calls from Wisconsin nurses will continue to be about 1,000 per month.

Requested (d.c.) Fifth Year $18,600

This project was ranked third in order of funding priority by the WRMP.

Project #5-C Single Concept Films - University of Wisconsin - This project initiated in 1968 is designed to provide physicians and nurses in Wisconsin hospitals access to short teaching films to improve their skills and knowledge in order to provide better patient care. Continued funding is requested for an additional year for the purpose of producing or adapting films primarily for nurses and other specialized hospital personnel such as the physical therapists. Since September 1969, twenty new films have been added to the library, two of which were produced in the Region. More than 70 hospitals in the Wisconsin area and two hospitals in the upper peninsula of Michigan have participated in the programs.

Requested (d.c.) Fifth Year $15,500

Project #15 - Comprehensive Renal Program - This project was activated last year at a Council approved level of $542,155 d.c.o. (92,155 rebudgeted from other projects). The activity was approved by Council for a three-year period and this application requests funds for the remaining two years. It is sponsored by the Kidney Foundation of Wisconsin, Inc. The proposal is designed to develop a comprehensive renal disease program in Wisconsin.

Requested (d.c.) Fifth Year $469,234

Since the project was implemented, the following activities are in progress: 1) a large home dialysis training facility has been constructed at the Madison Methodist Hospital. The unit is presently operational with a capacity to train 40 patients yearly. It also serves as a resource to other dialysis units in the state for training technicians and physicians; 2) a postgraduate training program for physicians in other aspects of nephrology has been established at the Milwaukee County Hospital; 3) tissue typing labs have been established in Milwaukee and Madison which have allowed the development of a state-wide cooperative program in cadaver transplantation; 4) cadaver kidney procurement teams have been organized throughout the state; and 5) a program in the prevention and early detection of urinary tract infections has been initiated, and an index of catheter care has been designed. The present components will continue their activities on an expanded basis during the next two years. Efforts are currently underway to obtain state legislative support and insurance coverage for future support of this program.

This project was ranked first in order of funding priority by the Region.

Sixth Year
$469,234

Project #17 - Nurse Utilization Demonstration Unit. This activity is under the direction of the University of Wisconsin, Milwaukee School of Nursing in collaboration with Marquette University Graduate Department of Nursing and St. Mary's Hospital, Milwaukee and was initiated by utilization of carryover funds. It was designed to demonstrate better utilization of nurses and other health care personnel in a clinical setting. The project is divided into three phases: 1) development of patient care systems and procedures; 2) implementation and evaluation of new patient care systems and 3) actual demonstration to hospitals. Continued support is requested to carry out the last phase of the project. During this phase, actual working experience for health teams from other hospitals throughout the Region will be offered to assist them in developing more effective patient care systems on their own. The funds are largely for personnel who will disseminate the information gathered during the first two phases of the project.

Request (d.c.)
Fifth Year
$130,890

The initial design stage has been completed and ten of the sixteen systems are in the process of being implemented. Delay in the implementation of the patient care system was due to the loss of the nurse clinical specialist.

The Region plans to evaluate this project on the basis of the different types of data which have been collected, such as: patient interviews, personnel questionnaire, absentee rate, turnover rate, cost accounting practice, referrals for continuity of care, etc.

The Health Science Unit of the University of Wisconsin Extension Service will continue to participate in the development of the demonstration phase of this project after withdrawal of RMPS funds.

This project was ranked fourth in order of funding priority by the WRMP.

Project Continuation Beyond Approved Period of Support (Renewals)

Project #6 - Interrelated Program in Radiology and Nuclear Medicine - Wisconsin Radiological Physics Laboratory. This project was initially funded during September 1969 for a two-year period. One year renewal support is requested to: 1) continue the present services of computerized treatment planning, TDL verification of deliv-red dose, radiological physics services and radiotherapy consultation; 2) add services to reduce radiation exposure from diagnostic X-rays; 3) sponsor workshops on physical and clinical aspects of dosimetry and treatment protocol; and 4) provide dial access talks on radiation safety. Since September 1969, the Wisconsin Radiological Physics Laboratory has provided physics services and radiotherapy consultation to most of the hospitals and clinics that are doing radiotherapy in the Region. Over 100 visits have been made to hospitals by WRPL traveling physicists to provide calibrations and measurements which are vital to accurate radiation dosimetry. A total of 66 treatment plans have been done in hospital outside the major centers for GYN cases, external beam rotational cases and radium needle implant. The 71-72 request of 95,200 includes $75,643 for personnel.

