



E001471

CRITIQUE

The ARMP has made substantial progress since last year's site visit. The RAG has been expanded and restructured in a manner which insures greater community and less university participation in the program's decisionmaking process. The RAG now includes greater minority representation. The new RAG Chairman, Dr. James Bordley, III, was identified as a particularly capable and dedicated man who made a major contribution to the program's rapid development.

Further, the Committee concurred with the site visitors that the appointment of Dr. Girard Craft to the position of Deputy Director provided the impetus required to coordinate the large and talented program staff into a cohesived unit capable of administering an enlarged program.

The Committee shared the site visitors' concerns about the program staff's lack of fiscal management competence in light of the program's many projects. They were pleased to note that the ARMP had hired a fiscal specialist in the interim period between the site visit and the Committee's review. This tended to reflect the program's responsiveness to site visit recommendations and assured increased staff competence in an area which had been seen as a deficient.

The Committee shared the site visitors' emphasis that the ARMP's excellent projects should be converted into a more integrated program. There was a consensus that this would be done in light of the competence of Dr. Craft, Dr. Bordley, and Mr. Robert M. Briber, Vice Chairman of the RAG.

In summary, the Committee accepted the report and recommendations of the site visitors as expressed in the site visit report.

EOB/DOD 9/26/72

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level _____ Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	774,592	768,230	787,563	811,626	638,000	693,090	731,225
CONTRACTS	X	X	X	X	X	X	X
DEVELOPMENTAL COMPONENT	-0-	90,000	90,000	90,000	30,000	45,000	60,000
OPERATIONAL PROJECTS	75,314	1,568,691	1,768,691	2,158,691	950,000	1,045,000	1,149,500
Kidney	X	()					
EMS		()					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	900,000	2,426,921	2,646,254	3,060,317	1,618,000	1,783,090	1,940,725
COUNCIL RECOMMENDED LEVEL	900,000						

Site Visit Report

Albany Regional Medical Program

August 1-2, 1972

Site Visit Participants

Consultants

John Krlewski, Ph.D., Chairman, Associate Professor and Director,
Division of Health Administration, University of Colorado Medical
Center, Denver, Colorado, RMPS Review Committee Member
Adelbert L. Campbell, Acting Coordinator, California Regional Medical
Program, Area 9
Granville W. Larimore, M.D., State Director, Florida Regional Medical
Program
John S. Lloyd, Ph.D., Associate Coordinator, California Regional Medical
Program, Area 5
Alton Ochsner, M.D., Ochsner Clinic, New Orleans, Louisiana, NAC Member
Robert C. Ogden, President and General Counsel, North Coast Life
Insurance Company, Spokane, Washington, NAC Member

RMPS Staff

Thomas C. Croft, Jr., Financial Management Officer
A. Burt Kline, Jr., Public Health Advisor, Eastern Operations Branch
Frank Nash, Acting Chief, Eastern Operations Branch
Miss Elsa J. Nelson, Senior Health Consultant, Division of Professional
and Technical Development
Mr. Robert Shaw, Program Director for Regional Medical Programs Service,
Region II, DHEW

Regional Advisory Group

James Bordley III, M.D., Chairman, Executive Committee
Robert M. Briber, Vice Chairman, Executive Committee, Executive Director
Hudson-Mohawk Association of Colleges and Universities
Peter Crawford, Director, Community Medical Care Program, Executive
Committee Member
Robert A. Dyer, Executive Committee Member
Marjory A. Keenan, R.N., Associate Professor of Nursing, Russell Sage
College, Executive Committee Member
F. Donald Lewis, President, Heart Association of Eastern New York, Executive
Committee Member
Daniel P. McMahon, M.D., Regional Health Director, State of New York
Department of Health, Executive Committee Member
Paul F. Robinson, Associate Executive Director, New York State Health
Planning Commission, Executive Committee Member

Regional Advisory Group (continued)

Eugene H. Bohi, General Manager, WAST Television, Menands, New York
Ruth Buchholz, R.N., Director of Nursing Service, Columbia Memorial Hospital, Hudson, New York
Charles Eckert, M.D., Professor and Chairman, Department of Surgery, Albany Medical College, Albany New York
Elizabeth B. Haile, Schenectady, New York
Thomas L. Hawkins, Jr., M.D., Executive Vice President and Director, Albany Medical Center Hospital, Albany New York
John C. Marsh, Vice President-Treasurer, Blue Cross of Northeastern New York, Inc., Albany New York
Thomas W. Mou, M.D., Provost for the Health Sciences, State University of New York, Albany, New York
John Murphy, Administrator, Saranac Lake General Hospital, Saranac Lake, New York
William H. Raymond, M.D., Johnstown, New York
Bernard Siegel, Vice President-Business & Finance, Albany Medical College, Albany, New York
The Rev. John R. Sise, Cooperstown, New York
Seth W. Spellman, D.S.W., Dean, James E. Allen, Jr. Collegiate Center, State University of New York, Albany New York
Jerome C. Stewart, Executive Director, St. Clare's Hospital, Schenectady, New York
Marie N. Tarver, Executive Director, Model Cities Program, Poughkeepsie, New York
David E. Wall, Hospital Director, Veterans Administration Hospital, Albany, New York
Harold C. Wiggers, Ph.D., Executive Vice President and Dean, Albany Medical College, Albany, New York

PROJECTS

<u>Director</u>	<u>Title</u>
Michael A. Nardolillo	South End Community Health Center
Nathaniel McNeil	Carver Comprehensive Community Health Center
Lawrence N. Fuchs	Training for the Delivery of Home Care
Peter Jones	Health Career Incentive Program
Harold A. Rodgers	Migrant Health in Columbia County
Ursula Poland	Medical Library and Information Service
Bernard H. Rudwick	Community Health Education Service
Donald C. Walker, M.D.	Design and Development of a Comprehensive Emergency Health Care System
Bette Hanson	Rural Community Health Guides
Henry Tulgan, M.D.	County-wide Cardiac Monitoring System
Mary C. Bromirski, R.N.	An Expanded Concept of Home Health Care
Freyda M. Crow	To Have a Voice -- Post-Laryngectomy Rehabilitation
John A. Olivet, M.D.	Cooperative Training Program for Allied Health Professionals
Donald E. Schein	This Week in Health

COMMUNITY REPRESENTATIVES

Joseph Byrne
Joseph E. Harrigan

Catherine Harwood
James Heron
Sister Anne Lawlor
Dorothy Paul
Leo J. Roy

Capital Area HMO Planning Council
Upper Hudson Regional Comprehensive Health
Planning Organization
Schoharie County Community Action Program
Council of Community Services
Maria College
Community Medical Care Program
Heart Association of Eastern New York

PROGRAM STAFF

Frank M. Woolsey, Jr., M.D.	Director
Girard J. Craft, M.D.	Deputy Director
J. Clark Winslow	Administrative Assistant
Byron E. Howe, Jr., M.D.	Associate Coordinator, Northern Division
William P. Nelson, III, M.D.	Associate Coordinator, Eastern and Interface Divisions
Ward L. Oliver, M.D.	Associate Coordinator, Western Division
John B. Phillips, M.D.	Associate Coordinator, Southern Division
Arnold W. Pohl, M.D.	Associate Coordinator, Central Division
Paul L. Brading, Ph.D.	Evaluation Specialist, Educational Psychologist
Robert J. Ambrosino, Ph.D.	Evaluation Specialist, Educational Psychologist
Raymond Forer, Ph.D.	Evaluation Specialist, Sociologist
Anne M. Anzola	Coordinator, Community Health Education
Irma Wilhelm, R.P.T.	Coordinator of Physical Therapy
Sally K. Rorabaugh, R.N.	Acting Coordinator, Nursing
Arthur A. DeLuca	Director, Community Affairs
Jeremiah Blanton	Community Affairs Specialist
Dale L. Morgan	Community Affairs Specialist
Roy E. Perry	Community Affairs Specialist
Henry J. Zarzycki	Community Affairs Specialist
William C. Batchelder	Director, Information Service
Robert W. O'Neill	Director, Public Relations
Albert P. Fredette	Coordinator, Instructional Communications
Robert B. Marshall	Fiscal Specialist
Carl Oberle	Fiscal Specialist

INTRODUCTION:

The Albany Regional Medical Program was site visited in June 1971 and at that time the site team was concerned over the program's rather narrow and unimaginative thrusts, based largely on a two-way radio continuing education program. The team was also concerned over the structure of the program in terms of minority representation, the lack of a deputy director and indeed the lack of any depth in administration, a weak RAG, and a dependent relationship on the Medical School.

These deficiencies were called to the ARMP's attention when their grant was awarded last year and they immediately began to restructure their program to implement these suggestions.

As the current site visit report will indicate, the ARMP successfully restructured the RAG and involved it in the program's development, strengthened the program staff, attracted the interest of the region's health professionals and, in all, met with considerable success in overcoming most of the deficiencies noted by the site visit team of 1971. The turnabout in the program's direction can be traced to some specific events which highlighted the activities of the past year.

- September 1971 - A meeting between the Director, RMPS, and the ARMP Coordinator, the RAG Chairman and four members of the RAG's Executive Committee. At this meeting, the Director, RMPS, provided specific guidance to the key personnel of the ARMP and outlined what they would need to do to enhance their success as an RMP.
- September 1971 - Mr. Jeremiah Blanton is appointed as the ARMP's first black professional program staff member. In his role as a Community Information Coordinator, Mr. Blanton begins to provide an important link between ARMP and the region's black communities. In retrospect, it is possible to see that the ARMP involvement in improving the availability and accessibility of health care in the region's black communities can be traced to this appointment.
- December 1971 - Mr. Roger Warner, Evaluator, Arkansas RMP visits the ARMP to advise on matters related to the program's organizational structure, review process, and project development.
- January 1972 - Dr. James Bordley assumes the post of RAG Chairman following the resignation of Dr. Harold Wiggers, Dean, Albany Medical College. This was the program's first change in RAG Chairmen since it began operation in 1966.

Dr. Girard Craft is officially appointed as Deputy Coordinator to Dr. Woolsey.

INTRODUCTION (CONTD)

Dr. Bordley, former Chairman of the RAG Executive Committee, and Dr. Craft, former program staff member, as a result of their past experiences, brought outstanding competence to their new positions. At this juncture, the ARMP had gained strength in two vital areas and the major ingredients for radical change had been added.

- . January 1972 - The RAG, at Dr. Bordley's urging, votes to meet nine times per year instead of four times per year.
- . January 1972 - The entire RAG membership, now expanded from 27-37 members, is broken into four "goal oriented" task forces to more closely involve each member in the review process and program development.
- . February - June 1972 - The RAG Task Forces meet two to three times per month; the RAG Executive Committee meets twice monthly, and the full RAG meets monthly. The product of these meetings is as follows:
 - . 52 project proposals reviewed and ranked relative to ARMP's goals, objectives and priorities
 - . 47 project proposals approved with varying degrees of priority
 - . 23 projects voted for inclusion in the June 1972 application for triennial support

During this period of furious activity, Dr. Craft coordinated, channeled, and guided the program staff energies while, at the same time, Dr. Bordley motivated the RAG, its Executive Committee, and its Task Forces to successfully meet the tremendous work load being forced upon it by the need to review the projects being developed by the ARMP program staff.

- . April 11, 1972 - Roger Warner, at the request of the ARMP, visits the region to review and comment on the progress made since his December consultative visit. His report reflects that he perceived significant progress.

INTRODUCTION (CONTD)

- April 30, 1972 - All ARMP support for the Two-Way Radio and Coronary Care Unit terminates. At this point, all vestiges of past project efforts ends and the ARMP entered into a new era which involved only projects which had been developed since the previous year's site visit.
- December 1971 - July 1972 - Throughout this extended period, the ARMP staff worked in a dedicated fashion to assist the 52 project applicants to refine their original concepts into sound project proposals.

The following site visit report will document the impact of the changes resulting from the above events and will attempt to point out some residual deficiencies and some of the problems that remain to be resolved.

1. Goals, Objectives and Priorities (8)

At the time of the June 1971 site visit ARMP was found to have two long-range program goals and seven short-range objectives as follows:

Goals

1. 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.
2. 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.

At that time the site visit team felt that the ARMP needed "a set of operating objectives which are quantifiable and measurable, time-dependent, and ranked in priority order." This recommendation was conveyed to the Coordinator via the RMP's Advice Letter.

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PREPARED BY: A. BURTON KLINE

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At the time of the August 1972 site visit the following goals and objectives for ARMP were presented:

GOAL I: To improve the delivery of health care.

OBJECTIVE A: To improve the accessibility of comprehensive health care with particular attention to medically deprived urban and rural communities.

OBJECTIVE B: To design and implement innovative methods of health care delivery through the utilization of personnel in new roles.

OBJECTIVE C: To improve emergency health services.

OBJECTIVE D: To increase public awareness in health matters.

GOAL II: To monitor and improve the quality of health care.

OBJECTIVE A: To plan, promote and conduct educational and training programs for members of the health team.

OBJECTIVE B: To design and develop mechanisms for evaluating the quality of health care delivered.

GOAL III: To help solve the health manpower problem.

OBJECTIVE A: To recruit health manpower.

OBJECTIVE B: To increase the efficiency of health manpower.

OBJECTIVE C: To improve the distribution and utilization of health manpower.

GOAL IV: To further the process of regional cooperative arrangements.

OBJECTIVE A: To mobilize consumer and provider participation in the identification and solution of local and regional health problems.

The goals and long-range objectives were prioritized as follows:

<u>Very High Priority</u>	<u>High Priority</u>	<u>Average Priority</u>
I - A	III - B	II - A
III - C	I - C	III - A
	I - B	I - D
	IV - A	
	II - B	

Projected activities and already funded projects were listed under each of the goals and objectives to which they pertained and the distribution was as follows:

Very High Priority Objectives:

7 projects 46% of project funds

High Priority Objectives:

10 projects 35% of project funds

Average Priority Objectives:

6 projects 19% of project funds

In summary, the goals and objectives have been restated and prioritized since the 1971 site visit and the progress has been significant. As the program matures, there should be a continued effort to further refine these goals and objectives in terms which can be more easily quantified and measured and more specifically related to the identified health needs of the Albany region. The current goals and objectives were developed by the ARMP program staff and approved and prioritized by the RAG. They have been published throughout the region via their newsletter, the Albany Regional Medical Program Report.

Recommended Action

See pages 27-30.

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PREPARED BY: A. BURTON KLINE DATE: 10/72

2. Accomplishments and Implementation (15)

The change in the goals and objectives of the RAG has been reflected in the change in activities and emphasis of the program staff. The program staff now has more direction and enthusiasm to operate within that direction. The result has been the stimulation of 52 new proposals and the development of new and fruitful relationships between ARMP and several community organizations which had not previously been a part of the ARMP process.

A significant accomplishment of ARMP has been the phasing out of old projects and the development of new funding support for the continuation of successful programs. The Cancer Coordinator Project for Schenectady is now supported by Ellis Hospital. The Coronary Care Training Program has made a great contribution to the manpower pool of the region and continues at a reduced level under the auspices of the Heart Association and a consortium of community hospitals with some ARMP program staff support as faculty. The Two-Way Radio Project, ARMP's oldest project and most successful in terms of regional impact and acceptability, is being continued as a program of the Albany Medical College. The program staff is proud to have been able to phase out of successful projects and direct its energies into new activities. Provider groups have long looked to the ARMP for technical and professional assistance, now as the program staff broadens its spectrum of activities in conjunction with its new directions, consumer groups are also becoming acquainted with the ARMP and are seeking assistance in the development of new programs.

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3. Continued Support (10)

At the time of the June 1971 site visit it was recommended that "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 18 months. ARMP financial input for this operation must cease by March 1973.
2. No more than one year's terminal support for coronary care unit training can be borne by RMP. Other sources of support must be found by September 1972."

These recommendations were made in the Advice Letter of August 1971, with the exception that the Two-Way Radio operation was to cease by September 1972, rather than March 1973. Both of these projects were phased out in an orderly fashion and each is now sustained, in whole or in part, with funds provided by sources other than RMPs. This was accomplished by April 30, 1972, well in advance of the deadline given in the Advice Letter.

The region's proposal review criteria contain items which refer to the need for continued support after RMP funding. In addition, each proposal addresses this point. The ARMP policy is to reduce or terminate funding to any project which cannot produce adequate assurance of continued support by the end of the first year of ARMP funding.

Recommended Action

See pages 27-30.

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4. Minority Interests (7)

Objective I-A, "To improve the accessibility of comprehensive health care with particular attention to medically deprived urban and rural communities", has four top priority projects. Three of these address themselves to the health problems of minority groups and minority communities. The fact that these projects grow out of the new relationships with minority communities is reflected by some of the uneasy alliances which exist between the providers and consumers who are involved in some of the projects. Until the minority community, i.e., those involved in the direction of projects and those who are the recipients of the benefits of these activities, have worked with the ARMP for some period of time they will retain some degree of skepticism with respect to the ARMP's sincerity in its efforts to help them. The ARMP will need to work closely and faithfully with these groups to win their confidence. They should bear this in mind in all their future efforts with projects involving minority members who have become conditioned to being suspicious because they have been the victims of insincere efforts in the past.

The program staff has only one black professional and one black secretary. Staff needs more black professionals as well as support staff. The Coordinator seems most anxious to get more minority representation on staff, but needs assistance in this regard.

Since the top priority projects of ARMP address themselves to minority interests, considerable effort should be made to increase minority representation on the RAG. The site visit team acknowledges and lauds the efforts made to date to improve minority representation on the RAG; however, it is important that the trend be continued beyond its present status. The Coordinator must seek innovative approaches to minority professional involvement in the RMP process. He may need to seek outside consultation in this regard; however, he may find it possible to use some of the good people he has already involved. Minorities need to be involved, particularly on his Executive Committee, and in working on project development. The program staff could be instrumental in assisting other providers in the region to improve their services to and their relationships with minority groups.

Recommended Action

See pages 27-30.

5. Coordinator (10)

Although Dr. Woolsey, the Coordinator, is not what one would consider to be an outstanding Administrator, he has built a capable organization and has proven his leadership capabilities by re-orienting the program from the categorical projects previously developed and displayed last year to a totally new program thrust designed to strengthen the health care delivery system. The program staff is committed to this re-orientation, appear to be solidly behind the program and the administration and appear to be functioning as a cohesive unit, even though the organization lacks clear cut job descriptions and well defined lines of authority and responsibility. Dr. Woolsey's success in this regard has, in part, resulted from the efforts of Deputy Director, Dr. Girard Craft, who was appointed by the RAG last January. Dr. Craft has a great deal of organizational experience and has provided a focal point for staff direction and cohesion. Dr. Woolsey has also been greatly aided in his attempt to restructure the program by his close working relationship with the RAG and the leadership which has been displayed by Dr. James Bordley, the RAG Chairman, as well as the Executive Committee.

Recommended Action

See pages 27-30.

6. Program Staff (3)

Although some program staff changes have taken place during the past year, much remains to be done. The staff is currently overweighted with physician talent and lacks skills in other areas such as financial management and general program administration. Similarly, the lack of well defined job descriptions and work assignments still allow the perpetration of what appears to be at least some duplication of effort, especially between the community affairs staff and the area health coordinators. The program staff provides a good basic full-time resource with diversified talents and the site visit team felt that Dr. Craft had made substantial progress in developing the staff into a cohesive production unit. The team also felt that Dr. Craft's

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6. Program Staff (Contd)

plans for future program staff reorganization were sound and that he will continue to strengthen the organization as he implements these plans.

Recommended Action

See pages 27-30.

7. Regional Advisory Group (5)

The RAG has been greatly expanded within the last year and is now far more representative of the region. Membership from the Albany Medical College has been reduced to a reasonable percentage, and program staff members no longer serve on the RAG. The RAG has met with more than usual frequency (monthly) over the past nine months with an excellent level of participation and dedication during a period of great change and redirection of the program. The attendance and attention may decline now that the push is over.

The RAG has played an effective role in establishing objectives and priorities and its Executive Committee has, during this period, exemplified true leadership. It has met twice a month, and, in addition, its Chairman spends one day a week in the ARMP office. The RAG bylaws call for adequate representation of the interests, institutions and groups in the region.

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8. Grantee Organization (2)

Albany Medical College, the Grantee Organization, provides adequate and effective fiscal administrative support. All of the program staff of ARMP are employees of the Albany Medical College and participate in its fringe benefits including insurance and retirement programs. The physicians on the ARMP staff hold faculty appointments and are expected to give some teaching time to Albany Medical College. The grantee appears to have given the ARMP full freedom on programmatic action without restraint or veto.

Albany Medical College has a mandatory retirement age of 65, but we were told that this would not apply to employees of ARMP; although at 65, those with faculty status would lose it unless an exception (1 year) was granted or emeritus status voted.

Recommended Action

See pages 27-30.

9. Participation (3)

Participation of professional and voluntary health agencies in ARMP is judged to be quite satisfactory. Among the agencies and groups involved in the program are: (1) the Medical Society of the State of New York, whose two District Branches III and IV within the region are represented on the RAG; (2) Hospitals, while the New York State Hospital Association is not represented officially there are three hospital administrators on the RAG together with a VA hospital administrator who serves in an ex-officio role. Nursing homes are also represented; (3) Official Health Agencies both State and local are represented in the membership of the RAG; (4) Educational representation including the State University system is included on the RAG; (5) Nursing and Allied Health are also well represented on the RAG; (6) The Model Cities Program, Catholic Charities, the Albany Council of Community Services also participate in ARMP; (7) Voluntary

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9. Participation (Contd)

Health Agencies: The New York State Heart Association is represented on the RAG and the TB and RD Association as well as other voluntary health agencies are included in the membership of ARMP's consultant groups.

Recommended Action

See pages 27-30.

10. Local Planning (3)

For reasons, which are described as "political" in a broad sense, there are no CHP "b" agencies within the area encompassed by the ARMP. The State CHP "a" agency is, however, represented on the RAG by its Associate Director who also serves as a member of the RAG's Executive Committee. ARMP maintains working relationships with several councils of social agencies within its area and with the State and local health departments. These groups have enhanced local health planning input because of the absence of CHP "b" agencies in the area. In view of the circumstances, ARMP's participation in local planning activities is considered to be satisfactory.

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11. Assessment of Resources and Needs (3)

The ARMP has had a history of compiling an excellent data base upon which to plan and implement its program. Ironically, as of 1971, this data base was extensive; however, the program had not developed in such a way that it could meet the needs the data brought to light. In 1972 when a program developed to meet the needs which had been previously identified by the data base, it was learned that the program was no longer maintaining the data base as current as it had been done in the past. However, it was indicated that it had been maintained at a level sufficient to guide the program in its emphasis and priority establishment. Unlike the situation a year ago, this excellent source of data is being used by the ARMP for project development and is being shared with other agencies in the region. Generally, the ARMP programmatic efforts are consonant with the identified needs of the region and the current development is being guided by a talented and representative RAG which, as a body, has a firm hand on the health pulse of the region.

Recommended Action

See pages 27-30.

12. Management (3)

The Coordinator directs the program staff in a style which might be described as somewhat "over participative management". His essential belief is that one who expresses an interest and desire to do a specific task is more likely to be successful at that task than one who receives it as an arbitrary assignment. This approach, in part, accounts for the extremely high morale exhibited throughout the program staff. However, a valid question would be to ask what happens to a specific task which needs to be done to further the program's stated goals and objectives when there is no program staff member who expresses a willingness to undertake the task. There was evidence that the question is academic, since the staff has a great loyalty to the Coordinator, is made up of long-term professionals, has high morale, and appears dedicated to the enhancement of the ARMP program. The scope of the efforts put forth by the program staff in the past

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12. Management (Contd)

year are testimony to the fact that, in this instance at least, the Coordinator's style appears to work well for him.

Since the ARMP, now embarking on the fiscal management and surveillance of projects scattered throughout the region, needs to modify its program staff competencies in a manner consistent with the programmatic change which has recently taken place. The ARMP needs to supplement its current staff competencies with people having skills in fiscal administration and in "in house" personnel management. For a program which has grown as large and complex as the ARMP, there is a need for more formalized direction of program staff efforts and an increased utilization of project data and surveillance information for making enlightened decisions with respect to reducing support, terminating support, and rebudgeting of funds to support new initiatives which may be required to accelerate the accomplishment of program's stated goals. The need for these competencies has been identified by the key ARMP people and they are currently taking steps to enhance the staff's competency in these areas.

Recommended Action

See pages 27-30.

13. Evaluation (3)

There is a Regional Program Staff Planning and Evaluation Section consisting of three part-time evaluation specialists, one of whom is the Chairman of the Section. It is difficult to discern how the results of evaluation have been used in the region's decisionmaking process. While the recommendations and suggestions of the Planning and Evaluation Section are built into the ARMP's proposal review procedures, it appears that their recommendations and suggestions do not have as much impact on the final decision as they should. The ARMP should consider placing more emphasis on the skills these people bring to the program and utilize their talents in program planning. Furthermore, the RAG and Coordinator should make use of the efforts

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13. Evaluation (Contd)

of the Planning and Evaluation Section in their determinations regarding the extent to which ARMP funded activities contribute to the attainment of the region's goals and objectives.

Recommended Action

See pages 27-30.

14. Action Plan (5)

As previously indicated, the region has stated its goals and objectives, and prioritized them, and they are congruent with RMPS directions. Both proposed and actually funded operational projects, planning and feasibility studies, and central regional service activities have been related to the region's goals and objectives.

Although the ARMP appears to be on course at the moment, it is suggested that they could enhance the probability of staying on course as their program develops if they were to carefully assess and document the region's current and projected needs and, from this, develop a short-range plan to serve as a guide to enlightened decisionmaking. Each project, as it passes through the local review process, could be assessed from a technical standpoint, but could also be assessed in light of how it fits into the overall plan the ARMP has developed to insure that it continues to address the region's real problems. The hazard associated with such a plan is that it may become outdated and, as such, ineffective. If such a plan were designed, provisions should be made to insure that it remains current. This appears to be a task which lies within the competencies of the ARMP program staff and its RAG and should be seriously considered since it will tend to insure maximum involvement of many of these people in the pursuit of an even more effective program surveillance. The preliminary plan developed for the conduct of monitoring and of the project activities appears to be a sound beginning for an effective and systematic assessment of

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14. Action Plan (Contd)

progress. The ARMP should be complimented for its awareness of the problem and for taking the initial steps which will insure a good orientation for project directors.

Recommended Action

See pages 27-30.

15. Dissemination of Knowledge (2)

The ARMP has always been heavily involved in the dissemination of new knowledge and technical material for providers through its Two-Way Project. It also seems to have a good communications relationship with other educational institutions in the region.

One of its top new projects, being sponsored by New York State Education Department, will disseminate new knowledge about health occupations to secondary school educators and counselors.

The public information officer on the program staff reports high "pickup" of news releases to local media. With new emphasis on new target groups, considerable time and effort should be given to developing ways of disseminating information to these groups. There is a need to be able to identify the community health education component in all proposals.

With community understanding and appropriate utilization of new resources generated by the new projects, better health care should result for people who previously had been neglected and deprived. Consideration should be given to widening the distribution of the fine ARMP Newsletter.

The ARMP should be applauded for having a Health Educator on its

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15. Dissemination of Knowledge (Contd)

staff. These special skills and talents should be utilized in program staff development activities as well as community activities.

Recommended Action

See pages 27-30.

16. Utilization of Manpower and Facilities (4)

Several of the high priority projects encourage the better utilization of existing resources. The South End Community Health Center Project will develop a satellite type ambulatory care center and more fully utilize the resources of St. Peters Hospital. This kind of resource sharing should be encouraged.

Several projects and activities of the program staff are directed at training and utilization of allied health manpower. These projects should have closer monitoring and evaluation to insure effectiveness of training and proper utilization after training.

Recommended Action

See pages 27-30.

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17. Improvement of Care (4)

The program currently being conducted by the ARMP places heavy emphasis on the improved access to health care for people who are underserved. The low income groups in the inner city areas of Albany and Schenectady have had the availability of health care enhanced by the establishment of community health centers in the area. These centers have been made possible by the coordination and mobilization of existing resources in the community. The ARMP did the coordinating and provided partial support to the conduct of these activities. These activities, as satellites of established hospitals, will tend to strengthen the relationships between primary care and specialty care.

In the rural area of Chateaugay (Franklin County) the ARMP program staff provided the needed professional competence to secure a physical plant, state licenses, etc., so that the National Health Service Corps was able to place two physicians, a dentist, and a dental hygienist into a remote community which, up until this time, had not had access to health care services.

In a joint project with the OEO, the ARMP helped develop the curriculum, underwrote 50% of the costs (\$10,000) for the training of Primary Care Nurses. After their training has been completed, the ARMP will assume the role of proper placement of these highly trained nurses, i.e., they will attempt to locate the communities which have the most critical need for the nurses and which express a willingness to accept them in this rather new role.

In all, the recently implemented projects, the projected activities, the program staff services, and the program staff feasibility studies reflect a recognition of the need to improve the quality and quantity of health care throughout the region. The recognition of the need appears to be accompanied by the development and implementation of efforts which will help meet the needs in the Albany region.

Recommended Action

See pages 27-30.

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18. Short-Term Payoff (3)

It is apparent that many of the activities currently in progress or projected will bring immediate relief of those who currently require health services. There are plans to enhance the effectiveness of the monitoring and surveillance of projects to feedback the information required to gauge prospective payoffs from each of the activities. This procedure is in its infancy at present; however, as the ARMP becomes more sophisticated it is reasonable to expect that the system will improve since there appears to be a great sensitivity among the key people in the program to the need for such monitoring.

Recommended Action

See pages 27-30.

19. Regionalization (4)

One of the primary concerns voiced by the site visit team of 1971 was the region's failure to regionalize its activities. Interestingly enough, one of the primary concerns of the site team of 1972 is that the program's activities are so geographically spread out that there is a need to consolidate some related activities under a multi-project umbrella to simplify their administration and fiscal control. The ARMP, if anything, over reacted to the need to regionalize and must now look toward the orderly assembling of projects by logical grouping to insure that it is possible to relate the program's goals and objectives to the efforts underway, and those which can be expected to be introduced into the system now that there is widespread interest in the ARMP throughout the region. The ARMP, now that it had decentralized its base of operations from Albany to points scattered throughout the region, must begin to pay closer attention to improving linkages and to a more coordinated approach to the provision of health care on a regionwide basis. This problem is perceived by the key people in the program and as the program settles into a more routine course of doing business it is reasonable to assume that the "shot-gun" regionalization will give way to a more tightly knit program conducted on a regionwide base.

Recommended Action

See pages 27-30.

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20. OTHER FUNDING (3)

The current group of projects reflects an excellent input from funding sources other than RMPS. Approximately 30% of the total request for project support (or \$800,000) has been acquired from other community agencies or charities. This can be attributed to a sensitivity to the need for this type of outside support and to the administrative skills of the Deputy Coordinator in negotiations which involve the input of dollars from sources other than the ARMP.

Recommended Action

See pages 27-30.

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SUMMARY

The ARMP has made substantial progress since last year's site visit. The RAG has been expanded and restructured in a manner that will insure greater community and less university participation in the program's activities and provisions have been made to include more minority groups. The RAG Chairman is devoting considerable time and energy to the program and has been instrumental in creating excitement and enthusiasm over the program among the entire RAG membership. It is clear that RAG now establishes priorities for the projects and assumes responsibility for the program's activities. In addition to these changes at the policy making level, substantial changes have taken place at the organizational level. Dr. Craft, a physician with considerable experience in medical group practices, has been appointed Deputy Director of the program and under his leadership, the program staff is being restructured and reformulated into a strong operating group. As a result of the above changes, the program has been completely reoriented from what could at best be described as unimaginative to a new array of "interesting" projects. It is evident, however, that these projects have been hastily conceived and do not as yet fit together into a coordinated effort. Similarly, the program staff, although strengthened since last year's visit, still remains somewhat lacking in their ability to monitor, evaluate, and, in general, manage these projects. It was also noted that some of the proposed projects must be excluded from the program due to RMPS' policies.

The site team, therefore, recommends that project numbers 23, 31, and 43 be excluded from consideration and that the budget be accordingly reduced. Furthermore, in order to force the organization to rethink and restructure the remaining proposed projects, we recommend that the project budget be reduced from the requested \$1,653,329 to \$950,000 for the first year, \$1,045,000 for the second year, and then \$1,249,500 for the final year. Under this funding scheme, the RAG will have to again review the projects and reformulate them to a program scheme.

In terms of the program staff budget, we recommend that the program be funded at the present levels with a 5% increase per year for the second and third year and a \$20,000 one position increase in the second year to be carried also through the third year. This will allow some program expansion but will encourage a reallocation of the present budget and a reorganization of the present staff.

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The site team recommends that, as part of their total funds, the ARMP has a developmental component identified for three years in the reduced amounts as follows:

<u>01</u>	<u>02</u>	<u>03</u>
\$30,000	\$45,000	\$60,000

We also recommend that the university be requested to furnish space for the program in return for the 52% overhead that is being charged, and that the space rental funds requested in this application therefore be removed from the budget. The site team further recommends that the above budgets be accompanied by the following advice and recommendations to the program.

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RECOMMENDATIONS

The site visit team recommends that the ARMP be funded for three years in the reduced amounts as follows:

01 operational year	\$1,618,000
02 operational year	\$1,783,090
03 operational year	\$1,940,725

Specifically, the site visit team makes the following recommendations and suggestions.

1. Project #23 is a health careers recruitment activity and is not permitted under RMPs policy. On page 38 of a booklet entitled A Special Report to the National Advisory Council--Regional Medical Programs Service (dated May 11-12, 1971) it states "RMP grant funds are not to be used for direct operational health careers recruitment projects." It is recommended that this activity be phased out of ARMP support during the next 12 months.
2. The program development appeared to be hastily conceived and, as a result, there emerged a general feeling among the site visit team members that the program now faces a need to consolidate their project activities, to integrate those activities which, on a region-wide basis are interrelated, and to, insofar as possible, reduce the fragmentation of efforts resultant when activities/projects are conducted in a somewhat autonomous fashion.
3. Project #24, Design and Development of a Comprehensive Emergency Health Care System, appears to need additional developmental work. It is suggested that, prior to initiating this project, the advice of competent people with specific expertise in the area of emergency medical care be obtained. Project #31, Orientation of Non-Practicing Physicians to Clinical Practice, was viewed as too global in nature and not sufficiently directed at the priority health needs of the Albany region. Project #43 was considered too expensive from a cost/benefit standpoint and possibly duplicative of similar work done by other RMP programs. It is strongly recommended that ARMP explore what is available before venturing forth too far in the production of visual materials.
4. The ARMP is becoming extensively involved in the management of grants to support the conduct of many projects. This is a relatively new function for the program and will require increased program staff

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competence in the financial management discipline. The significant size and the increasing complexity of the tasks to be performed by the program staff brings about a need for additional expertise in organizational structuring and personnel management. It is recommended that future recruitment activities place high priority on securing staff members who will increase the fiscal, administrative, and personnel management competencies of the existing staff.

5. The Albany Medical College (AMC) expects that ARMP program staff members holding faculty appointments will spend 10% (approximately four hours/week) of their time teaching for the college. It is recommended that this mutual understanding be documented in the form of a written agreement between the AMC and the ARMP. Most of the site visitors viewed this arrangement to be mutually beneficial; however, there was a feeling that a written agreement should be prepared to serve as a safeguard to protect the interests of both parties. This agreement should clarify any misunderstanding which could develop in the event there are changes in the administrative hierarchy of either the college or the program.
6. The ARMP faces a need to update and revise the current RAG bylaws. At present they are silent on the RAG's role in hiring/firing/ appointing the ARMP Coordinator and they empower the grantee to appoint RAG members. It is recommended that the bylaws be updated to reflect the recent RMPS policy statement which defines the roles of the grantee, the RAG, and the program staff. This statement was sent to all Coordinators on June 13, 1972, as part of highlights of the June National Advisory Council meeting.
7. It is recommended that a document which defines the relationship between the AMC and the ARMP be prepared to guarantee a clear understanding on the part of both parties with respect to their roles in the conduct of the ARMP. This document will be a safeguard against misunderstandings of this relationship which could potentially arise and also will provide guidance for the actions of new people which come into the system when there are administrative changes in the hierarchy of either party.
8. The site visitors, as a group, perceived a need for the ARMP to more specifically identify its operational objectives, to delineate the tasks necessary to achieve these objectives, and to assign the conduct of these tasks to particular job classifications. Specifically, it is recommended that the program staff be tailored to the

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- needs of the program rather than gearing the program to the competencies and interests of the existent program staff.
9. The site visit team noted that the ARMP Coordinator and four other staff members were quartered in the AMC while the remainder of the program staff had their offices in a nearby off-campus building. This arrangement was questioned from an administrative standpoint in light of the difficulties it imposes on the Coordinator and the program staff in terms of communication, management, supervision, etc. It is recommended that the program attempt to find a means to consolidate its offices in one location.
 10. The site visit team expressed concern over the high overhead rate being charged by the AMC. Since the program staff expressed a belief that the college was providing services which could not be purchased at a lesser cost, it is recommended that a cost analysis study be conducted to document these statements. The RAG Task Force which recently studied the current relationships between the AMC and the ARMP concluded that the current arrangement was, "at this time" the best arrangement for the program. However, this report made no apparent reference to a cost/benefit analysis and this leaves the conclusion open to question in this particular aspect.
 11. There was an expression of concern over the future development of the program from the standpoint of monitoring, surveillance and evaluation of interrelated activities. It is recommended that the RAG designate a subcommittee of its members to maintain close watch on the course followed by the program during its upcoming implementation period. The subcommittee should be responsible for the evaluation of the impact of all funded activities (i.e. Program Staff, Planning and Feasibility Studies, Central Regional Service Activities, Operational and Developmental Component projects) on the regional goals and objectives. The subcommittee should work closely with the Planning and Evaluation section. The need to provide a mechanism for continuous programmatic evaluation is viewed as a matter of high priority since the program is in the early stages of its development and attention to these important matters at this time could prevent difficulties in the future.
 12. The site visit team recommends that the rental money from the ARMP program staff budget be removed and that the AMC be informed that they are expected to provide quarters for the ARMP staff in light of the overhead monies they are currently receiving from the program.

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The report of this site visit team would not be complete unless it was clearly pointed out that the ARMP, complied in fact and in spirit, with the recommendations forwarded in the Advice Letter following the 1971 site visit. Further, it should be noted that although the ARMP still has problems to resolve, that it has, in fact, been successful at bringing about a dramatic turnabout in the program's direction and thrust. While a year ago it was operating on the inside, looking out at the region's health problems; this year it is operating throughout the region and is looking at its own inside administrative problems which have been brought about as a result of the many health activities that have been initiated throughout the region. This type of change is a healthy one.

RMPs STAFF BRIEFING DOCUMENT1.6
1.7
1.9REGION: Albany RMPOPERATIONS BRANCH: EasternNUMBER: 00004Chief: Frank NashCOORDINATOR: Frank M. Woolsey, Jr, M.D.Staff for RMP: Burt Kline

LAST RATING: _____

TYPE OF APPLICATION:

 Triennial 3rd Year
 Triennial 2nd Year
 Triennial OtherRegional Office Representative:
Robert Shaw

Management Survey (Date):

Conducted: 1970 ✓
or
Scheduled: _____Last Site Visit: June 2-3, 1971

(List Dates, Chairman, Other Committee/Council Members, Consultants)

Chairman - John E. Kralewski, Ph.D. (NRC)

Consultants - Joseph G. Gordon, Vice Chairman, North Carolina RMP RAG;
Edward D. Coppola, M.D., James P. Harkness, Ph.D., Deputy Coordinator,
New Jersey RMP, Roger Warner, Director of Planning & Evaluation,
Arkansas RMP.Staff Visits in Last 12 Months:

(List Date and Purpose)

Oct. 1971 To provide staff assistance to the region in its efforts to
Nov. 1971 develop clearer goals and objectives which would ultimately
Dec. 1971 lead to a more viable program which could acquire triennial
April 1972 status.Recent events occurring in geographic area of Region that are affecting RMP program:

The region currently does not have any CHP (b) agencies and there are movements at this time to get them established in one or two areas. The ARMP is assisting in their development with the thought that, in so doing, they will have good working relationships with the emerging complementary agencies. The National Health Service Corps recently designated the town of Chateaugay in the Northwest corner of Franklin County (one of the ARMP's Interface Division's counties) as a location for the placement of three health professionals. The ARMP staff provided the required expertise and staff time required to secure the operational headquarters for these workers, the licenses and certificates required by New York State law, etc., to permit this placement to take place effectively. This early placement in the Albany region brought forth good working relationships between the ARMP and the NHSC representative in the Region II office and, indirectly, enhanced the program's working relationship with a number of Region II's regional office staff.

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.

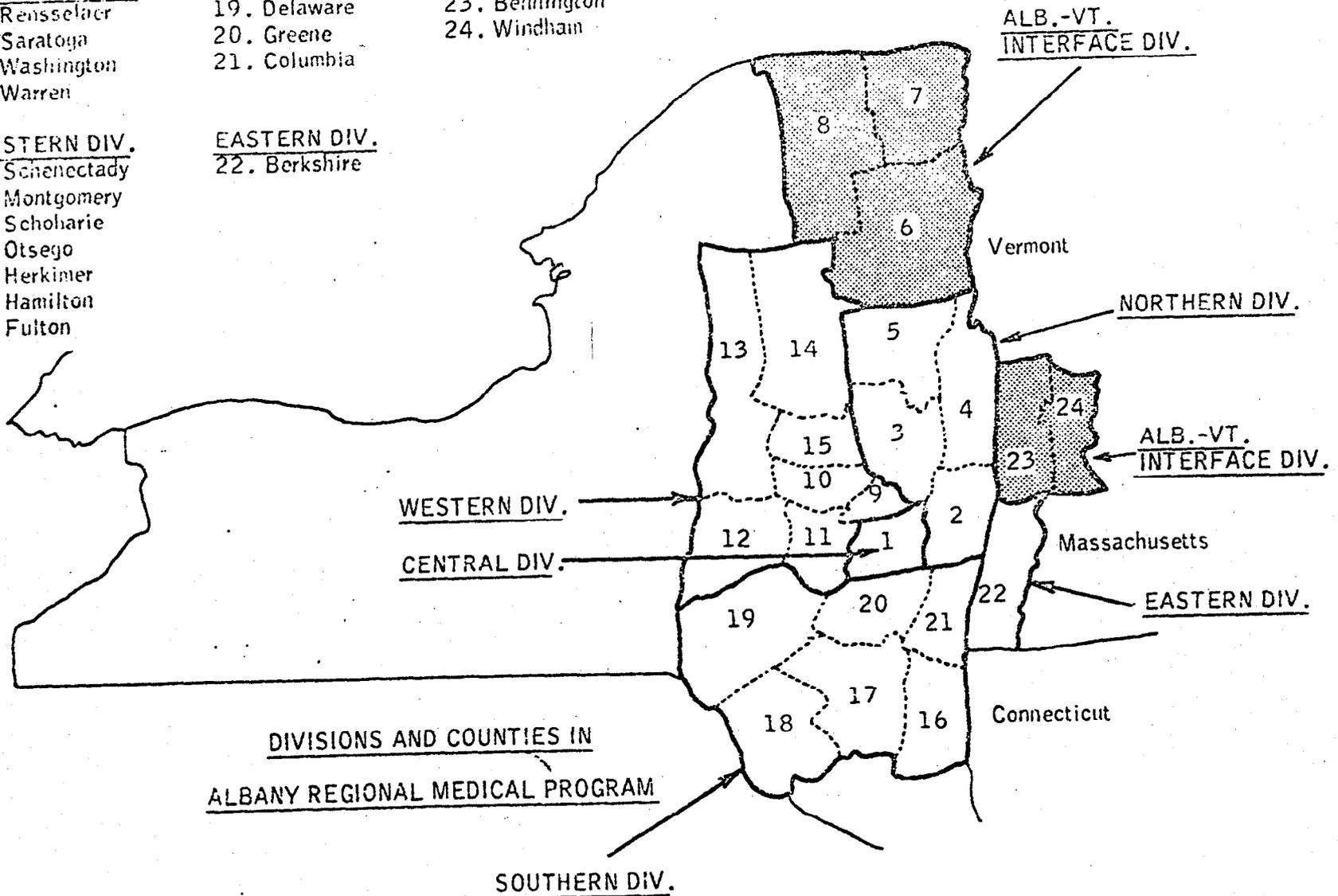
16. Dutchess
17. Ulster
18. Sullivan
19. Delaware
20. Greene
21. Columbia

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

Demographic Information

Population of the Region: 1,993,261

Population density is 101 per square mile.

Population of Albany County: 285,618

Population of Albany: 114,873

Rural population: 46.7% of total

Urban population: 53.3% of total

Minority Facts

% of entire region's population: 4.3% (85,710)

% in Albany County: 5.4% (15,423)

% in Albany: 12.5% (14,359)

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>05</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 774,592	\$ 768,230	\$ 787,563	\$ 811,626			
CONTRACTS		--					
DEVELOPMENTAL COMPONENT	- 0 -	90,000	90,000	90,000			
OPERATIONAL PROJECTS	75,314	1,568,691	1,768,691**	2,158,691*			
Kidney	X	(--)	--	--			
EMS		(--)	--	--			
Hs/ea		(--)	--	--			
Pediatric Pulmonary		(--)	--	--			
Other		50,094	(--)	--	--		
TOTAL DIRECT COSTS	\$ 900,000	\$2,426,921	\$2,646,254	\$3,060,317			
COUNCIL RECOMMENDED LEVEL	\$ 900,000						

*Includes \$397,603 projected growth in project category between the 1st and 2nd years.
 **Includes \$829,237 projected growth in project category between the 1st and 3rd years.

N.B. The growth projected is placed in the project category, but will be in the program staff and project area. The division cannot be reliably forecasted.