Requested (d.c.) Fifth Year $95,200

The project was ranked sixth in order of funding priority by the Region.

The Region is currently considering applying for a three-year supplemental grant to extend through August 1975. The grantee has just begun to charge for the services provided and expects that the project will eventually become self supporting.

Project #12 - Uterine Cytology - This project which is headquartered in the Wisconsin State Laboratory of Hygiene became operational on September 1, 1969. The project is a demonstration program designed to implement and evaluate a new semi-automated technique for screening the adult female population for uterine cancer. One year additional funding is requested to

Requested (d.c.) Fifth Year $50,820

pursue the original objectives of: (1) the demonstration of cell sizing as a method for mass screening of a female population for uterine cancer; (2) definition and further refinement of the technique itself; and adaptation of the technique of cell sizing to the detection of other types of neoplasm, and the extension of this method to other laboratories.

During the first 18 months of the project, 6,200 women in Wisconsin have been screened by the size distribution method along with simultaneous papanicolaou smears. The project involves the cooperation of two clinics in different areas of the state and two State Board of Health Mobile Units, a third clinic will be added to the study during the next year. The results of the study have indicated that the size, distribution, pre-screening method is highly useful in detecting early cancerous and pre-cancerous lesions of the uterus and will effect more efficient use of cytotechnologists since the method reduces the proportion of negative smears which constitute the majority of smears currently being read. It is anticipated that this method of cancer screening will be incorporated into the local clinics and other medical service facilities. The study will also assess the capability of paramedical personnel and patients to obtain the specimen. This project was ranked fifteenth in order of funding priority by the RAG.

Project #16 - Medical Library - University of Wisconsin - This project, initiated in September 1969, is designed to develop methods of providing improved access to medical information for the health personnel in Wisconsin. This overall objective is to be accomplished through three interrelated programs: 1) a series of four-day courses for clerical personnel in the operation of hospital libraries; 2) the development of a union list of serials for libraries in Wisconsin; and 3) a consultation service to health information personnel upon request.

Requested (d.c.)
Fifth Year
$1,525

This request is for one additional year for funds to be used in purchasing computor time, and the cost of printing and distributing the union list. It is also planned to update and edit the initial union list, expanding coverage by adding the scientific and psychological holdings of several major non-hospital libraries. The applicant reports that serial holdings for 46 to 48 participating hospitals have been added to the data base.

The course material and curriculum have been developed and tested in five areas of the State, and the University of Wisconsin Extension Department intends to offer the course over the Educational Telephone Network in September 1971. The appropriate revisions of the course material are being made for ENT programming. Because of the lack of available personnel to devote substantial time and effort in motivating

hospital administrators to utilize the consultant service, it has not been utilized to the extent originally anticipated. Only fifteen formal consultations and an unspecified number of informal consultations have been conducted.

Approved Projects Not Previously Funded

Project #13 A - Inactive Nurse - University of Wisconsin - The original application directed toward the preparation of inactive nurses was initiated March 1, 1969. The total project originally seen as a two-year project was designed in three parts:

Requested (d.c.) Fifth Year (1st year Triennium) $66,500

1) Specially designed courses for inactive nurses in selected areas of the state.

2) A series of telephone/radio conferences offered to inactive nurses on a statewide basis.

3) Individual study guides on selected nursing tapes.

Funding was provided to support only one aspect of the project which was #2 - the provision of telephone/radio conferences for inactive nurses. The grant was made in September 1969 for one year only. An application was submitted for the continuation of this project (September 1970 - August 1971) and was approved, but not funded.

This request is for the support of the second year, to carry out the intent of the original proposal. The applicant states that the program has met an educational need among inactive nurses. Evidence of this has been the response and support of a total of 699 inactive nurses who have participated in all three phases of the project. One hundred and two inactive nurses have returned to practice between September 1, 1969 and August 30, 1970, and the assumption is that this impact will continue. The overall objective of the program remains the same. It is to facilitate the return of the inactive nurse to the practice of nursing. This project was ranked 12th in order of funding priority by the WRMP. No support for the sixth and seventh years is requested.

Project #18 - A Medical College of Wisconsin Manpower - This project was approved by the July 1970 National Advisory Council. The project calls for the establishment of a Coordinating Council for Continuing Health Education in the newly created Department of Continuing Education of the Medical College of Wisconsin. The Council will be composed of representatives from a variety of professional groups, consumers and planning agencies. Its major function will be to utilize existing resources for the development of an operational program in Continuing Education. The Council will focus on the development of team-teaching methods, development of ongoing programs

Requested (d.c.) Fifth Year $57,965

in community hospitals and the development of a system of continuing consultation. Educational activities utilizing methods and content identified by practical experiences will also be developed and implemented.

Requested (d.c.) Sixth Year	Requested (d.c.) Seventh Year
$57,965	$57,965

Project #22 - Continuing Education in Rehabilitation Medicine - Division of Health, Wisconsin Department of Health and Social Services. This is a three-year request for a project which will provide physicians and allied health professionals an opportunity to develop skills, increase their knowledge and will improve the coordination of rehabilitation activities. The target area is a three-county rural area located in Central Wisconsin. Therapy consultants will be provided by the State Division of Health to assist in education and consultation programs. Project coordinators will work with local health agencies and physicians in the planning and development of programs. An information and referral service will be developed in target areas to provide them a source of information on the care of the patient. Local and state advisory groups will provide general guidance, interpretation and liaison with organizations and will be responsible for planning the continuation activities when the project terminates. Most of the budget ($33,989) will be for the support of professional personnel and to conduct appropriate evaluation studies. This project was ranked eleventh in order of funding priority by the Region.

Requested (d.c.) Fifth Year (1st year triennium) $54,341

Requested (d.c.) Sixth Year	Requested (d.c.) Seventh Year
$57,428	$62,016

Project #23 - An Educational Program for Cardiac and Intensive Care Nursing - University of Wisconsin, Milwaukee - This proposal was approved for a three-year period by the June 1970 National Advisory Council. The project proposed to train 72 nurses during each of the three years. The purpose of the program was to prepare nurses to function effectively in a Coronary Care and/or intensive care unit by means of a six-week educational program. In the absence of WRMP funding two courses (which were supported in part by a grant from the Wisconsin State Board of Nursing) were offered by the Milwaukee School of Nursing which provided training for 12 RN's during 1970-71. It is anticipated that a third course will be given during the spring.

Requested (d.c.) Fifth Year $97,177

This program was ranked tenth in order of priority funding by the WRMP.

Requested (d.c.) Sixth Year	Requested (d.c.) Seventh Year
$83,007	$83,007

New Projects

Project #24- Cancer Review and Emendation System — Requested (d.c.) Fifth Year (1st year of triennium) $28,945

This proposal requests three-year support to establish a viable decision-making mechanism within all Wisconsin hospitals. The specific objectives are: 1) to strengthen existing cancer centers; 2) develop a multidisciplinary team approach to cancer patient care; 3) determine the need for new centers and personnel; 4) initiate training programs for the development and demonstration of the best methods of cancer treatment; and 5) support and assist medical groups to assure widespread use of the best available methods of early detection and cancer therapy. The first year is devoted to training programs, providing interdisciplinary consultation to hospitals, implementing desired standards in hospitals and determining the viability of the project on a statewide basis. The project will become self-supporting through fees charged to the hospitals for services and through patient charges.

Evaluation will be based on the degree objectives are met: improvement in treatment success or referral demonstrated by patient records, percentage of hospitals participating with cancer evaluation and meeting data and training requirements.

This proposal was ranked ninth in order of funding priority.