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMP5-05H-JY0FHL-20

REGION 04 ALBANY

RMP SUPP YR 05

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		01	02	03	04	05 10/71 - 12/72	TOTAL	06 01/73 - 12/73	07 01/74 - 12/74	08 01/75 - 12/75	TOTAL
C000	PROGRAM STAFF	173000	705500	712100	607800	774592	2972992	768230	787563	811626	2367419
C001	FEASIBILITY AN					35294	35294				
C002	COMMUNITY INF C	73800	78400				152200				
C000	DEVELOPMENTAL C							90000	90000	90000	270000
C01A	TWO WAY RADIO C	86500	32000	31600	10600	5679	166379				
C01B	TWO WAY RADIO C	57600	52700	112400	123400	58160	444260				
C004	POSTGRAD INSTRU	102600	69900	80700	18700		271900				
C005	COMMUNITY HOSP	75800	76600	111100	11300		274800				
C006	COMMUNITY CARE Y	125200	103500	71700	51900	7250	359950				
C007A	COMM HSP CC TRN	27700	20700	17900			66300				
C007B	COMM HSP CC TRN	27700	18900	19000			65600				
C012	ICCU FARMER PE	25500	33500	7200			66200				
C013	COORDINATION FOR	2100	5400	5000	5000		17500				
C016	DEVELOPMENT OF			9000	7300	4225	20525				
C020	SCUTH ENC COMM					62840	63840	119220	122465	132850	374535
C021	CARVER COMPREH					41000	41000	101133	105227	107223	313583
C022	TRAINING FOR T					24910	24910	44926	48273	53417	146616
C023	HEALTH CAREER					23202	23202	30500	41225	42177	122452
C024	MIGRANT HEALTH					19576	19576	18952	12922		31874
C025	RGAL PRGMS FOR					14512	14512	41134	42834	44750	128718
C026	MEDICAL LIBRARY							42600	40436	41898	124934
C027	SPECIAL TRNG FO							56845	55775	57495	170115
C028	COMMUNITY HEAL					37560	37560				
C029	COMMUNITY HEALT							197611	191657	196934	586202
C030	MOBILE PRIMARY							93705	95757	100494	289956
C031	ORIENTATION OF							172380	117830	61478	351688
C032	PRIM CARE TEAM							138700	142571	149648	430919
C033	COMM PLM ED S					14800	14800	14800			14800
C034	DESIGN DEV COMM							91999	94513	97850	284362
C035	RURAL COMMUNITY							57915			57915
C036	EVALUATION TRPA							36245	35445	36542	108232
C037	COUNTY WICE CAR							15475			15475
C038	RURAL PLTH CARE							41383			41383
C039	EXPANDED CONCEPT							52357	69834	46634	168825
C040	COMPREHENSIVE A							19575			19575
C041	TO HAVE A VOICE							18163			18163
C042	COMM TRAINING P							14675			14675
C043	THIS WEEK IN HE ESTIMATED GROWTH							139848	154324	160064	454236
									710000	1310000	2020000
	TOTAL	777500	1237500	1177700	836000	1129000	5153700	2426921	2958651	3541080	8922652

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11

JULY 18, 1972

BREAKOUT OF REQUEST
OF PROGRAM PERIOD

REGION - ALBANY
24 00004 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF		\$768,230		\$90,000	\$768,230	\$341,826	\$1,110,056
0000 DEVELOPMENTAL COMPONENT					\$50,000		\$50,000
020 SOUTH END COMMUNITY HEALTH CENTER		\$119,220			\$119,220	\$35,700	\$154,920
021 CARVER COMPREHENSIVE COMMUNITY HEALTH CENTER		\$101,133			\$101,133	\$30,897	\$132,030
022 TRAINING FOR DELIVERY CENTER HOME CARE		\$44,926			\$44,926	\$12,217	\$57,143
023 HEALTH CAREER INCENTIVE PROGRAM		\$39,050			\$39,050	\$9,801	\$48,851
024 MIGRANT HEALTH IN COLUMBIA COUNTY		\$18,952			\$18,952	\$4,861	\$23,813
025 REG PROG FOR HLTH TCHRS GUIDANCE COUNSELORS		\$41,134		\$42,600	\$41,134	\$10,836	\$51,970
026 MEDICAL LIBRARY AND INFORMATION SERVICE		\$41,134		\$42,600	\$41,134	\$13,406	\$54,540
027 SPECIAL TRNG FOR EMERG DEPARTMENT NURSES				\$197,611	\$197,611	\$55,999	\$253,610
029 COMMUNITY HEALTH EDUCATION SYSTEM				\$93,705	\$93,705	\$30,379	\$124,084
030 MOBILE PRIMARY CARE TEAM UNITS FOR RURAL HLTH DEL				\$172,380	\$172,380	\$48,146	\$220,526
031 ORIENTATION OF NCN PRACTICING PDS TO CLIN PRACT				\$138,700	\$138,700	\$38,700	\$177,400
032 PRIM CARE TEAM TRNG AND DELIVERY PROJECT		\$14,800			\$14,800	\$4,489	\$19,289
033 COMMUNITY HLTH ED SYS CLIN UNION ESSEX FRANKLIN COS				\$91,999	\$91,999	\$24,596	\$116,595
034 DESIGN DEV COMPR EMERG HLTH CARE SYSTEM				\$57,915	\$57,915	\$16,571	\$74,486
035 RURAL COMMUNITY HEALTH GUIDES				\$36,245	\$36,245	\$11,119	\$47,364
036 EVALUATION IMPACT PDS AS SEC ON HLTH CARE				\$15,475	\$15,475		\$15,475
037 COUNTY WIDE CARDIAC MONITORING SYSTEM				\$41,383	\$41,383	\$13,932	\$55,315
038 RURAL HLTH CARE DEL TRNG HIGH PRIM CARE NURSES				\$52,357	\$52,357	\$16,612	\$68,969
039 EXPANDED CONCEPT OF HOME HEALTH CARE				\$19,575	\$19,575	\$6,598	\$26,173
040 COMPREHENSIVE NUTRITIONAL SEEY WARREN COUNTY				\$18,163	\$18,163	\$1,994	\$20,157
041 TO HAVE A VOICE POST LARNGECTOMY REHAB				\$14,675	\$14,675	\$4,141	\$18,816
042 CCEP TRAINING PRCG ALLIED HEALTH PROFESSIONALS							

JULY 18, 1972

BREAKOUT OF REQUEST
 GO THROUGH PERIOD

FM 00004 10/72

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IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CCNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
043 THIS WEEK IN HEALTH				\$139,848	\$139,848	\$28,802	\$168,650
ESTIMATED GROWTH FUNDS CURRENT							
TOTAL		\$1,147,445		\$1,279,476	\$2,426,921	\$777,081	\$3,204,002

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BREAKOUT OF REQUEST
07 PROGRAM PERIOD

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RM 0004 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT CCSTS
C000 PROGRAM STAFF		\$787,563			\$787,563
D000 DEVELOPMENTAL COMPLMENT				\$50,000	\$50,000
020 SOUTH END COMMUNITY HEALTH CENTER		\$122,465			\$122,465
021 CARVER COMPREHENSIVE COMMUNITY HEALTH CENTER		\$105,227			\$105,227
022 TRAINING FOR DELIVERY CENTER HOME CARE		\$48,273			\$48,273
023 HEALTH CAREER INCENTIVE PROGRAM		\$41,225			\$41,225
024 MIGRANT HEALTH IN COLUMBIA COUNTY		\$12,922			\$12,922
025 REG PROG FOR HLTH TCHRS GUIDANCE COUNSLRS OTHERS		\$42,834			\$42,834
026 MEDICAL LIBRARY AND INFORMATION SERVICE				\$40,436	\$40,436
027 SPECIAL TRNG FOR EMERG DEPARTMENT NURSES				\$55,775	\$55,775
029 COMMUNITY HEALTH EDUCATION SYSTEM				\$191,657	\$191,657
030 MOBILE PRIMARY CARE TEAM UNITS FOR RURAL HLTH DEL				\$95,757	\$95,757
031 ORIENTATION OF NCA PRACTICING NRS TO CLIN MED				\$117,830	\$117,830
032 PRIM CARE TEAM TRNG AND DELIVERY PROJECT				\$142,571	\$142,571
033 COMMUNITY HLTH ED SYS CLINTON ESSEX FRANKLIN COs					
034 DESIGN DEV COMPR EMERG HLTH CARE SYSTEM				\$94,513	\$94,513
035 RURAL COMMUNITY HEALTH GUIDES					
036 EVALUATION IMPACT NRS AS SOC ON HLTH CARE				\$35,445	\$35,445
037 COUNTY WIDE CARDIAC MONITORING SYSTEM					
038 RURAL HLTH CARE DEL THROU REG PRIM CARE NURSES					
039 EXPANDED CONCEPT OF HOME HEALTH CARE				\$65,834	\$65,834
040 COMPREHENSIVE NUTRITIONAL & SEBY WARREN COUNTY					
041 TO HAVE A VOICE POST LANGUAGE CENTER					
042 CCRP TRAINING PRG ALLIED HEALTH PROFESSIONALS					

IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CCNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT CCSTS
043 THIS WEEK IN HEALTH					
ESTIMATED GROWTH FUNDS CURRENT				\$154,324	\$154,324
				\$710,000	\$710,000
TOTAL		\$1,160,509		\$1,798,142	\$2,958,651

JULY 18, 1972

BREAKOUT OF REQUEST
08 PROGRAM PERIOD

REGION - ALBANY
RM 0004 10/72

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IDENTIFICATION OF COMPONENT	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
C000 PROGRAM STAFF		\$811,626			\$811,626	\$2,367,419
D000 DEVELOPMENTAL COMPONENT				\$90,000	\$90,000	\$270,000
020 SOUTH END COMMUNITY HEALTH CENTER		\$132,850			\$132,850	\$374,535
021 CARVER COMPREHENSIVE COMMUNITY HEALTH CENTER		\$107,223			\$107,223	\$313,583
022 TRAINING FOR DELIVERY OF HOME CARE		\$52,417			\$52,417	\$146,616
023 HEALTH CAREER INCENTIVE PROGRAM		\$42,177			\$42,177	\$122,452
024 MIGRANT HEALTH IN COLUPEIA COUNTY						\$31,874
025 REG PROG FOR HLTH TCPRS GUIDANCE CUSLRS OTHERS		\$44,750			\$44,750	\$128,718
026 MEDICAL LIBRARY AND INFORMATION SERVICE				\$41,858	\$41,858	\$124,934
027 SPECIAL TRNG FOR EMERG DEPARTMENT NURSES				\$57,495	\$57,495	\$170,115
029 COMMUNITY HEALTH EDUCATION SYSTEM				\$196,934	\$196,934	\$586,202
030 MOBILE PRIMARY CARE TEAM UNITS FOR RURAL HLTH DEL				\$100,494	\$100,494	\$289,956
031 CREATATION OF NON PRACTICING MOS TO CLIN MED				\$61,478	\$61,478	\$351,688
032 PRIM CARE TEAM TRNG AND DELIVERY PROJECT				\$145,648	\$145,648	\$430,919
033 COMMUNITY HLTH EC SYS CLINTON ESSEX FRANKLIN COS						\$14,800
034 DESIGN DEV COMPR EMERG HLTH CARE SYSTEM				\$97,850	\$97,850	\$284,362
035 RURAL COMMUNITY HEALTH GUIDICES						\$57,915
036 EVALUATION IMPACT MOS AS SOC ON HLTH CARE				\$36,542	\$36,542	\$108,232
037 COUNTY WIDE CARDIAC PREVENTION SYSTEM						\$15,475
038 RURAL HLTH CARE DEL THRC UGH PRIM CARE NURSES						\$41,383
039 EXPANDED CONCEPT OF HOME HEALTH CARE				\$46,634	\$46,634	\$168,825
040 COMPREHENSIVE NUTRITIONAL SERV WAPPEN COUNTY						\$19,575
041 TO HAVE A VOICE PCST LAR YADGETCHY DELAP						\$18,163
042 COOP TRAINING PROG ALLIED HLTH PROFESSIONALS						\$14,675

JULY 18, 1972

BREAKOUT OF REQUEST
08 PROGRAM PERIOD

REGION - ALBANY
RM 00004 10/72

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IDENTIFICATION OF COMPONENT	(2) CNT. WITHIN APPR. PERIOD OF SUPPORT	(3) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(5) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
043 THIS WEEK IN HEALTH						
				\$160,069	\$160,069	\$454,236
ESTIMATED GROWTH FUNDS CURRENT				\$1,310,000	\$1,310,000	\$2,020,000
TOTAL		\$1,192,043		\$2,349,037	\$3,541,080	\$8,926,652

HISTORICAL PROGRAM PROFILE OF REGION

The Albany RMP received a planning award in June 1966 and its operational award in April 1967. The program's Coordinator from the outset has been Dr. Frank M. Woolsey, Jr. and his orientation and background experience, prior to becoming a part of RMPS, was in the field of Continuing Education for Physicians, specifically he believed in the use of two-way radio communication for this purpose. The program's single-minded approach to the improvement of health care for the residents of the Albany region began to cause concern to RMPS by May 1969. At that time, the National Advisory Council expressed concern about the over concentration of this aspect of the region's program which they believed was retarding the program's overall development. Further, there was a feeling that this activity was too closely linked to the Albany Medical College's Department of Postgraduate Medicine and that this close relationship obscured the accomplishments of the ARMP. The region's apparent inability to phase out projects after the three year support period was also a matter of concern at this time.

In September 1970, subsequent to a site visit, there was continued concern about the program's failure to develop new activities, to phase out activities, i.e., the two-way radio network and to regionalize the program's operations. At this time, there was only one activity conducted outside the confines of the Albany area and this was in its embryonic stages with little visible progress. It was noted that the RAG met only four times per year and that 11 of its 27 members were associated with the Albany Medical College and seven were on the ARMP's program staff. Thus, it was apparent that the RAG was somewhat inactive, not representative of the community at large and, as a result of its composition, doomed to a myopic vision of program development. During this period in the region's history the goals, objectives and priorities of the program were somewhat diffuse, global and, generally, not indicative of an organization that had given serious thought to where it was going or how it intended to get there.

Subsequent to the site visit of June 1971, the ARMP began to enter into a new era. The RAG was expanded to 37 members who were representative of the entire region (see RAG Chairman's report submitted with the current application), i.e., the program staff participation was eliminated, the Albany Medical College members were reduced to two members, the meetings were increased to nine times per year and the RAG Chairmanship passed from Dr. Harold Wiggers, Dean of the Albany Medical College to Dr. James T. Bordley III, a practicing physician from Cooperstown, N.Y. During this recent period the ARMP concentrated its efforts in several identifiable areas, e.g., goals, objectives and priorities were developed and clearly articulated and the RAG was subdivided into four Task Forces which were assigned the task of studying, developing, reviewing, and implementing activities which would assist in the accomplishment of a specific goal. The program staff and RAG members worked together to solicit, develop, review and initiate projects and activities which would generate a broad-based, viable, regionalized program.

HISTORICAL PROGRAM PROFILE OF REGION (Continued)

To speed up the review process and to provide additional RAG involvement, the RAG Task Forces met twice each month to review projects for submission to the Executive Committee of the RAG and, ultimately, to the full RAG for final ranking (prioritization) and funding. An ARMP program staff member was given a primary responsibility to follow through and assist in the development of each potential project. This approach provided assistance and continuity of communication between a potential project director and the ARMP. As a result of this intensive effort, the program was able to develop and review (prior to the submission of the current application) a total of 47 projects. Of these 47 developed projects, 23 are included as part of the current proposal.

It is of interest, in light of past criticism about the program's failure to phase out old activities, that all previous projects have been phased out. The phasing out was done in an orderly fashion and all the old activities are still being conducted in whole or in part with financial support from sources other than RMPS.

In summary, this brief history indicates that there are two identifiable periods in this region's history, the period from June 1966 - June 1971 and the period since June 1971, i.e., the era of transition which has seen the two-way radio phased out and 23 new activities developed throughout the entire region and submitted for consideration with the present application.

STAFF OBSERVATIONS

Principal Problems

The program is entering a new era and is somewhat inexperienced in grants management. They are working on agreements of affiliation; however, at present they are not sophisticated. The region is planning a method of project surveillance, monitoring etc. but it has not yet been tested thoroughly. The program staff, essentially unchanged from past years, needs increased administrative competencies which are consistent with the current and projected program. They need to squarely address the problems and techniques of rebudgetting. Most all of the aforementioned deficiencies are potential problems and may not develop since the ARMP Director and Deputy Director appear to recognize them and are in the process of taking steps to prevent the program from encountering these types of problems which arise when there are many projects being conducted simultaneously.

The ARMP, in order to permit all potential project directors to have a chance to acquire funds, has extended project development assistance (using program staff) to everyone who has applied, i.e. they have done no preliminary screening except for a few cases in which the project was completely out of the program's area of activity. This has placed a tremendous load on staff and reviewers which has been made possible only by efforts above and beyond the reasonable call of duty. Administratively, this momentum and workload cannot be carried on indefinitely and the ARMP will have to develop a suitable technique for initial screening of all potential projects to save work on the part of all parties involved. Testimony to this approach is illustrated by the fact that (in the current application) support is being sought for only 23 of the 47 projects which were completely developed and evaluated by the RAG.

In summary, the ARMP faces the problems associated with coming to an accomodation with the new approaches they are using in the implementation of a new program. The Coordinator and his deputy are cognizant of these problems, are attempting to resolve them, and, in time, will probably do so. However, at present, the ARMP faces the need to retrench because they have, in fact, come too far in too short a time period.

Issues Requiring the Attention of Reviewers

Most of these were brought out under the category of problems; however, the reviewers should probably be aware of this region's need and desire for guidance for future development. This can best be accomplished by carefully scrutinizing their past efforts, detecting deficiencies, and then pointing out means by which these oversights or errors might be corrected in the future. Otherwise, the problems the region faces and the issues the site visitors may wish to pay close attention to are those which may arise out of the development and implementation of a sophisticated program by a group of highly skilled and dedicated professionals who find themselves engaged in an activity which is somewhat new to them.

Principal Accomplishments

1. The RAG has been revitalized. This has included an expansion of the membership to 37 to include new members who would provide broader representation of the region's health interests. To increase individual RAG member involvement each new member was carefully selected, was provided an orientation to the role he was expected to play, and was then assigned to one of the RAG's four task forces. The four RAG task forces are set up to initiate, develop, and review activities or projects which would tend to advance the progress in the goal area the group was assigned to pay close attention to. Each of the task forces met twice per month and the full RAG, which evaluated the reports and recommendations of the task forces, met monthly. In the past there were no task forces, only quarterly RAG meetings and rather casual RAG member involvement. In the current situation each member is kept well informed and immersed in program activities.
2. Through the revitalized RAG, the ARMP developed four clearly stated goals, set their objectives and prioritized the objectives within each of the four major goal areas.
3. With increased assistance from the RAG, a new program was developed which reached into all areas of the region. The projects were evaluated in terms of the new goals and objectives.
4. All past projects were phased out in an orderly fashion and each is now sustained in whole or in part with funds provided by sources other than RMPS. This was accomplished by April 30, 1972.
5. The program staff was realigned and enlarged (slightly) to be better able to assist potential project directors in the development of effective projects. Dr. Girard Craft was officially appointed the Deputy Director and has been instrumental in providing the ARMP with more directed and coordinated staff efforts. Each program staff member was assigned primary responsibility to follow through on the development of a project from its inception to its submission to the RAG for a funding decision. In the event the project was approved and funded, the staff member was then assigned to the role of monitoring its progress and providing continuous feedback to the ARMP on its status. This approach permitted greater staff involvement and better communications with project directors and potential project directors.
6. The ARMP has successfully involved the black community in the program development and permitted it to be the beneficiary of project support. This was accomplished, in part, by adding a full time black professional staff member who could and did relate to the minority community and assist in the development of projects which would serve these underserved residents of the region. Beyond this, the ARMP was successful in attracting an outstanding black to participate as a RAG task force chairman.

7. The relationship between the ARMP and the Albany Medical College were studied by a subcommittee of the RAG and was found to be complementary and mutually supportative. The subcommittee reported that each understood its respective role and the interests of the ARMP program development could best be served by continuing to have the Albany Medical College serve in the role of grantee.

Recommendations From

SARP

Review Committee

Site Visit

Council

REQUEST: Review Committee considered BSRMP's triennial application which requested support in the following amounts:

04 - \$1,387,617
05 - \$1,463,310
06 - \$1,567,610.

RECOMMENDATIONS: Committee concurred with the site visitors' recommendation to award triennial status, to disapprove the developmental component, and provide funding at the following level:

04 - \$1,150,000
05 - \$1,230,500
06 - \$1,316,600.

Committee also recommended that a thorough evaluation, including a site visit, be held at the end of the 04 year, to assess the Region's progress toward meeting the reviewers' program concerns and to determine the level of funding for the 05 and 06 years.

REGIONS STRENGTHS: The review of the Program began with a report of the site visitors' findings which delineated the RMP's accomplishments, program plans and organizational problems. Among the Region's accomplishments are a strong and dedicated Coordinator, a highly capable program staff, a well-developed and relevant set of goals and objectives, and a new approach to program development. This approach involves the promulgation of the program goals and objectives to the health providers and institutions of the Region through the distribution of a prospectus to 8,000 individuals and agencies. Their program plan, which solicited small (\$25,000) proposals around the goals and objectives, appeared to reviewers to present a realistic method of developing activities whose results can be evaluated at the end of one year to enable the RMP to focus its resources on the most promising activities for future expansion and development. The site visitors also reported that the RMP, through Dr. Stoneman's involvement as a faculty member and his ability in relating to university representatives, has maintained the original interest and

backing of Washington, St. Louis, and Southern Illinois Universities in the program. The St. Louis-based medical schools have been brought closer together as a result of the RMP's categorical projects. Reviewers also noted that the BSRMP's Emergency Medical System proposal in St. Louis and two health service/education activities build on existing relationships of the RMP with groups such as an interagency council on allied health in St. Louis, the Southern Illinois University, and local hospitals.

The Committee observed that while the original projects were highly categorical, the proposals in the present submission reflect a trend toward more comprehensive activities. In addition, the newer proposals are more concerned with health care delivery problems in underserved areas, both rural and urban.

CRITIQUE: Despite all these positive points, the BSRMP has several serious problems which adversely affect its program operation at the present time. One is the threat to the BSRMP from the Illinois RMP in the southern Illinois area. The Illinois RMP has not until recently extended much program assistance to the area under question. However, within the last two months, the Illinois RMP leadership now appears desirous of assuming the entire state as its service area. In the light of these developments, some Committee members questioned the need for a Bi-State RMP. The response from those Committee members who visited the RMP indicated that both the medical referral-patterns in the southern part of the State, which relate to St. Louis, and the relationships of the three medical schools which originally substantiated the need for a separate Region still exist. In addition, the Bi-State RMP now has developed an organization which is strengthening the relationships among the providers, medical schools, and community groups, and which cannot be easily discounted. It was suggested by Committee that the issue be resolved by bringing the two RMPs together and declaring areas of primary and joint concern. In the meantime, Committee recommended that additional program staff funds be provided in order to permit the Coordinator an opportunity for promoting catalytic activities in the southern Illinois area.

The second major problem area is organization. Committee agreed that the RAG is large, overly provider-oriented and inactive. It has few working committees and had delegated much of its responsibility to the university-dominated Scientific and Educational Review Committee (SERC) and Administrative Liaison Committee (ALC). It was recommended by both the site visitors and Review Committee that 1) the ALC be made advisory to the RAG in fulfilling its fiscal responsibilities; 2) the SERC should be abolished and the Program Review Committee chairmen and the Executive Committee, join to determine how the proposals fit into the overall program. The RMP should also decrease the size of the RAG, establish working committees of the RAG around the Program's objectives and give the RAG membership greater responsibility. As far as the review process is concerned, Committee agreed that a formal structured process should be established, records of review be consistently maintained and the management of the process by staff be improved.

The management style of the Coordinator was also discussed. While Dr. Stoneman is a strong and able leader, his effectiveness is reduced because of the time he devotes to a part-time private practice in plastic surgery, his occasional teaching and a cumbersome program staff organization in which practically everyone reports directly to him. The fact that he has no effective deputy and does not appear to have the confidence in his staff to delegate much of the "inside" responsibility is a further drain on his time and energies. While some Committee members agreed that an important quality of a good Coordinator is delegating to and developing a staff, others replied that Dr. Stoneman's strengths in other areas made him a capable Coordinator. However, Committee felt strongly that the Coordinator be a full-time position and also recommended that a deputy coordinator with strong management skills be hired. With regard to the part-time associate coordinator positions held by faculty of each of the three universities, Committee agreed with the site visitors that if the RMP wants them to continue to be involved that full-time positions would be more valuable to the RMP.

The last area of major concern of review was the highly provider and categorical-disease orientation of the program. While the higher priority objectives are more comprehensive in nature (manpower, health care delivery systems, etc.), categorical medical care is still listed fourth in a ranking of seven program areas. Some of the associate coordinators continue to have categorical titles. The Pruitt Igoe project has been the only project funded until this year which addressed the health care needs of the underserved urban population and it has not been well-managed. Committee recommended that in light of RMPS' deemphasis of traditional categorical interests and the RMP's pressing needs in the urban and rural underserved areas, that the RMP should give greater attention to more comprehensive programs. Consumers and minority members have not been involved in the development of goals and objectives and are generally under-represented on decisionmaking and review groups. Committee felt strongly that minority, women and consumer participation needed to be more actively integrated in the Program. Special assistance should be given to orienting these members and to bringing the community groups and institutions with which they are involved into a working relationship with the RMP. It was also recommended that the Coordinator add more minorities to program staff and that the knowledge of present staff be better utilized to assess special need areas. Review Committee also agreed with the site visitors that the supplemental request for \$90,000 to obtain a needed assessment from CHP(b) agencies was not the best way to secure consumer input and should be disapproved.

CONCLUSION: Finally, Committee approved triennial status, but warns the Region that it is expected to make the changes recommended above. A thorough evaluation, including a site visit should be made next year to determine the RMP's progress. Committee also withheld approval of the developmental component this year until the RAG could prove it has obtained the maturity to handle the responsibility. The funding recommendation

for the 04 year (\$1,150,000) includes funds to hire a Deputy Coordinator and to give Dr. Stoneman some flexibility in the program staff budget (\$50,000) to allow him to take advantage of catalytic opportunities.

MCOB:DOD:10/3/72

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>03</u> Year \$924,113	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year 04	2nd year 05	3rd year 06	1st year 04	2nd year 05	3rd year 06
PROGRAM STAFF	\$517,962	\$ 650,126	\$ 696,100	\$ 744,000			
CONTRACTS	49,392	-	-	-			
DEVELOPMENTAL COMPONENT	-	115,513	127,210	133,610			
OPERATIONAL PROJECTS	356,759	621,978	640,000	690,000			
Kidney	X	()					
EMS		(25,000)					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$924,113	\$1,387,617	\$1,463,310	\$1,567,610	\$1,150,000	\$1,230,500	\$1,316,600
COUNCIL RECOMMENDED LEVEL							

MEMORANDUM

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

TO : See List Below

DATE: October 12, 1972

FROM : Acting Chief
Mid-Continent Operations Branch

SUBJECT: Revised Material for the September/October 1972 Review Cycle

Attached are revised budget sheets for the Bi-State Staff Briefing Document distributed to you on September 14th.

Please replace pages 5-14 of the briefing document with the attached.

Dore Harschel for Michael Posta
Michael Posta

Distribution of this memorandum to:

Dr. Margulies/Dr. Pahl - 1
Mr. Ringel - 5
Mr. Chambliss - 1
Dr. Sloan - 1
Mr. Baum - 1
Mrs. Schoeni - 1
Mr. Hilsenroth - 1
Mr. Croft - 1
Mr. Ichniowski - 5
Mr. Peterson - 6
Mr. Gardell - 3
Mr. Nash - 3
Mr. Posta - 3
Mr. Van Winkle 3
Mr. Russell - 3

RMPS STAFF BRIEFING DOCUMENT

REGION: Bi-State OPERATIONS BRANCH: Mid-Continent
NUMBER: RM 00056 Chief: Michael J. Posta
COORDINATOR: William Stoneman, III, M.D. Staff for RMP: Dona E. Houseal,
Operations Officer ; Charles
LAST RATING: 266 Barnes, GMB; Marlene Hall, P&E;
Ray Maddox, Regional Office
Program Director
TYPE OF APPLICATION:
 Triennial 3rd Year Triennial
 2nd Year Other
 Triennial Other
Regional Office Representative: Ray Maddox
Management Survey (Date):
Conducted: April 3-6, 1972
or
Scheduled: _____

Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)
April 10-11, 1969 Storm Whaley, Chairman; Luther Brady, Jr., M.D.;
John F. Stapleton, M.D.; Maurice Van Allen, M.D.

Staff Visits in Last 12 Months:

(List Date and Purpose)
May 18-19, 1972 - Orientation of RMPS Staff to the RMP and Technical
assistance for the RMP.
Ray Maddox, Regional Office Program Director - August 20, 1971; October 26-27,
1971; January 17-20, 1972; March 17, 1972; May 30, 1972 (EMS Site Visit)

Recent events occurring in geographic area of Region that are affecting RMP program:

Dr. David Derge recently appointed President of Southern Illinois University at Carbondale. Southern Illinois University reaffirms its consortium agreement with Washington and St. Louis Universities.

A \$1,040,000 Experimental Health Services Delivery System award granted to Health Delivery Systems Inc. of St. Louis.

Gubernatorial elections will be held in both Missouri and Illinois in November.

REGIONAL CHARACTERISTICS

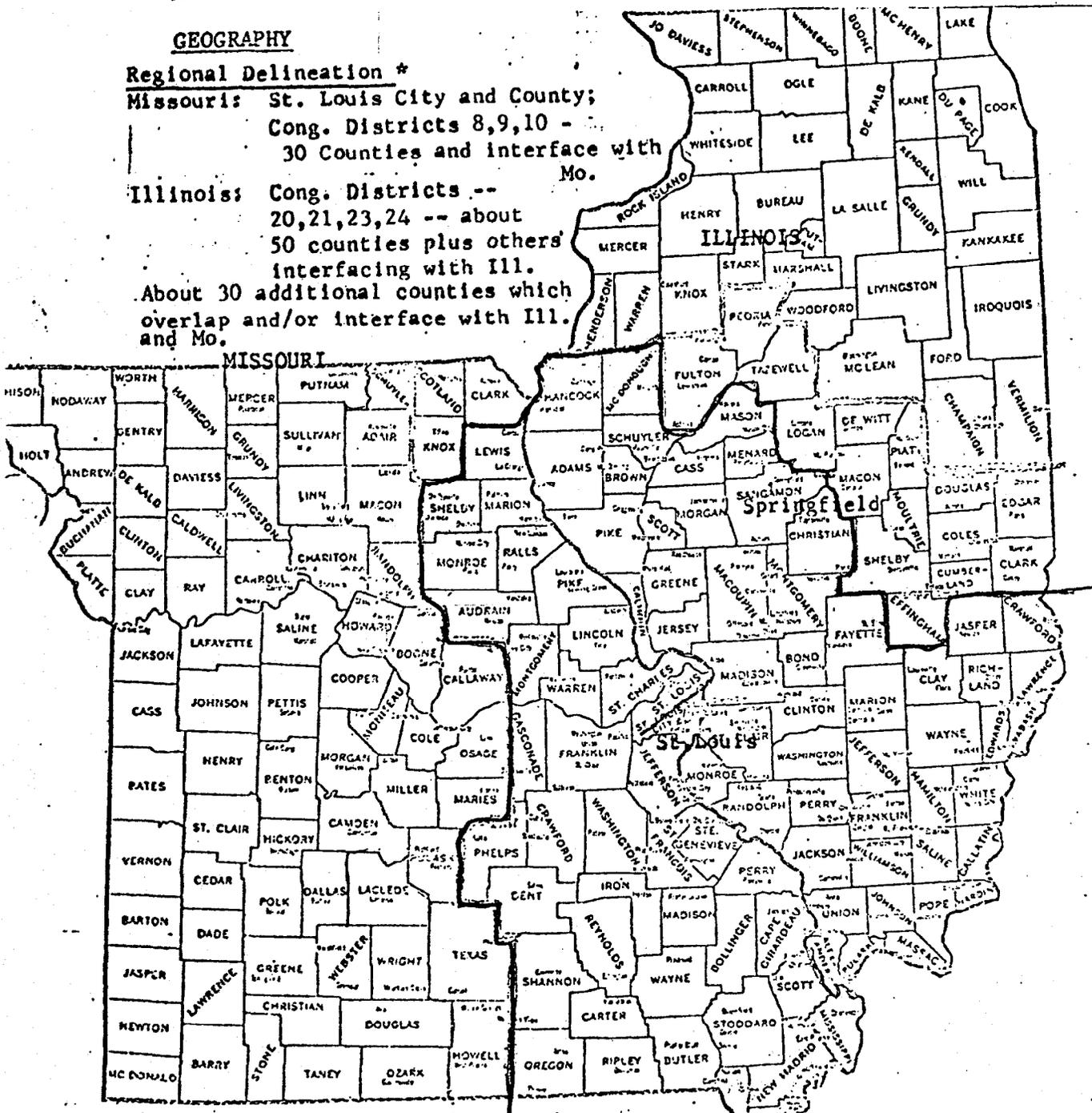
GEOGRAPHY

Regional Delineation *

Missouri: St. Louis City and County;
Cong. Districts 8,9,10 -
30 Counties and interface with Mo.

Illinois: Cong. Districts --
20,21,23,24 -- about
50 counties plus others
interfacing with Ill.

About 30 additional counties which
overlap and/or interface with Ill.
and Mo.



* NEW Regional Office VII.
Total Population (MO. and ILL)
Combined: 4,130,800

Covering 31 counties and City of St. Louis - Missouri; +overlap with Mo. RM
50 counties in Illinois ; some interface and overlap
with Illinois RMP

Demographic Information

Population Characteristics:

The Region centers around the Missouri and Illinois area around metropolitan St. Louis. Definite boundaries have not been established, but the Region encompasses more than 30 adjacent Missouri counties and about 50 counties in the southern half of Illinois. Overlap with the Missouri and Illinois RMPs account for an additional 30 counties and population of about 650,000.

The following is a summary of population distribution:

Missouri	
St. Louis County and City	1,573,600
Congressional Districts	
8, 9, 10 (30 counties)	659,500
Less overlap	<u>- 194,800</u>
	2,038,300
Illinois	
Congressional Districts	
20, 21, 23, 24 (50 counties)	1,852,300
plus scattered other areas	<u>240,500</u>
	2,092,500
Approximate combined population	4,130,800

Selected Population Characteristics:

State of Missouri

Total Pop.	% Urban	% Rural	% White	% Non-White	Density	Average Per Capita* Income
4,677.5 m.	64	36	91	11	68	\$3,659

State of Illinois

Total Pop.	% Urban	% Rural	% White	% Non-White	Density	Average Per Capita* Income
11,114.0 m.	80	20	86	14	198	\$4,516

St. Louis Metropolitan Area

Total Pop.	% White	% Non-White	Density	Average per Capita* Income
1,882,900	80	20	4,088	\$3,919

Springfield, Illinois

Total Pop.	% White	% Non-White	Density	Average Per Capita* Income
120,800	93	7	3,606	\$3,415

*Average for U. S. is \$3,680

Page 2 - Demographic Information

Average Age Distribution

	Missouri	Illinois	St. Louis	U.S.
% Under 18	33	34	32	35
% 18-64	55	56	53	55
% 65 +	12	10	15	10

Health Education Institutions

Medical Schools: St. Louis University
Washington University
Southern Illinois University (developing)

Dental Schools: St. Louis University
Washington University
Southern Illinois University
(students will enter Fall 1972)

Pharmacy: St. Louis College of Pharmacy

Nursing Schools: 15 Professional
4 Practical

Approved Allied Health Schools: 26
(includes cytotechnology, medical technology, radiologic
technology, physical therapy, and medical record librarian)

Pertinent Health Data

Hospital Facilities (Community General)

Missouri	St. Louis	Other Counties	Illinois
46	26 (includes 1 VA Hospital)	20	80

Manpower

Physicians (active, non-Federal; includes O.D.s): 4,627
Graduate Nurses (active): 9,920
Licensed Practica; Nurses (active): 3,822

Region: Bi-State
 Review Cycle: Sept/Oct 1972

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level — 03 Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 517,962	\$ 650,126	\$ 696,100	\$ 744,000			
CONTRACTS	49,392	—	—	—			
DEVELOPMENTAL COMPONENT	—	115,513	127,210	133,610			
OPERATIONAL PROJECTS	356,759	621,978	640,000	690,000			
Kidney	X	()					
EMS		(25,000)					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$ 924,113	\$1,412,617	\$1,463,310	\$1,567,610			
COUNCIL RECOMMENDED LEVEL	\$ 924,113	25 1,387,617					

JULY 21, 1972

BREAKOUT OF REQUEST
04 PROGRAM PERIOD

REGION - BI-STATE
RM 0056 10/72

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Scan

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT CCSTS	1ST YEAR INDIRECT CCSTS	TOTAL
0000 PROGRAM STAFF		\$650,126			\$650,126	\$225,670	\$875,796
0000 DEVELOPMENTAL COMPONENT				\$115,513	\$115,513		\$115,513
008 COOP REG INFORMATION SYS TEM FOR HEALTH PROCS	\$4,763				\$4,763	\$403	\$5,166
009 HEALTH SURV ED CARE FOR A WBR HSG EST	\$100,000				\$100,000	\$11,610	\$111,610
012 CORONARY CARE TRAINING P ROGRAM FOR NURSES	\$45,351				\$45,351	\$27,037	\$72,388
014 CLIN AND CYTO DETECT CAN CER INDC FOR PCP			\$40,000		\$40,000		\$40,000
015 PUB ED PROG HI ST MET AR EA ON CIG SMK		\$35,390			\$35,390		\$35,390
015 DEVELOP MODEL PHYS CONT D PAT MGMT		\$15,820			\$15,820		\$15,820
018 HEALTH SERVICE AIDE EDUC ATION		\$14,729			\$14,729		\$14,729
019 PRI HEALTH CARE DEL WELL YOUNG CHILD		\$22,094			\$22,094		\$22,094
020 FEAS EVAL EMPLOYING P N P IN VARIOUS SETTINGS		\$16,561			\$16,561	\$5,946	\$22,507
021 MANAGING MLD PROBLEMS OF AMBULATORY PATIENTS		\$23,336			\$23,336	\$10,020	\$33,356
022 DEV ALTERNATIVE MCLS HLT H INED SYSTEM		\$19,324			\$19,324	\$8,025	\$27,349
023 REG BLOOD BANK RES INFO NETWORK		\$25,000			\$25,000		\$25,000
024 TRANSPORTATION PREMATURE AND ILL INFANT		\$23,724			\$23,724		\$23,724
025 ESTABLISH COUNTY HEALTH INFORMATION SYSTEM		\$25,665			\$25,665		\$25,665
026 HEALTH CARE INST COOP IN SERVICE		\$21,620			\$21,620		\$21,620
027 NEW URBAN PRIMARY CARE S YSTEMS		\$25,500			\$25,500	\$10,200	\$35,700
028 EMERGENCY MEDICAL CARE		\$25,000			\$25,000		\$25,000
029 USE OF STD MED REC TO AC HIEVE BETTER PAT CARE		\$14,600			\$14,600	\$5,672	\$20,272
030 ESTABLISH CANCER TUMOR S UPPLEMENT PROGRAM		\$15,200			\$15,200	\$0,701	\$15,901
031 FEASIBILITY OF COMPUTRI ZATION TUMOR REGISTRIES		\$10,850			\$10,850	\$2,472	\$13,322
032 STROKE REHABILITATION		\$10,483			\$10,483		\$10,483
033 STROKE REHAB		\$26,229			\$26,229		\$26,229

JULY 21, 1972

BREAKOUT OF REQUEST
04 PROGRAM PERIOD

REGION - BI-STATE
RM 0056 1C/72

PAGE 2
HMPS-CSM-JTCGK2-1

IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CCNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT CCSTS	1ST YEAR INDIRECT CCSTS	TOTAL
034 SYS APP DEATH CERT DATA THRG MEDICLEGAL SYSTEM UNSPECIFIC GROWTH FUNDS		\$41,680			\$41,980	\$12,240	\$52,320
TOTAL	\$150,154	\$1,061,950	\$60,000	\$115,513	\$1,387,617	\$436,216	\$1,823,833

JULY 21, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - BI-STATE
RM 0056 10/72

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RMPS-CSM-JTCGR2-1

IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CCNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT CCSTS
0000 PROGRAM STAFF		\$696,100			\$696,100
0000 DEVELOPMENTAL COMPONENT				\$127,210	\$127,210
008 CCGP REG INFORMATION SYS TEM EDP HEALTH PRGMS					
009 HEALTH SURV ED CARE FOR A URB HSG PROJ					
012 CORONARY CARE TRAINING P ROGRAM FOR NURSES					
014 CLIA AND CYTO DETECT CAN CER TAGS EDP EGP			\$40,000		\$60,000
015 PUB ED PRGG BI ST MET AR EA CA CIG SMK		\$20,588			\$20,588
016 DEVELOP MODEL PHYS CCNT ED PAT MGMT		\$15,850			\$15,850
018 HEALTH SERVICE AIDE EDUC ATION					
019 PRI HEALTH CARE DEL WELL YOUNG CHILD					
020 FEAS EVAL EMPLOYING P N P IN VARIOUS SETTINGS					
021 MANAGING MED PROBLEMS OF AMBULATORY PATIENTS					
022 DEV ALTERNATIVE MCLS PLT H INFO SYSTEM					
023 REG PLCCG BANK RES INFO DEINCR					
024 TRANSPORTATION PREMATURE AND ILL INFANT					
025 ESTABLISH COUNTY HEALTH INFORMATION SYSTEM					
026 HEALTH CARE INST CCGP IN SERVICE					
027 NEW URBAN PRIMARY CARE S YSTEMS					
028 EMERGENCY MEDICAL CARE					
029 USE OF STD MED REC TO AC HIEVE BETTER PAT CARE					
030 ESTABLISH CANCER CHEM S UPPORT PROGRAM					
031 FEASIBILITY OF COMPUTERI ZATION TUMOR REGISTRIES					
032 STROKE REHABILITATION					
033 STROKE RFAE					

100

JULY 21, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - BI-STATE
RM 00056 10/72

PAGE 4
RMPS-CSM-JTCGR2-1

IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SLPPERT	(2) CNT. BEYOND APPR. PERIOD OF SUPPRT	(4) APPR. NOT PREVIOUSLY FLNGED	(1) NEW, NOT PREVIOUSLY APPRVED	2ND YEAR DIRECT COSTS
034 SYS APR DEATH CERT DATA THRU MEDICLEGAL SYSTEM UNSPECIFIED GROWTH FUNDS				\$18,022	\$18,022
TOTAL		\$732,938	\$60,000	\$145,232	\$538,170

JULY 21, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - E1-STATE
RM 00056 1C/72

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RMPS-CSP-JTC52-1

IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF		5744,000			5744,000	52,950,226
0000 DEVELOPMENTAL COMPONENT				5123,610	5123,610	5275,222
008 COOP REG INFORMATION SYS TEM FOR HEALTH PROCES						54,762
009 HEALTH SURV ED CARE FOR A LRG HSG PBCJ						1100,000
012 COMMUNITY CARE TRAINING P ROGRAM FOR NURSES						155,251
014 CLIN AND CYTO DETECT CAN CER INDO FEM POP			360,000		360,000	316,000
015 PUB ED PROG BI ST MET AR FA LN CIG SMK		115,000			115,000	171,375
016 DEVELOP MODEL PHYS CONT ED PAT MGMT						131,700
018 HEALTH SERVICE AICE EDUC ALIGN						114,785
019 PRI HEALTH CARE DEL WELL YOUNG CHILD						122,034
020 FEAS EVAL EMPLOYING P R P IN VARIOUS SETTINGS						116,551
021 MANAGING MED PROBLEMS OF AMBULATORY PATIENTS						123,224
022 DEV ALTERNATIVE MOLS HLT M INEG SYSTEM						115,224
023 REG HLCCO BANK RES INFC NETWORK						125,000
024 TRANSPORTATION PREMATURE AND ILL INFANT						123,724
025 ESTABLISH COUNTY HEALTH INFORMATION SYSTEM						125,000
026 HEALTH CARE INST COOP IN SERVICE						131,425
027 NEW URBAN PRIMARY CARE S YSTEMS						125,500
028 EMERGENCY MEDICAL CARE						125,000
029 USE OF STD MED REC TO AC HIEVE BETTER PAT CARE						114,600
030 ESTABLISH CANCER CHEM S UPPORT PROGRAM						115,200
031 FEASIBILITY OF COMPLETE ZONES INDCS FEASIBILITY						115,000
032 STROKE REHABILITATION						115,000
033 STROKE REFAE						124,100

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JULY 21, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - BI-STATE
RM 0056 10/72

PAGE 6
RMPS-CSM-JICCR2-1

IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPRT	(2) CNT. BEYOND APPR. PERIOD OF SUPPRT	(4) APPR. NOT PREVIOUSLY FUNCED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
034 SYS APR CEATH CERT DATA THRG MEDICLEGAL SYSTEM						\$41,980
UNSPECIFIED GRWTH FUNCS				\$68,022	\$68,022	\$68,044
TOTAL		\$759,000	\$60,000	\$201,632	\$1,020,632	\$3,346,419

JULY 24, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY BUDGET BY TYPE OF SUPPORT