Request (d.c.) Sixth Year $28,945

Requested (d.c.) Seventh Year $28,945

Project #26- Nurse Associate - University of Wisconsin, Program of Primary Care, Madison. — Requested (d.c.) Fifth Year (1st year Triennium) $116,901

This proposal requests three-year support to demonstrate the capability of the nurse associate and to include some tasks now performed by physicians. This is the first of a series of projects from the ad hoc committee on the Delivery of Primary Care by WRMP. Initially the project will focus on child health care then will move into the area of family health and finally to the area of geriatrics.

The project proposes to: 1) establish a cooperative education and consultation program for 68 RN's and physician teams; 2) place these nurses in practice settings; and 3) evaluate the nursing role and collaborative functioning in an office, group practice, health center or outpatient department community setting. The project will consist of a series of education, field experience, follow up, consultation and evaluation cycles. Evaluation will be conducted on

an ongoing basis and will include: 1) student performance; 2) role acceptance by physician, nurse and consumer; and 3) cost effectiveness analysis.

This proposal was ranked eighth in order of funding priority by the Region.

Requested Sixth Year	Requested Seventh Year
$118,225	$118,225

Project #28- Diagnostic and Therapeutic Criteria Review - This proposal requests three-year support to assist hospitals in Wisconsin in selecting diseases or conditions to be studied, setting criteria for them in the specific hospital and monitoring the performances in that hospital against the criteria.

Requested (d.c.) Fifth Year (1st year Triennium) $23,000

Consultation and assistance will be provided by the University of Wisconsin and WRMP to the hospitals in order to enable them to establish and carryout their own programs. Initially this will be done in four hospitals to determine its applicability in the state.

If the method appears promising additional support of approximately $50,000 will be proposed after the first year. This will enable an increase in the number of hospitals involved in the process.

Requested (d.c.) Sixth Year	Request (d.c.) Seventh Year
$23,000	$23,000

Project #30- North Central Wisconsin Outreach - This is a request for one-year support for an activity which was initially developed as a feasibility study as a part of core staff activity. This proposal will: 1) provide an ongoing medical consultation service between the medical staffs of small rural hospitals and the Marshfield Clinic; and 2) assist in the development of satellite clinics in communities where there is little likelihood of them recruiting a physician. It is proposed that the clinics will be staffed by a physician for a half day two times a week and a trained physician assistant the remainder of the week.

Requested (d.c.) Fifth Year (first year of triennium) $12,862

Personnel requests for 71-72 is $11,362 of the total direct cost budget of $12,862.

This proposal was ranked fifth in order of funding priority by the WRMP.

Project #31- South Side Health Contact Center - This proposal is the outgrowth of a planning study which involved Core staff assistance and financial support in planning and developing the initial plans for the creation of the South Side Health Contact Center. The Center was founded by a group of low-income persons in Milwaukee's South Side "Inner City." Its founders established three operational goals: 1) to serve as a source of information on medical resources to members of the local community; 2) to serve as a referral agent and health advocate; and 3) to attract more direct health services into the community, both through coordination of already existing services and the development of new services.

Request (d.c.)
Fifth Year
(1st year of Triennium)
$41,941

This request is for one-year support to expand and upgrade these services to a comprehensive ambulatory health service, and is requested as a program for the utilization of WRMP developmental component funds.

All of the services included in a comprehensive health service will be provided such as: medical care, dental services, social services, community organizations and the development of support sources.

Planning of the service will be directed toward an assessment of the medical services required, examination of the means through which the necessary service could be provided and ways in which the paper creation of the planning process might be concretely realized and maintained. This project was ranked second in order of funding priority by the Region.

(A Privileged Communication)

SUMMARY OF REVIEW AND CONCLUSION OF
JULY 1971 REVIEW COMMITTEE

WISCONSIN REGIONAL MEDICAL PROGRAM
RM 00037 8/71

FOR CONSIDERATION BY AUGUST 1971 ADVISORY COUNCIL

RECOMMENDATION: Committee recommended that the Region be awarded $1,5000,000 for its first and second triennial years and that it be awarded $1,085,000 as requested by the Region for its third year. The Committee further recommends that the request for developmental component funds be approved and included in the totals as set forth above.