PAGE 1

REGION 56 BI-STATE RMP SUPP YR 04
DESK MID-CONTINENT

REQUEST OCTOBER 1972 REVIEW CYCLE
RMP5-05M-JTOGRB-3

COMPONENT NO.	COMPONENT TITLE	SUPPORT YEAR	RMP5 DIRECT 1ST YR	INDIRECT 1ST YR	RMP5 TOTAL 1ST YR	RMP5 DIRECT 2ND YR	RMP5 DIRECT 3RD YR	TOTAL DIRECT ALL 3 YRS
NEW NOT PREVIOUSLY APPROVED								
0000	DEVELOPMENTAL COMPONENT	01	115,513		115,513	127,210	133,610	376,333
	UNSPECIFIED GROWTH FUNDS					18,022	68,022	86,044
NEW SUB-TOTAL			115,513		115,513	145,232	201,632	462,377
CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT								
0000	PROGRAM STAFF	04	650,126	335,650	985,816	696,100	744,000	2,090,226
015	PUB ED PREG BI ST MET ARE A ON CIG SMK	02	35,390		35,390	20,988	15,000	71,378
016	DEVELOP MCEL PHYS CONT E D PAT MGMT	02	15,850		15,850	15,850		31,700
018	HEALTH SERVICE AIDE EDUCA TION	02	14,729		14,729			14,729
019	PRI HEALTH CARE DEL WELL YOUNG CHILD	02	22,094		22,094			22,094
020	FEAS EVAL APPLCYING P N P IN VARIOUS SETTINGS	02	16,561	5,936	22,497			16,561
021	MANAGING MED PROBLEMS OF AMBLATCFY PATIENTS	02	23,336	10,030	33,366			23,336
022	DEV ALTERNATIVE MDLS HLTH INFC SYSTEM	02	18,324	8,025	26,349			18,324
023	REG BLEED BANK RES INFC N ETWCFK	02	25,000		25,000			25,000
024	TRANSPORTATION PREPATURE AND ILL INFANT	02	23,734		23,734			23,734
025	ESTABLISH COUNTY HEALTH I NFCMPATION SYSTEM	02	25,665		25,665			25,665
026	HEALTH CARE INST COOP IN SERVICE	02	21,620		21,620			21,620
027	NEW URBAN PRIMARY CARE SY STEMS	02	25,500	10,200	36,100			25,900
028	EMERGENCY MEDICAL CARE	02	25,000		25,000			25,000
029	USE CF STD MED REC TO ACH IEVE BETTER PAT CARE	02	14,600	4,672	19,272			14,600
030	ESTABLISH CANCER CHEMC SU PPLHI PPLCUM	02	15,209	6,701	21,910			15,209
031	FEASIBILITY CF CCMFUTERIZ ATION TUMOR REGISTRIES	02	10,850	3,472	14,322			10,850

-CONTINUED ON NEXT PAGE-

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JULY 24, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY BUDGET BY TYPE OF SUPPORT -CONT.-

PAGE 2

REGION 56 BI-STATE RMP SUPP YR 04
DESK MIC-CONTINENT

REQUEST OCTOBER 1972 REVIEW CYCLE
RMP5-DSM-JTOGR8-3

C O M P O N E N T		COMPONENT	RMP5	INDIRECT	RMP5	RMP5	RMP5	TOTAL
NO.	TITLE	SUPPORT YEAR	DIRECT	1ST YR	TOTAL	DIRECT	DIRECT	DIRECT
			1ST YR	1ST YR	1ST YR	2ND YR	3RD YR	ALL 3 YRS
032	STROKE REHABILITATION	02	10,483		10,483			10,483
033	STROKE REPAIR	02	26,399		26,399			26,399
034	SYS APR DEATH CERT DATA T HRG MEDICOLEGAL SYSTEM	01	41,080	12,240	53,320			41,080
CONT. BEYOND SUB-TOTAL			1,061,950	396,966	1,458,916	732,938	759,000	2,553,888
APPROVED ACT PREVIOUSLY FUNDED								
014	CLIN AND CYTO DETECT CANC ER INCC FEP PCF	01	60,000		60,000	60,000	60,000	180,000
NOT PREV SUB-TOTAL			60,000		60,000	60,000	60,000	180,000
CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT								
008	COOP REG INFORMATION SYST EM FOR HEALTH PROFS	03	4,763	603	5,366			4,763
009	HEALTH SERV ED CARE FOR A URB PSG PROJ	04	100,000	11,610	111,610			100,000
012	CONCERNARY CARE TRAINING PR CGRAM FOR NURSES	03	45,351	27,037	72,428			45,391
CONT. WITHIN SUB-TOTAL			150,154	39,250	189,404			150,154
REGION TOTALS			1,387,617	436,216	1,823,833	938,170	1,020,632	3,346,419

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JULY 24, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
LISTING OF ADDITIONAL FUNDS

PAGE 3

REGION 56 01-STATE RMP SUPP YR 04
DESK MID-CONTINENT

REQUEST OCTOBER 1972 REVIEW CYCLE
RMP5-05M-JT0GRB-3

COMPONENT NUMBER	RMP5 TOTAL	GRANT RELATED INTEREST	INCOME OTHER	STATE FUNDS	LCCAL FUNDS	OTHER FEDERAL FUNDS	OTHER NON-FEDERAL FUNDS	TOTAL DIRECT ASSISTANCE	TOTAL FUNDS THIS PERIOD
NEW ACT PREVIOUSLY APPROVED									
DCCC	115,513								115,513
999									
NEW SUB-TOTAL									
	115,513								115,513
CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT									
C000	985,816								985,816
015	35,390								35,390
016	15,850								15,850
018	14,729								14,729
019	22,094								22,094
020	22,497								22,497
021	33,366								33,366
022	26,349								26,349
023	25,000								25,000
024	23,734								23,734
025	25,665								25,665
026	21,620								21,620
027	36,100								36,100
028	25,000								25,000
029	19,272								19,272
030	21,910								21,910
031	14,322								14,322
032	10,483								10,483

JULY 24, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
LISTING OF ADDITIONAL FUNDS

PAGE 4

REGION 56 BI-STATE RMP SUPP YR C4
DESK MID-CONTINENT

REQUEST OCTOBER 1972 REVIEW CYCLE
RMP5-OSM-JTOGR8-3

COMPONENT NUMBER	RMP TOTAL	GRANT RELATED INTEREST	INCOME OTHER	STATE FUNDS	LOCAL FUNDS	OTHER FEDERAL FUNDS	OTHER NON-FEDERAL FUNDS	TOTAL DIRECT ASSISTANCE	TOTAL FUNDS THIS PERIOD
033	26,399								26,399
034	53,320								53,320
CCAT. BEYOND SUB-TOTAL									
	1,458,916								1,458,916
APPROVED NOT PREVIOUSLY FUNDED									
014	60,000								60,000
NOT PREV SUB-TOTAL									
	60,000								60,000
CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT									
008	5,366								5,366
009	111,610								111,610
012	72,428								72,428
CCAT. WITHIN SUB-TOTAL									
	189,404								189,404
REGION TOTALS									
	1,823,833								1,823,833

ALLOCATION OF DOLLARS AND STAFFING RESOURCES

1971-72 03				1972-73 04 (Request)					
		Dollars	% of Total			Dollars	% of Total		
Program Staff		\$542,083	58.7	\$		650,126	46.9		
Projects		382,030	41.3			621,978	44.8		
Developmental Component		—	—			115,513	8.3		
Total		\$924,113	100.0	\$1,387,617			100.0		
		Positions (F.T.E.)	Dollars	% of Total			Positions (F.T.E.)	Dollars	% of Total
Central	19	(18.00)	\$264,865	61.1	19	(18.25)	\$295,726	61.1	
Field	6	(5.25)	60,256	13.9	6	(5.25)	67,300	13.9	
University	10	(6.50)	108,373	25.0	10	(6.50)	121,100	25.0	
Total	35	(29.75 F.T.E.)	\$433,494	100.0	35	(29.75 F.T.E.)	\$484,326	100.0	

HISTORICAL PROGRAM PROFILE OF REGION

The BSRMP began its planning in an area rich in medical resources and complex in government structure and inner city problems. The initial planning award was made in April 1967. Drs. Danforth and Felix (Washington University and St. Louis University respectively) acted as co-coordinators until Dr. William Stoneman, a plastic surgeon and faculty member at St. Louis University, was appointed Coordinator in November 1968. A consortium of the Region's three universities (Washington, St. Louis and Southern Illinois) delegated the grantee responsibilities to Washington University. Early concerns of reviewers dealt with 1) the need for more minority members on the RAG, 2) the question of meaningful input from a RAG whose membership was so large (56 members), and 3) the heavy categorical emphasis. With regard to the latter, the RMP had structured its planning and proposal development utilizing a mechanism of eight program committees and associate categorical directors on Program Staff.

University people were heavily involved in the Scientific and Educational Review and Administrative Liaison Committees. During its second planning year the RAG's Executive Committee developed recommendations which sought to involve its members more directly in the planning and direction of the program by increasing its membership, holding more meetings and studying the RMP in depth.

After a pre-operational site visit, the RMP applied for and received operational status in 1969. Problems in getting the RMP going took RMPS Director, Dr. Stanley Olson, to St. Louis to meet with RMP representatives. He found intense separation of the two St. Louis medical schools which had shared a history of not being particularly interested in serving the community. It was hoped that the RMP might serve as a catalyst in getting the schools to pull together in an attempt to improve the health care delivery system. The program received an award of \$881,387. for Program Staff and five projects for its first operational year. Project activities included:

- #2 Radiation Therapy Support Program
- #4 Comprehensive Diagnostic
Demonstration Unit for Stroke
- #5 Nursing Demonstration Unit in Early Intensive Care of
Acute Stroke
- #8 Cooperative Regional Information System for the Health
Professions
- #9 Health Surveillance, Education and Care for Residents
of Pruitt Igoe

The new Southern Illinois University School of Medicine appointed a Dean and plans were made to add associate coordinators from S. I. U. to the staff. Problems began to surface in 1970 with the S. I. U. Medical School in Springfield where both Illinois and Bi-State RMPs planned to establish subregional offices in the area. The Illinois RMP placed a Subregional Coordinator in Springfield for a time, but neither RMP presently has staff in that area.

In reviewing the RMP's application for its second operational year, RMPS staff was concerned that the projects proposed had minimal impact outside the existing system and did little to improve the existing inequities. Reviewers noted that minority and consumer input on RAG had been increased, the Executive Committee was reorganized, and evaluation and outreach capabilities were added to Program Staff. The following projects were funded:

- #2 Radiation Therapy
- #4 Diagnostic Demonstration Unit for Stroke
- #5 Nursing Demonstration Unit for Stroke
- #8 Regional Information System for the Health Professions
- #9 Pruitt Igoe
- #12 CCU Nurse Training

The RMP is presently in its 03 year. Although the RMP requested triennial support last year, Council believed that an additional year was needed in order for the RMP to realign itself in order to develop a program more in line with the RMPS mission. While Bi-State had gained increased consumer participation in its program, most of the funds in the application were destined for institutional rather than community ventures. In addition, continuation and approved but unfunded projects appeared to be more of the "same old thing." Reviewers were also concerned about the continued categorical emphasis and the actual contribution of the categorical associate directors based in the medical schools. It was recommended that the RMP give further attention to the fragmentation of the Region in relation to the Illinois RMP. Parenthetically, since that time the Coordinators of the two programs have met with Southern Illinois University and Dr. Stoneman prepared a statement concerning BSRMP involvement in this part of the Region. As a result of this, S. I. U. has reaffirmed its commitment to the consortium. The BSRMP is actively recruiting for the two S. I. U. associate coordinatorships and the positions may be filled by the end of September. Dr. Stoneman also has someone in mind for the regional field coordinator position for the Springfield area.



A management assessment visit was held in April 1972. The team found the RAG and Executive Committee to be inactive and its members uninformed. The powerful committees created by the consortium of the three medical schools appeared to have assumed almost total authority for both the program and administrative aspects of the RMP. The team's recommendations included: 1) giving the RAG more decisionmaking authority, 2) reorganizing program staff, 3) improving fiscal reporting procedures, and 4) developing a property management system. The RMP's response to these recommendations is expected before the time of the site visit.

The RMP was awarded \$1,450,757 for a 15-month budget period (\$1,160,604 on an annualized level). This figure includes funds for the following groups of activities:

- A. Program Staff
- B. St. Louis EMS project
- C. Two health services/education activities (Carbondale and St. Louis)
- D. Other approved projects
 - #2 Radiation Therapy
 - #4 Comprehensive Stroke Unit
 - #5 Nursing Demonstration Unit - Stroke
 - #8 Regional Information System
 - #9 Pruitt Igoe
 - #12 CCU Nurse Training
 - #15 Smoking and Health
 - #16 Physician Continuing Education for Patient Management
- E. Three-months of support for 17 new one-year activities included in the triennial application.

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

MEMORANDUM

TO : The Site Visitors of the Bi-State RMP

DATE: August 15, 1972

FROM : Operations Officer
Mid-Continent Operations Branch

SUBJECT: Staff Review of the Bi-State Triennial Application, RM 00056

A staff review of the Bi-State Triennial Application was held Monday, July 31, and was attended by the following people:

- Marlene Hall, Office of Planning and Evaluation
- Loren Hellickson, Office of Systems Management
- Dona Houseal, Mid-Continent Operations Branch
- Margaret Hulbert, Division of Professional and Technical Development
- Jennie Peterson, Mid-Continent Operations Branch
- Pat Schoeni, Office of Communications
- Annie Stubbs, Grants Management Branch
- Jone Williams, Mid-Continent Operations Branch

Staff met to discuss the RMP's accomplishments, problems and issues for the visit.

The RMP's request for the triennium includes:

	04	05	06
Core	650,126	696,100	744,000
Projects	621,978	640,000	690,000
Developmental Component	<u>115,513</u>	<u>127,210</u>	<u>133,610</u>
TOTAL	\$1,412,617	\$1,463,310	\$1,567,610

Staff noted that the request for the developmental component exceeded the permissible amount of \$92,400 (computed on the basis of ten percent of the 03 year direct cost funding level).

A. Accomplishments

The Bi-State RMP has taken a new approach to program development which staff found noteworthy. Their plan, which solicited small (\$25,000 range) proposals around ideas generated by the RAC, appeared to present a realistic method of developing activities which would be relevant to the Region's goals, objectives and priorities. In addition, some of the

Page 2 - The Site Visitors of the Bi-State RMP

projects address regional health care delivery problems in ways which are more innovative and which may have more immediate payoff. Examples include primary health care programs for children and an urban population, use of the pediatric nurse practitioner, and an investigation of techniques of improving ambulatory care.

In addition to those examples of program staff assistance described in the RAG Report (pp. 42-45) and in the Core Activities summary (p. 137), RMPS staff noted that the Bi-State RMP provided staff assistance in developing the Experimental Health Services Delivery System application, which was recently approved and funded by the National Center for Health Services Research and Development, HSMHA.

B. Problems and Issues

1. The Region's response to the management assessment report will be in two parts. The first response has been submitted by the grantee agency and was included in the site visit packet. The second to be sent from the Coordinator and the RAG, will be available to you at the time of the site visit. In regard to the first, members of the management assessment team reiterated their belief that the problem basically lies in a difference of philosophy between RMPS and the Bi-State RMP as to who should control the program — RAG or grantee (the Consortium). While the RMP maintains that the Consortium reviews projects only to assure good stewardship of federal funds, the management assessment team's observation was that their fiscal control overlaps into program areas. The team feared that the schools would recommend funding only for projects which suit their special interests and that the RAG would be either unwilling or too weak to oppose the medical establishment. Staff also noted that Form 14 indicated minimal involvement of RAG in project monitoring.

Staff noted that of the 23 projects in the application, ten are university-sponsored and another five are associated with university-affiliated hospitals.

2. Staff examined the goals and objectives and concluded that the RMP needs a clearer understanding of the separation between goals, objectives and activities. The rationale behind the matching of goals, objectives and activities with each other, as well as the progression from one year to the next (with some goals and objectives being added or dropped) was unclear.

3. The charge to the site visit team with regard to the turf problem will be to gather more information and possibly make suggestions to RMPS staff as to how this might be handled. It will not be the responsibility of the team to settle this issue. Incidentally, staff

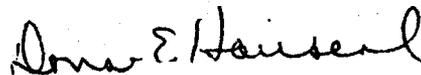
Page 3 - The Site Visitors of the Bi-State RMP

learned that Dr. Creditor, Coordinator of the Illinois RMP, had sent letters (copy attached) to the Illinois CHP "b" agencies requesting their impressions on the boundary problem. Of the 74 RAG members, 46 are from St. Louis, five from Missouri and 23 from Illinois.

4. Staff thought there was a need for more minorities on program staff and the RAG. They also found the representation of women on the RAG (8) and Executive Committee (2) to be low.

5. It was noted that Dr. Stoneman is President-Elect of the St. Louis Medical Society. Since Dr. Stoneman also carries out a part-time practice in plastic surgery, staff thought it imperative for him to consider both hiring a strong Deputy Director and reorganizing staff to allow him more time for overall program direction and development.

6. Staff was also concerned with the categorical emphasis as exhibited in the categorical associate directors on program staff, the program committees and a number of the projects. Some staff members indicated a need for more projects which would provide the consumer with information on how to better enter and use the health care system. They were also curious about the extent of consumer involvement on the health care delivery committee, as well as the amount of collaboration with CHP "b" agencies in subregional planning.



Dona E. Houseal

Attachment

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>03</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 517,962	\$ 650,126	\$ 696,100	\$ 744,000			
CONTRACTS	49,392	---	---	---			
DEVELOPMENTAL COMPONENT	---	115,513	127,210	133,610			
OPERATIONAL PROJECTS	356,759	621,978	640,000	690,000			
Kidney	X	()					
EMS		(25,000)					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$ 924,113	\$1,387,617	\$1,463,310	\$1,567,610			
COUNCIL RECOMMENDED LEVEL	\$ 924,113						

JULY 21, 1972

BREAKOUT OF REQUEST
04 PROGRAM PERIOD

REGION - BI-STATE
HM 00056 10/72

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Turn

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF							
0000 DEVELOPMENTAL COMPONENT		\$650,126			\$650,126	\$225,690	\$875,816
				\$115,513	\$115,513		\$115,513
008 CCRP REG INFORMATION SYS TEM FOR HEALTH PROGS	\$4,763				\$4,763	\$692	\$5,455
009 HEALTH SURV ED CARE FOR A URB HSC PROJ	\$100,000				\$100,000	\$11,610	\$111,610
012 CONSUMER CARE TRAINING PI ROGRAM FOR NURSES	\$45,351				\$45,351	\$27,637	\$72,988
014 CLIN AND CYTO DETECT CAN CER PROG FOR POP			\$60,000		\$60,000		\$60,000
015 PUB ED PROG PI ST MET AR SA ON CIG SMK		\$35,290			\$35,290		\$35,290
016 DEVELOP MODEL PHYS CONT ROL PLAN		\$15,850			\$15,850		\$15,850
018 HEALTH SERVICE AIDE EDUC ATION		\$14,725			\$14,725		\$14,725
019 PRI HEALTH CARE DEL WELL YOUNG CHILD		\$22,054			\$22,054		\$22,054
020 FEAS EVAL EMPLOYING P N P IN VARIOUS SETTINGS		\$16,561			\$16,561	\$5,520	\$22,081
021 MANAGING MED PROBLEMS OF AMBULATORY PATIENTS		\$23,336			\$23,336	\$10,730	\$34,066
022 DEV ALTERNATIVE MCLS HLT H INFO SYSTEM		\$18,324			\$18,324	\$8,025	\$26,349
023 REG BLCCD BANK RES INFO NETWORK		\$25,000			\$25,000		\$25,000
024 TRANSPORTATION INFORMATION AND ILL INFANT		\$23,734			\$23,734		\$23,734
025 ESTABLISH COUNTY HEALTH INFORMATION SYSTEM		\$25,665			\$25,665		\$25,665
026 HEALTH CARE INST COOP IN SERVICE		\$21,620			\$21,620		\$21,620
027 NEW URBAN PRIMARY CARE S YSTEMS		\$25,500			\$25,500	\$10,200	\$35,700
028 EMERGENCY MEDICAL CARE		\$25,000			\$25,000		\$25,000
029 USE OF STD MED REC TO AC HIEVE BETTER PAT CARE		\$14,600			\$14,600	\$4,672	\$19,272
030 ESTABLISH CAREER COUNSEL ING UNIT PROGRAM		\$10,200			\$10,200	\$5,700	\$15,900
031 FEASIBILITY OF COMMUNITY ACTION THROUGH SOCIETIES		\$10,850			\$10,850	\$2,100	\$12,950
032 STROKE REHABILITATION		\$10,483			\$10,483		\$10,483
033 STROKE REHAB		\$26,325			\$26,325		\$26,325

JULY 21, 1977

BREAKOUT OF REQUEST
04 PROGRAM PERIOD

REGION - 01-STATE
RM 0006 10/72

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IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW. NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
034 SYS APP DEATH CERT DATA THRS MEDICLEGAL SYSTEM UNSPECIFIED GROWTH FUNDS		\$41,680			\$41,050	\$12,252	\$53,322
TOTAL	\$150,154	\$1,061,950	\$60,000	\$115,513	\$1,387,617	\$436,216	\$1,823,833

JULY 21, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - BI-STATE
RM 0056 10/72
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IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
C000 PROGRAM STAFF		\$656,100			\$656,100
D000 DEVELOPMENTAL COMPONENT				\$127,210	\$127,210
008 COOP REG INFORMATION SYS TEM FOR HEALTH PRCS					
009 HEALTH SERV ED CARE FOR A URB HSG PROJ					
012 CORCARY CARE TRAINING P ROGRAM FOR NURSES					
014 CLIN AND CYTO DETECT CAN CER INDC FEM EOP			\$60,000		\$60,000
015 PUB ED PROG BI ST MET AR EA CN CIG SPM		\$20,588			\$20,588
016 DEVELOP MODEL PHYS CNT ED PAT MGMT		\$15,850			\$15,850
018 HEALTH SERVICE AIDE EDUC ATION					
019 PRI HEALTH CARE DEL WELL YOUNG CHILD					
020 FEAS EVAL EMPLOYING P N P IN VARIOUS SETTINGS					
021 MANAGING MED PROBLEMS OF AMBULATORY PATIENTS					
022 DEV ALTERNATIVE MDS HLT H INFO SYSTEM					
023 REG PLCCO BANK RES INFO NETWORK					
024 TRANSPORTATION, PREMATURE AND ILL INFANT					
025 ESTABLISH COUNTY HEALTH INFORMATION SYSTEM					
026 HEALTH CARE INST COOP IN SERVICE					
027 NEW URBAN PRIMARY CARE S YSTEMS					
028 EMERGENCY MEDICAL CARE					
029 USE OF STD MED REC TC AC MILVE HEALTH PAT COPS					
030 ESTABLISH CANCER CHEM S URVEY PROGRAM					
031 FEASIBILITY OF COMPUTERI ZATION IN REGISRIES					
032 STROKE REHABILITATION					
033 STROKE REHAB					

JULY 21, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - BI-STATE
RM 00056 10/72

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IDENTIFICATION OF COMPONENT	(5) CENT. WITHIN APPR. PERIOD OF SUPPORT	(2) CENT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY PLACED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
034 SYS APPR DEATH CERT DATA THRG MEDICOLEGAL SYSTEM UNSPECIFIED CROWTH FUNDS				\$543,612	\$543,612
TOTAL		\$732,938	\$60,000	\$670,822	\$1,463,310

JULY 21, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - BI-STATE
RM 00056 10/72

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RMPS-CSP-JTCGR2-1

IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPRT	(2) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
C000 PROGRAM STAFF		\$744,000			\$744,000	\$2,950,226
D000 DEVELOPMENTAL COMPONENT				\$133,610	\$133,610	\$276,322
008 CCGP REG INFORMATION SYS TEM FOR HEALTH RECS						\$4,762
009 HEALTH SURV ED CARE FOR A URB PSG PROJ						\$166,000
012 COMONARY CARE TRAINING P ROGRAM FOR NURSES						\$55,391
014 CLIN AND CYTO DETECT CAN CER INDG EEP POP			\$60,000		\$60,000	\$160,000
015 PUB ED PRCG BI ST MET AR FA CA CIG SMK		\$15,000			\$15,000	\$21,378
016 DEVELOP MODEL PHYS CNT ED PAT MGMT						\$31,700
018 HEALTH SERVICE AIDE EDUC ATION						\$14,725
019 PRI HEALTH CARE DEL WELL YOUNG CHILD						\$22,094
020 FEAS EVAL EMPLOYING P N P IN VARIOLS SETTINGS						\$16,561
021 MANAGING PED PROBLEMS OF AMBULATORY PATIENTS						\$23,224
022 DEV ALTERNATIVE MCLS HLT H INFO SYSTEM						\$18,324
023 REG BLCCC BANK RES INFO NETWORK						\$25,000
024 TRANSPORTATION PREMATURE AND ILL INFANT						\$22,726
025 ESTABLISH COUNTY HEALTH INFORMATION SYSTEM						\$25,605
026 HEALTH CARE INST CCGP IN SERVICE						\$21,620
027 NEW URBAN PRIMARY CARE S YSTEMS						\$25,500
028 EMERGENCY MEDICAL CARE						\$25,000
029 USE OF STD MED REC TO AC HIEVE BETTER PAT CARE						\$16,600
030 ESTABLISH CANCER CHEPC S UPPORT PROGRAM						\$15,200
031 FEASIBILITY OF COMPUTERI ZATION IUMLR LEGISLATION						\$12,000
032 STROKE REHABILITATION						\$10,900
033 STROKE REHAB						\$26,250

JULY 21, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - BI-STATE
RM 0056 10/72

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HMPS-CSM-J10CP2-1

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
034 SYS APR DEATH CERT DATA THRU MEDICOLEGAL SYSTEM UNSPECIFIED GROWTH FUNDS						\$41,000
				\$615,000	\$615,000	\$1,158,612
TOTAL		\$759,000	\$60,000	\$748,610	\$1,567,610	\$4,443,537

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FUNDING HISTORY LIST

RMPS-DSM-JTOFFL-20

REGION 56 BI-STATE

RMP SUPP YR 03

OPERATIONAL CRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		01	02 11/70-05/71	03 10/71-12/72	TOTAL	04 01/73-12/73	05 01/74-12/74	06 01/75-12/75	TOTAL
CCCC	PRCGRAM STAFF	559500	445093	647450	1652043	650126	656100	744000	2090226
0000	DEVELOPMENTAL C					115513	127210	133610	376333
002	CCCP REG RACRX	152100	108100	100275	360475				
004	COMPR DX DEMONS	92200	42000	43384	177584				
005	EST N DEMO UNIT	80100	57713	56055	193868				
008	CCCP REG INFO S	66700	30300	16739	113739	4763			4763
009	DEMO PPO OF HLT	142500	131600	125000	400100	100000			100000
012	CONCERNARY CARE T		60300	52000	112300	45391			45391
014	CLIA AND CYTO D					60000	60000	60000	180000
015	PUB EC PROGS I			8848	8848	35390	20988	15000	71378
016	DEVELOP MODEL			12000	12000	15850	15850		31700
017	MET. ST. LOUIS			200000	200000				
018	HEALTH SERVICE			3682	3682	14729			14729
019	PRI. HEALTH CA			7366	7366	22094			22094
020	FEAS. & EVAL.			5520	5520	16561			16561
021	MANAGING MED.			5835	5835	23336			23336
022	DEV OF ALTERNA			4581	4581	18324			18324
023	REG. ELCCD BAN			6250	6250	25000			25000
024	TRANSCRIPTION			5934	5934	23734			23734
025	ESTABLISH A CO			6416	6416	25665			25665
026	HEALTH-CARE IA			5405	5405	21620			21620
027	NEW URBAN PRIM			6475	6475	25900			25900
028	EMERGENCY MCDI			6251	6251	25000			25000
029	USE OF A STD P			3650	3650	14600			14600
030	ESTABLISH A CA			3603	3603	15209			15209
031	FEASIBILITY CF			2713	2713	10850			10850
032	STROKE REPARIL			2622	2622	10483			10483
033	STROKE REPARIL			6600	6600	26399			26399
034	SYS. APP.-DEAT			10271	10271	41080			41080
035	STRENGTHEN MET			46557	46557				
036	CCCPCINATE FEA			48665	48665				
	UNSPECIFIED GRO						18022	68022	86044
	- T C T A L -	1094 70	875106	1450757	3419963	1387617	938170	1020632	3346419

JULY 24, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY BUDGET BY TYPE OF SUPPORT

PAGE 1

REGION 56 BI-STATE RMP SUPP YR 04
DESK MID-CONTINENT

REQUEST OCTOBER 1972 REVIEW CYCLE
RMP5-05M-JTCGRB-3

C O M P O N E N T		COMPONENT SUPPORT YEAR	RMP5	INDIRECT	RMP5	RMP5	RMP5	TOTAL
NO.	TITLE		DIRECT 1ST YR	1ST YR	TOTAL 1ST YR	DIRECT 2ND YR	DIRECT 3RD YR	DIRECT ALL 3 YRS
NEW NOT PREVIOUSLY APPROVED								
0000	DEVELOPMENTAL COMPONENT	01	115,513		115,513	127,210	133,610	376,333
	UNSPECIFIED GROWTH FUNDS					18,022	68,022	86,044
NEW SUB-TOTAL			115,513		115,513	145,232	201,632	462,377
CONTINUATION BEYOND APPROVED PERIOD OF SUPPORT								
0000	PROGRAM STAFF	04	650,126	335,650	985,816	696,100	744,000	2,090,226
015	PUB ED PRCG BI ST MET ARE A ON CIG SMK	02	35,390		35,390	20,988	15,000	71,378
016	DEVELOP MCEEL PHYS CONT E D PAT MGMT	02	15,850		15,850	15,850		31,700
018	HEALTH SERVICE AIDE EDUCA TICA	02	14,729		14,729			14,729
019	PRI HEALTH CARE DEL WELL YOUNG CHILD	02	22,094		22,094			22,094
020	FEAS EVAL EMPLOYING P N P IN VARIOUS SETTINGS	02	16,561	5,936	22,497			16,561
021	MANAGING MED PROBLEMS OF AMBLIATCPY PATIENTS	02	23,336	10,030	33,366			23,336
022	DEV ALTERNATIVE MDLS HLTH IADC SYSTEM	02	18,324	8,025	26,349			18,324
023	REG BLCCC BANK RES INFC N ETWCRK	02	25,000		25,000			25,000
024	TRANSPORTATION PREPATURE AND ILL INFANT	02	23,734		23,734			23,734
025	ESTABLISH COUNTY HEALTH I NFCMPATION SYSTEM	02	25,665		25,665			25,665
026	HEALTH CARE INST COOP IN SERVICE	02	21,620		21,620			21,620
027	NEW URBAN PRIMARY CARE SY SILMS	02	25,900	10,200	36,100			25,900
028	EMERGENCY MEDICAL CARE	02	25,000		25,000			25,000
029	USE OF STD MED REC TO ACH IEVE BETTER PAT CARE	02	14,600	4,672	19,272			14,600
030	ESTABLISH CANCER CHEMC SU PPLHI PPLCHAM	02	15,209	6,701	21,910			15,209
031	FEASIBILITY OF COMPUTERIZ ATION TUMOR REGISTRIES	02	10,850	3,472	14,322			10,850

-CONTINUED ON NEXT PAGE-

JULY 24, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
SUMMARY BUDGET BY TYPE OF SUPPORT -CONT.-

PAGE 2

REGION 56 BI-STATE RMP SUPP YR 04
DESK MIC-CONTINENT

REQUEST OCTOBER 1972 REVIEW CYCLE
RMP5-OSM-JTOGR8-3

C O M P O N E N T NO.	TITLE	COMPONENT SUPPORT YEAR	RMP5 DIRECT 1ST YR	INDIRECT 1ST YR	RMP5 TOTAL 1ST YR	RMP5 DIRECT 2ND YR	RMP5 DIRECT 3RD YR	TOTAL DIRECT ALL 3 YRS
032	STROKE REHABILITATION	02	10,483		10,483			10,483
033	STROKE REHAB	02	26,399		26,399			26,399
034	SYS APP CEATH CERT DATA T PRG MEDICLEGAL SYSTEM	01	41,080	12,240	53,320			41,080
CONT. BEYOND SUB-TOTAL			1,061,950	396,966	1,458,916	732,938	759,000	2,552,888
APPROVED ACT PREVIOUSLY FUNDED								
014	CLIN AND CYTO DETECT CANC ER INCE FEP PCF	01	60,000		60,000	60,000	60,000	180,000
NOT PREV SUB-TOTAL			60,000		60,000	60,000	60,000	180,000
CONTINUATION WITHIN APPROVED PERIOD OF SUPPORT								
008	COOP REG INFORMATION SYST IM FOR HEALTH PROFS	03	4,763	603	5,366			4,763
009	HEALTH SURV ED CARE FOR A URB HSG PROJ	04	100,000	11,610	111,610			100,000
012	CCRNARY CARE TRAINING PR CGRAM FOR NURSES	03	45,391	27,037	72,428			45,391
CONT. WITHIN SUB-TOTAL			150,154	39,250	189,404			150,154
REGION TOTALS			1,387,617	436,216	1,823,833	938,170	1,020,632	3,346,419

RMPs STAFF BRIEFING DOCUMENTREGION: CaliforniaOPERATIONS BRANCH: WesternNUMBER: RM 00019Chief: Richard L. RussellCOORDINATOR: Mr. Paul Ward

Staff for RMP:

James Smith, Public Health AdvisorPeggy Noble, Back-upCharles Barnes, GMB OfficerJoe de la Fuente, P and ELAST RATING: 370

TYPE OF APPLICATION:

 / Triennial / 3rd Year
 / Triennial / Triennial / 2nd Year
 / Triennial / OtherRegional Office Representative:
Ronald Currie

Management Survey (Date):

Conducted: _____

or

Scheduled: _____

Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)
 June 10-11, 1971 Clark H. Millikan, M.D., Chairman, NAC Member
 Joseph W. Hess, M.D., Review Committee Member
 Henry M. Wood, Director of Urban Health Planning
 James A. Rock, M.D., Chairman RAG, Western Penn. RMP
 Edward Davens, M.D., Coordinator, Maryland RMP.

Staff Visits in Last 12 Months:

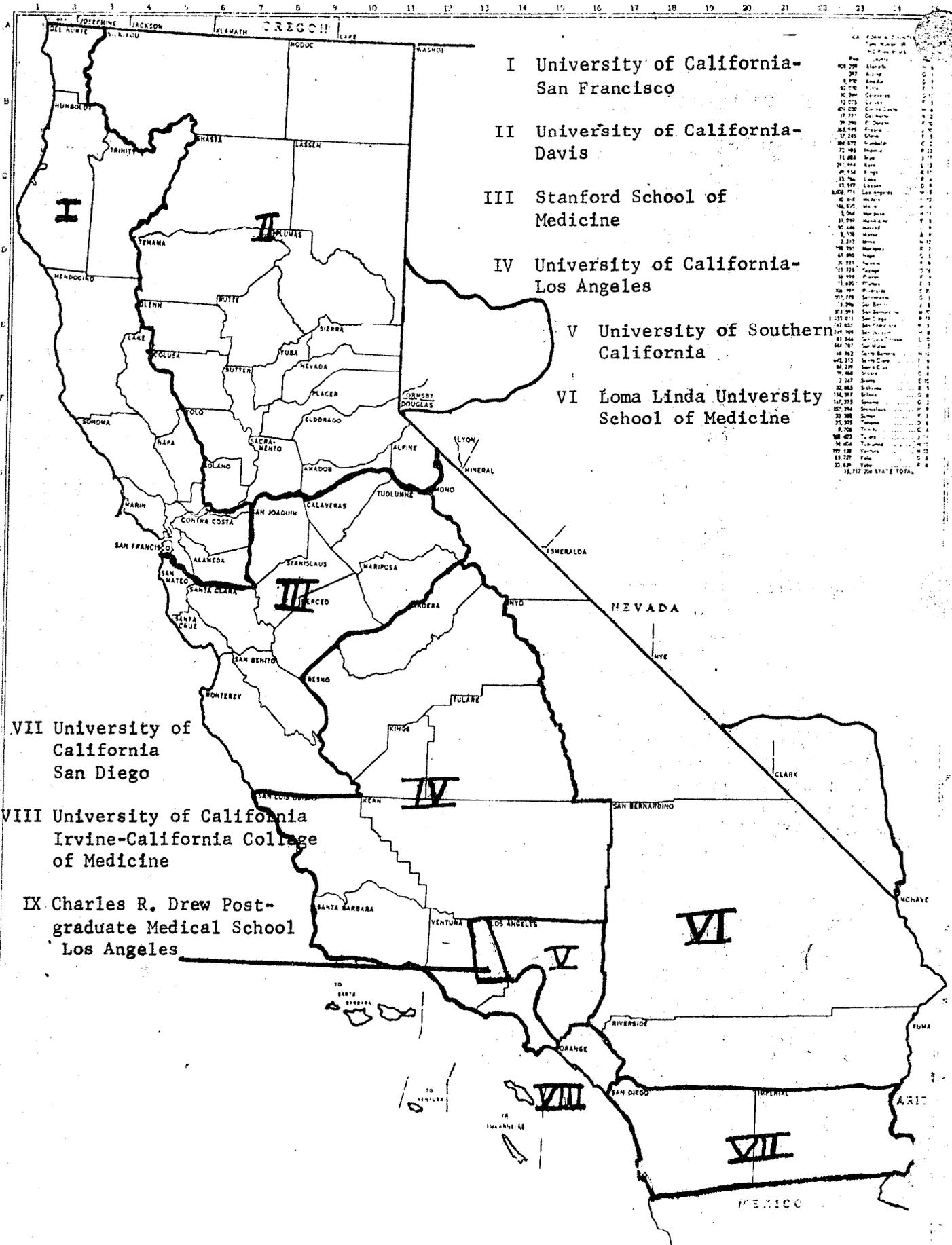
(List Date and Purpose)

- Nov. 11, 1971 Jessie Salazar, to participate in AHEC Conference
- Nov. 23, 1971 Richard Russell to meet with California Staff
- April 8-May 4, 1972 Peggy Noble, field training
- Sept. 28, 1971 Jessie Salazar, to participate in HMO Conference and to attend CCRMP Priorities and RAG meetings

Recent Events Occurring in Geographic Area of Region That Are Affecting RMP Program:

1. The CCRMP is presently undergoing DHEW (program) and OGAP (fiscal) audits of the 02-03 operational years.
2. During May 1971, a critical issue emerged in California over the role of the CHP/RMP in planning. CHP "B" agencies feel that the CCRMP is making an aggressive move to take on a planning function to the exclusion of CHP activities.

RAND McNALLY
STATE COUNTY OUTLINE MAP



I University of California-
San Francisco

II University of California-
Davis

III Stanford School of
Medicine

IV University of California-
Los Angeles

V University of Southern
California

VI Loma Linda University
School of Medicine

VII University of
California
San Diego

VIII University of California
Irvine-California College
of Medicine

IX Charles R. Drew Post-
graduate Medical School
Los Angeles

Pop.	Area	Pop. Density
828,728	Alameda	100.0
267	Alpine	0.1
8,476	Amador	0.1
10,244	Butte	0.1
10,244	Calaveras	0.1
12,573	Colusa	0.1
42,020	Contra Costa	0.2
17,221	Del Norte	0.2
10,244	El Dorado	0.1
165,195	Fresno	0.3
17,245	Ghana	0.1
88,879	Humboldt	0.2
72,463	Inyo	0.2
11,888	Kern	0.1
70,164	Kings	0.1
46,114	Lake	0.1
13,766	Lassen	0.1
13,977	Los Angeles	0.2
1,628,771	Los Angeles	0.3
46,424	Madera	0.1
146,872	Mariposa	0.1
1,564	Merced	0.1
10,244	Monterey	0.1
40,126	Napa	0.1
8,708	Nevada	0.1
2,217	Nevada	0.1
10,244	Orange	0.1
41,890	Placer	0.1
78,111	Plumas	0.1
11,123	Plumas	0.1
34,999	San Bernardino	0.1
11,692	San Bernardino	0.1
50,191	San Bernardino	0.1
970,728	San Bernardino	0.3
11,296	San Bernardino	0.1
81,911	San Bernardino	0.1
1,131,011	San Diego	0.3
141,825	San Diego	0.1
24,999	San Diego	0.1
81,844	San Diego	0.1
44,787	San Diego	0.1
44,942	San Diego	0.1
442,213	San Diego	0.1
84,218	San Diego	0.1
70,844	San Diego	0.1
2,247	San Diego	0.1
32,843	San Diego	0.1
134,977	San Diego	0.1
147,375	San Diego	0.1
87,294	San Diego	0.1
33,388	San Diego	0.1
75,325	San Diego	0.1
8,708	San Diego	0.1
105,423	San Diego	0.1
14,624	San Diego	0.1
99,128	San Diego	0.1
63,727	San Diego	0.1
33,429	San Diego	0.1
15,717	THE STATE TOTAL	

I. REGIONAL CHARACTERISTICS

DEMOGRAPHY

POPULATION: (See 4 a) Approximate populations by SubAreas.

Total Population : 19,953,100
 Population Density : 128 per sq. mi.

% Urban: 91
 % Non-white: 11% Rural 9%
 Blacks 7%
 other 4%

METROPOLITAN AREAS

Name of SMSA	Population (in '000's)
Total (14)	17,944.6
Anaheim-Santa Ana (Orange Cty)	1,409.3
Bakersfield-Kern Cty.	325.0
Fresno	407.0
Los Angeles-Long Beach	6,974.1
Oxnard-Ventura (Vent. Cty)	374.4
Sacramento	853.1
Salinas-Monterey	248.8
Santa Barbara	260.3
Stockton (San Joaquin)	284.5
Vallejo- Napa	241.3
San Bernadino	1122.0
Riverside-Ontario-San Diego	1,318.0
San Francisco-Oakland	3,069.8
San Jose (Santa Clara Cty)	1,057.0

AGE DISTRIBUTION

Percent of Total by Specified Age Group, 1970		
Age Group	State	U.S.
Under 18 yrs.	34	35
18 - 65 yrs.	55	55
65 yrs. & over	9	10

Source: Bureau of the Census- PC (V1 & V2) 1970 - 1970 Census of Population; State and County #6
 Bureau of the Census - PC (P3) - 3, U.S. Population of Standard Metropolitan Statistical Areas, 1970.

INCOME - Average Income per Individual, 1969/1970

State (of RMP)	\$4272	\$4469-----Ranks 8th
United States	\$3680	\$3910

Source: State data from Statistical Abstract of the U.S., 1970 (Dept. of Commerce)

California - Sub Areas

Population and Counties (1970 Census)

Cmerf - Calif. RMP comprises 9 sub areas, 3 in the Northern part and 6 in the Southern part, each centered around a medical school or developing center.

<u>Northern Areas</u>	<u>Counties</u>	<u>Approx. pop.</u>
Area I - San Francisco	11	3,029,800
II - Davis-Sacramento	20	1,448,200
III - Stanford (Palo Alto)	<u>11</u>	<u>2,644,100</u>
	42	7,122,100
 <u>Southern Areas</u>		
Area IV - UCLA	7	1,406,700
V - USC (Los Angeles)	1	6,882,000*
VI - Loma Linda	4	1,162,800
VII - San Diego	2	1,432,400
VIII - Irwine	1	1,420,400
IX - Watts-Willowbrook	<u>1</u>	<u>526,700</u>
	<u>16</u>	<u>12,831,000</u>
Totals	58	19,953,100

Total population since the Census is probably over 20 million.

*Parts of Los Angeles County overlap with other areas.

California - Sub Areas

Population by County (1970 Census)
(in thousands)

Northern Areas

Area I - San Francisco
(11 Counties)

San Francisco	715.7
Del Norte	14.6
Humboldt	99.7
Trinity	7.6
Menetocino	51.1
Sauoma	204.9
Lake	19.5
Napa	79.1
Marin	206.0
Contra Costa	558.4
Alameda	<u>1073.2</u>
	3029.8

Area II - Davis-Sacramento -
(20 Counties)

Siskiyou	33.2	Solano	169.9
Modoc	7.5	Sacramento	631.5
Shasta	77.5	Yuba	44.7
Tehama	29.5	Sierra	2.4
Lasswn	15.0	Placer	77.3
Glenn	17.5	Amador	11.8
Butte	102.0	Alpine	.5
Colusa	12.4	El Dorado	43.8
Plumas	11.7	Nevada	<u>26.3</u>
Sutter	41.9		1448.2
Yolo	91.8		

Area III - (Stanford)

Palo Alto

(11 Counties)

San Joaquin	290.2
Calaveras	13.6
Tuolumne	22.2
Mariposa	6.0
Merced	104.6
Stanislaus	194.5
Santa Clara	1064.7
Santa Cruz	123.8
Monterey	250.1
San Mateo	556.2
San Benito	<u>18.2</u>
	2644.1

Total of 42 Counties (Northern)

California - Population by County (1970)
(in thousands)

Southern Areas

Area IV - UCLA-L.A.
(7 Counties)

Madera	41.5
Fresno	413.1
Tulare	188.3
King	64.6
Kern	329.2
San Luis Obispo	105.7
Santa Barbara	264.3
	<u>1406.7</u>

Area V - USC

Los Angeles Co. 6882.0

Area VI - Loma Linda
(4 Counties)

Mano	4.0
Inyo	15.6
San Bernadino	684.1
Riverside	459.1
	<u>1162.8</u>

Area VII - San Diego
(2 Counties)

San Diego	1357.9
Imperial	74.5
	<u>1432.4</u>

Area VIII - Irwine

Orange County 1420.4

Area IX - Watts - W.

Ventura County	376.4
(part L.A.)	+ 150.3 (e)
	<u>526.7</u>

Total of 16 Counties (So. Calif.)

I. REGIONAL CHARACTERISTICS (Cont'd) - 7 -

FACILITIES AND RESOURCES

SCHOOLS

Schools	No.	Enrollment (1969/70)	Graduates (1969/70)	Location
<u>Medicine and (Osteopathy) (8)</u>				
Loma Linda U. Sch of Med		387	85	Loma Linda
Stanford Univ. Sch of Med.		342	69	Palo Alto
Univ. of Calif. Col. of Med		445	78	Los Angeles
Univ. of Calif. Col. of Med.		254	58	Irvine
Univ. of Calif. Sch of Med.		516	126	San Francisco
Univ. of So. Calif. "		302	72	Los Angeles
Univ. of Calif. Sch of Med.		101	--	San Diego
Univ. of Calif. Sch. of Med.		99	--	Davis
Charles C. Drew Postgraduate Sch.m of Med.		Developing.		Watts-W. LA
<u>Dental</u>	(5)	Loma Linda, U. of Calif, LA, Univ. of Southern Calif., San Francisco MC., Coll. of the Pacific, SF		
<u>Pharmacy (1967/68)</u>	(3)			
<u>Schools of Public Health</u>	(3)	U. of Calif. Berkeley; U. of Cal. LA, Loma Linda.		
<u>Nursing Schools</u>				
<u>Professional Nursing</u>				
Number	77	(69 are College or Univ. based)		
<u>Practical Nursing</u>				
Number	67	The majority at technical and Junior Colleges.		
<u>Allied Health Schools</u> (Approved Programs) *				
<u>Cytotechnology</u>				
Number	6			
<u>Medical technology</u>				
Number	65	(2 at VA hosp. Long Beach & LA)		
<u>Radiologic Technology</u>				
Number	110	(2 at VA hosp. Los Angeles and SF)		
<u>Physical therapy</u>				
Number	7			
<u>Medical record Librarian - 2</u>				

Notes: See Manpower Table for sources - page 8.