DIRECT COSTS ONLY

YEAR	REQUEST	RECOMMENDED
05	$1,917,076	$1,500,000
06	1,509,777	1,500,000
07	1,084,858	1,085,000
TOTAL	$4,511,711	$4,085,000

The member of the Review Committee that participated in the December 1970 site visit was unable to attend this meeting. Therefore, the reviewers were unable to benefit from his first hand information.

CRITIQUE: The reviewers noted that the Region was last site visited during December 1970 with reference to its application for support of a developmental component. Because of the short time since December, another site visit was not scheduled for this application. The December site visitors recommended approval of the developmental component. However, the January 1971 Review Committee believed that action on the request should be deferred and reviewed in relation to the total program proposed in the triennial application. The February 1971 National Advisory Council concurred with this recommendation.

The reviewers further noted that the Region had responded to the advice and suggestions of the December site visitors and had:

1) Added depth and strength to the core staff by the addition of a physician Associate Coordinator for Program development by the replacement of a lay Associate Coordinator by a qualified individual, and by the addition of three liaison representatives who are to work with the funded CHP "B" Agencies and the Marshfield Clinic.

2) Improved the extent and quality of evaluation procedures by the establishment of a Review and Evaluation Committee which will be responsible for conducting project site visits at least once a year and by developing methods to produce "outcome" data rather than theoretical information.

3) Improved their subregionalization efforts by establishing collaborative relationships with some of the large proprietary clinics. (Marshfield and Gundersen)

4) Expanded the Board of Directors from three to nine members.

The Review Committee also considered and accepted the findings of an April 1971 staff site visit team report on the large Comprehensive Renal Disease Program which is funded through the Region.

The Regional Advisory Group which has a total of 47 members (including nine females and two blacks) appears to be a well-balanced group; it represents a broad range of professional and health interests and a wide geographic area; it has a very strong role in the policy direction and guidance of the Region and a very strong input into the review and planning process.

During September 1970, the Regional Advisory Group approved new program priorities which are essentially in line with the National Health Priorities. The Planning Committee of the Regional Advisory Group, during their July 1971, meeting are to reexamine and restructure the goals, purposes, basic program objectives and policies to bring them more in line with the Regional and National Priorities.

The reviewers believed that the WRMP is now in a period of transition, shifting its emphasis from a project to a program approach.

Most of the Region's categorical programs which have received support for a number of years will be transferred to other than RMP support during the first year of its triennium.

Two of the new projects proposed in this application - North Central Outreach and South Side Health Contact Center were believed to be in line with the national priorities.

The Review Committee agreed with the December 1970 site visitors that the Region has demonstrated that it has the machinery, expertise and local autonomy to successfully and prudently utilize a developmental component in the planning and development of programs which will improve the health care services within the Region.

The reviewers were favorably impressed with the current small core staff's role in this Region. The Core staff has demonstrated excellent leadership and competence in working with both providers and consumers of health services as well as the many agencies and neighboring Regions (Iowa and Northlands) who have an interest in health.

As noted before, the application request funds to support additional core staff members. The reviewers agreed that an increase in the level of core support was warranted.

The Region's review process meets the requirements for decentralization. The process involves staff, the Executive Committee of the RAG, appropriate study groups or subcommittees of the RAG, appropriate areawide comprehensive planning agencies, Project Review and Evaluation Committee and then the Regional Advisory Group. The Region appears to have a very sophisticated method in arriving at the ranking of program and project proposals.

The recommended level of support developed and recommended by the Committee for the fifth operational year was arrived at in the following manner:

Core Support	$ 495,675
Developmental Component	140,000
Operational Activities (new, renewal & continuing)	864,325*
Total	$1,500,000

* The Committee believed that this amount should be sufficient to partially support the Region's top ten priority activities. Also, Council's attention is drawn to Project #23 - An Education Program for Cardiac and Intensive Care Nursing - University of Wisconsin which was approved for a three-year period by the June 1970 National Advisory Council. This proposal is ranked number ten by the Regional Advisory Group and thus would be included in the proposals recommended for funding.

Dr. White was not present during the discussion of this application.

RMPS/GRB 7/13/71