Sources: * Directory of Approved Allied Medical Educational Programs, Council on Medical Education, Amer. Med. Assoc. Chicago 1971.

I. REGIONAL CHARACTERISTICS (Cont'd)

FACILITIES AND RESOURCES (Cont'd)

HOSPITALS

Non Federal Short and Long-term general hospitals, 1969

	<u>Number</u>	<u>Number of Beds</u>
Short term	534	72,160
Long term	24	6,870
V.A. General hospitals	6	4,623

Bed-size (general hospitals)
of hospitals

Under 50
 50 - 100
 100 - 200
 200 - 300
 300 - 400
 400 - 500
 500 and over

Number of hospitals with
Special Facilities

of facil.
 Intensive CCU 243
 Cobalt therapy 68
 Radium therapy 128
 Renal Dialysis 58
 in patient
 Rehab-in patient 54
 Isotope facility 213

Source: Amer. Hospital Assoc. 1970 Guide Issue
August 1970

NURSING AND PERSONAL CARE HOMES, 1967

	<u>Number</u>	<u>Number of Beds</u>
Skilled Nursing Homes	1148	77,354
Personal care Homes with Nursing Care	451	16,015
Long-term care Units	108	5,997

Source: NCHS - A Master Facilities Inventory
County and Metropolitan Area Data Book
PHS- Number 2043 - Section 2, November 1970

*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.

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>01</u> 04 operational year	Council-Approved Level For TR Year _____	Region's Request For TR Year <u>02</u> 05 operational year	Recommended Funding For TR Year _____ <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium	
PROGRAM STAFF	\$ 4,313,532	X	4,112,586 \$ 4,112,506		X	
CONTRACTS	859,896					
DEVELOPMENTAL COMP.	586,692		800,000 6,110,273	<input type="checkbox"/> Yes <input type="checkbox"/> No		
OPERATIONAL PROJECTS	3,196,786		6,110,349			
Kidney	X		(532,157)	()		
EMS			(377,930)	()		
hs/ee			(- 0 -)	()		
Pediatric Pulmonary			(110,000)	()		
Other			()	()		
TOTAL DIRECT COSTS	8,956,906			\$ 11,022,855 11,022,859		
COUNCIL-APPROVED LEVEL	\$10,043,175	\$10,043,175				

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

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FUNDING HISTORY LIST

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1	C2	C3	C4	TOTAL	05 01/73-12/73	06 01/74-12/74	07 01/75-12/75	TOTAL
					617455	617495	** 488332	504312		992644
					64365	64365	** 45100	49100		98200
						1013500	**			
		91900	426600	493000		1956610	** 563404	619744		1183148
		146300	634600	451300	684410	868413	** 285235	313758		598993
		58500	244900	210700	354313	868413	** 324893	357382		682275
		73000	354200	260700	403190	1091090	** 806634	887297		1693931
		189900	802300	677600	1015777	2685577	** 600902	660992		1261854
		149700	647000	551400	743781	2091881	** 247456	272000		519456
		34200	198700	144300	265969	643169	** 268036	294840		562876
		41700	224600	177500	295971	739771	** 286200	314820		601020
		55000	225100	178600	318590	777250	** 192394	211633		404027
			185500	112300	220129	517929	** 800000	800000		1600000
					427882	427882	**			
					17700	17700	**			
					1500	1500	**			
					17135	17135	**			
					31005	31005	**			
					17090	17090	**			
					10400	10400	**			
					14145	14145	**			
					19350	19350	**			
					11156	11156	**			
					15700	15700	**			
					19830	19830	**			
					27400	27400	**			
					33900	33900	**			
						825900	**			
						229300	**			
		274900	312600	238200		605800	**			
		69700	92100	47500		966700	**			
		218200	236200	151400		1088131	**			
		207200	498300	441300	387212	1534012	** 303860	208667		512527
		324700	392000	250000		877664	**			
		325400	436131	256000		103000	**			
			330600	312200	234864	877664	**			
		42000	11000	50000		865000	**			
		268800	362100	238900		538200	**			
		206100	206500	125600		287212	**			
			113500	95200	78112	376000	**			
		120000	160500	95100		441446	**			
			167100	148800	105546	125000	**			
			10600	2300		66562	** 242062			
			93000	82500		55000	** 61902			61902
						901974	**			
			370800	313600	217574	164982	** 50655			50655
			19600	69200		244553	** 56196			56196
			17500	58500	128593	79900	**			
			25000	54900		456108	** 95888			95888
			45100	166700	244308	173400	** 48000			48000
			12500	66400	94500	434127	** 39211			39211
			26700	160000	247427	172537	** 28194			28194
			47150	51700	73687	218096	** 47648			47648
			58800	65500	93796					

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REGIONAL MEDICAL PROGRAMS SERVICE

FUNDING HISTORY LIST

RMPS-CSP-JTCFHL-20

REGION 19 CALIFORNIA RMP SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NC	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	** REQUESTED	REQUESTED	REQUESTED	REQUESTED	
		01 01	02 02	03 03	04 04	TOTAL	05 05	06 06	07 07	TOTAL
			07/69-08/70		09/71-12/72	TOTAL	01/73-12/73	01/74-12/74	01/75-12/75	TOTAL
054	RAPIC M I AREA				56334	56334	** 16666			16666
056	COMP INFC AND R				53574	53574	** 40480	26987		67467
060	MEDICAL INFORMA				19929	19929	** 20000	13333		33333
062	CONTINUING MCCI				59375	99375	** 78720	65600		144320
063	PEPINATAL CRISE				56000	96000	** 72000	48000		120000
067	RESPIRATORY CAR				120248	120248	** 204816	204816		409632
068	COMPENSILP CF L				69400	69400	** 52800	44000		96800
069	COMP RESPIRATOR				70200	70200	** 62400	52000		114400
070	ALLIED HEALTH E				48801	48801	** 50000	50000		100000
072	RADIATION THERA				23334	23334	** 68252	62603		130855
073	ONCOLOGY AREA I				12800	12800	** 9600	6400		16000
075	INDIAN HEALTH				163881	163881	** 131643	91188		222831
077	INTENSIVE CARE				209329	209329	** 209354	126667		335021
079	EXTENSIVE CARE				78214	78214	** 70901	59084		129985
081	URBAN INDIAN H				52525	52525	** 52407	34938		87345
084	NEONATAL INTEN				108388	108388	** 110000	110000		220000
085	RICHMOND MODEL				79952	79952	** 50762			50762
086A	KIDNEY DISEASE				76480	76480	** 106886	53851		160737
087A	KIDNEY - GREAT				50558	50558	** 41076	23266		64342
087B	TRANS. & ORGAN				8000	8000	**			
087C	REGL TRANSPLAN				70353	70353	**			
087D	REGIONAL TRANS				13321	13321	** 41700	41700		83400
087E	REGIONAL TRANS				26988	26988	** 35500	35500		71800
087F	REGIONAL TRANS				26000	26000	** 30000	30000		60000
087G	REGIONAL TRANS				24485	24485	** 54300	54300		108600
087F	REGIONAL TRANS				23747	23747	** 38500	38500		77000
087I	REGIONAL ORGAN				45772	45772	** 47200	48116		95316
087J	TRANSPLANT SAL				27089	27089	** 35185	22597		61782
087K	REGIONAL TRANSP						** 16200	16200		32400
087L	REGIONAL TRANSP						** 25000	29000		58000
087M	REGIONAL TRANSP						** 13000	13000		26000
087N	REGIONAL TRANSP						** 34000	34000		68000
088A	NEPHROLOGY AND				15500	15500	**			
088C	FROZEN BLOOD T				50466	50466	** 20834	12167		33001
088D	PREVENTION CF				23026	23026	** 64946	52102		117048
088E	HOME HEMODIALY				5204	5204	** 10407			10407
088F	CUTPACH KIDNE				8550	8550	** 23130	24986		48116
089	RENAL DISEASE				41666	41666	** 47150	51145		98295
091	EMERGENCY MCCI				50000	50000	** 134325	108075		242400
092	NEIGHBORHOOD E				50000	50000	** 242605	309955		553560
094A	REGIONAL CANCER				48690	48690	** 82583	95786		179369
094B	REGIONAL CANCER				60750	60750	** 121500	121500		243000
095	MEDICAL UNIT				33189	33189	** 66379			66379
096	HEALTH CARE -				96300	96300	** 196089	203242		399331
097	ASSISTANTS TC				56606	56606	** 172186	179427		351613
098	FIREBAUGH-MEND				42786	42786	** 128051	128941		256992
099	PEDIATRIC NURS				27078	27078	** 82758	100747		183505
100	VENTURA HEALTH				35818	35818	** 100068	95198		195266
101	HEALTH CAREER				19270	19270	** 58453	59884		118337
102	MEDICAL TRANSP				34347	34347	** 106052	126146		232198
103	VOLUNTEER STRO				33888	33888	** 102433	96858		199291

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FUNDING HISTORY LIST

AMPS-CCM-JYCFHL-20

REGION 19 CALIFORNIA

RMP SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NC	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1 07/69-08/70	C2	C3	C4 09/71-12/72	TOTAL	** C1/73-12/73	** 06 01/74-12/74	** C7 01/75-12/75	TOTAL
104	SCACMA EASEC M				646611	646611	**			
105	COMMUNITY BASE				237898	237898	**			
106	FRESNO VA. CCM				76062	76062	**			
107	SAN FERNANDO VA				269367	269367	**			
108	CLAYMONT COMM				45370	45370	**			
110	EAST L.A. COMM				145746	145746	**			
111	INLAAC EMPIRE				117820	117820	**			
112	COMMUNITY BASE				189181	189181	**			
114	CCOPC. - COMM.				112098	112098	**			
115	SUPERIOR CALIF				50000	50000	**			
118	COMM BASED MAN				50000	50000	**			
119	REG STR PROJ RE						**	55213	62200	117413
120	VOLUNTEERS IN S						**	28103		28103
121	STROKE VOLUNTEE						**	20820	21561	42381
122	STROKE RESCCIAL						**	20690	22284	42974
123	STROKE VOLUNTEE						**	18173		18173
124	STROKE VOLUNTEE						**	22620	34872	57492
125	VCL IN RESCCIAL						**	16954	17663	34617
126	VOLUNTEER STROK						**	65870	108122	173992
127A	LA CC EP MED CA						**	73251	75510	148761
127B	LA CO EM MED CA						**	87144	122551	209695
127C	LA CC EM MED CA						**	146179	117358	263537
128	EM MED CARE PLA						**	51698		51698
129	EMER CARE CRITI						**	134185	132353	266538
130	CUP LACY CF GUA						**	193258	264293	457551
131	TRNG PRCG CCM						**	115202	101318	216520
132	COMPREHENSIVE C						**	27300	75345	102645
133	PHYS SPECIALIST						**	144429	152219	296648
134	PARAMEDIC EM CA						**	50496	52023	102522
135	ACCLESSENT NURS						**	152171	204672	356843
136	NUTRITION AND D						**	77852	78170	156022
137	TELE MED AREA V						**	122327	124436	246763
138	PEDIATRIC NURSE						**	63754	67454	131208
139	COMPTON SICKLE						**	102330	107943	210273
- TOTAL -		2917200	8012081	6919500	12180123	30028904	**	11022854	10639097	21661956

ORIGINAL SOURCE

DEI

JULY 25, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - CALIFORNIA
RM 00019 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
000A PROGRAM STAFF REGIONAL OFFICE	\$488,332				\$488,332		\$488,332
000B PROGRAM STAFF CENTER STUDIES	\$49,100				\$49,100	\$2,359	\$51,459
0001 PROGRAM STAFF AREA I UCSF	\$563,404				\$563,404	\$198,959	\$762,363
0002 PROGRAM STAFF AREA II UC DAVIS	\$285,235				\$285,235	\$88,209	\$373,445
0003 PROGRAM STAFF AREA III STANFORD	\$324,893				\$324,893	\$134,775	\$459,668
0004 PROGRAM STAFF AREA IV UC LA	\$806,634				\$806,634	\$115,191	\$921,825
0005 PROGRAM STAFF AREA V USC	\$600,902				\$600,902	\$119,488	\$720,390
0006 PROGRAM STAFF AREA VI LLU	\$247,456				\$247,456	\$69,752	\$317,208
0007 PROGRAM STAFF AREA VII UC C SD	\$268,036				\$268,036	\$64,753	\$332,789
0008 PROGRAM STAFF AREA VIII UC IRVINE	\$286,200				\$286,200	\$61,705	\$347,905
0009 PROGRAM STAFF AREA IX DPH EM PG	\$192,394				\$192,394	\$66,110	\$258,504
000 DEVELOPMENTAL COMPONENT PCCI	\$4,112,586				\$4,112,586	\$21,292	\$5,033,878
006 DREW POSTGRADUATE MEDICAL SCHOOL AREA IX	\$800,000				\$800,000		\$800,000
0275 FAMILY PRACTICE PROGRAM AREA I UCSE	\$303,860				\$303,860	\$102,076	\$405,936
030 CORONARY CAPE AREA VII STANFORD	\$61,902				\$61,902	\$12,058	\$73,960
037 STROKE AREA III STANFORD	\$50,655				\$50,655	\$3,973	\$54,628
043 STROKE AREA I UC SF	\$56,196				\$56,196	\$23,602	\$79,798
045 STROKE AREA II UC DAVIS	\$95,888				\$95,888	\$34,942	\$130,830
046 SAN JOAQUIN MULTIPHASIC AREA III	\$48,000				\$48,000	\$8,445	\$56,445
050 FACEPAPER REGISTRY AREA V USC	\$39,211				\$39,211	\$16,469	\$55,680
052 PERINATAL MONITORING AREA VI LLU	\$28,194				\$28,194	\$5,183	\$33,377
054 RAPID RESP M I AREA VIII UC IRVINE	\$47,648				\$47,648	\$13,359	\$61,007
056 COMM INFO AND REFERRAL SERV AREA VIII	\$16,666				\$16,666	\$3,381	\$20,047
060 MEDICAL INFORMATION SYSTEM AREA VI LLU	\$40,480				\$40,480	\$280	\$40,760
EM AREA VI LLU	\$20,000				\$20,000	\$5,438	\$25,438

JULY 25, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIODREGION - CALIFORNIA
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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
062 GEN MED EDUCATION AREA V II UCSD	\$78,720				\$78,720	\$15,172	\$93,892
063 PERINATAL CRISES AREA IV UCLA	\$72,000				\$72,000	\$10,304	\$82,304
067 RESPIRATORY CARE AREA I UC SF	\$204,816				\$204,816	\$76,673	\$281,489
068 COMPENDIUM OF LEARNING A PEP II UC DAVIS	\$52,800				\$52,800	\$4,269	\$57,069
069 COMPREHENSIVE RESPIRATOR Y DISEASE AREA VII UCSD	\$62,400				\$62,400	\$21,696	\$84,096
070 ALLIED HEALTH EDUCATION AREA II UC DAVIS	\$50,000				\$50,000	\$3,095	\$53,095
072 RADIATION THERAPY AREA V III UC IRVINE	\$68,252				\$68,252	\$24,935	\$93,187
073 CANCEROLOGY AREA III STANFC RD	\$9,600				\$9,600	\$4,032	\$13,632
075 INDIAN HEALTH PROGRAM AR EA I UCSE	\$131,643				\$131,643	\$22,205	\$154,848
077 INTENSIVE CARE PROGRAM A REA I UCSE	\$208,354				\$208,354	\$78,606	\$286,960
079 EXTENDED CARE FACILITIES AREA IV UCLA	\$70,901				\$70,901	\$8,337	\$79,238
081 URBAN INDIAN HEALTH AREA V USC	\$52,407				\$52,407	\$7,126	\$59,533
084 NEONATAL INTENSIVE PULP TRY AREA VIII UC IRVINE	\$110,000				\$110,000	\$27,421	\$137,421
085 RICHMOND MODEL CITIES AR EA I UC SF	\$50,762				\$50,762	\$11,057	\$61,819
086A KIDNEY DISEASE INFORMATI ON SYSTEM CCPMP	\$106,886				\$106,886		\$106,886
087A GREATER L A ORGAN PROCUR EMENT AREA IV UCLA	\$41,076				\$41,076	\$11,857	\$52,933
087D REGIONAL TRANSPLANTATION AREA I UCSE	\$41,700				\$41,700	\$18,762	\$60,462
087E REGIONAL TRANSPLANTATION AREA III STANFCRD	\$35,900				\$35,900	\$15,078	\$50,978
087F REGIONAL TRANSPLANTATION AREA IV UC UCLA	\$30,000				\$30,000	\$10,862	\$40,862
087G REGIONAL TRANSPLANTATION AREA V USC	\$54,300				\$54,300	\$3,949	\$58,249
087H REGIONAL TRANSPLANTATION AREA VIII UC IRVINE	\$38,500				\$38,500	\$17,090	\$55,590
087I REGIONAL ORGAN PRESERVATI ON AREA VII UCSD	\$47,200				\$47,200	\$19,416	\$66,616
087J TRANSPLANT SALVAGE COORD INATION AREA IV UCLA	\$39,195				\$39,195	\$17,018	\$56,203
087K REGIONAL TRANSPLANTATION AREA II UC DAVIS				\$16,200	\$16,200	\$7,449	\$23,649

JULY 25, 1972

BREAKOUT OF REQUEST
OF PROGRAM PERIOD

REGION - CALIFORNIA
RM 00019 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
087L REGIONAL TRANSPLANTATION AREA IV UCLA				\$29,000	\$29,000	\$13,335	\$42,335
087M REGIONAL TRANSPLANTATION AREA VI L L U				\$13,000	\$13,000	\$4,869	\$17,869
087N REGIONAL TRANSPLANTATION AREA IX DREW PG				\$34,200	\$34,200	\$13,661	\$47,861
087 COMPONENT TOTAL	\$327,861			\$2,200	\$420,061	\$153,356	\$573,407
088C FROZEN BLOOD TRANSFUSION REGICAL OFFICE	\$20,834				\$20,834		\$20,834
088D PREVENTION OF IMMUNIZATI ON KIDNEY AREA IV UCLA	\$64,946				\$64,946	\$12,436	\$77,382
088E HOME HEMODIALYSIS AREA V II UCSF	\$10,407				\$10,407	\$746	\$11,153
088F OUTREACH KIDNEY DISEASE AREA II UC DAVIS	\$23,130				\$23,130	\$2,397	\$25,527
088 COMPONENT TOTAL	\$115,317				\$119,317	\$15,579	\$134,896
089 FENAL DISEASE ADMINISTRA TION REG OFFICE	\$47,150				\$47,150		\$47,150
091 MANAGEMENT OF MEDICAL CR ISES AREA VI LLU	\$134,325				\$134,325	\$28,400	\$162,725
092 NEIGHBORHOOD EMERG TRANS PORT TREAT AREA IX	\$243,605				\$243,605	\$48,721	\$292,326
094A REGIONAL CANCER EXTENDED PROGRAM AREA I UCSF	\$83,583				\$83,583	\$31,265	\$114,848
094B REG CANCER PHYSICS COMPC NENT AREA I UCSF	\$121,500				\$121,500	\$32,926	\$154,426
094 COMPONENT TOTAL	\$205,083				\$205,083	\$64,191	\$269,274
095 MEDICAL AUDIT AREA I UCS F	\$66,375				\$66,375	\$23,337	\$89,712
096 HEALTH CARE RURAL AREAS AREA II UC DAVIS	\$196,089				\$196,089	\$40,508	\$236,597
097 ASSISTANT TO PRIMARY CAR E PHYS AREA III STANFORD	\$172,186				\$172,186	\$65,431	\$237,617
098 FIREBAUGH WISCONSIN HEALTH CARE AREA IV	\$128,051				\$128,051		\$128,051
099 PEDIATRIC NURSE PRACTITI ONCE AREA IV UCLA	\$82,758				\$82,758	\$12,046	\$94,804
100 VENTURA HEALTH SERVICES NETWORK AREA IV	\$100,068				\$100,068	\$12,008	\$112,076
101 HEALTH CAREER RETENTION AREA V	\$58,453				\$58,453	\$8,537	\$66,990
102 MEDICAL TRANSPORTATION S ERVICES AREA VI LLU	\$106,052				\$106,052	\$26,958	\$133,010
103 VOLUNTEER STROKE AREA IX DREW P G	\$102,433				\$102,433	\$27,109	\$129,542
119 REG STR PROJ REENTRY COD ED ALL AREAS EXCEPT III				\$55,213	\$55,213	\$7,059	\$62,272
120 VOLUNTEERS IN STROKE RES OCIALIZATION AREA I				\$28,103	\$28,103		\$28,103

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121 STROKE VOLUNTEER PROJECT AREA II U C DAVIS				\$20,820	\$20,820	\$4,160	\$24,980
122 STROKE RESECTALIZATION A REA IV UCLA				\$20,690	\$20,690	\$6,180	\$26,870
123 STROKE VOLUNTEER PROGRAM AREA V				\$18,173	\$18,173		\$18,173
124 STROKE VOLUNTEER PROGRAM AREA VI LLU				\$22,620	\$22,620	\$4,532	\$27,152
125 VCL IN RESECTALIZATION A MC PHAS AREA VII UC SD				\$16,954	\$16,954	\$427	\$17,381
126 VOLUNTEER STROKE PROGRAM AREA VIII UC IRVINE				\$65,870	\$65,870	\$15,515	\$81,385
127A LA CO EM MED CARE MGMT A SD EVAL AREA IX DREW P G				\$73,251	\$73,251	\$23,535	\$96,786
127B LA CO EM MED CARE ED ARE A IX HOSP COUNCIL SO CAL				\$87,144	\$87,144	\$5,142	\$92,286
127C LA CO EM MED CARE DEVELO P AREA IX UCLA				\$146,179	\$146,179	\$26,992	\$173,171
127 COMPONENT TOTAL				\$306,574	\$306,574	\$55,669	\$362,243
128 EM MED CARE PLAN AREA II UC DAVIS				\$51,698	\$51,698	\$11,424	\$63,122
129 EMER CARE CRITICALLY ILL NEWLEN AREA III SIOGRO				\$134,185	\$134,185	\$44,010	\$178,195
130 CLR LADY OF GLADALUPE FL TH CRT AREA III SIOGRO				\$123,258	\$123,258	\$19,000	\$212,258
131 TRNG PRGG COMM PLTE WORK EPS AREA III				\$115,202	\$115,202	\$26,760	\$141,962
132 COMPREHENSIVE COMM DENTA L HLTH PRCG AREA IV				\$27,300	\$27,300	\$3,276	\$30,576
133 PHYS SPECIALISTS IN EM P ED CASE AREA IV UCLA				\$144,429	\$144,429	\$56,562	\$200,991
134 PARAMEDIC EM CARE AREA I V UCLA				\$50,499	\$50,499	\$14,445	\$64,944
135 ADULESCENT NURSE PRACTIT I AREA V				\$152,171	\$152,171	\$5,436	\$157,607
136 NUTRITION AND DENT SERV RIVERSIDE CO AREA VI LLU				\$77,852	\$77,852	\$17,057	\$94,909
137 TELE MED AREA VI				\$122,327	\$122,327	\$20,816	\$143,143
138 PEDIATRIC NURSE PRACTIT I AREA VII UCSD				\$63,754	\$63,754	\$23,783	\$87,537
139 COMPTON SICKLE CELL PRCG RAP AREA IX DREW P G				\$102,330	\$102,330	\$29,790	\$132,120
TOTAL	\$9,140,637			\$1,882,222	\$1,022,859	\$2,358,498	\$13,381,357

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C00A PROGRAM STAFF REGIONAL E FFICE	\$504,312				\$504,312	\$992,644
C00B PROGRAM STAFF CHERF STUD IES	\$49,100				\$49,100	\$98,200
C001 PROGRAM STAFF AREA I UCSI E	\$619,744				\$619,744	\$1,183,148
C002 PROGRAM STAFF AREA II UC DAVIS	\$313,758				\$313,758	\$598,993
C003 PROGRAM STAFF AREA III S TANECED	\$357,382				\$357,382	\$682,275
C004 PROGRAM STAFF AREA IV UC LA	\$887,297				\$887,297	\$1,693,931
C005 PROGRAM STAFF AREA V USC I	\$660,992				\$660,992	\$1,261,894
C006 PROGRAM STAFF AREA VI LL U	\$272,000				\$272,000	\$519,456
C007 PROGRAM STAFF AREA VII UC C SD	\$294,840				\$294,840	\$562,876
C008 PROGRAM STAFF AREA VIII UC IRVINE	\$314,820				\$314,820	\$601,020
C009 PROGRAM STAFF AREA IX CR EW PG	\$211,633				\$211,633	\$404,027
C00 PCCS SEE TOTAL	\$4,485,878				\$4,485,878	\$8,598,464
D000 DEVELOPMENTAL COMPONENT PCC	\$800,000				\$800,000	\$1,600,000
006 DREW POSTGRADUATE MEDICAL I SCHOOL AREA IX	\$208,667				\$208,667	\$512,527
0275 FAMILY PRACTICE PROGRAM AREA I UCSE						\$61,902
030 CORONARY CARE AREA VII S O CR HT ASSOC						\$50,655
037 STROKE AREA III STANFORD						\$56,196
043 STROKE AREA I UCSE						\$95,888
045 STROKE AREA II UC DAVIS						\$48,000
046 SAN JOAQUIN MULTIPHASIC AREA III						\$39,211
050 PACEMAKER REGISTRY AREA V LSC						\$28,194
052 PERINATAL MONITORING ARE A VI LLU						\$47,648
054 RAPID RESP M I AREA VIII UC IRVINE						\$16,666
056 COMM INFO AND REFERRAL S ERV AREA VIII	\$26,987				\$26,987	\$67,467
060 MEDICAL INFORMATION SYST EM AREA VI LLU	\$13,333				\$13,333	\$33,333

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062 CON MED EDUCATION AREA V II UCSD	\$55,600				\$55,600	\$144,320
063 PERINATAL CRISES AREA IV UCLA	\$48,000				\$48,000	\$120,000
067 RESPIRATORY CARE AREA I UC SF	\$204,816				\$204,816	\$409,632
068 COMPENDIUM OF LEARNING A REA II UC DAVIS	\$44,000				\$44,000	\$96,800
069 COMPREHENSIVE RESPIRATOR Y DISEASE AREA VII UCSD	\$52,000				\$52,000	\$114,400
070 ALLIED HEALTH EDUCATION AREA II UC DAVIS	\$50,000				\$50,000	\$100,000
072 RADIATION THERAPY AREA V III UC IRVINE	\$62,603				\$62,603	\$130,855
073 ONCOLOGY AREA III STANFORD RD	\$6,400				\$6,400	\$16,000
075 INDIAN HEALTH PROGRAM AREA I UCSE	\$91,188				\$91,188	\$222,831
077 INTENSIVE CARE PROGRAM A REA I UCSE		\$126,667			\$126,667	\$335,021
079 EXTENDED CARE FACILITIES AREA IV UCLA	\$59,084				\$59,084	\$129,985
081 URBAN INDIAN HEALTH AREA V USC	\$34,938				\$34,938	\$87,345
084 NEONATAL INTENSIVE PULM TRY AREA VIII UC IRVINE	\$110,000				\$110,000	\$220,000
085 HIGHCARE MODEL CITIES AP EA I UC SF						\$50,762
086A KIDNEY DISEASE INFORMATI ON SYSTEM CORP	\$53,851				\$53,851	\$160,737
087A GREATER L A CPAN PROCU REMENT AREA IV UCLA	\$22,266				\$22,266	\$64,342
087D REGIONAL TRANSPLANTATION AREA I UCSE	\$41,700				\$41,700	\$83,400
087E REGIONAL TRANSPLANTATION AREA III STANFORD	\$35,900				\$35,900	\$71,800
087F REGIONAL TRANSPLANTATION AREA IV IV UCLA	\$30,000				\$30,000	\$60,000
087G REGIONAL TRANSPLANTATION AREA V USC	\$54,300				\$54,300	\$108,600
087H REGIONAL TRANSPLANTATION AREA VIII UC IRVINE	\$38,500				\$38,500	\$77,000
087I REGIONAL ORGAN PRESERVATI ON AREA VII UCSD	\$48,116				\$48,116	\$95,316
087J TRANSPLANT SALVAGE CORP AREA IV UCLA	\$22,597				\$22,597	\$61,782
087K REGIONAL TRANSPLANTATION AREA II UC DAVIS				\$16,200	\$16,200	\$32,400

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087L REGIONAL TRANSPLANTATION AREA IV UCLA				\$29,000	\$29,000	\$58,000
087M REGIONAL TRANSPLANTATION AREA VI L L U				\$13,000	\$13,000	\$26,000
087N REGIONAL TRANSPLANTATION AREA IX DEER PG				\$34,000	\$34,000	\$68,000
087 COMPONENT TOTAL	\$294,375			\$92,200	\$386,575	\$806,640
088C FROZEN BLOOD TRANSFUSION REGIONAL OFFICE	\$12,167				\$12,167	\$33,001
088D PREVENTION OF IMMUNIZATION ON KIDNEY AREA IV UCLA	\$52,102				\$52,102	\$117,048
088E HOME HEMODIALYSIS AREA V II UCSD						\$10,407
088F OUTREACH KIDNEY DISEASE AREA II UC DAVIS	\$24,586				\$24,986	\$48,116
088 COMPONENT TOTAL	\$89,255				\$85,255	\$208,572
089 RENAL DISEASE ADMINISTRATION REG OFFICE	\$51,145				\$51,145	\$98,295
091 MANAGEMENT OF MEDICAL CRISIS AREAS AREA VI LLU	\$108,075				\$108,075	\$242,400
092 NEIGHBORHOOD EMERGENCY TRANS PORT AREA IX	\$309,955				\$309,955	\$553,560
094A REGIONAL CANCER EXTENDED PROGRAM AREA I UCSE	\$95,786				\$95,786	\$179,369
094B REG CANCER PHYSICS COMPON ENT AREA I UCSE	\$121,500				\$121,500	\$243,000
094 COMPONENT TOTAL	\$217,286				\$217,286	\$422,369
095 MEDICAL ALDIT AREA I UCSF						\$66,379
096 HEALTH CARE RURAL AREAS AREA II UC DAVIS	\$203,242				\$203,242	\$399,331
097 ASSISTANT TO PRIMARY CARE PHYS AREA III STANFORD	\$179,427				\$179,427	\$351,613
098 FIREARMS MEDICAL HEALTH CARE AREA IV	\$128,941				\$128,941	\$256,992
099 PEDIATRIC NURSE PRACTITIONER AREA IV UCLA	\$100,747				\$100,747	\$183,505
100 VENTURA HEALTH SERVICES REINTEGR AREA IV	\$95,198				\$95,198	\$195,266
101 HEALTH CAREER RETENTION AREA V	\$59,884				\$59,884	\$118,337
102 MEDICAL TRANSPORTATION S ERVICES AREA VI LLU	\$126,146				\$126,146	\$232,198
103 VOLUNTEER STROKE AREA IX DEER PG	\$96,858				\$96,858	\$199,291
119 REG STR PROJ REENTRY COO RD ALL AREAS EXCEPT III				\$62,200	\$62,200	\$117,413
120 VOLUNTEERS IN STROKE RES OCIALIZATION AREA I						\$28,103

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121 STROKE VOLUNTEER PROJECT AREA II UC DAVIS				\$21,561	\$21,561	\$42,381
122 STROKE RESOCIALIZATION A AREA IV UCLA				\$22,284	\$22,284	\$42,974
123 STROKE VOLUNTEER PROGRAM AREA V						\$18,173
124 STROKE VOLUNTEER PROGRAM AREA VI LLU				\$34,872	\$34,872	\$57,492
125 VOL IN RESOCIALIZATION A AREA VII UC SF				\$17,663	\$17,663	\$34,617
126 VOLUNTEER STROKE PROGRAM AREA VIII UC IRVINE				\$108,122	\$108,122	\$173,992
127A LA CC EM MED CARE MGMT A AREA IX UC SF				\$75,510	\$75,510	\$148,781
127B LA CC EM MED CARE EC ARE A IN HCSP COUNCIL UC CAL				\$122,551	\$122,551	\$209,695
127C LA CC EM MED CARE DEVELO P AREA IX UCLA				\$117,358	\$117,358	\$263,537
127 COMPONENT TOTAL				\$315,419	\$315,419	\$621,993
128 EM MED CARE PLAN AREA III UC DAVIS						\$51,698
129 EMER CARE CRITICALLY ILL AREAS AREA III STANFORD				\$132,353	\$132,353	\$266,538
130 ELF LACY OF GUADALUPE FL IN STD AREA III STANFORD				\$264,293	\$264,293	\$457,551
131 TRNG PROG COMM HLTH WORK SES AREA III				\$101,318	\$101,318	\$216,520
132 COMPREHENSIVE COMM DENTA L HLTH PROG AREA IV				\$75,345	\$75,345	\$102,645
133 PHYS SPECIALISTS IN EM M ED CARES AREA IV UCLA				\$152,219	\$152,219	\$296,648
134 PARAMEDIC EM CARE AREA I V UCLA				\$52,023	\$52,023	\$102,522
135 ADOLESCENT NURSE PRACTIT IONER AREA V				\$204,672	\$204,672	\$356,843
136 NUTRITION AND DENT SERV RIVERSIDE CO AREA VI LLU				\$78,170	\$78,170	\$156,022
137 TELE MED AREA VI				\$124,436	\$124,436	\$246,763
138 PEDIATRIC NURSE PRACTIT IONER AREA VII UCSD				\$67,454	\$67,454	\$131,208
139 COMPTON SICKLE CELL PROG AREA IX UC SF				\$107,943	\$107,943	\$210,273
TOTAL	\$8,477,883	\$126,667		\$2,034,547	\$10,639,097	\$21,661,956

HISTORICAL PROGRAM PROFILE OF REGION

With the passage of P.L. 89-239 in 1965, the California State Department of Health, together with the active participation of representatives of the California Medical Association, the California Hospital Association, the deans of the eight schools of medicine, and voluntary health agencies and resources, organized a "Coordination Agency" for the purpose of developing an overall plan for cooperative medical arrangements throughout the State.

Planning for developing regional medical programs proceeded at each of the participating medical centers. The Coordination Agency developed geographic areas of responsibility for each of the medical centers, and coordinated and mediated other questions.

The proposed method of cooperation relied heavily on systems analysis techniques. The coordinating agency submitted an application to RMPS outlining its **structure** and goals as described above.

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 P.L. 89-329.

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), with the California Medical Education and Research Foundation (CMERF), a second nonprofit corporation, as the grantee.

Eight area offices were organized and based with the administrative structure of California's eight medical schools. Area IX, the most recent addition to the "federation" is based at the Drew Postgraduate School of Medicine in Watts.

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 visit team visited the region in February 1967 and expressed concern about the apparent lack of cooperation among the subregion and little evidence of overall planning.

Historical Program Profile of Region (cont.)

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--Area I, UCLA--Area IV, USC--Area V, and California Medical Association and California Hospital Association. Three supplemental planning grants during the first year added the areas of Davis--Area II, San Diego--Area VII, and Stanford--Area III.

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

In April 1969, the CCRMP was site visited for the purpose of evaluating progress of the overall program and to review in depth the individual program staff requests. The site team was impressed with most of the areas, particularly Area I--San Francisco, Area II--Davis, Area IV--Los Angeles, Area V--UCSA, Area VII--San Diego, and Area VIII--Irvine. Most impressive 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 was supported at the direct cost level of \$7,548,457 which included a carryover from previous years unexpended balance of \$480,168. The base level at that time was \$7,068,289.

In April 1971, all regions were notified of national funding constraints which would require reduced budgets. California submitted two plans designated A and B. A, reduced the programs to the \$6.2 million level and plan B was presented at a \$10 million level in the hope that additional funds might become available.

In June 1971, the site visitors and the Review Committee to the region felt that the \$6.2 million plan A was viable and represented good decisionmaking. The \$10 million plan developed, should funds become available, proposed the activation of several previously approved, but unfunded activities which would require careful screening in view of the region's new program direction in response to new RMPS priorities. The Council, however, recommended a level of funding at \$10,043,175 on the basis that the CCRMP and its subdivisions had demonstrated a high level of competency in decisionmaking.

The CCRMP 04 operational year originally Sept. 1, 1971, through August 31, 1972, was extended four months to Dec. 31, 1972, due to

Historical Program Profile of Region (cont.)

the RMPS change from a four to three review cycle year. In addition to the initial award of \$8,956,936, funds were provided for the grant extension and for support of health services and educational activities and emergency medical service projects, which increased the grant to its current level of \$12,180,123.

STAFF OBSERVATIONS

Principal Problems:

1. Continued support to the weak areas for the purpose of strengthening and raising the areas to CCRMP standards. Considerable progress has been made with this problem and only Area VI--Loma Linda, Area VII--University of California--San Diego, and Area VIII--University of California--Irvine--are considered weak.
2. Although the CCRMP has made a great improvement in preparing budget sheets (forms 16's), there appears to be an administrative problem at the central office with regards to budget.

Principal Accomplishments:

1. The CCRMP central office has undergone an organizational reorganization which has permitted the provision of a much broader range of technical assistance to area offices in the first year of anniversary review status.
2. A regional kidney disease program plan with specific component objectives has been developed, and priorities have been established among these objectives.
3. One of the new program emphasis of the CCRMP is on manpower assessment. They have been sponsoring programs to develop a regional health services/educational activities plan.

Issues Requiring Attention of Reviewers:

It might be well to keep in mind the CHP/RMP controversy.

FUNDING HISTORY
(Direct Cost 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 Stage
(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 *
04	9/1/71--8/31/72	8,956,936
04 (with 4 mos. extension)	9/1/71--12/31/72 (16 mos.)	12,180,123 **

* An award statement was issued reducing this amount to \$6,292,065 plus \$703,509 reauthorized unspent.

** This amount includes HS/EA and EMS supplementals funded at \$1,940,153 and \$100,000 respectively.

MEMORANDUM

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

TO : Director, Division of
Operations and Development

CPC 9/8/72

DATE: September 8, 1972

FROM : Director, Regional Medical Programs Service

SUBJECT: Action of September 5-6 Staff Anniversary Review Panel
Recommendation Concerning the Application of the California
Committee on Regional Medical Programs RM 00019

Accepted

R/M

9/11/72
(date)

Rejected

(date)

Modifications:

*must clarify status of grants to
support kidney activities, again accord
from CCAMP on their separate status
as part of RMP's kidney center
plans.*

3. Projects 86, 87A, 87D, 87E, 87F, 87G, 87H, 87I, and 89 are the original projects begun in FY 72 following Council approval of the California Kidney Disease proposal. The region is to be notified that continuation of these projects is approved for FY 73 at a funding level of \$322,000. Any greater support of these projects is inappropriate in that we have received no justification for an increased funding level when guidelines call for a decremental funding pattern in the 02 and 03 years.
4. Because of the confusion regarding the current status of the CCRMP's kidney activities, staff from RMPS will make a consultation visit to assess the situation on October 2 and 3.

The \$9,951,175 funding recommendation was decided on when SARP anticipated that CCRMP would resubmit the new kidney proposals 87K, 87L, 87M, and 87N, and deducted \$92,000 (requested amount for these activities) from the National Advisory Council approved level of \$10,043,175. This maneuver will keep the CCRMP within the Council approved level for the 02 anniversary year.

Other specific concerns noted by SARP relative to several of the nine CCRMP area programs were:

1. Areas I, IV, and VI, are not requiring written assurances from program sponsors of conformance to Title VI of the Civil Rights Act.
2. Area VII has a half-time coordinator. SARP believes the coordinator's position should be a full-time job.
3. SARP questioned the practice of salaried chairmen for consultant panels in Area V.
4. Area III has a 12-member faculty advisory committee which recommends approval or disapproval of all RMP proposals for funding and advises the coordinator. SARP believes that this committee is functioning in the same capacity as the Area Advisory Group. Additionally, it was noted that the dean of the medical school appoints new Area Advisory Group members. Because of these two factors, it appears that the medical school may be dominating the program.
5. Several of the areas are not following proper review and management procedures; i.e., failure to distribute review and procedure criteria to applicants and/or failure to review expenditure reports from operational activities.
6. Evaluation procedures are weak or nonexistent in Areas III, IV, V and VII; i.e., Area III has no overall program evaluation, and Area IV, V and VII do not have RAG involvement in program evaluation.

7. Area I appears to be in violation of RMPS policy guidelines by supporting basic medical education training; i.e., the Area is supporting medical residents in a family practice program.
8. SARP noted the sickle cell request from Area IX. Although there is no clearly defined RMPS policy regarding support of this kind of activity, it was noted that similar projects from other RMPs have been advised by the National Advisory Council to seek funding from the Sickle Cell Anemia Program, National Center for Family Planning Services, HSMHA.

RMPS/WOB
9/8/72

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>01</u> (04 operational year)	Council-Approved Level For TR Year _____	Region's Request For TR Year <u>02</u> (05 operational year)	Recommended Funding For TR Year <u>02</u> <input checked="" type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
AM STAFF	\$ 4,313,532	X	\$ 4,112,586	\$ 4,112,586	X
ACTS	859,896		800,000	<input checked="" type="checkbox"/> 800,000 <input type="checkbox"/> No	
OPMENTAL COMP.	586,692		4,814,402	4,114,132	
TIONAL PROJECTS	3,196,786		(693,414)	(322,000)	
ney	X		(492,457)	*(492,457)	
ea			(-)	(-)	
iatric Pulmonary			(110,000)	*(110,000)	
er			(-)	(-)	
. DIRECT COSTS		8,956,906	11,022,859	9,951,175	
COUNCIL-APPROVED LEVEL	\$10,043,175	*SARP gave no specific recommendations on these projects.			

4

Region Central New York
Review Cycle 10/72
Type of Application;
Anniversary before
Triennium
Rating 239

Recommendations From

SARP

Review Committee

Site Visit

Council

RECOMMENDATION: The Committee agreed with the site visitors in recommending approval of the anniversary request for the 05 year in a reduced amount of \$889,000. This amount includes the continuation of Project #6--Home Dialysis Training Program with no increase in funding above its 1972 level. The Committee paralleling the recommendation of the site visitors and outside technical reviewers disapproved Project #38--Cooperative Organ Bank with advice to follow the Kidney Guidelines and develop a regional plan for renal disease.

The recommended funding level would permit the region to actively recruit a well qualified staff and at the same time not permit the program to be overburdened by a large number of projects. Committee also recommended the scheduling of a Management Survey visit to evaluate and strengthen the region's fiscal capabilities.

The total request and recommendation are as follows:

<u>Year</u>	<u>Requested</u>	<u>Recommended</u>
05	\$1,420,349	\$889,000*

Critique - The CNYRMP has made a valiant effort during the past year to remedy the deficiencies noted during the 1971 site visit. For most of the year the program worked with an Acting Director which was a difficult arrangement for him and an even greater handicap to a program making an attempt to bring about required changes.

The region has established new goals and objectives which are consistent with national goals, but still fail to directly reflect the local health needs. The RAG has been expanded to include more consumer representation, but still needs to strengthen its representation to insure additional input from young providers, minorities, nurses and allied health members.

*Includes \$16,000 for Project #6--Home Dialysis Training
\$429,000 for recruiting and hiring an adequate program staff
\$469,000 for support of project activities.

Unquestionably, the program's highest priority is to increase its program staff size. It requires competencies which can be provided by physicians, health planners, nurses, fiscal managers and workers in the allied health areas. In the area of fiscal management, the program has an overriding need to strengthen its competencies in light of the unexpended funds accumulated during the past year. The Management Assessment visit will help the program to identify its problems in more specific terms and will provide guidance to the implementation of possible solutions.

In summary, the program did well during the past year in light of the circumstances; however, it faces a need to correct many deficiencies if it is to become a mature RMP. It must abandon its emphasis on the "mini-contract" mechanism and place its faith on acquiring a program staff which is capable of generating and implementing a plan which will address some of the region's pressing health needs. The year ahead is seen as a year in which the CNYRMP acquires a program staff which is capable of developing and implementing an integrated, coordinated group of activities which will result in a solid RMP program in the Central New York region. The recommended funding level has been carefully scrutinized and was broken into two distinct categories, i.e., program staff and project support. The Review Committee felt strongly that the CNYRMP would be well advised to place its priorities in the coming year to these two categories in the proportions indicated and to view the near future as a "staffing up and planning" period. Implementation should be relegated to a point in time which comes after the program has acquired a program staff with a wide range of competencies and has developed a sound plan for the future programmatic efforts to be undertaken by the CNYRMP. In so far as possible, they should avoid the "piecemeal" approach which characterizes the mini-contracts efforts.

There was considerable discussion by the Committee concerning the site visitors recommendations.

EOB/DOD 9/25/72

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION BEFORE TRIENNIUM

Component	Current Annualized Level	Request For	Request Funding For
	<u>'04</u> Year	<u>05</u> Year	<u>05</u> Year <input type="checkbox"/> SARP <input checked="" type="checkbox"/> Review Committee
PROGRAM STAFF	\$444,908	\$489,102	\$889,000 combined
CONTRACTS			
DEVELOPMENTAL COMPONENT			<input type="checkbox"/> Yes <input type="checkbox"/> No
OPERATIONAL PROJECTS	\$255,183	\$931,247	
Kidney		(44,660)	(16,000)
EMS		(91,062)	(*)
hs/ea		(142,320)	(*)
Pediatric Pulmonary		()	()
Other		()	()
TOTAL DIRECT COSTS	\$700,091	\$1,420,349	\$889,000
COUNCIL-APPROVED LEVEL	\$850,000		*Committee does not specifically discuss these projects.

CENTRAL NEW YORK
REGIONAL MEDICAL PROGRAM

SITE VISIT REPORT

August 9-10, 1972

I. Site Visit Participants

Consultants

Dorothy E. Anderson, R.N., M.P.H., Site Visit Chairperson, Review Committee, Associate Coordinator Area V, California RMP
George E. Scheiner, M.D., National Advisory Council, Professor of Medicine, Georgetown University
F. M. Simmons Patterson, M.D., Executive Director, Association for North Carolina RMP

RMPS

Frank S. Nash, Acting Chief, Eastern Operations Branch
Robert Shaw, Program Director, DHEW Region II
Nicholas Manos, Emergency Medical Service Task Force, Division of Professional & Technical Development
Jerome J. Stolov, Public Health Advisor, Eastern Operations Branch

Central New York RMP

John J. Murray, Coordinator
Ernest Carhart, M.D., Medical Advisor
Sandra Anglund, Public Relations
Marjorie Jordal, Assistant Director for Administration
Walter Curry, Emergency Medical System, Coordinator
Robert Wheeler, Ph.D., EMS Consultant
Nicholas Collis, Ed.D., Director Health Service/Education Activities
Ottilia Nesbit, Health Planner
Robert Schneider, Evaluator
Lawrence Polly, Audio Visual Maintenance
John Koch, Technical Assistant, Learning Resource Center
Suzanne Murray, Librarian
Larry Rummel, Community Coordinator (East)
Micheal Reich, Administrative Assistant Trainee

CNYRMP Executive Committee

Clarke T. Case, M.D., Chairman, Physician (Surgeon) Private Practice*
Gordon J. Cummings, Ph.D., Rural Sociologist, Cornell University*
Horace S. Ivey, M.A., Director of Social Service Department, Upstate Medical Center*
Bruce E. Chamberlain, M.D., Physician (Surgeon) Private Practice*

* Central New York RAG Members

CNYRMP Review and Evaluation Committee - Generalist Nurse Clinician
Training Program

Barbara Bates, M.D., Consultant, University of Rochester
Irwin K. Stone, M.D., Physician (Gen. Prac.) Emergency Room *
Virginia McAllister, B.S., SUNY Agricultural & Technical College,
Professor & Chairman, Department of Health Technology *
Gertrude Cherescavich, Project Director of Nurse-Clinician Program
Betty Katona, Acting Nurse Coordinator
Helmon Rubinson, M.D., Physician Coordinator
Sister John Nicholas, Nurse-Clinician Student
Maryanne Miraglilo, Nurse-Clinician Student
Benjamin Levy, M.D., Preceptor, N. Y. Telephone Co.
Robert F. McMahon, Preceptor, General Practitioner, Syracuse

CNYRMP Primary Patient Care Committee

McDonald Dixon, Foreman, Revere Copper & Brass, Inc. *
Herbert K. Ensworth, M.D., Physician (Internist) Private Practice/Ithaca *
Robert Gelder, M.D., Physician (Surgeon) Private Practice in Sidney,
New York *
Jerome Wayland Smith, Oneida Ltd., Silversmiths, Secretary of Company *
Robert Westlake, M.D., Chairman, Physician (Internist) Private
Practice - Syracuse *

CNYRMP Regional Kidney Disease Meeting

B. A. Bernstein, M.D., Physician Private Practice - Syracuse
Dorothy Bruno, staff - Senator Lombardi - Albany
Paul Bray, staff - Senator Lombardi - Albany
Thomas Flanagan, M.D., Physician, Private Practice *
Ron Fonda, Syracuse-Onondaga Planning Office
John Harding, M.D., Binghamton
Bucky Helmer, NY-Penn
Gerald Hoffman, Legislative Assistant - Senator Lombardi
Edward C. Hughes, M.D., RMP, Chairman Planning & Priorities Committee
CNY RAG *
A. O. McPherson, Upstate Medical Center
Stephen Kucera, M.D., Johnson City
Otto Lilien, M.D., Department of Urology, Upstate Medical Center
Honorable Tarky Lombardi, Chairman, Senate Health Committee
Jason Moyer, Medical Director - Binghamton General Hospital
Ms. Harriet Morse, Executive Director - Senate Health Committee
Zahi Nia Makhul, M.D., Department of Urology - SUH
Richard Schlesinger, CHP, ALPHA, Syracuse
Richard Schmidt, M.D., Dean, Medical School, Upstate Medical Center *
Edward T. Schroeder, M.D., RMP Project Director, Home Dialysis
Training Program
Ronald D. Smith, M.D., Utica

* Central New York RAG Members

II. INTRODUCTION

The Central New York Regional Medical Program (CNYRMP) site visit was conducted following the receipt of their application for one year's support in the amount of \$1,420,349 direct cost. The application requests support for the continuation of six projects and ten new activities. Of the ten new projects, two had previously been funded as nine separate projects and are now administratively merged under two new project numbers.

The charge to the site visit team was:

1. To review the region's overall progress since the last site visit in June 1971.
2. To determine the newly appointed Director's role in program direction.
3. To determine how regional needs and resources are identified and analyzed.
4. To evaluate the monitoring and surveillance of ongoing program activities.
5. To study the roles of RAG and its committees in program direction and to relate them to the recently published RMPS policy governing these relationships.
6. To review the region's mini-contract activities and obtain progress reports on those projects which have recently been initiated as supplementary activities.
7. To arrive at a funding recommendation which would include the region's kidney activities as well as its general programmatic activities.

III. Conclusions and General Impressions

The site visit team was fortunate in having three members who took part in last year's visit. The site visitors noted that the region had made many positive changes since the last site visit.

The region has established new goals and objectives which are consistent with national goals, but still fail to directly reflect the local needs. The RAG has been expanded to include more consumer representation, but still needs to strengthen its representation to include more input from young providers, minorities, nurses and allied health members. The Executive Committee has also added consumers. The team found the RAG Chairman to be dedicated and knowledgeable about the total program.

The recently appointed Director has generated a new enthusiasm within the RMP and has been successful in achieving a greater visibility for the program throughout the entire region. The program staff needs to be expanded. It requires competencies in the physician, nursing and allied health personnel areas.

The region has made a sincere effort to comply with the recommendations set forth in the 1971 advice letter. However, a Physician Associate Director has not been appointed.

The team was favorably impressed with the CNYRMP's ability to involve CHP "b" agencies as an aid to the program in its project review and program planning.

While the site visitors noted the program's progress and its new direction, the following deficiencies and concerns were reported to the region during the feedback session.

1. The site visitors felt that the present program staff is not large enough to effectively implement a successful RMP program. The following positions and competencies are recommended.

- a. A full-time physician in the role of an Associate Director. In the recruitment process the program should attempt to attract an individual who would bring strong administrative and public relations competencies to this position. It was noted that the CNYRMP has successfully recruited a Medical Consultant; however, his primary value is as a family practice consultant and, as such, does not fill the program's needs for strengthening its administrative and public relations capabilities.
- b. There is a need for the recruitment of program staff in the roles of Assistant Director for Operations, an Assistant Director for Administration, and an Assistant Director for Program Planning and Development.
- c. There is a need for a Nurse Generalist to aid the Manpower Coordinator in the planning and development of health service/education activities.
- d. The utilization of community resources could be enhanced by the hiring of a Community Coordinator for each of the area's subregions.
- e. Evaluation is an important aspect of a successful RMP and although this is currently being done, there is a need to enhance this aspect of the program's operations. Consideration should be given to the recruitment of an experienced full-time Evaluator.

In summary, there is a need to enlarge the staff in a manner which will provide the competencies outlined. In the recruitment process there should be an attempt to recruit minority candidates who can provide the balance and insights which will be helpful in program development. In addition, minority staff members can provide a communication link with the minority groups in the CNYRMP area who have a need for the benefits which can be provided through the auspices of the RMP.

2. The site visit team recommends that no additional mini-contracts be initiated. It was noted that these contracts required an excessive number of program staff man-hours to monitor and evaluate. In light of the small program staff, the efficiency of manpower utilization must be optimal and in using the mini-contracts approach, the manpower/dollar administrative costs appear unwarranted.

3. The CNYRMP's goals and objectives are broad and fail to specifically reflect the local needs of the region. It is recommended that the program systematically identify the needs of the region, develop short and long term objectives to meet these needs and, in the process, redefine its goals and objectives in a manner which more specifically addresses the region's pressing health problems.

4. There is evidence that a programmatic thrust is developing in one of the subregions; however, there is a need to coordinate the relationship between program planning, operational projects, and program staff activities to capitalize on these positive developments.

5. The RAG membership needs a greater balance to provide insight from various sectors of the region. Specifically, there is a need for greater representation from young providers, minorities, women, and allied health personnel.

6. There is no formalized appeal procedure provided in the current CNYRMP grant application packet. The region's review process is scheduled for a complete analysis at a later date; however, there should be the immediate implementation of a formalized appeal procedure for all grant applicants.

7. Project #38, The Cooperative Organ Bank is disapproved. The project, as presently conceived, demonstrated a lack of coordination and integration with other renal activities and fails to meet the region's total needs for a kidney program.

8. Project #6, Home Hemodialysis Training Program is recommended for continued support at its present level. It was noted that the goals of the training unit are not clearly stated and that the project will not attain maximum efficiency until such time as this has been accomplished.

9. Project #40, Satellite Clinics Serving Rural Areas of Central New York. This project is disapproved on administrative grounds. In its present form the agreement of affiliation is to be with two private physicians rather than with a nonprofit corporation or institution as required by grants management policy.

10. The CNYRMP Bylaws fail to comply with the RMPS policy which sets forth the respective roles and responsibilities of the grantee, the RAG, and the program staff. This policy was formally issued in the form of a News, Information and Data (NID) publication on August 30, 1972 and has been sent to all regions. Under the current Bylaws, the Council of the Upstate Medical Center is given the authority to appoint RAG members upon the advice of the RAG. The Bylaws require modification to turn the authority for RAG member appointment over to the RAG, thus making the RAG a self-perpetuating body.

11. The region has a need to strengthen its fiscal management capabilities. A Management Survey Visit will be scheduled in the future to evaluate the situation and to provide constructive guidance. The site visitors expressed concern over the low rate of expenditures and the resultant lapsing of funds.

Funding Recommendation

The site visit team recommends approval of the anniversary request for program staff and projects in a reduced amount of \$889,000. The team recommended \$429,000 for program staff salaries and \$460,000 for project activities. It was believed that this amount would be sufficient to permit the active recruiting of a well qualified staff and, at the same time, not permit the program to be overburdened by a large number of project activities. The site team is impressed with the program's need for an enlarged staff which will increase its competencies to develop a solid program. This must be the region's highest priority in the upcoming year.

RMP: Central New York

PREPARED BY: Jerome Stolov

DATE: 10/72

1. GOALS, OBJECTIVES, AND PRIORITIES (8)

The region's new goals and objectives represent a new direction which is consistent with the RMPS mission statement; however, as noted earlier, they do not reflect local health needs. The objectives were developed by the Planning & Priorities Committee created in December 1971. The Committee was chaired by Dr. Edward Hughes, Director of Community Medical Service (New York Medical Society). Other members of the Committee were chosen because of their personal knowledge of the region's health needs. The Committee had representatives from both consumers and providers. The CHP "B" and the CHP "A" agencies were also invited to participate in the formulation of the region's new goals and objectives.

The Planning & Priorities Committee used the following basis for the formulation of the goals and objectives:

1. The data made available at the RAG meeting of December 2, 1971.
2. The stated goals and priorities of the CHP "A" and CHP "B" agencies.
3. Mini-contract proposals which had been submitted by health professionals. This procedure enabled the region to see what people in the region perceived to be their problem areas.
4. The RMPS mission statement.
5. Data provided by the Community Medical Services (New York Medical Society).

On March 2, 1972 the following goals and objectives were approved:

1. "Improvement in the system of health care delivery by assisting in the evaluation of existing health systems and in the development and evaluation of potentially effective alternative health care systems with particular attention to the rural, inner city, and elderly medically disadvantaged."
2. "Increasing the availability, efficient utilization and capacity of health care personnel while providing for their continuing competency."
3. "Strengthening regional cooperative arrangements in order to make maximum use of available resources."

RMP: Central New York

PREPARED BY: Jerome Stolov

DATE: 10/72

1. GOALS, OBJECTIVES, AND PRIORITIES (8) (Contd)

Although these objectives are listed in priority order, the Planning and Priority Committee hopes to formalize explicit priorities by the end of the calendar year.

In addition to a lack of explicit priorities, the site visit team found no evidence that the program had established short or long-term goals.

The final statement of the goals and objectives was mailed to 5000 health professionals in March 1972, at the time the requests for grant applications for 1973 were circulated. Approximately 57 letters of intent were submitted. Of these, only 15 failed to fall within the CNYRMP's goals and objectives. This was an indication that the health providers had understood and accepted the region's program and a further indication of the broad nature of the stated objectives.

An examination of the CNYRMP grant application reveals that 52% of the region's requested operational activities are directly related to their highest priority objective of improving primary patient care for the medically deprived rural, inner city and elderly residents of the region.

The region has made an honest attempt to revise its goals, objectives, and priorities; however, it has been handicapped by the resignation of its former Coordinator, operating for the better part of the year with an interim Coordinator, a small staff, a RAG which requires restructuring and a number of other disadvantages which have combined to make progress difficult. Now that the new Coordinator has been named, the situation should begin to stabilize and the coming year should see the evolution of more specific and more meaningful goals and objectives. Once this has been accomplished the program should begin to take on a more positive outlook.

Recommended Action

RMP: Central New York PREPARED BY: Jerome Stolov DATE: 10/72

2. ACCOMPLISHMENTS AND IMPLEMENTATION (15)

It should be recognized that this program had only three professional staff members for most of the year since the last site visit; however, the site visitors were able to identify some noteworthy accomplishments.

The RMP's new Spanish-speaking Health Planner worked closely with the NY-Penn HMO Coordinator and Model Cities staff in Binghamton. Her work resulted in the development of a proposal to Model Cities to fund an Ambulatory Care Clinic.

The Library Coordinator stimulated hospitals to apply for library improvement grants. As a result of her efforts, three hospitals each received \$3,000 grants.

The Emergency Medical System Consultant developed an Information Guide to be used in working with the New York State Bureau of Emergency Services and the CHPs in the development of local and regional plans for the delivery of Emergency Health Services.

The CNYRMP program staff planned and implemented two training programs. The purpose of the first program, Medication Education Program, was to update nursing home personnel with respect to the proper utilization of recently developed medications. The second program will take place in September 1972, and will address itself to the training of nursing home personnel to enhance their skills as activities leaders.

Some activities initiated by the CNYRMP have been extended or replicated throughout the region. The site visit team noted that the Pulaski Model Rural Ambulatory Care Center, operated in conjunction with the Family Practice program at St. Joseph's Hospital in Syracuse, is being replicated by the C. S. Wilson Hospital in Johnson City, New York. This hospital has submitted a proposal to create a comprehensive rural health care system at Barnes-Kasson Hospital in Susquehanna, Pennsylvania. This development is a tribute to the efforts of the CNYRMP to move its expertise to areas outside Syracuse.

The Nurse-Clinician program provides another example of a project being extended throughout the region. Two-thirds of the participants of the first class were from Syracuse while less than one-fourth (22%) of the participants in the second class came from Syracuse. The regionalization aspect of this program effort was viewed positively by the site visitors.

RMP: Central New York PREPARED BY: Jerome Stolov DATE: 10/72

2. ACCOMPLISHMENTS AND IMPLEMENTATION (15) (Contd)

In addition, the region plans to work with the other New York State RMPs in such joint efforts to enhance its activities in public relations, program evaluation, and cancer registries.

A unique coordinating board has been developed in which the RMP program staff and members of the NY-Penn Health Management Corporation work together to insure integration and cooperation of all planning and implementation of programs in that subregion. In this way the CNYRMP is fulfilling, in part, its role as a coordinating health agency.

A mini-contract has been given to the Neighborhood Health Center in Utica. This has resulted in making health care more readily accessible to inner city residents and in moderating health costs by providing primary care outside of a hospital emergency room. This had been the only other alternative left to these inner city residents.

The Pulaski Rural Ambulatory Care Center has increased the availability and accessibility of care for people living in Northern Oswego County. Many of the 200 patients per week which are seen in this center had formerly been patients of a Pulaski general practitioner who is now retired.

The Librarian, EMS Consultant, and Health Planner have given professional assistance to those people in the region who have requested their help. For example, the Medical Consultant, who recently joined the CNYRMP, is providing professional assistance and consultation to those engaged in family practice care.

Up until now, the CNYRMP has not been involved in peer review mechanisms and has not specifically examined the quality of health care being rendered in this region. However, the minutes of the Executive Committee meeting held on May 25, 1972, states the following: "The Executive Committee directed the staff to consider the problem of quality of care as a priority for the next program year and to direct efforts of the program staff in the establishment of means of measuring quality care and upgrading that care when it is found inadequate." In light of this mandate, the program can be expected to address this aspect of health care in the near future.

Recommended Action

RMP: Central New York PREPARED BY: Jerome Stolov DATE: 10/72

3. CONTINUED SUPPORT (10)

All proposals submitted to the CNYRMP must give evidence of possible sources for continued funding. In the course of examining the projects presently being funded, the site visitors observed that during the evaluation of the Nurse-Clinician project, the phasing in of tuition was strongly emphasized. The Model Rural Ambulatory Care Center is expecting that patient fees and local fund raising will aid in phasing out RMP support for this activity. Thus, the recycling of funds is being accomplished and the need to accomplish this is recognized by the region.

On the negative side, the site visitors noted that the Dial Access project will not be self-sustaining since it is having problems in finding sources of continued support. The region will be forced to find alternate means of supporting this activity or will need to accept the fact that it has failed to demonstrate its value to the users.

The St. Regis Reservation Clinic, Project #31, has not shown evidence that the CNYRMP staff has adequately negotiated formal agreements with funding institutions which define the extent of their present and future participation. This must be done if the region is to avoid problems which can arise when there are misunderstandings of responsibilities and authority.

A major problem which has confronted the Home Dialysis Training project has been its lack of success in locating financial support for each patient.

Of the sixteen proposals submitted for funding, very few had realistic plans for continued support. This was a major factor in several CHP reviews. For this reason, the region faces a true need to recruit a full-time staff person who is skilled in administrative negotiations which will result in the acquisition of continued support for the worthwhile activities initiated in the region by the RMP.

Recommended Action

RMP: Central New York

PREPARED BY: Jerome Stolov

DATE: 10/72

4. MINORITY INTERESTS (7)

As mentioned in the section on goals, objectives and priorities, the number one priority of the CNYRMP relates to improving the system for health care delivery to rural, inner city, elderly medically disadvantaged, and etc. To accomplish this, the region will need to add minority members to its staff who will bring the insights and linkages necessary to work with the minority groups.

The population of the entire 17 county region is about 3% minorities. The site team observed that only three out of 17 mini-contracts were targeted to the inner city populations, while the majority of projects appear to serve rural residents.

The CNYRMP has not significantly improved the quality of care delivered to the black minority populations. However, the region's highest priority project was the St. Regis Reservation Health Clinic for Indians.

An example of RMP supported activities that resulted in training members of minority groups was the funding of the training of a nurses aide and a LPN for the Utica Neighborhood Health Center. The St. Regis Reservation Clinic, Project #31, also has a training component for local manpower development from among the local Indian population.

In January 1972, a Spanish speaking Health Planner was added to the CNYRMP program staff. Her assignment was to work with consumers, model city agencies, community action programs, and the Spanish Action League. She has also made contact with the Mohawk Nation which resulted in CNYRMP funding a mini-contract to this group. It is fair to assume, based on her early accomplishments, that this staff member will make a significant contribution to the future efforts of this program.

As of June 1, 1972, the Central New York professional program staff had three females and three male members. One of the females represents the Spanish speaking minority group.

Recommended Action

RMP: Central New York PREPARED BY: Jerome Stolov DATE: 10/72

5. COORDINATOR (10)

The present Director has been with the CNYRMP since 1968; however, he has only been in his new position since July 1, 1972. From October 1, 1971 through July 1, 1972, he was serving as the region's Acting Director. While he was the Acting Director he was successful in expanding the RAG's minority membership and in gaining the appointment of the directors of the region's three CHP "b" agencies to the RAG. He employed a management consultant to help him develop an organizational chart which was consistent with the new CNYRMP direction. In this process the duties of program staff members were redefined through the development of job descriptions. This resulted in changes for several of the staff members and provided a guide to the type of competencies the program needed to seek in its future recruitment efforts.

A paragraph in the annual report of the RAG states, "John Murray, Assistant Coordinator, was named Acting Coordinator and has done a remarkable job in adapting our program to the evolved RMP national mission, as well as local needs. He has instilled in all of us a new enthusiasm for RMP." It was apparent that he had acquired the respect of the local health community and, on this basis, was appointed to the role of Director in July. The site visitors were concerned because he has failed to establish an effectively functioning program staff. The visitors questioned the Director's failure to delegate authority and his strategy in not filling the Associate Director, Assistant Director for Program Planning and Development and the Assistant Director for operations positions. The Director planned to consider existing program staff as potential candidates for the above positions. The team felt that the program needed these positions filled with well qualified health professionals in order to establish an effective staff. On the basis of the Coordinator's views toward the delegation of authority and his failure to seek highly experienced health professionals for the key program positions mentioned, the site visitors believed there is a need for the Director to rethink his approach and to attempt to strengthen the program through improved administrative procedures.

The Director's good working relationship with RAG is attested to by the fact that the RAG's Ad Hoc Selection Committee nominated him to be the program's Director, and the full RAG unanimously voted to approve this nomination.

In summary, the site visitors viewed the Director with ambivalence.

RMP: Central New York PREPARED BY: Jerome Stolov DATE: 10/72

5 COORDINATOR (10) (Contd)

They perceived him as a man who related well with people, groups, and institutions throughout the region and, in so doing, represented the CNYRMP in an excellent fashion. On the other hand, they saw him as a man who lacked the managerial skills to recruit and properly utilize the program staff. This reinforced the need for an "in-house" Assistant Director for Operations who could effectively build and properly utilize the staff.

Recommended Action

6. PROGRAM STAFF (3)

The former Director and many of the staff have left in the past year. This has left the program vastly understaffed. Both the new Director and his remaining staff are to be commended for the heavy work load they have carried in recent months. It is also quite apparent that it is impossible for them to continue at this pace. Unquestionably, the top priority this program faces is the enlargement of the program staff with qualified individuals to fill the key staff vacancies which have been mentioned repeatedly throughout this report. The site team noted that a physician associate director has not been appointed as recommended in the 1971 Advice Letter.

The team learned that at the present time a member of the program staff has been designated to serve in the dual roles of Assistant Director of Operations and Coordinator of Emergency Medical Services. This practice is contrary to RMPS policy and is obviously too much for one man to handle effectively. In addition to those positions requested by the region, the site visitors recommend that consideration be given to hiring a well qualified nurse and an allied health professional to balance the range of competencies of the program staff which is expected to carry out a broad-based public health program consistent with its stated goals and the overall mission of the RMPS.

Recommended Action

7. REGIONAL ADVISORY GROUP (5)

The present CNYRMP RAG breakdown is as follows: 13 practicing physicians, 14 members of the public at large, 7 hospital administrators, 5 educators, 4 government officials, 3 CHP "b" agency directors, 2 lawyers, 2 nurses, 1 dentist, and 1 head of a social service organization. The RAG has good geographic representation.

There are five minority members on the CNYRMP RAG. In light of the program goals, there needs to be greater representation from these groups. Four out of the five minority RAG members are black; the fifth member is a representative of the Spanish-speaking community. There are no Indian representatives and this must be corrected in light of the program's need for input from this segment of the population. The site visitors also noted that there were only three female members on the RAG and felt that this should be increased. The Binghamton Model City Agency, the Oswego County Migrant Health Care Committee, and the Community Action Program of St. Lawrence County each have representation on the RAG and this was viewed as an excellent means of getting inputs from throughout the region.

Four of the five minority members serve on CNYRMP Technical Review Committee and one minority member serves on the Executive Committee. Minority representation on the Executive Committee needs to be increased.

With the establishment of a new Planning and Priorities Committee, along with a new Review and Evaluation Committee, more RAG members are going to be more directly involved in the decisionmaking. This increased involvement and decentralization of the decisionmaking process was viewed as a step in the right direction.

The Executive Committee meets bi-monthly and not less than one week prior to each RAG meeting. The recommendations of the Executive Committee are presented to RAG and are subject to questioning and reversal by the RAG. The RAG Chairman is knowledgeable and involved in the program and, as such, is an aid to enlightened actions which will strengthen and coordinate the program's activities.

The site visitors learned that the RAG exercised its authority in at least one instance by approving a project which had not been recommended for funding by the Executive Committee.

The site visit team was unable to determine whether the RAG provides guidance to the program staff. However, it was noted that the Chairman of the RAG is in telephone contact with the CNYRMP Director.

7. REGIONAL ADVISORY GROUP (5) (Contd).

on a weekly basis. This close communication between the RAG Chairman and the Director was viewed as constructive in the sense that it established a bridge between two segments of the CNYRMP which will enable them to work in a more coordinated fashion.

The reorganization of CNYRMP's RAG resulted in the establishment of the following standing committees: Nominating, Executive, Planning and Priority, Evaluation, Manpower, Primary Patient Care and Coordinating Board for the NY-Penn area. In addition to the standing committees there are Ad Hoc Committees on matters related to kidney disease, emergency medical services, and cancer.

In summary, the RAG has undergone some dramatic changes during the past year and has made some progress; however, there is still a long way to go to acquire a RAG which can effectively fulfill its mission as defined by RMPS. The process of restructuring must continue and the News, Information and Data (NID) bulletin issued by RMPS on August 30, 1972 should serve as the guide to the future efforts to revitalize this body.

Recommended Action

8. GRANTEE ORGANIZATION (2)

The Research Foundation provides support through the Upstate Medical Center Business Office in the areas of purchasing, personnel, and grants administration. They have also assisted the region by giving special assistance in areas such as mini-contract formulation and negotiation. The region plans to utilize the Upstate Medical Center's Office more for additional legal advice, personnel recruitment, preparation of salary schedules which are consistent with the job descriptions which have emerged on the new organization chart as a result of the management consultation which had been contracted to study this aspect of the program.

The bylaws, however, need to take into account the recently formalized relationships required by RMPS between the grantee and RAG. This policy has been forwarded to all regions in an August 30, 1972 issue of News, Information, and Data (NID). According to the RMPS policy, the RAG has the responsibility of selecting and appointing its own members. The current bylaws specifically give the Council of Upstate Medical Center the responsibility to appoint RAG members and this must be modified.

9. PARTICIPATION (3)

The CNYRMP Program Director meets with staff and board members of the four CHP organizations in the region on a monthly basis to discuss program activities and plans. Both the Binghamton and Syracuse Model Cities agencies elected one delegate each as members to the CNYRMP RAG. In addition, there are also members from the Board of Directors of the Community Action Programs. Many CNYRMP RAG physicians serve in official capacities in various committees of the New York State Medical Society.

Still another indication of participation is the 134 applications which were requested for the mini-contracts and the 57 letters of intent which were actually submitted to the CNYRMP. In previous years, proposals numbered from 5 to 10 per year. The use of mini-contracts, although they have many drawbacks, do serve to involve and interest more people in the activities of the program.

Although four out of seven members of the Executive Committee are from the Syracuse area, the mini-contracts and proposed projects which were approved for funding resulted in a program with geographical balance. No major interest group appears to be exercising arbitrary control over the program's activities.

Recommended Action

10. LOCAL PLANNING (3)

When the RMP receives an inquiry or letter of intent for a proposal the CHP is immediately contacted. Joint meetings are then held with both the RMP and the local CHP planning groups to further develop the proposal. When the proposals are completed, the request is sent to the representative CHPs for them to review in light of their role in regional health planning. In the past this procedure was carried out in the month preceding the submission of the CNYRMP's annual application; however, the CNYRMP is currently attempting to give the CHPs and their own RAG more time to act on CHP comments by having the proposals reviewed on a continual basis throughout the year.

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10. LOCAL PLANNING (3) (Contd)

The CNYRMP plans to work closely with the local CHPs on a major project for Emergency Medical Services. Supplemental funds have recently been provided to the CNYRMP to conduct such an activity. The current plan is to contract with the local CHPs for setting up EMS councils and hiring local EMS Coordinators. It is interesting to note that the region hopes to utilize this project effort as a vehicle for the establishment of a CHP "b" agency in an area which does not have one at this time.

There is evidence to suggest that the CNYRMP has been successful in its attempts to gain participation from other health agencies in the region.

Recommended Action

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11. ASSESSMENT OF NEEDS AND RESOURCES (3)

As cited in the section on goals and objectives the region uses five sources to identify its regional and subregional needs. However, the site visitors failed to see how these sources of identifying needs could be integrated to provide the information required to generate a well directed programmatic thrust. In addition, the site visitors found only a few examples of present program staff activities which were in anyway related to the health care problems which had been identified by the five input sources. It is hoped that the recently established Planning and Priorities Committee will be able to synthesize this information in such manner that they will be able to establish priorities and refine the objectives in light of the current information. This is crucial to the CNYRMP if it is to be successful at re-orienting its program so that it can effectively implement activities which will alleviate the region's most pressing health needs rather than continue to pursue the path of doing "good works" in a fragmented, isolated, and uncoordinated fashion.

The region also plans to recruit four community coordinators for its designated subregions and also a health system planner. It is hoped that the above personnel will help in the assessment of needs and in the identification of resources, so the program can develop a meaningful plan of action for the program's future activities.

Recommended Action

12. MANAGEMENT (3)

With the small staff that has been available to the Director, the CNYRMP has been engaged in an impressive number of activities. However, the site visit team observed that program staff activities did not appear well coordinated. It was observed that the Learning Resource Center personnel and the Librarian were people who could have been used to assist the manpower coordinator in his tasks. There were no indications that such a working relationship existed or was developing.

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12. MANAGEMENT (3) (Contd)

As was mentioned in the section related to the Coordinator, the proper utilization of staff appears to be one of his major weaknesses. It is hoped that experience and confidence will help him to improve his management skills.

The region requires a monthly financial report and a bi-monthly progress report. In the past they required quarterly financial reports and semi-annual progress reports. This procedure should eventually aid the program to have current fiscal data which can be used for effective rebudgeting and enhancing its capabilities to capitalize on opportunities to move rapidly into activities which will advance the program. However, at this time, the region has an unexpended balance of \$417,339 which speaks to the need to improve its fiscal management capabilities.

Each project and mini-contract has been assigned to a program staff member. The program staff member was assigned to the project or contract when the initial letter of intent was received. In addition, the staff member arranges for technical review and is also required to give the results of the technical review back to the project director and to assist him in making changes which are required as a result of the review process. This approach places a heavy workload on each staff member and prohibits him from utilizing his time to assist in program planning and development. It is on this basis that the mini-contract approach is viewed as an ineffective approach to project development by this region at this time. It reduces staff to a role in which they are forced to react rather than act on matters related to program planning and development. Further, the volume of contracts under review results in a workload which tends to delete staff time to the point that activities can become fragmented, disjointed, and uncoordinated rather than synthesized into a solid program which addresses the region's needs.

Job descriptions have been developed without stating the required qualifications. It was noted that the Assistant Director for Administration was appointed to this position and there are indications that she does not have the qualifications and abilities to perform effectively in this role. This is evidenced by the fact that the program has accrued \$417,339 in unexpended funds during the past year.

The team consequently recommended that a Management Survey Visit be scheduled early next year to provide the region with constructive assistance in the handling of its fiscal management activities.

Recommended Action

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13. EVALUATION (3)

The site visitors observed that the region followed last year's advice and designated a program staff person as its evaluator. However, the training and experience of the evaluation director was in the field of education and not in analysis. The CNYRMP RAG report recognizes the program's weakness in this area by stating the following: "Evaluation has been an extremely difficult problem for this RMP, although we believe that the problem is shared by many others throughout the region. We are hopeful our two-pronged effort to correct this problem will bear fruit: (1) Reorganize our Evaluation Committee along subregional CHP area lines and involve RAG members on site visits; (2) Institute an interregional RMP effort in evaluation, spearheaded by our organization, to bring standardization and more expertise to all of the evaluation efforts in the Upstate New York's

The site visitors expressed concern that only one project had been evaluated prior to the RAG's approval of the submission of the CNYRMP's annual application to RMPS. Although, the visitors recognized the evaluation of the Nurse-Clinician project, it was felt this process should have been done prior to the deadline for submission. The evaluation of this activity was viewed as quite superficial and, in fact, was no more than progress reporting and discussion.

The new charge to the Review and Evaluation Committee is to site visit each project twice during a 12-month period. In addition to the projects, the Committee must also assess program staff activities and RAG functions. A task and a timeline plan for the Review and Evaluation Committee has been established.

The region is to be encouraged to implement the plan of the Evaluation Committee as portrayed in the task and timeline chart given to the site visitors. There is also to be involvement of total staff in the evaluation process, so that all proposals can be continuously evaluated for continued funding or termination. The track record for evaluation is quite poor; however, there are signs that the future will see a substantial improvement if the current plan is successfully implemented.

Recommended Action

14. ACTION PLAN (5)

As stated earlier, 52% of the project requests are related to the CNYRMP's first objective, to improve the health care delivery of the rural, inner city and the medically disadvantaged, but there is a need for greater community involvement and commitment.

The site visitors felt that the newly proposed activities were not realistic in view of the types and numbers of program staff presently on board. They further felt that the utilization of the mini-contract approach was unrealistic at this time and, in a sense, placed the cart in front of the horse. In this approach the RMP was asking the region-at-large to develop its program rather than developing its own program which it could present to the region's residents for their ratification. The region's involvement in the formulation of the program is viewed as rightfully originating from the RAG members who should represent the region's health interests and not directly from people in the region seeking financial support to "do his thing" through a mini-contract.

In view of the region's request to recruit ten key program staff members and recognizing that their planning and evaluation committees are undergoing reorganization, the CNYRMP's application which requests funds to manage 16 projects and 20 mini-contracts appears to be more than they can successfully accomplish during the next program year. Most of the current action plan is focused on "Projects" and does not involve the implementation of a coordinated, integrated program.

In summary, it appears the region needs to find a new approach to program development and it is hoped that new staff will alleviate the need to look for short-cuts and will permit the development of a well constructed action plan which effectively and methodically attempts to alleviate the health problems of the region.

Recommended Action

15. DISSEMINATION OF KNOWLEDGE (2)

An example of program staff disseminating skills is represented by the work of the Library Coordinator. Requests for inter-library loans were increased to 5,127 or 56.5% over the previous year. The Biomedical Communications Network handled 343 computer searches or

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15. DISSEMINATION OF KNOWLEDGE (2) (Contd)

or 64.9% more than last year. She also taught hospital personnel throughout the region some of the means they might employ in order to obtain additional funding to enhance their operations. Three hospitals have received National Library of Medicine improvement grants as a direct result of the work and training done by the CNYRMP Librarian.

Recommended Action

16. UTILIZATION OF MANPOWER AND FACILITIES (4)

Increasing the availability, efficient utilization, and capacity of health care while providing for continuing competency is a major objective of the CNYRMP. Several projects, namely, the Generalist Nurse Practitioner Training Program, health service/education activities, medical emergency technician training and Health System North directly address this objective. These projects represent 34% of the total requested project funds.

Examples of approved mini-contracts for the current funding year which include the utilization and/or training of allied health personnel are:

- 1) Creation of a Neighborhood Health Clinic (an LPN and a community worker/nurses aid was hired with RMP funds).
- 2) Training professionals and paraprofessionals to work as a team in remotivation and reality orientation.
- 3) Geriatric Day Care Center.
- 4) Homemaker service for the Madison Company.
- 5) Establishment of satellite medical centers.
- 6) Expansion of Volunteer Childrens' Clinics to rural areas.
- 7) Comprehensive Home Care as a follow-up to Pulmonary Rehabilitation.

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16. UTILIZATION OF MANPOWER AND FACILITIES (4) (Contd)

It is difficult to determine how much these activities will benefit the population in underserved areas. In an attempt to reach the underserved areas, the region is setting selectivity standards for applicants to the Nurse-Clinician Program. These standards will attempt to insure that applicants from rural and ghetto areas will receive high priority in terms of being the beneficiaries of the training provided in the Nurse-Clinician Program.

The region through its health service/education activities is attempting to involve the health education institutions. The site visitors learned that CNYRMP is involving the Maxwell School of Government by having its Masters Public Health Administration candidates participate in evaluation and planning studies. The idea of training interns from the Maxwell School is commendable, providing the staff can adequately supervise this endeavor.

A bibliography on geriatric patients with chronic respiratory disease has been assembled by CNYRMP staff.

Overall, the region is making a sincere attempt to utilize existing manpower and facilities and, in this instance, the mini-contract approach may have been somewhat helpful to them in their efforts. On the other hand, the approach to this problem is handicapped by the shortage of program staff and the need for a more systematic approach which a larger staff could make possible.

Recommended Action

17. IMPROVEMENT OF CARE (4)

The CNYRMP has utilized studies and data supplied by the CHPs. The ALPHA CHP "b" agency, for example, has established improved ambulatory care as its main priority. Both proposals, #19 - Pulaski Model Rural Ambulatory Care Center and #40 - Satellite Clinics Serving Rural Areas, address the problem of improving ambulatory care which the CHP agency, from its vantage point, recognizes as the area's major health problem.

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17. IMPROVEMENT OF CARE (4) (Contd)

Attempts to exploit transportation services are best shown by the CNYRMP mini-contract to the Geriatric Day Care Center in Canton. This proposal has enabled the contractor to bring patients to and from the day care center. There is no public transportation in this area. Thus a simple, but highly significant problem has been resolved by the CNYRMP intervention. The CNYRMP should be commended on this effort.

The CNYRMP is currently working with a Neighborhood Health Center in Utica, the Pulaski Model Rural Ambulatory Care Center and the Rural Urban System of Health Care in an attempt to amplify the capabilities of each of these programs to being better ambulatory care to the areas they are serving.

Recommended Action

18. SHORT-TERM PAYOFF (3)

The St. Regis Reservation Clinic appears to promise early access to improved health services within the next year. The Pulaski Clinic is already making additional services available to its rural population and is receiving assistance from the CNYRMP in this effort. It is too early to evaluate the impact the Nurse Practitioner Training Program will have on moderating costs of health care; however, it appears that this effort will add to the efficient utilization of personnel and result in an increase in the accessibility and availability of health care services in the region.

There is reason to believe that the EMS project will enhance the availability and quality of health care in the next two or three years. The region has already begun activities which are designed to attract individuals and agencies to participate in its Emergency Medical Service (EMS) project. It is hoped, that through involvement in the EMS activity, the people and organizations in the region will develop linkages with the CNYRMP which will result in additional activities which can be worked on in cooperative fashion.

In the overview, the CNYRMP has been making a contribution to the improvement of care in the region; however, this contribution will become more significant as the program continues to restructure and

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18. SHORT-TERM PAYOFF (3) (Contd)

increases the size and competencies of its program staff. The overriding problem faced by the CNYRMP is the shortage of program staff and, until this is resolved, the programmatic efforts will suffer. Under the staffing circumstances this program has faced during the past year, the accomplishments in this area are commendable.

Recommended Action

19. REGIONALIZATION (4)

Both the EMS project and health services/education activities are examples of activities aimed at multiple provider groups. Although the Nurse-Clinician project is located in a single provider institution, the students come from all parts of the region.

The CNYRMP plans to assign program staff to each of the four CHP subregions. These coordinators, by proper exchange of information, will be in a position to encourage sharing of facilities and manpower on a regionwide basis.

The Health System North project is an example of how new linkages are being established with the University Health Science Center in Syracuse by providing for an on-going rotation of medical students, interns, and residents throughout the CNYRMP's northern area to provide health care in a section which is particularly short of physicians. This has proven to be an effective means of providing health care services to the underserved residents of this isolated portion of the region.

New linkages between northern Oswego County and St. Josephs Hospital Health Center in Syracuse, and between the rural Susquehanna County in Pennsylvania and C. S. Wilson Hospital in Johnson City, New York are also being established. The region believes these preliminary negotiations will assist it to extend its program more effectively throughout the region in the future.

The EMS project is expected to create a regionwide and ultimately a statewide network for communication and transportation for the enhancement of Emergency Medical Services and Ambulance Transportation Centers throughout all of New York.

The region appears to be making headway in the extension of the benefits it can bring to the Central New York area.

Recommended Action

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20. OTHER FUNDING (3)

The CNYRMP has attracted other funds when planning Project #46, Health System North. The E. J. Noble Foundation paid for the summer fellowship program because RMP funds could not be used to pay for this type activity. As mentioned earlier, three hospitals have received National Library of Medicine improvement grant funds as a result of assistance provided by CNYRMP staff.

The team, however, was disappointed to note that several of the new projects being proposed appear to be mere extensions of activities normally conducted by other agencies. In spite of this, the CNYRMP approved them for RMP funds. For example, Project #28, The Well Baby Clinic and Project #45, A Coordinator for the Spanish Speaking Community, appear to be services that should be provided by the County Health Department and the County Mental Health Board respectively. Thus, the CNYRMP program staff and the RAG appear to be in need of closer contact with RMPs and to become more familiarized with the specific nature of the RMPs mission.

The Dial Access project is being terminated in September 1972. Reports from the CNYRMP staff indicate that the hospital is exploring other governmental or commercial sources of funding; however, it does not appear that this program will be able to become self sustaining. Once again, it is possible to speculate that this project could be sustained if the CNYRMP program staff was sufficiently large and had the competencies required to provide the necessary assistance to the project director to help him find alternate sources of support. This has apparently been a useful service to the region and may be the victim of inadequate RMP staffing.

The Nurse-Clinician Training Program, which is entering its second year of CNYRMP funding, has been encouraged to charge tuition for the training being rendered and thus become independent of the need for RMP support. It is hoped that this can be done successfully so the activity will not collapse when RMP funds are withdrawn.

The development of the St. Regis Reservation Clinic gives no evidence of having generated funds from any sources other than RMP. The Home Dialysis unit is also failing to meet its funding needs because there has been no success in having the A. C. Silverman Hospital incorporate the expenses of the unit into its per diem rate. The CNYRMP, in light

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20. OTHER FUNDING (3) (Contd)

of the failure to secure the backing of the A. C. Silverman Hospital, is attempting to organize a Dialysis Buyers' Cooperative as an aid to renal patients.

There is concern over the Pulaski Rural Model Ambulatory Care Center which has been funded by the CNYRMP for one year. It has been unable to generate patient fees. It is encouraging to note that a local fund raising program has provided some funds and that five acres of land have been donated to it. These are temporary steps and the major funding problem still remains unresolved.

The mini-contracts, on the other hand, as a precondition to funding, have been generating other private, local, state and federal dollars. For example, one mini project is utilizing National Health Service Corps personnel to provide family centered primary medical care is also receiving CNYRMP support.

Overall, the CNYRMP has not been successful at acquiring other sources of funding for projects they have initiated. Until such time as the program addresses the need for administrative/fiscal competence and is successful in bringing this expertise to bear on the development of projects in their formative stages --- the ability to sustain activities will be limited, as is now the case.

Recommended Action

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Renal Disease Activities

The CNYRMP has funded the Home Dialysis Training program, Project #6, and two feasibility studies which are currently in operation. It is requesting support to initiate Project #22, Cooperative Organ Bank of Central New York.

The Dialysis Buyers' Cooperative feasibility study was found to be lacking specific objectives. The study also lacks evidence of a working relationship between the patients and a local Kidney Foundation. At this time, the region lacks a Kidney Foundation and an effort should be made to encourage the establishment of such an agency which once established, could be helpful to the region's entire kidney program.

The Comprehensive Areawide Kidney Service feasibility study for the NY-Penn area appears to dovetail its objectives with those of the Dialysis Buyers' Cooperative feasibility study. It too has no specific objectives that could be measured at the end of one year. This group could also benefit if it were able to work with a local Kidney Foundation. Since most of the region's proposed activities are directly related to the functions conducted by the Kidney Foundation, they would be well advised to place high priority on efforts to get the placement of a local Kidney Foundation activity in their area to supplement the entire kidney program.

The Home Dialysis project goal of training 12-15 patients per year appears to be non-specific. The end stage renal population of Central New York is in the range of 60 to 75 patients per year. The training capacity of the Home Dialysis two-bed unit and the stated number of personnel far exceeds the anticipated number of patients who need to be trained. In addition, the training facilities are now located in high cost, high overhead hospitals. The site visitors believe the region should take cognizance of cost factors in all future decisions.

The goals of the Cooperative Organ Bank, Project #22, are too general. It was reported that only six to nine transplants will be done in the first year. The project proposal leads one to believe that there would be a far larger number of organs potentially available and therefore it follows that a greater number of transplants should be possible. The past year only three transplants were performed and only 14 transplants have been done in the past four years. Unless the goals are elevated and unless the numerous organizations who are involved such as the Hemodialysis Committee, the Transplant Committee, the Consumer

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Renal Disease Activities (Contd)

Cooperative Committee and the Organ Retrieval Committee are coordinated, the region will be unable to care for its renal failure patient population. No kidney program can expect to be successful in light of this type of fragmentation.

It was therefore recommended that a Regional Kidney Proposal be developed with a time goal that is realistic and related to the community needs. Any future kidney planning should include provision for care of patients throughout the entire Central New York region and not be limited to the urban areas, i.e., Syracuse, etc. The Central New York area is uniquely suited for Home Dialysis and for this reason this aspect of the region's kidney program should be expanded.

With regard to the Organ Donor Program, it was suggested that this program needs to relate to other CNYRMP programs in the region. As an example, the Organ Transplant Center should utilize the Emergency Medical Care program to relate to communications and transportation of the organs. The trauma surgeons and neurosurgeons working in emergency services represent the greatest resources for donor kidneys. They must be included in the planning for the program in order to capitalize on the advantages they can bring to increasing kidney donations. The Organ Donor Program needs to develop a procedure list, permission forms, develop sterile containers for organ transportation and develop a perfusion device which can be placed in a centralized location and in a location which is well known to all potential users. A cost and recovery schedule should also be developed. Lastly, there needs to be lay education in regard to organ donation which will further increase the supply of organs needed for the region's renal failure patients.

SUMMARY

The sense of the site visit team was that this program made a valiant effort during the past year to remedy the deficiencies noted during the 1971 site visit; however, the obstacles which they faced were insurmountable. For most of the year the program was forced to work with an Acting Coordinator and this was a difficult arrangement for him and an even more severe handicap to a program making an attempt to bring about required changes. Under the circumstances, the Director (now officially appointed) and his small staff must be commended for their personal commitment and sacrifices made during this period to improve the program.

The future for this program is viewed as promising in light of some positive developments noted during this visit. First and foremost, Mr. John Murray has won the confidence of the RAG and has earned the role of Director and, in this sense, can now begin to operate more effectively. Although the site visitors are convinced that Mr. Murray needs to sharpen his administrative skills, they share the respect and admiration of the local officials who selected him for this new role. Time and experience will bring him confidence and his dedication and determination to generate an outstanding RMP in Central New York will, in all probability, be realized to the benefit of the region's residents and RMPS.

The program has added three new staff members and they will certainly reinforce the efforts of the currently overworked small staff. The region is requesting ten new professional staff members and, in this request, the site visit team lends a strong endorsement. A selective recruiting program should bring the competencies Mr. Murray needs to build the effective program he desires.

There is little doubt that the program needs to enhance its planning. It must specifically identify where it wants to go and determine the best way to proceed. To effectively accomplish this, the Director must receive help from the established Priorities Committee, Evaluation Committee, his RAG, and from the new staff he is planning to recruit. It is essential that he make maximum use of these resources to develop a sound plan.

In the area of fiscal management, the program faces a definitive need to strengthen its competencies. This must be recognized as a priority matter which needs to be addressed and resolved at the earliest possible moment. Effective planning will be an aid to the resolution of this deficiency.

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SUMMARY (Contd)

In all, the program faces a challenging year ahead; however, the site visitors feel the potential for success is on hand and are optimistic that the CNYRMP will have success in their efforts.

Condition 13 questionnaire
Management Survey !!
Price to 1/1/73

Review Cycle: October 1974

\$889,000 Program Staff
(424,000) Programs

RMPs STAFF BRIEFING DOCUMENT

REGION: CNYRMP OPERATIONS BRANCH: Eastern Operations Branch

NUMBER: 0050 Chief: Frank Nash

COORDINATOR: Mr. John Murray Staff for RMP: Jerome J. Stolov

LAST RATING: 226

TYPE OF APPLICATION:

Triennial 3rd Year Triennial Regional Office Representative: Robert Shaw

2nd Year Triennial Other Management Survey (Date):

Triennial Anniversary Before Conducted: None
A Triennial or Scheduled: 1973

Needs assistance in financial management

429,000

incl 16,000 Hemodialysis

Last Site Visit:

June 3, 1971

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, Association 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
Chairman IRMP RAG Committee

Per Mr. Injalis

Staff Visits in Last 12 Months:

June 13-16, 1972 - Jimmy Roberts, M.D. and Jerome Stolov
Staff assistance regarding health service/educational activities

June 8, 1972 Robert Shaw CNYRMP RAG Meeting

April 12, 1972 Marian E. Leach, P.H.D, DPDT, Staff Assistance regarding health service/education activities

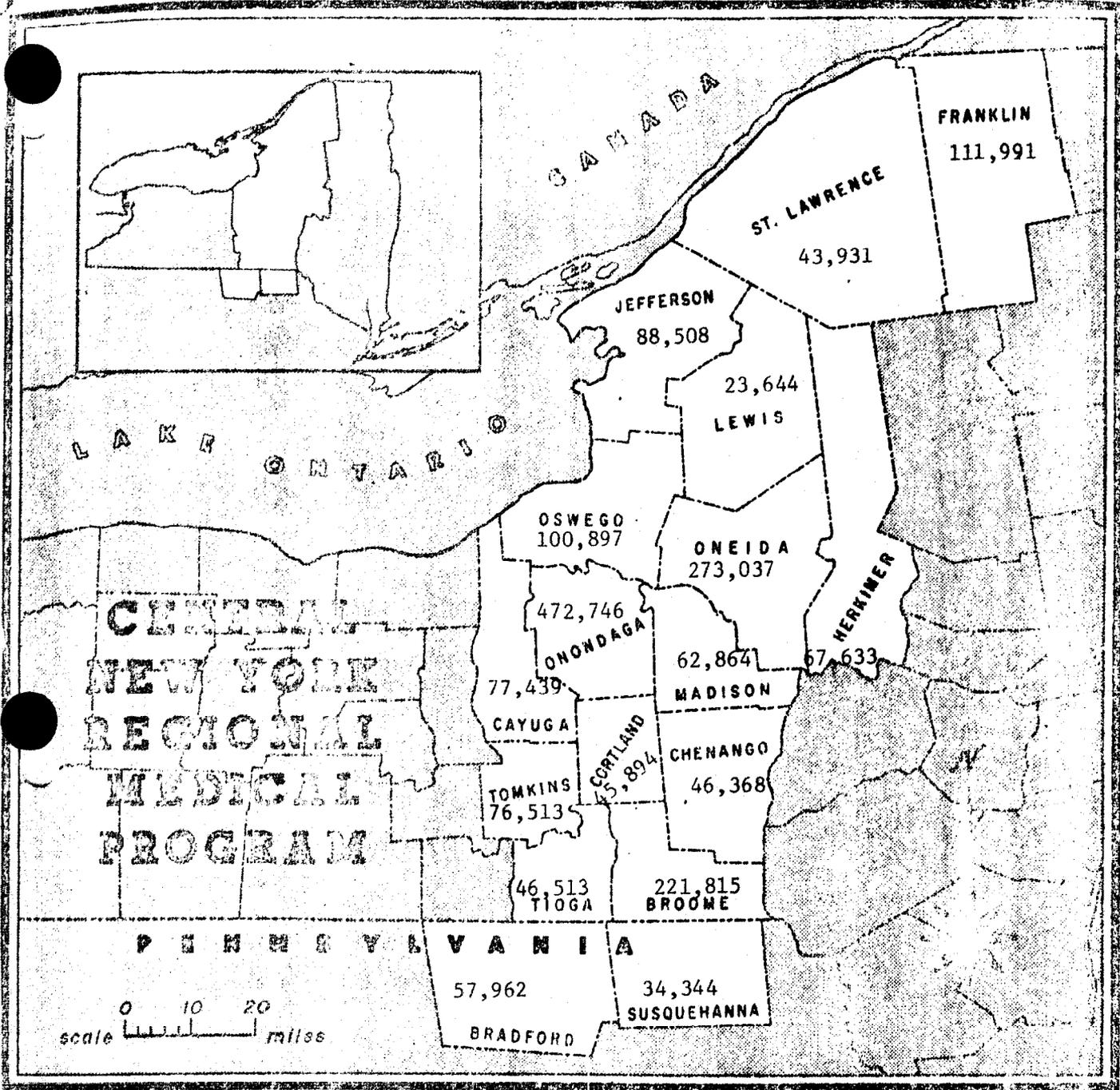
March 22-24, 1972 J. Stolov, Executive Committee Meeting February 2-5, to observe mini contract negotiation

December 1971-J. Stolov RAG meeting and Staff Assistance followup of advice letter

Recent events occurring in geographic area of Region that are affecting RMP program:

- July 1, 1971 Experimental Health Services Delivery System Funded for the NY Penn Area (southern tier of CNY) \$275,000

2. Approved National Health Service Corps Sites (Cato Meridian, Chenago Memorial, Barnes Kasson, W. Winafield [Little Falls Hospital] Faxton Hospital Chateaugay, N.Y.)
3. Transfer of Neighborhood Health Center transferred to Medical Center (Upstate Medical Center)
4. Maxwell School in Public Administration offers degree in Public Health Program 7/72.



DEMOGRAPHIC INFORMATION

Population characteristics: rural, urban, minority, income level, age distribution

Health education institutions

Pertinent health data

Geography:

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 Border on the north. Geographically, it is one of the larger but relatively thinly populated Regions in New York State. The total land area is 26,016 square miles.

Population: Approximately 1,800,000 Population density 68/square miles
Approximately 60% Urban
Approximately 97% white

INCOME - Average Income per Individual, 1969
State (of RMP) \$4421 (NY)*--SMSA - \$3154
United States \$3680

AGE DISTRIBUTION - Median Age Approximately 30
Percent of Total by Specified
Age Group, 1970

Age Group	State (NY)	U.S.
Under 18 yrs.	33	35
18 - 65 yrs.	57	55
65 yrs. & over	10	10

METROPOLITAN AREAS

Name of SMSA	Population (in 000's)
Total	1,263.0
Binghamton NY-Pa.	298.0
Syracuse, NY **	629.2**
Utica - Rome, NY	335.8

** - 1970 Census for Metro area - increased from 564,000 in 1960

City of Syracuse - 197,000 total population;
incl. 21,000 Negro (about 10.8%)

FACILITIES

Hospital Data

In New York State there are 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 per cent of these institutions have less than 125-bed rural character of the area, and the need for smaller 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.

In Pennsylvania 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.

Personnel

Physicians - There are approximately 2,700 M.D.s (133/100,000 and approximately 55 D.O.s

Nurses - There are approximately 15,000 registered nurses of which only about 9,000 are active.

Pertinent Health Data

MORTALITY RATES, CY 1967

MORBIDITY - ILLNESS RATES (1965 - 1967)

Deaths per 100,000 Population

Rates per 100 persons, by Age Group					Cause	RMP (State)	U.S.196
Age Group	Persons w. acute cond.		% with chronic cond.		Heart Disease	437.4	364.5
Age Group	N. East Geog. Reg.	U.S.	N.East Geog.Reg.	U.S.	Cancer	186.4	157.2
All Ages	194.9	190.2	47.0	49.5	Vasc. lesions (aff. CNS)	88.8	102.2
45-64 yrs.	119.9	124.5	64.5	71.1	All causes, all ages	1019.4	935.7
65 & over	107.9	103.4	80.6	85.6	45-64 yrs.	1143.9	1143.5
					65 & over	6168.8	6042.5

HEALTH EDUCATION INSTITUTIONS

COUNTY-INSTITUTION

PROGRAM

(Special note of paramedical programs)

St. Lawrence

Clarkson College
St. Lawrence University
SUNY ** College at Potsdam
SUNY Agriculture & Technical
Institute at Canton

Technical Institute
Liberal Arts
Liberal Arts

Nursing (2-year program)

Madison

Colgate University
Hamilton College
SUNY Agriculture & Technical
Institute at Morrisville

Liberal Arts
Liberal Arts
Nursing (2-year program)
Practical Nursing
Medical Laboratory Technology
Nursing (2-year program)

Cazenovia College

Tompkins

Cornell University

Sloan Institute of Hospital
Administration
Graduate School of Nutrition
Physical Therapy

Ithaca College

Broome

SUNY University Center at Binghamton

Health professions programs in
planning stage
Medical Technology
Dental Hygiene
X-ray Technology

Broome County Technical Institute

Onondaga

LeMoyne College
Syracuse University

Liberal Arts
School of Nursing, Special Medical
Education Programs
Dental Hygiene, Medical Laboratory
Technology
Medicine, Nursing, X-ray
Technology, Medical Laboratory
Technology, Graduate School

Onondaga Community College

SUNY Upstate Medical Center

Cortland

SUNY College at Cortland

Health Education

Oswego

SUNY College at Oswego

Liberal Arts

Oneida

Utica College (of Syracuse University)
Mohawk Valley Technical Institute

Medical Technology
Nursing

Cayuga

Auburn Community College

Associate Degree Program

Jefferson

Jefferson Community College

Associate Degree Program

Hospital Schools of Nursing
(Three-Year Diploma Programs)

COUNTY-HOSPITAL

CITY

St. Lawrence

A. Barton Hepburn
St. Lawrence State

Ogdensburg
Ogdensburg

Cayuga

Auburn Memorial

Auburn

Broome

Binghamton General
Binghamton State
Charles S. Wilson

Binghamton
Binghamton
Johnson City

Onondaga

Crouse-Irving
St. Joseph's

Syracuse
Syracuse

Oneida

Marcy State
St. Elizabeth's
Utica State

Marcy
Utica
Utica

Jefferson

Mercy
House of Good Samaritan

Watertown
Watertown

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION BEFORE TRIENNIAL

Component	Current Annualized Level 04 Year *	Request For 05 Year	Request Funding For Year <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee
PROGRAM STAFF	\$ 341,745	\$ 489,102	
CONTRACTS	--	--	
DEVELOPMENTAL COMPONENT	--	--	<input type="checkbox"/> Yes <input type="checkbox"/> No
OPERATIONAL PROJECTS	196,000	653,205	
Kidney	X	(44,660)	()
EMS		(91,062)	()
hs/ea		(142,320)	()
Pediatric Pulmonary		(--)	()
Other		(--)	()
TOTAL DIRECT COSTS	780,091 537,745	1,420,349	
COUNCIL-APPROVED LEVEL	\$ 850,000		
* - per award dated 12/3/71			

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FUNDCING HISTORY LIST

RMPPS-CSM-JTCFHL-20

REGION 50 CENTRAL NY RMP SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		01	02	03	04 10/71-12/72	TOTAL	** 05 01/73-12/73	** 06 01/74-12/74	** 07 01/75-12/75	TOTAL
000	PROGRAM STAFF		462500	244500	486575	1293575	** 489102			489102
001	CCNED NURS TELC	164100	201800	144400		510300	**			
002	REFAR CONSUL SE	163100	163100	75300		421500	**			
003	CNEIDA CTY TUPC	7200	7100	7200		21500	**			
004	FAMILY PRACT LE	38000	43800	33000		114800	**			
005	MD N SUPERV CC		18300			18300	**			
006	HCMPE DIALYSIS T		43200	14600	18228	76128	** 35259			35259
008	NY SIGMOID DEMC		41200			41200	**			
009	DIAL ACCESS		21200	11300	15000	47500	**			
011	REG LRNG FESDR		90600	14800		105400	**			
018	AREA HEALTH ECU				74870	74870	**			
019	MOCEL RURAL AMB				53433	53433	**	56687		56687
021	NURSE CLINICIAN				43632	43632	**	50355		50355
022A	EMERGENCY MEDIC				40330	40330	**	35312		35312
022B	EMERGENCY MEDIC				57320	57320	**	22090		22090
022C	EMERGENCY MEDIC				107250	107250	**	10000		10000
022D	EMERGENCY MEDIC				25900	25900	**	17200		17200
022E	EMS PUBLIC EDUC				6000	6000	**			
022F	EMS PUBLIC EDUC				20905	20905	**	6460		6460
023	HEALTH SYSTEM N				21507	21507	**			
024	HEALTH SYSTEM N				10250	10250	**			
026	HEALTH SYSTEM N				2520	2520	**			
027	HEALTH SYSTEM N				8000	8000	**			
028	HEALTH SYSTEM N				3900	3900	**	7672		7672
029	HEALTH SYSTEM N				4000	4000	**			
030	HEALTH SYSTEM N				24445	24445	**			
031	HEALTH SYSTEM N				67566	67566	**	138300		138300
032	HEALTH SYSTEM N				33526	33526	**			
033	COMMUNITY HEALT				6135	6135	**			
037	RURAL LRBAK SYS						**	84582		84582
038	COOPERATIVE ORG						**	44660		44660
039	HEALTH MAINTENA						**	24831		24831
040	SATELLITE CLINI						**	64730		64730
041	CCCFCINATCH FOR						**	14990		14990
042	WELL WOMAN CLIN						**	19685		19685
043	GERIATRIC DAY C						**	25258		25258
044	CENTRALLY ADP F						**	44840		44840
045	HEALTH SYSTEM E						**	142320		142320
046	HEALTH SYSTEM N						**	84016		84016
- TOTAL -		372400	1112800	645100	1135796	3266096	** 1420349			1420349

JULY 17, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - CENTRAL NY
RM 0050 10/72

PAGE 1
RMPS-OSM-JTOGR2-1

PROGRAM DESCRIPTION	APPR. PERIOD OF SUPPORT	APPR. PERIOD OF SUPPORT	APPR. PERIOD PREVIOUSLY FUNDED	APPR. PERIOD PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF		\$489,102			\$489,102	\$177,981	\$667,083
006 HOME DIALYSIS TRAINING PROGRAM		\$35,259			\$35,259	\$9,028	\$44,287
019 MODEL RURAL AMBULATORY CARE CENTER		\$58,687			\$58,687	\$17,059	\$75,746
021 NURSE CLINICIAN TRAINING		\$50,355			\$50,355		\$50,355
022A EMS COORDINATION		\$35,312			\$35,312	\$15,255	\$50,567
022B CMP AREA EMS COUNCIL COMPONENT		\$22,090			\$22,090		\$22,090
022C EMS RADIO COMMUNICATION SYSTEM		\$10,000			\$10,000		\$10,000
022D EMS MET TRAINING MODEL		\$17,200			\$17,200		\$17,200
022F EMS PUBLIC ED CGMP HEART ASSOCIATION OF UPSTATE		\$6,460			\$6,460		\$6,460
022 COMPONENT TOTAL		\$91,062			\$91,062	\$15,255	\$106,317
028 WELL BABY CLINIC		\$7,672			\$7,672		\$7,672
031 ST REGIS RESERVATION CLINIC		\$138,300			\$138,300		\$138,300
037 RURAL URGAN SYSTEM OF HEALTH CARE				\$84,582	\$84,582		\$84,582
039 COOPERATIVE URGAN BANK OF CENTRAL N.Y.				\$44,660	\$44,660	\$25,086	\$69,746
039 HEALTH MAINTENANCE TESTING PROGRAM				\$24,831	\$24,831		\$24,831
040 SATELLITE CLINICS IN RURAL AREAS				\$64,730	\$64,730		\$64,730
041 COORDINATOR FOR SPANISH SPEAKING COMMUNITY				\$14,990	\$14,990		\$14,990
042 WELL WOMAN CLINIC				\$19,685	\$19,685		\$19,685
043 GERIATRIC LAY CARE CENTERS				\$25,258	\$25,258		\$25,258
044 CENTRALLY ADM PT DISCHARGE PROGRAM				\$44,840	\$44,840		\$44,840
045 HEALTH SYSTEM EDUCATION ACTIVITIES				\$142,320	\$142,320	\$16,272	\$158,592
046 HEALTH SYSTEM NORTH		\$84,016			\$84,016	\$18,332	\$102,348
TOTAL		\$954,453		\$465,896	\$1,420,349	\$279,013	\$1,699,362

HISTORICAL PROGRAM PROFILE OF REGION

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 perceived 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.

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. Bylaws 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 decisionmaking 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) was requested.

In February 1970, the Region requested funds for a continuing Medical education project in Rural Pennsylvania but no additional funds were recommended.

During the July 1970 review cycle Council approved at a reduced level, project 45 - Medical Library and Information Service. The Region submitted a supplemental operational grant application in November 1970. The National Advisory Council recommends funding of the Mobile Stroke Rehabilitation Service - project 2R for an additional year. Two other projects were not recommended for funding. On April 1971 the Region had to reduce its funding \$59,507 since RMPS had a reduction in our apportionment.

In May 1971, the Region submitted a triennial application, and requested for its 04 year of operation \$1,413,928 d.c. Consequently on June 3-4 the Region was site visited by Effie O. Ellis, M.D., Henry Lemon, M.D., Alfred Frechette, F.M. Simmons Patterson, M.D., William Lawrence, M.D., Jean Schwer, R.N., and RMPS staff.

Major recommendations of the site visitors were: the appointment of an associate director, the RAG to expand its membership, a program priority and decisionmaking process to be developed, and a program plan to be developed. Council recommended only one year funding. After receiving the advice letter, Dr. Lyons resigned. Mr. Murray was appointed Acting Director.

11/11/71

In December 1971, \$537,745 d.c. was awarded to the Region for 10/1/71 - 9-30/72. Later that month staff visited the Region to follow up on the August advice letter.

The turning point in this Region's history appeared to be when the Region requested from its constituency ideas for mini contracts of less than \$5,000. It received 134 proposals. In February, staff was able to observe the negotiation process involved in awarding these contracts. On March 1, 1972, the Region moved into new quarters.

*Had Miss
not considered
too wise
not related to
general objectives*

Under the implementation of the 3 cycle review system the Region has been extended an additional 3 months.

At the request of the Region the staff recommended and the Director approved a level of \$700,091 for a 12-month period which when prorated over a 15-month period equals \$874,091. The rationale for approval was the need to implement Health Systems North Projects 23, 24, 25, 26, 27, 28, 29, and 30 and to aid the Mohawk Nation through support of Project 31. The Region was also permitted to expand its area health education cooperative efforts in Projects 18 and 30 (Project 30 was part of Health System North). This decision was based on recommendations from a member of the Professional Technical development staff following a special consultation visit April 12, 1972.

Since the Region received funds to expand its health service/educational activities, Reviewers felt that the Region's request for special education monies for Projects 34, 35, and 36 were duplicative. Consequently, staff requested to visit all the sub-regions to review health service/educational planning efforts. The decision to have a site visit team review efforts to date was recommended. Although staff felt the Southern Tier could utilize funds, this decision would have to be delayed until after the site visit.

The Region did, however, receive approval of its "Emergency Medical Service Activity Project" 29A-F for \$261,705. This amount was awarded June 21, 1971.

The Region, as of August 1972, now has \$1,135,796 d.c. for its 04 year which terminated December 31, 1972.

Recently we were informed that Mr. Murray, in June 1972 was made executive director.

Includes 300K EMS H80A

STAFF OBSERVATIONS

Principal Problems:

1. A program plan must be better defined and measurable over time
2. Better project monitoring is needed
3. The Program staff coordinating health service/education activities needs to be more effective
4. The goals and objectives need to be more specific
5. Continued support of ongoing projects appears weak

Principal Accomplishments

1. New Coordinator appointed
2. RAG expanded
3. New organizational structure
4. Active CHP-B participation
5. Greater access to RMP funds for disadvantage groups
6. Participation of many groups in CNYRMP as observed through the mini contract and project proposal submission
7. The review process appears workable and equitable

Issues requiring attention of reviewers

1. What is the program plan for CNYRMP?
2. What data was used to aid RAG in its decisionmaking?
3. Is the Executive Committee balanced in terms of representation and effectively functioning?
4. What is the recruitment plan of the coordinator?
5. Will expenditures be lapsed as in the past? *Approved 2/20/16*
6. Since, as reported on p. 80 of the CNYRMP Anniversary application only one project evaluation was completed, the program's evaluation process should be thoroughly reviewed.
7. A special effort should be directed to correlate the relationship between program planning, operational programs and the interaction of program and staff activities.
8. Projects still appear to have been developed spontaneously rather than based on need and a regional plan.

RMPS
STAFF BRIEFING DOCUMENT

Region: COLORADO/WYOMING

Operations Branch: MID-CONTINENT

Number: RM 00040

Chief: Michael J. Posta

Coordinator: THOMAS A. NICHOLAS, M.D.
(Executive Director)

Staff for RMP:
Mary E. Murphy, MCOB Oper. Officer
Harold O'Flaherty, MCOB, Back-up
Charles Barnes, GMB
Robert Walkington, OPE
Regional Office Representative
(Program Director)
Daniel Webster

Last Rating: 294

TYPE OF APPLICATION:

Triennial 3rd Year
 Triennial Triennial
 2nd Year
 Triennial Other

Management Survey: Tentative-early '73

Last Site Visit: (Dates, Chairman, Committee/Council Members, Consultants)

September 9-10, 1971: Philip T. White, M.D., Chairman Review Committee
Mrs. Florence R. Wyckoff, National Advisory Council
Jessie B. Barber, Jr. M.D., Consultant
Humphrey H. Hardy, Jr., M.D., Consultant

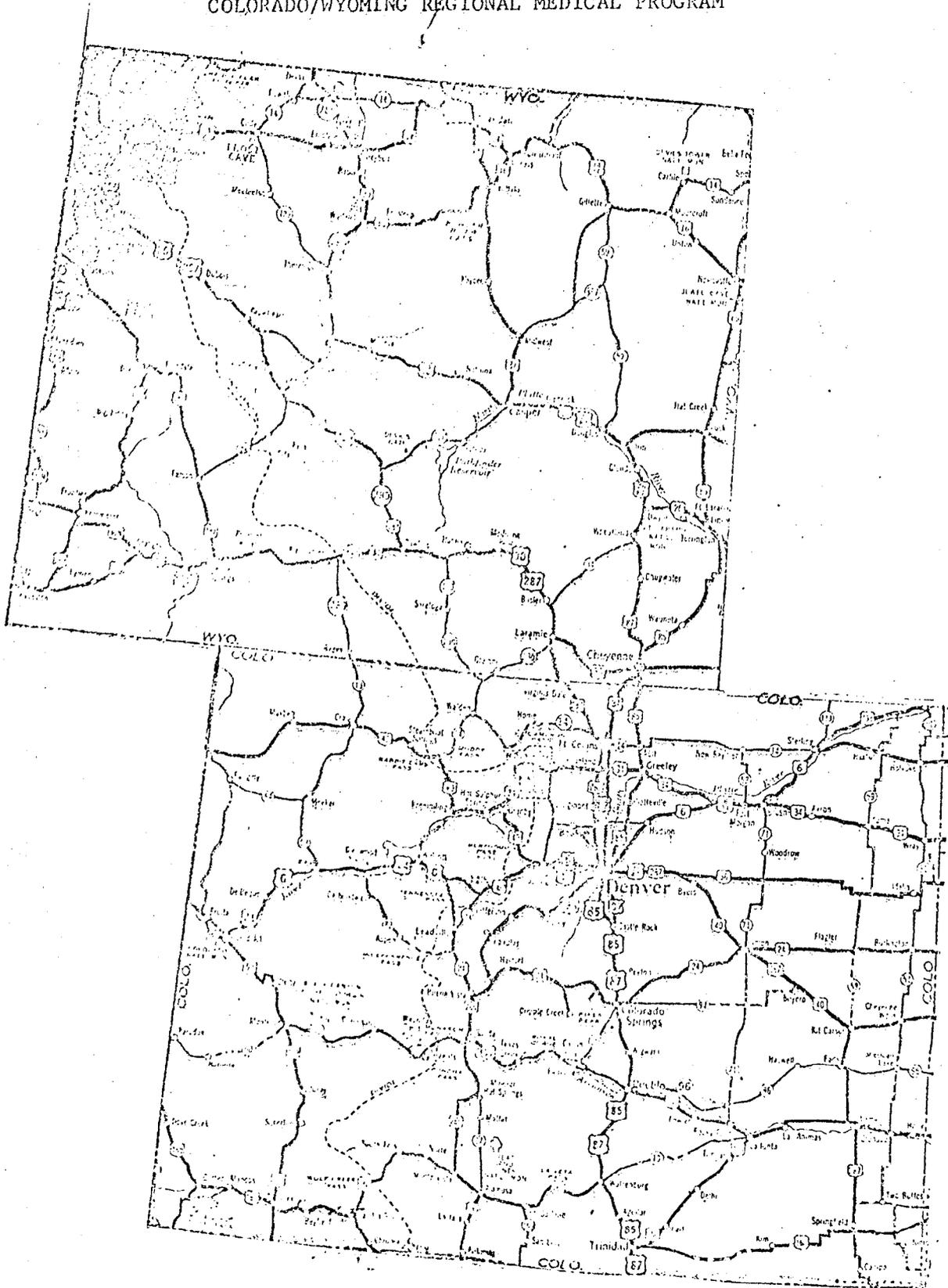
Staff Visits in Last 12 Months: (Date & Purpose)

April 10, 1972: Consultation on Educational Centers
May 22-26, 1972: RMP Orientation - RAG Meeting
June 6-18, 1972: Evaluation Visit
August 1971 - July 1972: Technical Consultation & Site Visits
(ROR - Program Director) - 20

Recent Event Occurring in Geographic Area of Region that are Affecting RMP Program:

1. New Coordinator (Executive Director), Thomas A. Nicholas, M.D. as of 7-1-72
Interim Coordinator, Robert Jones, M.D. continues as Assistant or Program
Director.
2. HMO Continuation Grants (910) to:
Alamosa Community Hospital, Alamosa, Colorado
Rocky Mountain HMO, Inc., St. Mary's Hospital, Grand Junction, Colorado
Poudre Valley Foundation for Medical Care, Fort Collins, Colorado
3. Pediatric Hemodialysis Center Grant Award of \$102,000 (in cycle) to serve
Rocky Mountain Region.
4. Pediatric Pulmonary Project refunded as supplemental grant of \$40,000.
5. Harry P. Ward, M.D., newly appointed Dean, University of Colorado Medical
School.

COLORADO/WYOMING REGIONAL MEDICAL PROGRAM



HEW Region VIII

Two entire States, overlap with Colorado portion of Intermountain
overlap with Wyoming portion of Mountain States

Counties: Colorado 63; Wyoming 24

Congressional Districts: Colorado 4; Wyoming 1 at large

REGIONAL CHARACTERISTICS

GEOGRAPHY - Colorado/Wyoming RMP encompasses the entire states of
 Colorado and Wyoming (201,400 square miles)
Colorado - 97,400 Wyoming - 104,000

POPULATION (1970 Census)

Total: 2,539,700	Density:
Colorado - 2,207,300	Colorado - 20 per sq. miles
Wyoming - 332,400	Wyoming - 3 per sq. miles
% Urban: Colorado - 78.5	Wyoming: 60.5
% Non-White: Colorado - 4.0	Wyoming: 3.0

AGE DISTRIBUTION

% Under 18 yrs: Colorado-36; Wyoming-37
 % 18-65 yrs: Colorado-55; Wyoming-54
 % 65 yrs. & over: Colorado-9; Wyoming-10

INCOME (1969):

Average/per individual
 Colorado - \$3,680
 Wyoming - \$3,447

MORTALITY RATES - Per 100,000 (1969)

	Colo.	Wyo.	U.S
Heart Disease	291.0	312.4	364.5
Cancer	125.2	130.2	157.2
Vascular Lesions (Aff.Cns.)	82.1	91.4	102.2
All Causes, all ages	828.1	881.0	935.7

FACILITIES AND RESOURCESSCHOOLS -

Medical School - Univ. Colorado, School of Medicine

1969/70 - Student enrollment: 398

1969/70 - Graduates: 80

Pharmacy Schools

2 Schools - Student enrollment: 117 (Colorado-113; Wyoming-64)

Nursing Schools

Professional Nursing - 13 schools; (Colo. - 12; Wyo. - 1)

1969/70 Student enrollment: 1,551 (Colo. 1,379; Wyo. - 172)

Practical Nursing - 15 schools (Colo. - 13; Wyo. - 2)

Accredited Schools for Health Professionals

Cytotechnology: Colo. - 2; Wyo. - 0

Medical Technology: Colo. - 16; Wyo. - 1

Radiological Technology: Colo. - 16; Wyo. - 2

Physical Therapy: Colo. - 1; Wyo. - 0

HOSPITALS - Community General and V. A. General - No. of Beds

	Colo.	Wyo.	Colo.	Wyo.
Short term	74	27	9497	1825
Long term	5	2	679	698
V.A. General	2	1	593	174

REGIONAL CHARACTERISTICSNURSING AND PERSONAL CARE HOMES

	No.		No. of Beds	
	Colo.	Wyo.	Colo.	Wyo.
Skilled Nursing Homes	<u>113</u>	<u>13</u>	<u>9576</u>	<u>977</u>
Personal Care Homes (with nurse. care)	18	7	1475	330
Long term Care Units	22	5	565	95

MANPOWERPhysicians - Non-Federal M. D.'s and D. O's (1967)

Active: Colorado - 3248; Wyoming - 297

Inactive: Colorado - 258; Wyoming - 29

Ratio: Colo. - 165 Active per 100,000 pop.; Wyo. - 94 active per 100,000 pop.

U. S. Rate: 132 per 100,000 population

<u>M.D. Group Practices (1969)</u>	<u>Colo.</u>	<u>Wyo.</u>
Single Specialty	<u>104</u>	<u>10</u>
General Practice	13	4
Multi Specialty	40	4

Professional Nurses

Active 8208 1204

Inactive 2619 410

Ratio: Colo. - 425 actively employed; Wyo. - 379 - per 100,000 population

Licensed Practical Nurses

	<u>Colo.</u>	<u>Wyo.</u>
Active	<u>3657</u>	<u>277</u>
Inactive	809	92

Ratio: Colo. - 181 actively employed; Wyo. - 80 - per 100,000 population

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>04</u>	Council-Approved Level For TR Year <u> </u>	Region's Request For TR Year <u>05</u>	Recommended Funding For TR Year <u> </u> <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
PROGRAM STAFF	492,506	X	636,916	<input type="checkbox"/> Yes <input type="checkbox"/> No	X
CONTRACTS	107,260		110,000		
DEVELOPMENTAL COMP.	96,000		565,275		
OPERATIONAL PROJECTS	406,580		(91,800)		
Kidney	X		()		
EMS			()		
hs/ea			()		
Pediatric Pulmonary		()			
Other		()			
TOTAL DIRECT COSTS	1,102,346		1,403,991		
COUNCIL-APPROVED LEVEL	1,292,346*	*NAC level raised by \$150,000 (Special action NAC 6/72) Supplemental funds of \$40,000 for Pediatric Pulmonary Project continuation.			

-5-

REVIEW CYCLE: October 1972

JULY 18, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

RHPS-OSM-JTOGR2-1

IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPLRT	(2) CCNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF CNRMP	\$636,916				\$636,916	\$59,052	\$695,968
0000 DEVELOPMENTAL COMPONENT					\$110,000		\$110,000
017 CHEMP ULTRASONIC TRAINING PROGE	\$110,000				\$71,771	\$4,392	\$76,163
021 8AM RADIATION THERAPY PLANNI NG BY TIME SHARING COMPU	\$20,556				\$20,556	\$2,986	\$23,542
025 DEL PHYSICIAN SUPPLRT PERSON	\$35,335				\$39,335		\$39,335
026 DEL NURSE TRAINING FOR EXPAN DED ROLES	\$25,914				\$25,914	\$5,265	\$31,179
027 BCCRAM LABORATORY IMPROVEMENT P ROGRAM	\$23,425				\$23,425	\$6,234	\$29,659
028 LEM NURSE PRACTITIONERS PRCE OBJENTED MED RECORDS	\$101,216				\$101,216	\$15,887	\$121,103
029 ENTER PEDIATRIC HEMODIALYSIS C RICKY MOUNTAIN REC	\$91,800				\$91,800	\$19,730	\$111,530
030 CCWSELING RURAL AND URBAN GENETIC AND SCREENING				\$111,826	\$111,826	\$22,463	\$134,289
031 WYCMING HOSPITAL SHARED INFORMATION SYSTEM				\$52,011	\$52,011		\$52,011
032 HEALTH PROGRAM FOR HIGH MOUNTAIN RURAL PCCB		\$119,221			\$119,221	\$7,076	\$126,297
TOTAL	\$1,049,162	\$119,221	\$71,771	\$163,837	\$1,403,991	\$147,785	\$1,551,776

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REVIEW CYCLE October 1972

JULY 18, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - COLD-WYOMG
RM 00040 10/72

PAGE 2
RMPS-CSM-JTCGP2-1

IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
C000 PROGRAM STAFF CWRMP	\$673,481				\$673,481	\$1,310,397
D000 DEVELOPMENTAL COMPONENT CWRMP	\$110,000				\$110,000	\$220,000
017 ULTRASONIC TRAINING PROG RAM			\$55,788		\$55,788	\$127,559
021 RADIATION THERAPY PLANNI NG BY TIME SHARING COMPUT	\$28,504				\$28,504	\$49,060
025 PHYSICIAN SUPPORT PERSON NEL	\$38,090				\$38,090	\$77,425
026 NURSE TRAINING FOR EXPAN DED ROLES	\$27,181				\$27,181	\$53,095
027 LABORATORY IMPROVEMENT P ROGRAM WYOMING	\$22,282				\$22,282	\$45,707
028 NURSE PRACTITIONERS PRCB LEM ORIENTED MED RECORDS	\$117,794				\$117,794	\$219,010
029 PEDIATRIC HEMODIALYSIS C ENTER ROCKY MOUNTAIN REG	\$71,400				\$71,400	\$163,200
030 RURAL AND URBAN GENETIC COUNSELING AND SCREENING				\$114,515	\$114,515	\$226,341
031 WYOMING HOSPITAL SHARED INFORMATION SYSTEM				\$52,185	\$52,185	\$104,196
032 HEALTH PROGRAM FOR MIGRA NT WORKERS RURAL POOR						\$115,221
TOTAL	\$1,088,732		\$55,788	\$166,700	\$1,311,220	\$2,715,211

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REVIEW CYCLE: October 1972

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FUNDING HISTORY LIST

REPORT OF

REGION 40 COLC-WYOMG

RMF SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		01	02	03	04	TOTAL	05	06	07	TOTAL
					01/72-12/72		01/73-12/73	01/74-12/74	01/75-12/75	
0000	PROGRAM STAFF	482000	529500	487500	644641	2143641	636916	673481		1310357
0000	DEVELOPMENTAL C				96000	96000	110000	110000		220000
002	CCLC ST CA RGST	55000	50300	47800		154000				
003	MULTI SPECIALT	45000	34700			79700				
004	HOME DIALYSIS T	39900	39700	27300		106900				
006	TR APPL RES INT	120500	120700	83500		324700				
007	TRAINING PROGRA	26900	58300	70200	57831	213231				
008	ED SCF CHILDREN	20700	25300	16200		61200				
009	CCNED CCFE PRG	62200	70900	54900		188000				
010	CONED STAFF	65600	50700	65700		222000				
013	XP FACIL FEC PU	58100	76000	23600		167900				
014	STAT DX PROG CA		13300	7800		21100				
015	REGIONAL PEDIAT		73700	24500	43401	152001				
016	CCNFR CARDC CAR		42800	16000		58800				
017	ULTRASONIC TRAI						71771	55788		127559
018	NLRSE TRAINING		15700	15700	15700	47100				
019	CHR DIS EVAL PT		41600	37700		79300				
021	RADIATION THERA				24484	24484	20556	28504		49060
025	PHYSICIAN ASSIS				41187	41187	35335	38090		77425
026	NLRSE TRAINING				24732	24732	25914	27181		53055
027	LABCFATORY IMPR				21457	21457	23425	22282		45707
028	NLRSE TRACT PRO				83048	83048	101218	117794		219010
029	PEDIATRIC HEMOC				102000	102000	91800	71400		163200
030	RURAL AND URBAN						111826	114515		226341
031	WYOMING HOSPITA						52011	52185		104196
032	HEALTH CARE FOR				50500	90500	119221			119221
033	PEDIATRIC PLL C				40000	40000				
- T C T A L -		976800	1283200	558000	1284981	4542981	1403991	1311220		2715211

REVIEW CYCLE: October 1972

HISTORICAL PROGRAM PROFILE OF REGION

Initial Planning Grant set boundaries of the proposed region as co-terminal with those of states of Colorado and Wyoming. Rationale was that University of Colorado Medical Center, with other referral facilities and Health Services of Greater Denver Area, serve as nucleus for most of Colorado and Wyoming. Since 90% of region population resides in Colorado, the boundaries of Colorado will be followed for data-gathering purposes. Adoption of political boundaries of Colorado simplifies the collection of data and coordination of the Regional Medical Program with other state health programs. Another factor in this decision is that portions of Wyoming fall under influence of three Regional Medical Programs: Intermountain, Mountain States and Colorado-Wyoming. Studies show that patient referral patterns in some Wyoming communities reflect allegiance to all three regions.

First Planning Application submitted September 1966. Funded at \$297,678 (D.C.) first year (1/1/67 - 12/31/68). Commitment for 02 year in same amount. Committee and Council recommended approval. However, concern expressed regarding Region's geographic overlap in Wyoming with Intermountain and Mountain States RMP s.

Pre-operational site visit in September 1968. Visitors confident regarding development of regionalization concept. Became operational 1/1/69. Awarded \$849,053 (D.C.) for support of Core and seven operational projects.

Continuation application review 12/69. Three project progress reports showed weaknesses. Requests for use of carryover funds vague and poorly justified. Related educational projects lacked coordination and evaluation was limited. Problem later corrected.

Site visitors (12/70) concluded CW/RMP had not obtained anticipated sophistication. Program project oriented, RAG input limited, and data resources not utilized. Region not acting as project stimulator, but rather as project broker for ideas from health organizations. Developmental component vetoed. Need to become Program oriented, rather than project oriented.

Previous goals, objectives and priorities general and not related to specific time frame.

Throughout Colorado and Wyoming, primary effort in rural areas directed toward manpower and community organization.

Greatest impact of OCRMP from 1969-71 has been in area of continuing professional education. RMP met needs of regional physicians, nurses and allied health personnel, especially those in rural areas.

Awarded triennial status 11/71.

STAFF OBSERVATIONS

Principal Problems

1. Minority and "True Consumer" representation on RAG needs increasing.
2. Increased minority representation on staff, especially in professional category, needs attention.
3. CWRMP Program Staff is small (20). RMP has indicated need to increase staff.
4. Evaluation of Program Staff activities needed, as 51% of budget is used for program activities.
5. RAG lacks involvement in the evaluation process.
6. Overlap of regional activity with Intermountain and Mountain states.

Principal Accomplishments

1. Program Staff has been stimulating project activity to a greater degree, rather than waiting for project proposers to initiate activity.
2. Evaluation process in regard to project activity has considerable visibility and impact.
3. CWRMP Staff has excellent cooperative working relationship with other health agencies.
4. Program has changed emphasis from categorical approach to that of improving the quality, quantity, and accessibility of health care services in Colorado and Wyoming.
5. Subregionalization is underway, with offices active in Canon City, Colo. and Dubois, Wyoming. Offices are ready to open in Casper, Wyoming and Alamosa, Colorado. Tentative plans are for an additional subregion in Grand Junction, Colorado.
6. Former RAG Chairman, Thomas A. Nicholas, M.D., appointed new Coordinator 7/1/72.

Issues requiring attention of reviewers

For information only

1. Need for RAG to appoint an Evaluation Committee.
2. Consider "Turf Problem" (overlap RMP s) recommendations as presented at 7/20/72 meeting.
 - a. That an Inter-Regional Executive Council be established
 - 1) to approve by majority vote all new program concepts proposed for overlap areas.
 - 2) to review regularly and informally evaluate on-going programs in overlap areas.
 - b. That IRMP's boundaries be re-aligned and areas of overlap among three RMP s be identified.
 - c. That each RAG expand its membership to include the Coordinator (Executive Director) of each of other two RMP s.

For attention

CWRMP is requesting an increase in funding above NAC approved level. Additional funds will allow for potential growth needed and will assist in meeting defined, unmet needs.

Colorado/Wyoming RMP Continuation Application Staff Review

August 4, 1972

Mary E. Murphy, R.N., M.P.H., Chairman

Participants:

Michael J. Posta (MCOB)	James Smith (WOB)
Harold O'Flaherty (MCOB)	Peggy Noble (WOB)
Yvonne Green (MCOB)	Annie Dicks (GMB)
Richard Reese, M.D. (DPTD)	Eva Spell (OSM)
Julia Kula (DPTD)	

Recommendation:

Staff recommended funding of the Colorado/Wyoming application at the National Advisory Council approved level of \$1,292,346. This amount represents a reduction of \$111,645 below the application request of \$1,403,991.

At the request of the MCOB and by special action of the June 1972 National Advisory Council, the approved funding level for the Program was raised from \$1,102,346. The approved request of \$150,000 plus the \$40,000 supplemental funds for the Pediatric Pulmonary Project (#13) raised the funding level to \$1,292,346. This substantial increase, it was felt, would provide Colorado/Wyoming RMP sufficient latitude for expansion.

Concern was expressed regarding two new projects: 1) Rural and Urban Genetic Counseling and Screening, #30, and 2) Health Program for Migrants and Rural Poor, #32.

The Rural and Urban Genetic Counseling and Screening Project requests funding in the amount of \$111,826 (d.c.). Major emphasis of the genetic screening is on Tay-Sachs Disease, peculiar to the Jewish race, and on Sickle Cell Anemia, peculiar to the Black race. The areas of concentration were thought to be too limited. The budget was thought to be too large, especially in view of the small segment of the population which would be included. With such widespread national interest on Sickle Cell Anemia, the question was raised as to the availability of other resources.

Developmental component funds have already been used to initiate project planning. It was later learned that Denver's black population has been stimulating interest and fund-raising, with a substantial goal, in order to further the project.

Page 2

The genetic and counseling clinic is to be located in Denver. However, staff with modest screening equipment will travel throughout the area. Patients will be referred to the Denver clinic for specific tests which cannot be done by the mobile staff.

Staff recommended that if the project becomes operational, screening be extended to include a broader spectrum of disease categories.

The Health Program for Migrants and Rural Poor raised concern regarding the stipend item of \$75,000 on Form 34-1 (page 16). The stipends are to be paid to nursing and medical students who deliver health services to the target group. The activity was interpreted as stipends for "basic education" which is adverse to RMPS guidelines. The project is worthy of merit and should become operational. The funds allotment to stipends requires re-evaluation.

Questions were also raised regarding the previously approved, but unfunded, Project #17, Training in Diagnostic Ultrasound in Community Hospitals. Concern was expressed as to the need of smaller hospitals for as refined a technique. Such a technique would require very experienced personnel for equipment operation and result interpretation. A low priority, as given the project by the RAG, was staff consensus.

Radiation Therapy Planning by Time Sharing Computer, Project #21, is planned for extensive expansion. Dr. Reese questioned the feasibility of costly expansion in training in relation to the actual need for such facilities.

Relative to the application, it was noted that the priorities are more finite in scope than are the objectives. Why have the objectives not been prioritized? An apparent reason for this basic incongruity could be the fact that the priorities are consonant with the proposed projects.

The region has been successful in securing local funding for continuation of projects whose funding has been terminated by RMP.

The CWRMP is broadening its horizon through subregionalization and several key areas have been identified through regional planning needs.

Generally speaking, the RAG composition is satisfactory, although it was felt that more "true consumer" representation, as well as minority types, is desired.

Page 3

Evaluation of the Program Staff and activities is of high priority, as 51% of the RMP budget is allotted to this area.

In view of the concerns expressed, staff recommended that funding remain at the present NAC approved funding level of \$1,292,346.

RMPS/MCOP 8/15/72

MEMORANDUM

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

TO : Director
Division of Operations and Development

CR 9/8/72

DATE: September 7, 1972

FROM : Director
Regional Medical Programs Service

SUBJECT: Action on September 5-6 Staff Anniversary Review Panel Recommendation
Concerning the Colorado/Wyoming Regional Medical Program Application
RM 00040, 10/72

Accepted *Ham*, *9/10/72*
(date)

Rejected _____, _____
(date)

Modifications:

*None but fully aware & concern
over the projects criticized by
SARP
DJ*

REVIEW CYCLE: October 1972
TYPE OF APPLICATION: Anniversary
within triennium

RECOMMENDATIONS FROM

RATING: 290

SARP REVIEW COMMITTEE
 SITE VISIT COUNCIL

FUNDING RECOMMENDATION: The Staff Anniversary Review Panel (SARP) recommended funding for the Colorado/Wyoming RMP in the amount of \$1,292,346 for the 05 operational year. This amount includes \$91,800 for the kidney project #29, Pediatric Hemodialysis for the Rocky Mountain Region. The recommended amount (\$1,292,346) reflects a reduction of \$111,645 below the application request of \$1,403,991.

RATIONALE: SARP felt that the recommended amount would provide the Program sufficient financial latitude for the projected expansion of Program Staff and activities within the Region. The National Advisory Council's approved funding level for CW/RMP was raised in June 1972, from \$1,102,346 to \$1,292,346 as the result of a special action by Council.

CRITIQUE: SARP concurred with Staff regarding its assessment of the Colorado/Wyoming RMP. The new Coordinator, Dr. Thomas Nicholas, a former active rural General Practitioner, is well known to most staff members having served as RAG Chairman for CW/RMP. He is also a RAG member on the Intermountain RMP. Dr. Nicholas' interests, talents and knowledge of RMP are in his favor. It will be with interest and anticipation that the CW/RMP is observed during the coming year.

The priorities as established by the RAG appear consonant with project activity. Concern was expressed that the RAG did not have its own Evaluation Committee. In view of the fact that 51% of the CW/RMP budget is spent on Program Staff and staff activity, an evaluation by RAG was considered top priority.

The RAG should place more emphasis on increasing its minority representation. "True consumer" representation could also be improved. Although the RAG lists thirteen "public members", the majority represent public leaders, top management etc. The need for representation from the allied health field was also stressed. The CW/RMP is very much aware of RMPS' urgent request regarding increased minority representation on the RAG and committees, as well as on Program Staff. Although in compliance, re-emphasis is needed.

Subregionalization has made significant progress during the past year. Cooperative working relationships exist with CHP(a) and (b) agencies and should continue in view of the establishment of subregional offices. Caution should be exercised on the part of CW/RMP in avoiding duplication of service or in assuming CHP functions. Sharing of subregional coordinator's time with universities or planning agencies raised concern.

Kidney project #29 - Pediatric Hemodialysis for the Rocky Mountain Region, has made satisfactory progress and presents no problems at this time. As more emphasis is being placed on outside sources of support, during RMPS funding

period, as well as following, third party payment resources require indepth exploration. The exact source of such support should be explicitly stated.

New Project #17, Training in Diagnostic Ultrasound in Community Hospitals, previously approved but unfunded, was considered a most sophisticated and expensive procedure for general use in community hospitals. Documented evidence of the participating hospitals' actual need for such a procedure should be provided.

Project #21, Radiation Therapy Planning by Time Sharing Computer, raised concern as to the need for extensive expansion. Participating hospitals should document their need and desire for such services.

Project #30, Rural and Urban Genetic Counseling and Screening, was recently revised. Study emphasis will be on families with coronary disease for evidence of hyperlipidemia, families with pulmonary emphysema for alpha trypsin inhibitor deficiencies, and families with a high incidence of cancer. Lesser emphasis will be placed on the detection of sickle cell hemoglobin and Tay-Sachs carrier states. Staff was unenthusiastic regarding the project in relation to the Region's priorities. One area given as a target for development was Scottsbluff; Nebraska. In view of past "turf" problems and in order to prevent any future ones, a documented request from the area, as well as from the Nebraska RMP should be available.

RECOMMENDATIONS: 1. Encourage CW/RMP RAG to establish an Evaluation Committee 2. Evaluate Program Staff and Program activities. 3. Emphasize the need for more minority representation on RAG, committees, and Program Staff. 4. Appoint more "true consumers" and allied health representatives to RAG. 5. Consider CHP functions in relation to subregionalization and proceed cautiously.

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>04</u>	Council-Approved Level For TR Year _____	Region's Request For TR Year <u>05</u>	Recommended Funding For TR Year <u>05</u> <input checked="" type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
PROGRAM STAFF	492,506	X	636,916		X
CONTRACTS	107,260				
DEVELOPMENTAL COMP.	96,000		110,000	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
OPERATIONAL PROJECTS	406,580		565,275		
Kidney	X		(91,800)	(91,800)	
EMS			()	()	
hs/ea			()	()	
Pediatric Pulmonary		()	()		
Other		()	()		
TOTAL DIRECT COSTS	1,102,346		1,403,991	1,292,346	
COUNCIL-APPROVED LEVEL	1,292,346*	*NAC level raised by \$150,000 (Special action NAC 6/72) Supplemental funds of \$40,000 for Pediatric Pulmonary Project continuation.			

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RMP'S STAFF BRIEFING DOCUMENT

REGION: Georgia
NUMBER: 00046
COORDINATOR: J. Gordon Barrow, M.D.
LAST RATING: 399 (4/12/72)

OPERATIONS BRANCH: South Central
Chief: Lee E. Van Winkle
Staff for RMP:
Joseph Jewell - SCOB
Eugene Nelson - P.&E.
Lawrence Pullen - G.M.B.

TYPE OF APPLICATION:

Triennial 3rd Year Triennial
 2nd Year Triennial Other

Regional Office Representative:
Theoda H. Griffith

Management Survey (Date):
Conducted: _____
or
Scheduled: Not Scheduled

Last Site Visit: June 23-24, 1971

- Philip T. White, M.D. - Chairman
- John R. F. Ingall, M.D.
- W. Lester Henry, Jr., M.D.
- Jurij Savyckyj, M.D.

Staff Visits in Last 12 Months:

- 3/7/72 - PURPOSE: 1. Indoctrination of newly assigned operations staff member to the Georgia RMP. 2. To attend a portion of the region's facilities and services task force.
- 6/8-9/72 - PURPOSE: Verification of review process.
- 8/15-18/72 - PURPOSE: Visit to selected projects, health access stations, area facilities, etc.

Recent events occurring in geographic area of Region that are affecting RMP program:

During the early spring of 1972, the State government was reorganized which has created a Board of Human Resources. The board is comprised of the State Health Department, which includes the CHP(a) agency, Vocational Rehabilitation, Mental Health and the Department of Public Welfare. This is a different group of people from those whom the region had to plan with previously. Physicians in the state are having much less to say about directions taken by public health than prior to the reorganization. Therefore, GRMP has to involve a totally new group of people in planning.

The Governor is personally very interested in the health access stations and is exploring ways in which he can supplement these activities with state funds.

The 18 area planning development commissions in the state have, for the first time, been designated the official planning groups for health for their portion of the state. Their turf have been finalized and there have been assignments of health planners who are supported from other than GRMP funds. Since these groups have previously done primarily economic and recreational type of planning, it is essential that public health planning input is obtained as early as possible in each area.

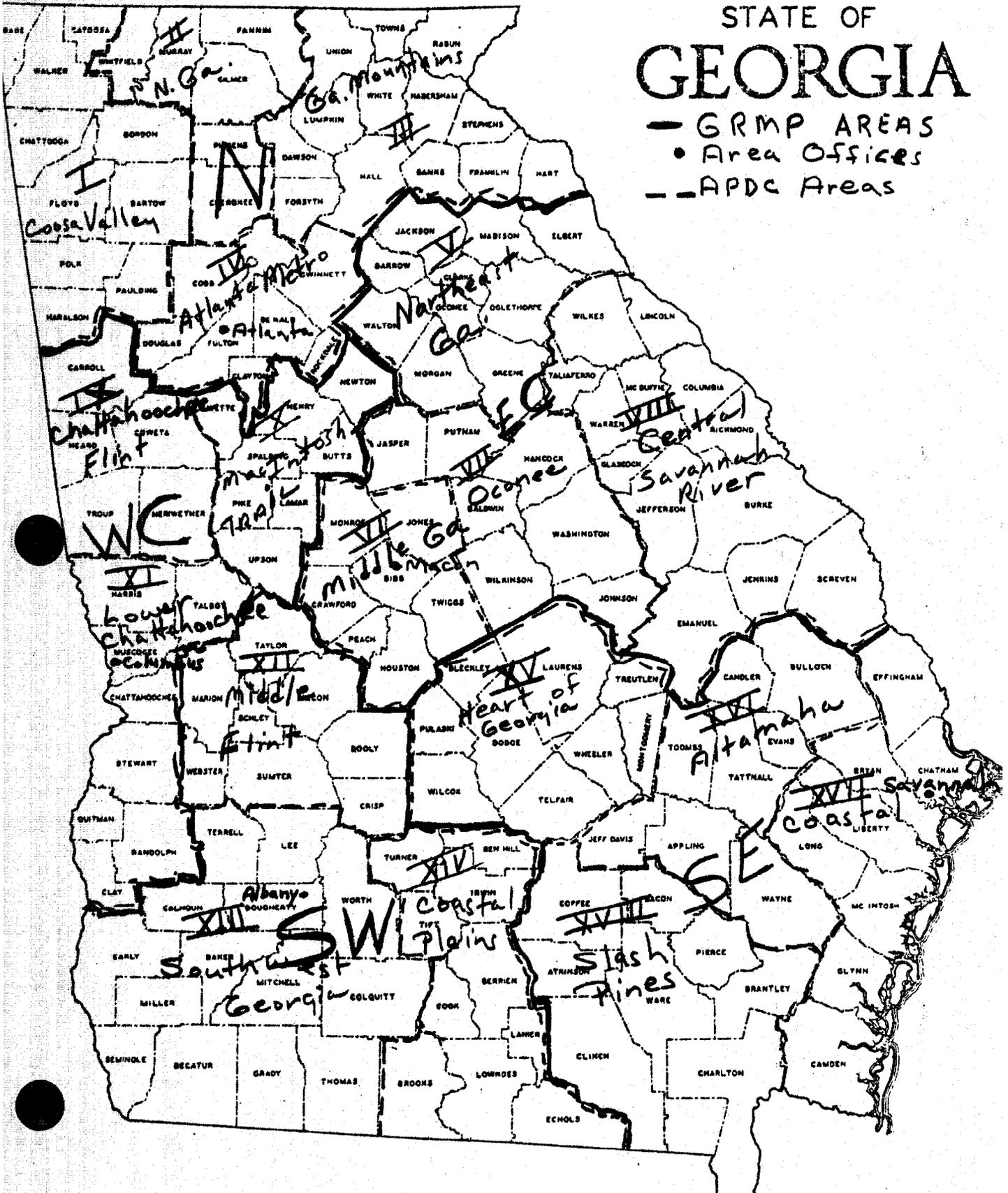
The region's five subregional offices tie in with these area planning development commissions boundaries.

There is increased utilization of the Governor's planning office, which is separate from the CHP(a) agency.

A new CHP(b) agency has become operational in Southwest Georgia.

STATE OF GEORGIA

- GRMP AREAS
- Area Offices
- APDC Areas



DEMOGRAPHIC INFORMATION

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

Rural: 39.7%

Age Distribution:	Under 18 - 37%	U.S. 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%

<u>Resources and Facilities</u>	<u>Enrolled</u>	<u>1969/70 Graduate</u>
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		
		Southern School of
Pharmacy - 2 University of Georgia, Athens; Pharmacy, Mercer Univ.		Atlanta

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

Professional Nursing Schools
27-(18 of them based at Colleges and universities)

Practical Nurse Training
44 - majority are vocational schools

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>1st</u> (04 Year)	Council-Approved Level For TR Year <u>2nd</u> (05 Year)	Region's Request For TR Year <u>2nd</u> (05 Year)	Recommended Funding For TR Year <u>2nd</u> (05 Year) <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium	
PROGRAM STAFF	663,310	X	705,704	<input type="checkbox"/> Yes <input type="checkbox"/> No	X	
CONTRACTS	60,130		NONE			
DEVELOPMENTAL COMP.	135,086		177,986			
OPERATIONAL PROJECTS	1,704,474		2,137,934			
Kidney	X		(114,334)			(/)
EMS			(478,000)			()
hs/ea			(75,000)			()
Pediatric Pulmonary			(33,300)			()
Other		()	()			
TOTAL DIRECT COSTS	2,563,000	X	3,021,624			
COUNCIL-APPROVED LEVEL	3,032,490		3,032,490	3,032,490		

JULY 20, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - GEORGIA
RM 00046 10/72

PAGE 1
RMPS-05K-870GR2-1

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
C000 PROGRAM STAFF ACTIVIES	\$705,704				\$705,704	\$98,454	\$804,158
D000 DEVELOPMENTAL COMPONENT	\$177,986				\$177,986		\$177,986
001A CONF FOR IMPROVING PT SE RVICES GEMP	\$10,000				\$10,000		\$10,000
001B CONF FOR IMPROVING PT SE RVICES EMORY	\$10,000				\$10,000		\$10,000
001C CONF FOR IMPROVING PT SE RVICES PGG	\$10,000				\$10,000		\$10,000
001 COMPONENT TOTAL	\$30,000				\$30,000		\$30,000
003A VISITING CONSULTANT PRCG PAM GEMP	\$30,000				\$30,000		\$30,000
003B VISITING CONSULTANT PRCG PAM EMORY	\$15,000				\$15,000	\$2,122	\$17,122
003 COMPONENT TOTAL	\$45,000				\$45,000	\$2,122	\$47,122
013A STATEWIDE CANCER PROGRAM AREA FACILITIES GEMP	\$122,550				\$122,550	\$4,328	\$126,878
013E STWD CA PROGRAM MCG MACO N	\$5,000				\$5,000		\$5,000
013F STATEWIDE CANCER PROGRAM AREA FAC M CENTER COLUM	\$7,000				\$7,000		\$7,000
013G STWD CA PRCG AREA FACILI TIES SAVANNAH	\$5,000				\$5,000		\$5,000
013I STWD CA PROGRAM AREA FAC ILITIES ALBANY	\$5,000				\$5,000		\$5,000
013J STWD CA PROGRAM AREA FAC ILITIES ATLANTA MED CIR	\$5,000				\$5,000		\$5,000
013L STWD CA PROGRAM AREA FAC ILITIES AUGUSTIA	\$5,000				\$5,000		\$5,000
013T STWD CA PROGRAM AREA FAC ILITIES ST JOES ATLANTA	\$5,000				\$5,000		\$5,000
013M STWD CA PRCG AREA FACILI TIES LONG BEACH MSP ATLANTA	\$5,450				\$5,450		\$5,450
013Y STWD CA PRUG AREA FACILI TIES LA GRANGE	\$5,000				\$5,000		\$5,000
013Z STWD CA PRCG AREA FACILI TIES ROME	\$5,000				\$5,000		\$5,000
013 COMPONENT TOTAL	\$175,000				\$175,000	\$4,328	\$179,328
014C NEG PEDIATRIC RESP CENTE R MCG	\$33,300				\$33,300	\$8,316	\$41,616
0208 AREA FACILITIES FOR CON D ENCEY	\$19,300				\$19,300		\$19,300
0200 AREA FACILITIES FOR CON CU ATLANTA GLN HOSPITAL	\$15,700				\$15,700		\$15,700
020E AREA FACILITIES FOR CON ED MCTR CENT GEORGIA	\$51,700				\$51,700		\$51,700
020F AREA FACILITIES FOR CON FO MCTR COLUMBUS	\$35,200				\$35,200		\$35,200

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD CF SUPPORT	(2) CONT. BEYOND APPR. PERIOD CF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
020G AREA FACILITIES FOR CON ED. PEP. MED. CENTER	\$53,000				\$53,000		\$53,000
020I AREA FACILITIES FOR CON ED. P. MORE MEN. HSP	\$12,200				\$12,200		\$12,200
020S AREA FACILITIES FOR CON ED. TIFT MEM. HOSPITAL	\$13,600				\$13,600		\$13,600
020V AREA FACILITIES FOR CON ED. KENNESICU MEM. HSP	\$5,800				\$5,800		\$5,800
020 COMPONENT TOTAL	\$206,500				\$206,500		\$206,500
027K A COMMUNITY HYPERTENSION PROGRAM GRPP	\$67,000				\$67,000	\$8,792	\$75,792
030L FACILITY PLAN AND DEV AU GUSTIA RAD. INDY. CIR	\$25,000				\$25,000		\$25,000
031A CVA AREA FACILITIES GRPP	\$27,600				\$27,600		\$27,600
031D CVA AREA FACILITIES ATHE NS. GEN. HSP	\$19,800				\$19,800		\$19,800
031F CVA AREA FACILITIES MED CIR. COLUMBUS	\$31,600				\$31,600		\$31,600
031G CVA AREA FACILITIES MEM MED. CIR. SAVANNAH	\$17,400				\$17,400		\$17,400
031J CVA AREA FACILITIES ATLA NTA. MED. CTR	\$42,300				\$42,300		\$42,300
031M CVA AREA FACILITIES UNIV HSP. AUGUSTIA	\$13,400				\$13,400		\$13,400
031P CVA AREA FACILITIES ARCH HOLD. MEM. HSP. JUDMSVILLE	\$21,900				\$21,900		\$21,900
031S CVA AREA FACILITIES TIFT GEN. HOSPITAL	\$12,500				\$12,500		\$12,500
031 COMPONENT TOTAL	\$186,500				\$186,500		\$186,500
032A STROKE AREA FACILITIES G PNC	\$5,600				\$5,600		\$5,600
032N STROKE AREA FACILITIES C ANDLER GEN. HSP. SAVANNAH	\$27,800				\$27,800		\$27,800
032T STROKE AREA FACILITIES S T. JOE. INE. ATLANTA	\$26,600				\$26,600		\$26,600
032 COMPONENT TOTAL	\$60,000				\$60,000		\$60,000
036B REGIONAL NEPHROLOGY CENT ER. E. COBY	\$22,167				\$22,167	\$8,404	\$30,571
036C REGIONAL NEPHROLOGY CENT ER. PCC. AUGUSTIA	\$22,167				\$22,167	\$6,735	\$28,902
036F RENAL AREA FACILITIES ME D. CIR. COLUMBUS	\$35,000				\$35,000		\$35,000
036X RENAL AREA FACILITIES	\$35,000				\$35,000		\$35,000
036 COMPONENT TOTAL	\$114,334				\$114,334	\$15,139	\$129,473
037L KLS DIS AREA FACILITIES MED. CIR. CENTRI. GA	\$13,400				\$13,400		\$13,400

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BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - GEORGIA
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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD CF SUPPORT	(2) CONT. BEYOND APPR. PERIOD CF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
037J RES DIS AREA FACILITIES							
ATLANTA MED CTR	\$14,000				\$14,000		\$14,000
037T RESP DIS AREA FACILITIES							
ST JOE INFIRMARY	\$15,000				\$15,000		\$15,000
037X RESP DIS AREA FACILITIES							
	\$17,600				\$17,600		\$17,600
037 COMPONENT TOTAL	\$60,000				\$60,000		\$60,000
038I CYLRG CARE FOR SO GA AND NO. FLA. SO. GA. MED CTR	\$93,000				\$93,000		\$93,000
041B DETEC AND ELIPINA ELECTH ICAL LABS EMOBY	\$9,500				\$9,500	\$3,326	\$12,826
042B PLAN STND SYSTEM CARE SI CK MEMPHIS EMOBY	\$17,000				\$17,000	\$5,984	\$22,984
042C PLAN STND SYSTEM CARE SI CK MEMPHIS MED COL GA	\$55,700				\$55,700	\$13,810	\$69,510
042 COMPONENT TOTAL	\$172,700				\$172,700	\$19,794	\$192,494
043A PATIENT AND FAMILY EDUCA TION GEMP	\$15,000				\$15,000		\$15,000
043F PATIENT AND FAMILY EDUCA TION MED CTR COLUMBUS	\$10,000				\$10,000		\$10,000
043G PATIENT AND FAMILY EDUCA TION MEM MED CTR SAVANNAH	\$12,000				\$12,000		\$12,000
043H PATIENT AND FAMILY EDUCA TION NORTSIDE HSP ATLANTA	\$13,000				\$13,000		\$13,000
043 COMPONENT TOTAL	\$50,000				\$50,000		\$50,000
048A SPARED ALLIED HEALTH SER VICE GEMP	\$50,000				\$50,000		\$50,000
049A HEALTH OCCUPATIONS COURSE ELING G. P. H. P.	\$15,000				\$15,000		\$15,000
050F PHY ASSISTANT DEVELOP PR OG MED CTR COLUMBUS	\$30,000				\$30,000		\$30,000
051B EDUCATING HEALTH PROFS ORIGINAL PRIM CARE EMOBY	\$10,000				\$10,000	\$3,791	\$13,791
052H IMPROV PRIM CARE ACCESSA BILITY ATLANTA	\$52,500				\$52,500		\$52,500
052P IMPROV PRIM CARE ACCESSA BILITY N. E. GEORGIA	\$44,000				\$44,000		\$44,000
052R IMPROV PRIM CARE ACCESSA BILITY WILCOX COUNTY	\$46,600				\$46,600		\$46,600
052S IMPROV PRIM CARE ACCESSA BILITY HENRY COUNTY	\$70,000				\$70,000		\$70,000
052 COMPONENT TOTAL	\$213,100				\$213,100		\$213,100
054G FURST MILITARY SERV MILITARY COUNTY AREA BRUNSWICK	\$35,000				\$35,000		\$35,000
054X STD PROF HEALTH EDUCATI ON SYSTEM	\$75,000				\$75,000		\$75,000
055T EMER MED SERVICE SAVANNAH	\$294,000				\$294,000		\$294,000

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05 PROGRAM PERIOD

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IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CCNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
055U EMER MED SERVICE COLUMBUS	\$184,000				\$184,000		\$184,000
055 COMPONENT TOTAL	\$478,000				\$478,000		\$478,000
TOTAL	\$3,021,624				\$3,021,624	\$164,062	\$3,185,686

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BREAKOUT OF REQUEST
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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
C000 PROGRAM STAFF ACTIVIES						
0000 DEVELOPMENTAL COMPONENT	\$734,787				\$734,787	\$1,450,491
001A CONF FOR IMPROVING PT SE RVICES GMP	\$177,986				\$177,986	\$355,972
001B CONF FOR IMPROVING PT SE RVICES EMOPY	\$10,000				\$10,000	\$20,000
001C CONF FOR IMPROVING PT SE RVICES PCG	\$10,000				\$10,000	\$20,000
001 COMPONENT TOTAL	\$30,000				\$30,000	\$60,000
003A VISITING CONSULTANT PRCG RMP GMP	\$30,000				\$30,000	\$60,000
003B VISITING CONSULTANT PRCG RMP EMOPY	\$15,000				\$15,000	\$30,000
003 COMPONENT TOTAL	\$45,000				\$45,000	\$90,000
013A STATEWIDE CANCER PROGRAM AREA FACILITIES GMP	\$122,550				\$122,550	\$245,100
013E STWD CA PROGRAM PCG MACO N	\$5,000				\$5,000	\$10,000
013F STATEWIDE CANCER PROGRAM AREA FAC N CENTER COLUM	\$7,000				\$7,000	\$14,000
013G STWD CA PROG AREA FACILI ILLES SAVANNAH	\$5,000				\$5,000	\$10,000
013I STWD CA PROGRAM AREA FAC ILITIES ALBANY	\$5,000				\$5,000	\$10,000
013J STWD CA PROGRAM AREA FAC ILITIES ATLANTA MED CTR	\$5,000				\$5,000	\$10,000
013L STWD CA PROGRAM AREA FAC ILITIES AUGUSTA	\$5,000				\$5,000	\$10,000
013T STWD CA PROGRAM AREA FAC ILITIES ST JOES ATLANTA	\$5,000				\$5,000	\$10,000
013M STWD CA PROG AREA FACILI ITIES LONG MCH HSP ATLANTA	\$5,450				\$5,450	\$10,900
013Y STWD CA PROG AREA FACILI ITIES LA GRANGE	\$5,000				\$5,000	\$10,000
013Z STWD CA PROG AREA FACILI ITIESROME	\$5,000				\$5,000	\$10,000
013 COMPONENT TOTAL	\$175,000				\$175,000	\$350,000
014C REG PEDIATRIC RESP CENTE R PCG	\$13,332				\$13,332	\$26,664
020B AREA FACILITIES FOR CCN D EMOPY	\$19,300				\$19,300	\$38,600
020C AREA FACILITIES FOR CCN ED ATHENS GEN HOSPITAL	\$15,700				\$15,700	\$31,400
020E AREA FACILITIES FOR CCN ED MCTR CENT GEORGIA	\$51,700				\$51,700	\$103,400
020F AREA FACILITIES FOR CCN ED MCTR COLUMBUS	\$35,200				\$35,200	\$70,400

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JULY 20, 1972

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD CF SUPPORT	(2) CONT. BEYOND APPR. PERIOD CF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
020G AREA FACILITIES FOR CCN ED MEN MED CENTER	\$53,000				\$53,000	\$106,000
020I AREA FACILITIES FOR CCN ED BRIDGE MEM HSP	\$12,200				\$12,200	\$24,400
020S AREA FACILITIES FOR CCN ED TIFT MEM HOSPITAL	\$13,600				\$13,600	\$27,200
02CV AREA FACILITIES FOR CCN ED BELLESSION MEM HSP	\$5,800				\$5,800	\$11,600
02Q COMPONENT TOTAL	\$206,500				\$206,500	\$413,000
027K A COMMUNITY HYPERTENSION PROGRAM GROUP						\$67,000
03GL FACILITY PLAN AND DEV AU GUSIA SMO TIFT CTR						\$25,000
03IA CVA AREA FACILITIES GRMP	\$27,600				\$27,600	\$55,200
03ID CVA AREA FACILITIES ATHC NS GEN HSP	\$19,800				\$19,800	\$39,600
03IF CVA AREA FACILITIES MED CTR COLUMBUS	\$31,600				\$31,600	\$63,200
03IG CVA AREA FACILITIES MEM MED CTR SAVANNAH	\$17,400				\$17,400	\$34,800
03IJ CVA AREA FACILITIES ATLA NIA MED CTR	\$42,300				\$42,300	\$84,600
03IM CVA AREA FACILITIES UNIV HSP AUGUSTA	\$13,400				\$13,400	\$26,800
03IP CVA AREA FACILITIES ARCH BOLD MEM HSP THOMASVILLE	\$21,900				\$21,900	\$43,800
03IS CVA AREA FACILITIES TIFT GEN HOSPITAL	\$12,500				\$12,500	\$25,000
03J COMPONENT TOTAL	\$186,500				\$186,500	\$373,000
032A STROKE AREA FACILITIES C RHP	\$5,600				\$5,600	\$11,200
032N STROKE AREA FACILITIES C ANDLER GEN HSP SAVANNAH	\$27,800				\$27,800	\$55,600
032T STROKE AREA FACILITIES S T JOE INF ATLANTA	\$26,600				\$26,600	\$53,200
032 COMPONENT TOTAL	\$60,000				\$60,000	\$120,000
0368 REGIONAL NEPHROLOGY CENT ER EMORY	\$10,333				\$10,333	\$32,500
036C REGIONAL NEPHROLOGY CENT ER MCG AUGUSTA	\$10,333				\$10,333	\$32,500
036F RENAL AREA FACILITIES ME D CTR COLUMBUS						\$35,000
036X RENAL AREA FACILITIES						\$35,000
036 COMPONENT TOTAL	\$20,666				\$20,666	\$115,000
037E RLS DIS AREA FACILITIES MED CTR CENTRAL GA	\$13,400				\$13,400	\$26,800

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
037J RES DIS AREA FACILITIES						
ATLANTA MED CIR	\$14,000				\$14,000	\$28,000
037T RESP DIS AREA FACILITIES						
ST JOE INFIRMARY	\$15,000				\$15,000	\$30,000
037X RESP DIS AREA FACILITIES						
	\$16,400				\$16,400	\$34,000
037 COMPONENT TOTAL	\$58,800				\$58,800	\$118,800
039H EMERG CARE FOR SO GA AND						
NO FLA SO GA MED CIR	\$93,000				\$93,000	\$186,000
041B DETEC AND ELIMINA ELECTRI						
CAL HAZARDS EXPOS						\$9,500
042B PLAN STD SYSTEM CARE SI						
CK MEMORPH EMOSY		\$17,398			\$17,398	\$34,398
042C PLAN STD SYSTEM CARE SI						
CK MEMORPH MED COL GA		\$29,255			\$29,255	\$58,255
042 COMPONENT TOTAL		\$46,653			\$46,653	\$119,353
043A PATIENT AND FAMILY EDUCA						
TICN GEMP	\$46,100				\$46,100	\$91,100
043F PATIENT AND FAMILY EDUCA						
TICN MED CIR COLUMBUS	\$1,600				\$1,600	\$3,600
043G PATIENT AND FAMILY EDUCA						
TICN MEM MED CIR SAVANNAH	\$2,300				\$2,300	\$4,300
043M PATIENT AND FAMILY EDUCA						
TICN HQSIDE MSP ATLANTA						\$13,000
043 COMPONENT TOTAL	\$50,000				\$50,000	\$100,000
048A SHARE ALLIED HEALTH SER						
VICE CAMP	\$68,100				\$68,100	\$118,100
049A HEALTH OCCUPATIONS COURSE						
ELING G E M P						\$15,000
050F PHY ASSISTANT DEVELOP PR						
CG MED CIR COLUMBUS	\$30,000				\$30,000	\$60,000
051B EDUCATING HEALTH PROFS						
OPHIAL DIAB CARE EMOSY						\$10,000
052H IMPROV PRIM CARE ACCESSA						
BILLY ATLANTA	\$55,250				\$55,250	\$107,750
052P IMPROV PRIM CARE ACCESSA						
BILLY N E GEORGIA	\$45,600				\$45,600	\$89,600
052R IMPROV PRIM CARE ACCESSA						
BILLY WILCOX COLONY	\$48,000				\$48,000	\$96,600
052S IMPROV PRIM CARE ACCESSA						
BILLY HENRY COUNTY	\$74,800				\$74,800	\$144,800
052 COMPONENT TOTAL	\$273,650				\$273,650	\$536,750
053D ADMS MILITARY SERV MILIT						
COUNTY AREA BRUNSWICK	\$28,000				\$28,000	\$67,000
054X STD PROF HEALTH EDUCATI						
ON SYSTEM	\$387,560				\$387,560	\$462,560
055T EMER MED SERVICE SAVANNA						
H	\$291,741				\$291,741	\$587,741

JULY 20, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
055U EMER MED SERVICE COLUMBU	\$171,899				\$171,899	\$355,859
055 COMPONENT TOTAL	\$465,652				\$465,652	\$941,642
TOTAL	\$3,054,523	\$46,653			\$3,101,176	\$6,122,800

AUGUST 2, 1972

REGIONAL MEDICAL SERVICE
FUNDING HISTORY LIST

RHPS-OSM-JTCFHL
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ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

REGION 46 GEORGIA

RMP SLPP YR 04

FEDERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		01	02	03	C4 09/71-12/72	TOTAL	05 01/73-12/73	06 01/74-12/74	07 01/75-12/75	TOTAL
CCCC	PROG FAP STAFF	770000	761300	648400	864407	3064107	705704	734787		1440491
C190	DEV AREA PRG HS		882CC			88200				
D000	DEVELOPMENTAL F				120500	120500	177986	177986		355972
D001	IMPROVED PRIMAR				21284	21284				
D002	A NUFSE MIEWIFE									
DCC3	IMPROVED PRIMAR				10578	10578				
D004	IMPROVED PRIMAR				10530	10530				
D005	COMPLIANT FEALT				7920	7920				
D006	IMPROVED PRIMAR				9315	9315				
001	CCAFERENCES FOR	60500	107000	41000	29731	238231				
001A	CCAF FOR IMPROV						10000	10000		20000
001B	CONF FOR IMPROV						10000	10000		20000
001C	CCAF FOR IMPROV						10000	10000		20000
002	POST RESID TR P		10400	20000		30400				20000
003	VISITING CONSUL	9000	24500	21000	43333	97833				
003A	VISITING CONSUL						30000	30000		60000
003B	VISITING CONSUL						15000	15000		30000
004	INTERLIB SERV F	23100	23200	1800		48200				
005	COLUMBUS MC EMGR	36700	42800	28000		107500				
006	COMMUNICATIONS	522500	355500	148000		1027000				
008	CCRD CVA LAB E	86800	105100	12600		204500				
010	CPRT PRG STWDE	69600	113700	72700		256000				
011	CC EQUIP SM HCS	19700	34200	10000		63500				
013	STATEWIDE CANCER	225500	401300	234100	219133	1080033				
013A	STATEWIDE CANCER						122550	122550		245100
013E	STWD CA PRGGRAP						5000	5000		10000
013F	STATEWIDE CANCER						7000	7000		14000
013G	STWD CA PRG AR						5000	5000		10000
013I	STWD CA PRGGRAP						5000	5000		10000
013J	STWD CA PRGGRAP						5000	5000		10000
013L	STWD CA PRGGRAP						5000	5000		10000
013T	STWD CA PRGGRAP						5000	5000		10000
013V	STWD CA PRG AR						5000	5000		10000
013Y	STWD CA PRG AR						5450	5450		10900
013Z	STWD CA PRG AR						5000	5000		10000
014	REG PEDIATRIC R	133600	170800	114100	73332	451833				
014C	REC PEDIATRIC R						33300	13332		46632
015	TRNG PRG MED SP	38700	48500	44300		151500				
016	PLAN CLT HSP S	28200				28200				
017	COMC PUB INFO A	20000	23000			43000				
020	AREA FACILITIES		84200	68100	249504	401804				
020B	AREA FACILITIES						19300	19300		38600
020D	AREA FACILITIES						15700	15700		31400
020E	AREA FACILITIES						51700	51700		103400
020F	AREA FACILITIES						35200	35200		70400
020G	AREA FACILITIES						53000	53000		106000
020I	AREA FACILITIES						12200	12200		24400
020S	AREA FACILITIES						13600	13600		27200
020V	AREA FACILITIES						5800	5800		11600
021	DEV SYS OF CC T		53700	49050		102750				
022	PHYSIOLOGY FOR		26100	14100		40200				

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FUNDING HISTORY LIST

RMP5-05M-JYDFHL-20

REGION 46 GEORGIA

RMP SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED	
		01	02	03	04	TOTAL	05	06	07	TOTAL	
		09/71-12/72					01/73-12/73 01/74-12/74 01/75-12/75				
023	REN FAIL TRN DE		37800	29400		67200	**				
024	TCHG TRN DEM FY		43800	26400		80200	**				
027	COMMUNITY HYPER			84000	133333	217333	**				
027K	A COMMUNITY HYP						**	67000		67000	
028	DEV COMM STATE		37000	14100		51100	**				
029	COOP ED SERV CH		11000	8800		19800	**				
030	FACILITY PLANNI			5700	32420	38120	**				
030C	FACILITY PLAN A						**	25000		25000	
031	CARDIOVASCULAR			63050	179560	242610	**				
031A	CVA AREA FACILI						**	27600	27600	55200	
0310	CVA AREA FACILI						**	15800	19800	35600	
031F	CVA AREA FACILI						**	51600	31600	83200	
031G	CVA AREA FACILI						**	17400	17400	34800	
031J	CVA AREA FACILI						**	42300	42300	84600	
031M	CVA AREA FACILI						**	13400	13400	26800	
031P	CVA AREA FACILI						**	21500	21900	43400	
031S	CVA AREA FACILI						**	12500	12500	25000	
032	STROKE AREA FAC			10500	53976	64476	**				
032A	STROKE AREA FAC						**	5600	5600	11200	
032N	STROKE AREA FAC						**	27800	27800	55600	
032T	STROKE AREA FAC						**	26600	26600	53200	
036	A KIDNEY DISEAS				111279	111279	**				
036B	REGIONAL NEPHRC						**	22167	10333	32500	
036C	REGIONAL NEPHRC						**	22167	10333	32500	
036F	RENAL AREA FACI						**	35000		35000	
036X	RENAL AREA FACI						**	35000		35000	
037	AREA FACILITIES				41291	41291	**				
037E	RES CIS AREA FA						**	13400	13400	26800	
037J	RES DIS AREA FA						**	14000	14000	28000	
037T	RESP DIS AREA F						**	15000	15000	30000	
037X	RESP CIS AREA F						**	17600	16400	34000	
038	EMERGENCY CARE SOU				186455	186455	**				
038H	EMERG CARE FOR						**	93000	93000	186000	
041	DETECT AND ELIM				10290	10250	**				
041B	DETEC AND ELIMI						**	5500		5500	
042	PLAN STD SYS C				48280	48280	**				
042B	PLAN STD SYSTE						**	17000	17398	34398	
042C	PLAN STD SYSTE						**	55700	29255	84955	
043	PATIENT AND FAM				50332	50332	**				
043A	PATIENT AND FAM						**	15000	46100	61100	
043F	PATIENT AND FAM						**	10000	1600	11600	
043G	PATIENT AND FAM						**	12000	2300	14300	
043H	PATIENT AND FAM						**	13000		13000	
045	PRCG TO EXPAND				14000	14000	**				
048	SHARED ALLIED H				27227	27227	**				
048A	SHARED ALLIED F						**	50000	68100	118100	
049	HEALTH OCCUPATI				19052	19092	**				
049A	HEALTH OCCUPATI						**	15000		15000	
050	PHYSICIAN ASSIS				75578	75578	**				
050F	PHY ASSISTANT G						**	30000	30000	60000	
051	EDUCATIONG FEAL				29867	29867	**				

STATEMENT 16

16

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMPS-DSM-JTCFHL-20

REGION 46 GEORGIA

RMF SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED	
		G1	G2	G3	G4	TOTAL	C5	G6	G7	TOTAL	
		09/71-12/72					01/73-12/73 01/74-12/74 01/75-12/75				
051B	EDUCATION FEAL						10000			10000	
052	IMPROVED PRIM C				133171	133171					
052H	IMPROV PRIM CAR						52500	55250		107750	
052P	IMPROV PRIM CAR						44000	45400		89600	
052R	IMPROV PRIM CAR						46600	48000		94600	
052S	IMPROV PRIM CAR						70000	74800		144800	
053	A NURSE MIDWIFE				32806	32806					
0530	NURSE MIDWIFE S						39000	28000		67000	
054	STATEWIDE PRCF				50000	50000					
054X	STND PROF HEALT						75000	387560		462560	
055	EMERGENCY MEDIC				577646	577646					
055T	EMER MED SERVIC						254000	293743		547743	
055V	EMER MED SERVIC						184000	171899		355899	
056	IMPROVED ENERGY						26757			26757	
- TOTAL -		2044500	2623600	1779800	3617328	9965228	3021624	3101176		6122800	

14113

14113



HISTORICAL PROGRAM PROFILE OF REGION

Georgia Regional Medical Program's initial planning year began on January 1, 1967, the region became operational on July 1, 1968 and it obtained triennial status on September 1, 1971.

GRMP includes the largest geographic area east of the Mississippi River, and is characterized by large rural areas sparsely populated with small hospitals and generally inadequate health facilities and services. This region is looked upon as one of the more progressive regions, and has a good concept of the problems and resources existing within its boundaries. No really serious problems have plagued this region.

One concern during GRMP's early stages of development was its weak evaluation process. The region responded extremely well to this concern and now has an excellent evaluation process. An evaluation specialist was added to the staff. New directions now allow each approved program element to have a specific evaluation plan drawn up by the program assessment coordinator and the project director at the time of project design. Implementation of the plan occurs shortly after funding.

Last year, program involvement with other Federal programs (CHP, Model Cities, Appalachia and OEO) was rather limited and consisted of cross-representation on advisory groups and cross-review of applications. GRMP is now participating with these agencies in developing their health programs in addition to reviewing their applications and serving on the advisory groups.

The primary care problems of the underserved urban population was one area of concern that GRMP has not, until recently, addressed to any degree. Developmental component money is now being channeled into projects centered around health care delivery to the rural and urban poor. Four access stations make use of allied health professionals to assist physicians to better serve patients in their geographic areas that are remote from the physicians' office.

Originally, the Steering Committee consisted of six members of which only one was a non-physician. In order to correct this situation, the Bylaws Committee recommended that the membership be increased from six to nine members with at least four of the nine being non-physicians. This recommendation will become effective in the fall of this year.

Lack of stimulation of activities at the Local Advisory Group level is a problem that the region dealt with through its subregionalization process.

GRMP developed the "area facility" concept which basically provides minimal financial support to selected larger community hospitals for the purpose of expanding and extending appropriate health services to the smaller

hospitals and health professionals in their area. Thirty area facilities for continuing education and categorical disease are presently supported. The Area Facility Concept is explained on pages 1 thru 7 of the present application. Staff, at the request of GRMP, plans a visit to the region during the week of August 14-18 and will be available to report on this phase of the total program along with the region's health access stations, etc., when the application is considered.

Twelve projects have successfully been terminated by either receiving support from other sources or having had elements that were absorbed into new projects. The Physiology for Nursing Instructors Course (Project #22) was terminated by Council because it was difficult to see the relevance of this project to the goals and objectives of the program and how it could relate to increasing the availability and accessibility of health care. The duration of most of the terminated projects was two and three years.

GRMP has been considered by Staff, Committee and Council to be a strong program with good management and organizational strengths, excellent leadership, involved and committed State and local relationships. Excellent cooperation exists between the two medical schools.

The emergence of Emergency Medical Service activities through \$100,000 supplemental funds to provide the planning for a total EMS system represents a new departure for GRMP.

The region's review process was the subject of a June 8-9, 1972 visit. They were found to exceed the minimum standards.

Region: Georgia
Review Cycle: 10/72

STAFF OBSERVATIONS

Principal Problems:

Recommendations from last year's review cycle revealed GRMP's problems to be those of a weak evaluation process, lack of program development to serve the health needs of the underserved urban population, the need for broader lay representation on the Steering Committee and lack of staff assistance to other Federal programs in developing their health programs.

Principal Accomplishments

GRMP has the capacity to adjust readily to changing priorities. The present application reflects definite response to the specific recommendations in last year's advice letter. There has been a task force reorganization to allow greater responsiveness to the new mission of RMP and reflect the three major program areas of interest to GRMP, additions to and change in the Steering Committee structure, and some slight reorganization of program staff to permit the setting up of an operations division.

GRMP has matured to the point where emphasis is now being placed upon working with larger community groups responsible for local and area planning, such as CHP (b) agencies and Area Planning and Development Commission of which there are 18 in the state instead of working with the Local Advisory Groups. GRMP staff is cooperating with the National Health Service Corps in site selection and in obtaining medical and dental society approvals for placement of health professionals in areas where health services are inadequate because of medical personnel shortages.

Three program areas which reflect GRMP's thrust for meeting local and national priorities are manpower development and utilization, specialized services, and primary health services. Task forces in these areas of competence develop goals, objectives and priorities. They also recommend appropriate strategies for reaching these goals and objectives. GRMP should be noted for the rapidity with which it was able to move into primary health care by utilizing developmental component money for planning and implementing the access station concept, a regional midwife service and planning a multicounty rural primary care system.

Overall, GRMP is characterized as being one of the better managed and organized regions. No previous problems have existed to decrease its funding during the past year.

Issues Requiring Attention of Reviewers

GRMP has an approved triennial program of which it is requesting the second year funding. The request does not exceed the N.A.C. level. Staff's recommendation after reviewing this application is to fund the region at the approved level for its second triennium year.

SCOB/DOD/RMPS
8/10/72

MEMORANDUM

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

TO : Director
Division of Operations and Development

CRC 9/7/72

DATE: September 7, 1972

FROM : Director
Regional Medical Programs Service

SUBJECT: Action on September 5-6 Staff Anniversary Review Panel Recommendation concerning the Georgia Regional Medical Program Application.

Accepted

Ham

(Date)

9/10/72

Rejected

(Date)

Modifications

Region Georgia
Review Cycle October 1972
Type of Application Family
within Triennium

Recommendations From

Rating - 366

SARP

Review Committee

Site Visit

Council

RECOMMENDATIONS:

That the region's funding level be continued for the requested amount of \$3,021,624, for its '05 operational year. The amount recommended for renal is \$114,334 as compared to '02 year National Advisory Council recommended level of \$51,000.

The total amount recommended is \$10,866 below the '05 year Council approved level.

CRITIQUE:

In arriving at the funding recommendation, the panel believed that the Georgia RMP continues to be a strong, viable region. They have responded and shown excellent progress as it relates to program concerns of the June 1971 site visitors. During the past year, the region has been involved in active programming for health care in both urban and rural medically deprived areas through its health access station network. They have broadened representation on the Steering Committee by the addition of several lay representatives.

Program evaluation is now under the direction of a full-time evaluator, who is also the director of a new division of operations in the program staff component.

During June 1972, the region's review process was reviewed. It was found to exceed the "RMP Review Process Requirements and Standards."

The composition of the region's task forces now include two members of the RAG. This provides for direct input into the decision makers from the Technical Review Committees.

The continuation application was found to be an excellent document which outlines the mission of a high rated Regional Medical Program.

There was an excellent impression regarding the management and organizational strengths of the region, which is coupled with outstanding leadership provided by the director and members of the program staff. It was noted that program staff funding accounts for only 23% of the current total funding for the region. Further, there was a clear demonstration of an organizational structure which permits strong inter- and intra-regional medical program relationships with other regions and the numerous agencies and institutions throughout the state.

Members of the panel spent a great deal of time in discussing the region's area facility concept. It was believed that this phase of regionalization, which has demonstrated excellent success, in most cases, could well serve as the basis of justification as a program which has made the smooth transition from the categorical to broader program areas.

The region has worked closely with representatives of the National Health Service Corp in the placement of personnel in needy areas of the state.

The region has established a logical method of involvement of CHP agencies with its program.

There was some concern expressed regarding the method of continued support for Project #6, Communications T.V. Network. In line with the National Advisory Council's advice, the region ceased to support this as a project activity on August 31, 1971. This action caused great consternation among certain members of the TAG. As a compromise, and to allow for the orderly termination of GRMP support of the activity by September 1974, a contractual matching agreement was established with Emory University, individual hospitals wishing to receive the live television programming (or tapes) and the GRMP. Staff's concern was that federal dollars may be being matched by federal dollars.

The regional program had been in operation approximately three months when this application was prepared. Currently, GRMP has two regional facilities (Emory and M.C.G.) and one area facility in operation. Additional area facilities will be initiated as manpower becomes available.

The panel agreed that the classical academic approaches, characterizing most of the Georgia activity to date, reflect programmatic actions that may influence other RMPs as well as the national concept of RMPs.

COMPONENT AND FUNDING SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Region: Georgia RMI
Review Cycle: Sept/Oct 1992

Component	Current Annualized Funding TR Year <u>1st</u> (04 Year)	Council-Approved Level For TR Year <u>2nd</u> (05 Year)	Region's Request For TR Year <u>2nd</u> (05 Year)	Recommended Funding For TR Year <u>2nd</u> (05 Year) <input checked="" type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
PROGRAM STAFF	663,310	X	705,704	705,704	X
CONTRACTS	60,130		NONE	NONE	
DEVELOPMENTAL COMP.	135,086		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 177,986		
OPERATIONAL PROJECTS	1,704,474		2,137,934	2,137,934	
Kidney			(114,334)	(51,000*)	
EMS			(478,000)	()	
hs/ca			(75,000)	()	
Pediatric Pulmonary			(33,300)	()	
Other			()	()	
TOTAL DIRECT COSTS	2,563,000			3,021,624	
COUNCIL-APPROVED LEVEL	3,032,490	3,032,490	3,032,490	3,032,490	

*The amount shown is the 02 year Council approved level.
SARP approved the \$114,334 requested.

Region HAWAII RM 00001
 Reivew Cycle October 1972
 Type of Application Triennium
 Rating 309

Recommendations From

<input type="checkbox"/>	SARP	<input checked="" type="checkbox"/>	Review Committee
<input type="checkbox"/>	Site Visit	<input type="checkbox"/>	Council

Recommendation: The Committee agreed with the site visitors and recommended that the RMPH's triennial application be approved.

Funding Levels

	05 Year (1/1/73--12/31/73)	06 Year (1/1/74--12/31/74)	07 Year (1/1/75--12/31/75)
Program Staff & Projects	\$1,805,488	\$1,689,213	\$1,670,577
Developmental Component	<u>0 ^{1/}</u>	<u>150,000</u>	<u>150,000</u>
Total <u>2/</u>	\$1,805,488	\$1,839,213	\$1,820,577

1/ Because the RMPH has not completely satisfied the management and review process requirements of RMPS, the developmental request for the 05 year was not approved.

2/ Total funds recommended for RMPH include earmarked funds for kidney project #47 and the Pacific Basin Area. The funding recommended for the kidney project #47 is \$15,000 less than the site visit recommendations.

Critique: Committee endorsed the site visitors recommendations that RMPS earmark funds from the RMPH's three-year recommended funding levels in the following amounts for the Pacific Basin Area.

05 Year	\$299,700
06 Year	\$288,221
07 Year	\$299,110

Committee was impressed with the site visitors' favorable report on the progress of the RMPH during the past year. There has been a significant change in the direction of the program along with increased productivity.

This is in part due to the strong leadership the coordinator (Dr. Hasegawa) provides to the program. Because of the satisfactory progress the program has made, both Committee and the site visitors believe that the region is capable of managing a three-year program. There was some concern that the proposed triennial plan might be too ambitious and could overextend the Regional Medical Program's capabilities. However, it was agreed that during the coming year the RMPH should have adequate opportunity to demonstrate that it has the efficiency and strength required of a mature and stable organization.

Areas of progress and accomplishments noted by the Review Committee are:

1. Most of the continuing education programs and categorical disease activities have ended. New priorities focus on health delivery systems to meet local and national goals and objectives.
2. The RMPH has established its own identity as a community leader in an extremely complex social environment.
3. The criteria for setting priorities on projects and staff activities are in line with the state's CHP efforts, especially those relating to the accessibility of better health service to the medically underserved areas of the region.
4. With the exception of allied health interest, the key health interests, institutions and groups are actively participating in the RMPH. Dr. Masato Hasegawa has been instrumental in bringing these many groups into the program.
5. While there was no evidence of a scientific approach to assessing needs and resources, the Committee noted that the RMPH seemed to know what needs to be done.
6. The RMPH has established priorities for project funding. First priority is given to ongoing projects and second priority to new projects. Also, priorities have been set within each of the two groups.
7. The Committee commended the increased involvement of the RMPH in the Pacific Basin. The goals, objectives and priorities of the Basin are reflected by the funded projects. Also, the representatives of the Basin are beginning to consider themselves a part of the RMPH, and are attempting to see how the Basin can relate to the program of Hawaii.

Areas of concern requiring RMPS attention during the coming year are:

1. In reevaluating the RMPH goals and objectives, the RAG should be realistic in terms of what can actually be accomplished.

2. The RMPH should require grant applicants to incorporate plans for developing other sources of funding for successful activities from the inception of the project. Consideration should be given to the possibility of decremental funding to the projects in the triennial application.
3. The director should be encouraged to more effectively utilize his deputy, and delegate more responsibility and authority accordingly. It is recommended that the deputy's role be fully clarified and documented for the RAG and program staff.
4. A concentrated effort be made to commit staff efforts in a coordinated manner to further strengthen the RMPH program development as reflected in all its major project activities.
5. The RMPH be encouraged to continue to refine its revised bylaws, giving close attention to the issues raised in the management survey and review verification reports. Special attention should be given to clarifying the role of the Executive Committee to insure that it acts in behalf of, and not instead of, the RAG.
6. The RMPH review process should be finalized with special attention given to the issues raised in the review process verification report.
7. There should be more active involvement of the allied health groups in the RMPH.
8. The RMPH should continue to develop new techniques to evaluate project activities and to assess how they will contribute to regional goals and objectives. Special attention should be given to providing information on progress and evaluation results to program management, the RAG, and other appropriate groups.
9. The RMPH carefully reevaluate the magnitude of its triennial plan, giving special attention to the RMPH's full responsibility to its major program components to determine how best to utilize organizational resources, especially program staff.
10. A mechanism be developed to utilize the findings of the Inter-Society Commission for Heart Disease Resources in establishing the EMS system.
11. Revision of RAG bylaws was recommended by the management survey and review process verification visit reports of May 1972. These revised bylaws should establish the RAG as the responsible body for formulating program policy, and as the decisionmaking body for all program matters. Also, other program areas would be clarified.

In August 1972, the site visit team was advised that a committee of the RAG had been formed and had drafted a revised set of bylaws. The revised draft of bylaws would require additional work, and the need for advice from someone knowledgeable in bylaw preparation was evident.

The final bylaws for the Regional Medical Program of Hawaii were received September 20, 1972, for review by RMPS. Initial reading of the bylaws revealed some deviation from the RMPS Policy Concerning Grantee and Regional Advisory Group Responsibilities and Relation.

Summary of Recommendations

Approval of the RMPH triennial application with the recommendation that the above concerns be communicated to the region in the advice letter.

WOB/RMPS
9/29/72

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level 04 Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year (05)	2nd year (06)	3rd year (07)	1st year (05)	2nd year (06)	3rd year (07)
PROGRAM STAFF & PROJECTS	\$1,405,185	\$1,886,223	\$1,780,150	\$1,420,276	1,730,000	1,650,000	1,650,000
DEVELOPMENTAL COMPONENT	- 0 -	287,583	287,583	287,583	-0-	150,000	150,000
Kidney	X	(90,488)	39,213	20,577	75,488	39,213	20,577
EMS		()					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$2,875,830*	\$2,264,294	\$2,106,946	\$1,728,436	1,805,488	1,839,213	1,820,577
COUNCIL RECOMMENDED LEVEL	\$1,102,000	*Includes \$1,470,645 direct cost for EMS project. These funds are for two years but were totally awarded during the 04 year for RMPS administrative purposes.					

SITE VISIT REPORT
REGIONAL MEDICAL PROGRAM OF HAWAII, AMERICAN SAMOA,
GUAM AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS
August 7-8, 1972

Site Visit Participants:

Leonard Scherlis, M.D., Chairman; Member of the Regional Medical Programs Review Committee; Professor of Medicine and Head, Division of Cardiology, University of Maryland School of Medicine, Baltimore, Maryland

Mr. Edwin C. Hiroto, Member of the National Advisory Council on Regional Medical Programs; Administrator, City View Hospital, Los Angeles, California

Mr. Kenneth Barrows, Bankers Life Company; and Chairman, Regional Advisory Group, Iowa RMP, Des Moines, Iowa

William I. Holcomb, M.D., Private Practitioner; and Member, Regional Advisory Board, Oregon RMP, Eugene, Oregon

RMPS Staff:

Mr. Richard L. Russell, Acting Chief, Western Operations Branch, DOD

Mr. Calvin Sullivan, Western Operations Branch, DOD

Mr. Ronald S. Currie, Program Director, RMP, Office of the Regional Health Director, DHEW Region IX, San Francisco, California

Edward J. Hinman, M.D., Director, Division of Professional and Technical Development

RMP of Hawaii Staff:

Masato Hasegawa, M.D., Executive Director

Mr. Omar A. Tunks, Deputy Director

Alexander Anderson, M.D., Consultant in Medical Care and Quality of Medical Care

Mr. Clyde Winters, Consultant in Medical Information System

Miss Susan Chandler, Assistant Director, Community Health

Mrs. Rosie K. Chang, Assoc. Director, Allied Health Manpower

Miss Manolita DeJesus, Office Manager

Satoru Izutsu, Ph.D., Assoc. Director, American Samoa, Guam & Trust Territory

Kanae Kaku, M.D., Biostatistician/Epidemiologist

Mr. Ross Rammelmeier, Assoc. Director, Planning and Systems Analysis

Miss Florence Katz, Assistant Health Planner

Mr. Michael Rodolico, Assistant in Systems Analysis and Evaluation

Mr. Norman Kuwahara, Assoc. Director in PPBS and Comptroller

RAG Members in Attendance:

Mr. Edward C. Bryan, Chairman, RAG; Executive Committee Member; Castle & Cooke, Inc., Honolulu, Hawaii
Mr. Ollie Burkett, Vice-Chairman, RAG; Executive Committee Member; Hospital Association of Hawaii, Honolulu, Hawaii
William M. Peck, M.D., RAG Representative from Micronesia; Trust Territory of the Pacific Islands, Office of the High Commissioner, Saipan, Mariana Islands
Mrs. Betty S. Guerrero, RAG Representative from Guam; Department of Public Health, Agana, Guam
Mr. Curtin A. Leser, RAG Member; Hawaiian Electric Company, Honolulu, Hawaii
Mr. Stanley B. Snodgrass, RAG Member; Administrator, Convalescent Center of Honolulu, Honolulu, Hawaii
Mr. Albert Yuen, RAG Member; Admin. Vice Pres., Hawaii Medical Service Association, Honolulu, Hawaii
Mr. Harold H. Ajirogi, Sr., RAG member and Executive Committee member; Program Officer, East-West Center, Honolulu, Hawaii
Mr. Ligoligo K. Eseroma, RAG Representative from American Samoa; District #1 House of Representatives, Legislature of American Samoa, Fagatogo, American Samoa
Herbert Y. H. Chinn, M.D., RAG member, Alexander Young Building, Honolulu, Hawaii

Others:

William E. Iaconetti, M.D., President, Hawaii Medical Association, Honolulu, Hawaii
Mrs. Sylvia Levy, Officer, Comprehensive Health Planning, Department of Health, Honolulu, Hawaii
Miss Edith Anderson, Dean, U. H. School of Nursing, Honolulu, Hawaii
Mr. David Pali, President, Waianae Coast Comprehensive Health & Hospital Board, Inc., Waianae, Oahu
Mrs. Claire Ho, President Elect, Hawaii Dietetic Association, Nutrition Branch, Department of Health, Honolulu, Hawaii
Mrs. Mary Lee Potter, Executive Director, Hawaii Nurses Association, Honolulu, Hawaii
Terence Rogers, Ph.D., Dean, U. H. School of Medicine, Honolulu, Hawaii
Mr. James Bunker, Exec. Vice President, American Cancer Society, Hawaii Division, Honolulu, Hawaii
Livingston Wong, M.D., Alexander Young Bldg., Honolulu, Hawaii
Mr. Jerrold M. Michael, U. H. School of Public Health, Honolulu, Hawaii
Mr. Mark Sperry, Assistant Director, Health & Community Services Council of Hawaii, Honolulu, Hawaii
Mr. George Moorhead, Assoc. Director, Health & Community Services Council of Hawaii, Honolulu, Hawaii
Mr. Pat Boland, Asst. CHP Officer, Comprehensive Health Planning, Honolulu, Hawaii
Miss Margaret Makekau, Asst. CHP Officer, Comprehensive Health Planning, Honolulu, Hawaii

Others, Cont.:

H. Tom Thorson, Exec. Director, Hawaii Medical Association, Honolulu, Hawaii
Mr. Raymond Lilly, Administrator, Waianae Coast Comprehensive Health Center, Waianae, Oahu
Mr. Robert W. Rhein, Asst. Administrator, Waianae Coast Comprehensive Health Center, Waianae, Oahu
Mr. Alexander Charter, Project Director, RMPS; Vice President, Syracuse University, Syracuse, New York
Miss Jane Arakaki, Consultant Dietitian, Hawaii Dietetic Association, Maunalani Hospital, Honolulu, Hawaii
Mr. William Coops, Administrative Officer, Research Corporation of the University of Hawaii, Honolulu, Hawaii

INTRODUCTION

The main section of this report follows the RMP Review Criteria and concerns primarily the activities of the RMPH in the State of Hawaii. A separate section is included on the RMPH activities in the Pacific Basin.

1. GOALS, OBJECTIVES, AND PRIORITIES (8)

The current goals, objectives and priorities were established in 1971 and represent a change from an emphasis on categorical diseases to the development of a program to assist in the improvement of the health care delivery system. The goals are broad and allow the RMPH considerable flexibility in programming. The criteria for setting priorities on projects and staff activities are in line with the State's CHP efforts, especially those relating to the accessibility of better health service to the medically underserved areas of the Region. The RMPH RAG plans to reevaluate the current goals and objectives and update them if necessary.

The team was extremely encouraged by the current program direction of the RMPH. There was, however, concern that the RMPH might well find itself overextended in terms of its organizational capabilities. The team emphasized that the RMPH must realize its full responsibility for successful programs, a responsibility which includes more than financial support and RMPH goals. RMPH grant recipients should be made aware that their projects are part of the RMPH and must conform to the established RMPH procedures and reviews. This concern will be discussed further under the Action Plan.

Recommended Action: In reevaluating its goals and objectives, the RAG should be realistic in terms of what can actually be accomplished rather than what it would like to have accomplished.

2. ACCOMPLISHMENTS AND IMPLEMENTATION (15)

The RMPH's efforts of past years are now resulting in concrete program results. The RMPH has definitely established its own separate identity as a community leader in an extremely complex social environment. In the process of development, the program has gained support and involvement of the community's power structure, or "establishment," and the community itself, or the "nonestablishment." A competent, dedicated and enthusiastic staff has been developed. There has not been, however, adequate involvement of all key staff in some of the major program areas. The change in direction, enthusiasm, and productivity of RMPH is impressive. Further, considerable progress has been made by the RAG in taking corrective measures in response to the Review Process Verification and Management Survey Visits conducted by RMPS staff in May 1972.

Recommended Action: The RMPH be encouraged to continue to build on its experiences and successes thereby strengthening its administrative and review processes to develop a fluid and adaptable structure so that the RMPH is able to be flexible to meet the different needs that arise in achieving its goals.

3. CONTINUED SUPPORT (10)

The team found this to be a particularly weak segment of the program and could not identify a clear RMPH policy aimed at developing other sources of funding for successful activities. Further, there was no evidence that decremental funding had been considered in reviewing proposals. It is expected that the cancer chemotherapy project will be funded by the American Cancer Society and the National Cancer Institute upon completion of its fourth and last year of RMPH support.

The Medical Care Review Organization project has been supported since June of 1971 by the NCHSRD, HSMHA, as an experimental project. In discussing long-term funding of this project, RMPH representatives reported that eventually the participating hospitals would share the cost. Whether or not the private physicians would be willing to share the costs is not clear at this time.

Recommended Action: The RMPH should require grant applicants to incorporate plans for developing other sources of funding for successful activities from the inception of the project. Further, consideration should be given to the possibility of applying decremental funding to the projects in the triennial application.

4. MINORITY INTERESTS (7)

It is difficult to address "minority interests" in Hawaii as the term is defined on the mainland. Of the 750,000 people of the State, 150,000 are Hawaiian or part Hawaiian, most of which are at the bottom of the social and economic scale. Other minorities include descendants of the people brought in from China, Japan, Puerto Rico, Portugal, and the Philippines to work in the plantations. These minorities are land oriented but unable to obtain land. The team believed that the RMPH is addressing the "minority interests" by placing high priority on making better health care accessible to people in medically underserved areas, as evidenced by the RMPH support of the Waianae Coast Comprehensive Health Center project. The Waianae District historically has had one of the poorest health profiles in the State, according to standard measures of health, including incidence of serious communicable diseases and chronic health conditions, incidence of restricted activity and bed days, lack of prenatal care, and incidence of infant mortality.

Recommended Action: The RMPH should be encouraged to pursue its interest in addressing the problems of the medically underserved areas.

5. COORDINATOR (DIRECTOR) (10)

There was no doubt of Dr. Masato Hasegawa's dedication to the RMPH. A significant amount of the program's accomplishments was attributed to the strong leadership he provides in the community and his ability to bring together diverse groups. Further, Dr. Hasegawa relates well with the RAG, especially its chairman, with whom he has regular and frequent meetings. Prior to the visit, one of the concerns of the team was that the Director was not allowing his deputy to function in an effective manner. RMPS staff members noted a marked change in the degree of responsibility the deputy had assumed in implementing changes in response to the management survey and review process verification visit reports, and in the conduct of the site visit. Dr. Hasegawa openly admitted that in the past he had not delegated appropriate authority and responsibility to the deputy. Further, he stated that he realized appropriate delegation was necessary. While the team was encouraged with the Director's change in attitude, there was some evidence that it might be some time before the deputy's responsibilities and authority would be fully established. A conflict, apparently one of personalities, exists between the deputy and comptroller. Further, the deputy, in a private session with RMPS staff, reported that he does not have access to fiscal information from the RMPH comptroller. The arrangements are that if the deputy needs fiscal

information, he must ask Dr. Hasegawa who in turn gets it from the comptroller. Representatives of the Hawaii Medical Association, in a separate meeting which will be discussed later, also voiced concern about not being able to get information from the RMPH comptroller. The withholding of information by the comptroller appears to be condoned by the Director as a way of controlling the type of information he wants released to various individuals.

Recommended Action: The Director should be complemented on his decision to use more effectively the deputy and for recognizing the need to delegate more responsibility and authority accordingly. It is recommended that the deputy's role be fully clarified and documented for the RAG and program staff. The team sees an effective deputy as a mechanism for improving communications between RMPH staff and the RAG and strengthening coordination of effort and communications among the program staff.

6. PROGRAM STAFF (Formerly known as CORE STAFF) (3)

The team found a competent, dedicated and enthusiastic staff. Although it was reported that the staff consulted with one another on individual projects and program areas, the team did not believe that staff involvement was adequate in a number of key projects, especially the Emergency Medical Service System, Hawaii Medical Care Review Organization, Waianae Coast Comprehensive Health Center, and the Pacific Basin Program. In view of the nature and significance of these programs, there is a need for total commitment of much of the staff. Along these lines, the team wondered if Dr. Alexander Anderson, Project Director of the Hawaii Medical Care Review Organization, was or would be actively involved in other RMPH activities. As noted earlier, the team was pleased with the increased involvement of the deputy, and believes that he should be able to assume greater responsibility in the coordination of staff activities in program development. If not already being done, perhaps periodic formal staff meetings should be held so all staff members have a general idea of the total RMPH program.

Recommended Action: A concentrated effort be made to commit staff efforts in a coordinated manner to further strengthen the RMPH program development as reflected in all its major project activities.

7. REGIONAL ADVISORY GROUP (5)

The team was extremely impressed with the RAG chairman, Mr. Edward Bryan. There is no question of his commitment to and involvement with the program. RMPH is fortunate to have his leadership. The discussions with Mr. Bryan and other RAG members convinced the team that the RMPH RAG is well aware that it should have the responsibility for setting the general direction of the RMPH and formulating program policies, objectives, and priorities.

Confusion exists, however, about the role of the Executive Committee, especially in the RMPH's review process. Mr. Bryan indicated that the Executive Committee may be relieved of its current responsibility of review and approval of applications. The team was pleased to note that the RMPH process plans for early involvement of CHP. Further, the team was impressed with the willingness and ability of the RAG to assign relative funding priorities to projects.

The team reaffirmed the findings of the management survey visit and review process verification visit. The reports of these visits included the recommendation that the RMPH revise its bylaws and strengthen its review process. The team was pleased to learn that a committee of the RAG had been formed and had drafted a revised set of bylaws. In addition, efforts to strengthen the review process had already begun.

The revised draft of bylaws will require additional work, and the need for advice from someone knowledgeable in bylaw preparation was evident. The visitors realized, however, that this first draft had been prepared in a short period of time.

There was evidence that the program staff is increasing its efforts to keep RAG members better informed of the overall administrative and program operations. The team stressed the need to continue this effort so that all RAG members have access to an adequate system of two-way communications. As the body which has the responsibility for setting program direction, policies, and priorities, the RAG must have access to an effective mechanism to communicate its decisions to the program staff. Also, and equally important, there must be an adequate mechanism by which the program staff transmits to the RAG and its committees the information they need to make decisions.

A major concern expressed over the composition of the RAG was a lack of adequate allied health representation. Of the 37 RAG members from the State of Hawaii, 34 are from Oahu and the remaining three represent the Maui, Hawaii and Kauai county medical societies. Approximately 25 percent of the State of Hawaii representatives on RAG are hospital administrators or serve on the board of a major hospital. In addition, most of the physicians on RAG have at least one hospital affiliation. As a result, Kuakini Hospital, for example, appears to be represented by at least four RAG members, including three members of the Board of Trustees and the Chief of Surgery. In contrast, voluntary health agencies and allied health interests are not represented and there appeared to be minimal consumer representation. The acceptance of the Pacific Basin Council by the RAG and the increased involvement of the Council is commendable.

Generally, the team was pleased with the strength, involvement and commitment of the RAG and was extremely encouraged with the administrative and programmatic changes which have occurred since the last site visit. There was evidence that the RAG as a whole is assuming some of the authority previously held by the Coordinator and Executive Committee. The direction which the RMPH is taking can only be commended and encouraged.

Recommended Action:

a. The RMPH be encouraged to continue to refine its revised bylaws, giving close attention to the issues raised in the management survey and review verification reports. Special attention should be given to clarifying the role of the Executive Committee to insure that it acts in behalf of and not instead of the RAG. Consideration might be given to seeking professional guidance in the wording and structure of the bylaws. Perhaps legal council could assist.

b. The RMPH review process should be finalized with special attention given to the issues raised in the review process verification report. Attention should also be given to eliminating unwarranted duplication in the process.

c. Additional allied health personnel be added to the RAG.

d. The adequacy of representation by voluntary health agencies and consumers be explored.

e. The RMPH continue its efforts in strengthening communication between the RAG and program staff.

8. GRANTEE ORGANIZATION (2)

Dr. Richard K. C. Lee, Executive Director, Research Corporation of the University of Hawaii, the grantee, was not present during the visit. The team assumed that he was heavily involved with two major Federal site visits to the University's Medical School. Mr. William Coops, the grantee's administrative officer, however, actively participated during most of the visit. Prior to the site visit, the grantee had notified RMPS of its favorable acceptance of the management survey report and a willingness to work with RMPH in implementing the report's recommendations. The primary concern of RMPS was that the RMPH Executive Committee had usurped some authority of the grantee. This had been sanctioned by the grantee since Dr. Lee served as an ex officio member of the Executive Committee.

During the visit, Mr. Coops stated that the grantee finds the RAG to be a very active and concerned group and, as a result, feels comfortable in permitting the RAG to do some of the grantee's work.

The team found no evidence that the issues raised by the management survey report would not be satisfactorily settled. The clarification of the role of the Executive Committee, as noted earlier, should further clarify the relationship between the RMPH and the grantee.

Recommended Action: The recent "RMPS Policy Concerning Grantee and Regional Advisory Group Responsibilities and Relationships" should be considered by the RMPH in revising its bylaws.

9. PARTICIPATION (3)

With the exception of allied health interest, the key health interests, institutions, and groups appear to be actively participating in the program. The team believed that Dr. Hasegawa had been instrumental in bringing these many groups into the program. Representatives of a number of professional, voluntary, governmental, and consumer groups attested to their involvement with the RMPH. Included were the Hawaii Medical Society; Hospital Association of Hawaii; Hawaii Nurses Association; The University of Hawaii's Schools of Medicine and Public Health and East-West Center; the American Cancer Society; the Health and Community Services Council of Hawaii, a private agency which represents 115 public and private groups; Waianae Coast Comprehensive Health Center; and the Health and Community Services Council of Hawaii. As indicated earlier, the team believed that the RMPH has involved the "establishment" and "nonestablishment."

Recommended Action: There should be more active involvement of the allied health groups in the RMPH.

10. LOCAL PLANNING (3)

As reflected in the Review Process Verification Visit Report, the area of cooperative endeavor with Hawaii CHP agency is one that requires increased attention. Planning to date appeared to be on a fragmented basis. The team was encouraged, however, by the RMPH plans to involve CHP early in the review process as recommended by the review process verification visit report. Although there are no CHP "B" agencies, the CHP "A" agency does have county committees on all but two of the Hawaiian Islands.

CHP in Hawaii is preparing a budget proposal for the next fiscal year which, if funded, will more than double the existing CHP agency staff of three professionals. As presently proposed, all personnel will be part of the A agency staff.

The proposal would add one full-time staff person, a research associate, to Mrs. Levy's immediate staff. In addition, the proposal would establish what are being termed as State Assisted B agencies. Under this concept, full-time planners will be assigned to the counties of Hawaii and Maui, the windward side of Oahu and a half-time planner would be assigned to Kauai. This staff will assist with the development of a statewide health plan for Hawaii. Over a period of years, it is anticipated that the State Assisted B agencies will develop into full-fledged independent B agencies.

In May 1972, RMPH employed an Associate Director for Planning and Systems Analysis for the purpose of developing long and short-range plans. The systems approach at this time is in the embryonic stage, and appeared rather confusing. Hopefully, this approach coupled with the involvement of CHP and other appropriate community groups, and the coordination of RMPH program staff in program development will result in an effective planning mechanism.

Recommended Action: The RMPH be encouraged to continue its increasing efforts to develop an effective planning mechanism. Future staff and/or site visits to the RMPH should pay special attention to the systems approach.

11. ASSESSMENT OF NEEDS AND RESOURCES (3)

Dr. Hasegawa reported that the data available from CHP had been gathered primarily by the RMPH. While there was no evidence of a scientific approach to assessing needs and resources, the team noted that the RMPH seemed to know what needs to be done. The participation of the RMPH in the Management Reporting and Evaluation System (MRES) being conducted by the University of Washington through a RMPS contract, should strengthen the RMPH's planning and assessment practices. MRES is a group of processes that serve as mechanisms for directing, planning, monitoring, and reporting the effects of a RMP...its personnel, its efforts, its resources. The major output of the system is the production of timely and practical information which enables coordinators and Regional Advisory Groups to effectively apply the decisionmaking processes.

Recommended Action: RMPH should continue its efforts to work more closely with CHP in assessing needs and resources.

12. MANAGEMENT (3)

In view of the recent Management Survey Visit, the team did not believe it necessary to question the fiscal management of the program. The need for better coordination of program staff in programs and project development has already been discussed. The monitoring of projects appeared adequate.

13. EVALUATION (3)

Evaluation was considered to be a serious deficiency of the program. The new Associate Director for Planning and Systems Analysis is also responsible for evaluation of project and program activities. RMPH is recruiting for a medical economist to insure a relationship of the RMPH to the total economic system of Hawaii and provide measures of cost effectiveness and cost benefit to insure that the delivery system has a measurable economic component built-in. An evaluation subcommittee of the RAG has been established and is currently in the developmental stage. Another subcommittee of the RAG, also in the developmental stage, is the Implementation Committee, which about five months ago initiated the site visit mechanism to ongoing and potential projects. There is a need for the program staff to provide project progress and expenditure reports to the RAG and its committees at each of their respective meetings to aid in the evaluation of projects.

Recommended Action: The RMPH should continue to develop new techniques to evaluate project activities and to assess how they will contribute to regional goals and objectives. Special attention should be given to providing information on progress and evaluation results to program management, the RAG, and other appropriate groups.

14. ACTION PLAN (5)

The RMPH has established priorities for project funding. First priority is given to ongoing projects and second priority to the new projects. Also, priorities have been set within each of the two groups. While all of the projects have a sense of reality to them and are in keeping with both RMPH and national objectives, the team believed that the magnitude of the program proposed would seriously tax the current capability of the RMPH.

Some of the RMPH's key projects, such as the Emergency Medical Service System, have been rapidly thrust upon the RMPH, which has responded admirably. There was a question, however, as to whether RMPH had had adequate time to evaluate the significance of their potential involvement with the EMS, Waianae Coast and Pacific Basin activities. Although these individual programs represent different types of joint involvement with a number of other agencies, they are the primary responsibility of the RMPH, and, therefore, will require the total commitment of much of the program staff.

The EMS program at this point is only a "paper system," and the full impact of RMPH's responsibility of making it a truly comprehensive system may not be fully realized. The RMPH has a responsibility of seeing that the EMS Advisory Council must be broadly represented to include those interests which are necessary to the successful development

of a quality operational system. RMPH should assure that the system—gives appropriate attention to the trauma, drug, psychiatric, and medical elements. Regarding the latter, advantage should be taken of the Inter-Society Commission for Heart Disease report on myocardial infarction. Also, the relationship of the Physiological Data Monitoring System project to the EMS project should be carefully examined and coordinated. The overlap between the two projects must be compatible. The RMPH plans to fund the EMS project, which is sponsored by the Hawaii Medical Association through a contract. Currently, the HMA and RMPH are having some difficulty in negotiating a contract. The morning following the site visit, RMPH staff was asked to meet with the following representatives of the HMA: Livingston Wong, M.D., Project Director, EMS Project; Herbert Y. H. Chinn, M.D., Member of RAG, Past President of the Hawaii Medical Association and Chairman of the HMA-EMS Executive Committee; Thomas Y. K. Chang, M.D., Assistant City and County of Honolulu Physician, Director of the City-County Ambulance System, and Assistant Director for Equipping Ambulances in the EMS Project; George Mills, M.D., Member of RAG and Executive Committee of RMPH, Past President of HMA, and Hawaii State Senator; and H. Tom Thorson, Executive Director, HMA. One of the problems seems to be that the HMA is hesitant to be placed in a position of having to answer to the RMPH. Dr. Wong, the project director, is concerned that the RMPH plans to hire a physician on its program staff to "keep an eye on him." HMA representatives said they were unable to get information from the RMPH comptroller regarding the RMPH fiscal policies. There was much discussion as to who would resolve the differences between the HMA and RMPH in contract negotiation. Dr. Mills suggested that this would have to be worked out between the HMA and the RMPH Executive Committee.

Although the RMPH will support about 15 percent of the Waianae Coast's total program, the team believed that the RMPH has a major responsibility in working with the development of the total program. The future of the Waianae program can be potentially exciting, or potentially troublesome, for the RMPH. Based on the testimony of Mr. David Pali, President, Waianae District Comprehensive Health and Hospital Planning Board, Inc., the RMPH has been an exceptional stimulus and catalyst toward the development of the total program. The role that RMPH has played seems to be well recognized and appreciated by the community. If the project continues to develop successfully, RMPH, no doubt, will receive much of the credit. On the other hand, if the progress of the project should be thwarted and the provision of health services should be delayed, the community may look to RMPH for explanation. It seems, therefore, that the RMPH would want to provide close surveillance and assistance to the other segments of the project. While support of this nature may well absorb a considerable amount of program staff's time, the team believed the investment would be most beneficial to the community and, therefore, the RMPH.

Another concern of the team was the lack of any clear relationship of the Hawaii Medical Care Review Organization project to other projects. It appears that many of the MCRO activities might be applied to the other projects. It was noted that the CHP Review Group pointed out the need to relate MCRO to the Oahu Patient Origin and Utilization Study.

In discussing the RMPH's plan for renal disease, the team noted that there seemed to be a problem of two competing hospitals, each wishing to perform identical functions. The RAG chairman assured a member of the team that the problem had been solved and there would be no duplication.

Recommended Action:

- a. The RMPH carefully reevaluate the magnitude of its triennial plan, giving special attention to the RMPH's full responsibility to its major program components to determine how best to utilize organizational resources, especially program staff.
- b. A mechanism be developed to utilize the Report of Inter-Society Commission for Heart Disease Resources in establishing the Emergency Medical Service System.
- c. That the RMPH and RMPS provide close surveillance and assistance as necessary on the progress of the EMS project.
- d. The relationship of the Hawaii Medical Care Review Organization to other RMPH activities, and the relationship of the Physiological Data Monitoring System project to the EMS project be explored further.

15. DISSEMINATION OF KNOWLEDGE (2)

The team expressed no concerns over this segment of the program. Provider groups and institutions and education and research institutions have been contacted and involved.

16. UTILIZATION MANPOWER AND FACILITIES (4)

Existing health facilities will be more fully utilized through projects such as the EMS, and Monitoring of Physiological Data projects. Productivity of physicians and other health manpower should be more fully utilized as a result of projects such as Manpower Utilization and Restraint of Costs in Hospital System, Hawaii Medical Care Review Organization, and Upgrading Bedside Nursing Care in Rural Community Hospitals. The use of allied health personnel is demonstrated to some extent in the Dietary Counseling and Outreach Service and the Waianae Coast projects. The team

believed that there was a need for greater allied health activity in the program related directly to Hawaii. (The use of allied health personnel in the Pacific Basin program is clearly demonstrated.) In addition, the manpower programs of the RMPH could be strengthened through a better integration of programs.

Recommended Action: The RMPH should reevaluate allied health involvement in its programs as related to the State of Hawaii. Further, the coordination of manpower programs for physicians, nurses, and allied health personnel should be explored.

17. IMPROVEMENT OF CARE (4)

All of the projects, in various ways and degrees, are aimed at the improvement of care.

18. SHORT-TERM PAYOFF (3)

It is reasonable to expect that some of the projects will increase the availability of and access to services. The Waianae Coast project is a prime example. The Medical Care Review Organization is to establish an ongoing system for quality of medical care review. As noted earlier, a medical economist is being recruited to address the economic component of the delivery system.

19. REGIONALIZATION (4)

In view of the geography of Hawaii and the fact that the majority of the population is in Honolulu, the team expressed no concerns over this aspect of the program. One example of joint effort and multi-agency coordination is the Waianae Coast Health Center Project. The membership of the Regional Advisory Group and its standing committees indicate regional involvement. Major health, business, labor and educational organizations are represented. Of the 24 performance sites shown in the application, 13 are outside of Honolulu. Further, there are program staff activities and operational projects which are specifically directed to Hawaiian Islands other than Oahu. The Pacific Basin program, of course, is an example of successful regionalization under most unusual circumstances.

20. OTHER FUNDING (3)

The only two concrete examples of other sources of funding were the American Cancer Society's intent to support the chemotherapy project and the support of the Waianae Coast project by state and Federal funds. The team was disappointed, as noted earlier, that there was no clear RMPH policy aimed at developing other sources of funding.

Recommended Action: The RMPH should develop a clear policy regarding continued support which could be used in the review and evaluation processes.

PACIFIC BASIN

The team was extremely pleased with the increased involvement of the RMPH in the Basin which by its very nature presents an unique challenge. The Basin covers a geographical area of over three million square miles, is populated by 228,000 people who speak ten languages and live on 105 of the 2,147 islands. Guam, American Samoa and the Trust Territory are distinct and separate in regards to people, culture, and government. More than 50 percent of the population have no ready access to health care.

The goals, objectives and priorities of the Basin are reflected by the funded projects, Constant Care Unit on Guam, Health Assistant Training, Improvement of Health Services through Otolaryngology, and Health Information System on Guam. In developing priorities for project selection, the specific health needs, availability of resources and the problem of vast distances were taken into account.

Perhaps the most significant accomplishment to date, excluding the results of individual projects, is that the representatives of the Basin are beginning to consider themselves as a part of the RMPH, and are attempting to see how the Basin can relate to the program of Hawaii. Mrs. Betty Guerrero, the RMPH RAG representative for Guam, for example, wanted to know if Guam could become part of the Hawaii EMS program. Dr. Wong, the EMS project director, said "we will have to talk." The earmarking of funds by RMPH as part of the RMPH award, has definitely helped close the credibility gap between the Basin and RMPH. The Basin was "tired of planning." The RMPH is supporting operational projects.

The team commended the enthusiastic leadership provided by Dr. Satoru Izutsu, Associate Director for the Pacific Basin. His ability to provide program direction and to identify with the cultural diversity of the area is impressive. The vast territory Dr. Izutsu covers requires that he spend between 10-15 days a month in the Basin.

The RAG for the Pacific Basin is the Pacific Basin Council which is composed of ten RMPH RAG members from Guam, American Samoa and the Trust Territory and 12 members of the now disbanded Pacific Basin Advisory Committee. Key health organizations are represented.

Deliberation of Pacific Basin matters are solely the prerogative of the Council and its representatives in the RMPH RAG are the primary contacts for Dr. Izutsu. Because of the cost of travel, one member from each area of the Basin is designated, by fellow Council members, to attend RMPH RAG meetings in Honolulu.

The three representatives from the Basin, Mrs. Guerrero from Guam, Dr. William Peck from Saipan, and Mr. Ligoligo K. Eseroma from American Samoa indicated that the Pacific Basin Council had adequate input in the RMPH. Mr. Eseroma, in a note to the Chairman of the team, questioned the possibility of changing the RMPH title to "Regional Medical Program Area." He said such a change would satisfy the Government of American Samoa. The Council finds meeting in Honolulu a practical and desirable arrangement. It is intended that Council members will convene a day prior to RAG meetings so that RAG members from Guam, American Samoa, and the Trust Territory may attend both meetings. Travel costs per Council meeting are \$5,500. It appeared that the key health interests of the Basin were becoming actively involved in the program.

Comprehensive Health Planning is established in each area of the Basin. A CHP plan has been completed for Guam. American Samoa's CHP is not really activated--there have been three CHP planners in the last three years. Just recently, American Samoa got a new planner who previously was the assistant to the CHP planner on Guam, Mrs. Guerrero. Mrs. Guerrero believes it will take American Samoa about three years to develop its CHP plan. Dr. Izutsu is actively involved with the Comprehensive Health Program Council for the Trust Territory which involves representatives from all consumer, provider, and governmental groups.

In general, the site visitors were highly impressed with the development of the Pacific Basin Program, and believed much had been accomplished with limited staff and budget.

The team recommended that the Pacific Basin Program be approved in the amount requested (\$299,700). Further, the team endorsed the specific identification of funds by RMPS for the Pacific Basin Program.

CONCLUSIONS AND RECOMMENDATIONS

The team was favorably impressed with the change in direction, enthusiasm, and productivity of the RMPH. While the team believed that the program is capable of managing a three-year plan, they were concerned with the magnitude of the proposed plan. The RMPH is currently in the midst of a transitional stage of organizational as well as programmatic development, and the proposed program might overextend the present capabilities of the RMPH. The team believed that during the coming year the RMPH will have adequate opportunity to demonstrate that it has developed the efficiency and strength required of a mature and stable organization. Since the RMPH has not completely satisfied the management and review process requirements of RMPS, it would have been inappropriate for the team to consider a developmental component request for the initial year of the triennium.

The team recommended that the RMPH be approved for triennium status, including the Developmental Component, for the second and third year of the triennium, provided:

- I. The amounts requested for each year be reduced. (See page 18 for detailed amounts.)
- II. The RMPH be site visited prior to the beginning of its next operational year.
- III. RMPS provide close surveillance and assistance to the EMS program.
- IV. The following advice and recommendations be relayed to the RMPH.
 - A. In reevaluating its goals and objectives and the magnitude of its triennial plan, special attention should be given to the RMPH's full responsibility to its major program components.
 - B. The RMPH is encouraged to continue building on its experiences by strengthening its administrative and review processes.
 - C. Consideration be given to developing other sources of funding for successful projects, and decremental funding of projects be applied where appropriate.
 - D. RMPH be encouraged to pursue its interest in addressing the problems of the medically underserved areas.
 - E. The Coordinator be complemented on his efforts to more effectively use his deputy.
 - F. A concentrated effort be made to commit staff efforts in a coordinated manner.
 - G. RMPH be encouraged to continue to refine its revised bylaws and in doing so, consider the RMPS Policy Concerning Grantee and Regional Advisory Group Responsibilities and Relations.
 - H. The review process be finalized with special attention given to the issues raised in the RMPS review process verification report.
 - I. Efforts to strengthen communications between the RAG and program staff should be continued.

REGIONAL MEDICAL PROGRAM OF HAWAII
SITE VISIT TEAM RECOMMENDATIONS

	05		06		07	
	Request	SV Recommends	Request	SV Recommends	Request	SV Recommends
	Initial Application Kidney	\$2,173,806 90,488	\$1,730,000 90,488*	\$2,067,733 39,213	\$1,800,000 39,213*	\$1,707,859 20,577
GRAND TOTAL	\$2,264,294	\$1,820,488	\$2,106,946	\$1,839,213	\$1,728,436	\$1,820,577
Initial Application Program Staff and Projects Developmental Component -Subtotal Kidney	\$1,886,223 287,583 2,173,806 90,488	\$1,730,000 -0- 1,730,000 90,488*	\$1,780,150 287,583 2,067,733 39,213	\$1,650,000 150,000 1,800,000 39,213*	\$1,420,276 287,583 1,707,859 20,577	\$1,650,000 150,000 1,800,000 20,577*
GRAND TOTAL	\$2,264,294	\$1,820,488	\$2,106,946	\$1,839,213	\$1,728,436	\$1,820,577
Hawaii Program Program Staff and Projects Developmental Component -Subtotal Kidney	\$1,586,523 287,583 1,874,106 90,488	\$1,430,300 -0- 1,430,300 90,488*	\$1,491,929 287,583 1,779,512 39,213	\$1,361,779 150,000 1,511,779 39,213*	\$1,121,166 287,583 1,408,749 20,577	\$1,350,890 150,000 1,500,890 20,577*
TOTAL	\$1,964,594	\$1,520,788	\$1,818,824	\$1,550,992	\$1,429,316	\$1,521,467
Pacific Basin Administration Projects TOTAL	\$ 107,700 192,000 \$ 299,700	\$ 107,700 192,000 \$ 299,700	\$ 110,880 177,341 \$ 288,221	\$ 110,880 177,341 \$ 288,221	\$ 114,219 184,901 \$ 299,110	\$ 114,219 184,901 \$ 299,110
Hawaii (Excluding Kidney) Pacific Basin TOTAL Kidney GRAND TOTAL	\$1,874,106 299,700 2,173,806 90,488 \$2,164,294	\$1,430,300 299,700 1,730,000 90,488* \$1,820,488	\$1,779,512 288,221 2,067,733 39,213 \$2,106,946	\$1,511,779 288,221 1,800,000 39,213* \$1,839,213	\$1,408,749 299,110 1,707,859 20,577 \$1,728,436	\$1,500,890 299,110 1,800,000 20,577* \$1,820,577

* Pending RMPS acceptance of RMPH technical review of kidney application, see page 20.

- J. RMPH be encouraged to continue its efforts in developing an effective planning mechanism, including closer association with CHP.
- K. Continue to develop new techniques to evaluate project activities and to assess how they will contribute to regional goals and objectives.
- L. A mechanism be developed to utilize the findings of the Inter-Society Commission for Heart Disease Resources in establishing the EMS system.
- M. The relationship of project activities be further explored.
- N. Additional allied health personnel be added to the RAG, and reevaluate the allied health involvement in programs relating to the State of Hawaii, and explore the coordination of manpower programs for physicians, nurses, and allied health personnel.
- O. The adequacy of representation of voluntary health agencies and consumers on the RAG be explored.
- P. Develop a clear policy on continued support of successful projects which could be used in the review and evaluation processes.

RATIONALE FOR FUNDING

As noted earlier, the team believed that the Pacific Basin program should be funded in the amounts requested.

The team could not endorse a developmental award for the first year of the triennium, but believed that in a year's time, the RMPH will have reached a stage of maturity which would justify a developmental award. The recommendation for support of a "Triennial Award" is believed necessary to encourage the RMPH to continue in the direction in which it is moving. In view of the rejection of the previous triennial application, the team believed a second rejection could hinder the progress being made.

For the Hawaii segment of the RMPH 05 year, the \$1,730,000 recommended for program staff and projects represents a \$842,445 over the current \$887,555 for the same purpose. The team had to consider that the RMPH has already been awarded \$1,470,645 for the two-year EMS project; the administration of the EMS project will require considerable RMPH staff effort.

In arriving at the total amount of \$1,730,000 it was understood that the amount requested for the kidney project would be added, if RMPS accepted the RMPH technical review of that project. ^{1/} The amount recommended was not based on the deletion of individual project budgets. However, the team did specifically include in the 05 year amount, funds for the Pediatric Pulmonary Center at the suggestion of RMPS staff, in view of the history of Pediatric Pulmonary funding by RMPS and its effect on the RMPH.

The amount recommended for the 06 and 07 years permits an \$80,000 increase over the 05 year, and includes \$150,000 for a developmental component.

1/ (Project #47--Dialysis and Transplant Center

Since the site visit, RMPS staff has determined that this project conforms to the Kidney Guidelines, received favorable outside renal technical review and has supportive RMPH RAG and CHP comments.

The RAG, however, did not resolve differing recommendations of the renal technical reviews regarding the procurement of a liquid scintillation system. Two of the technical site visitors recognized the research potential of mixed leukocyte culture as a retrospective measure of incompatibility, largely in a living related donor population, but doubted that this procedure is essential to the overall success of the cadaveric transplant program. Deletion of the liquid scintillation system, which would be principally used for leukocyte culture studies was recommended.

The third technical site visitor recommended funding of the liquid scintillation system, on the basis that from the use of some equipment there will result direct service-related advantages for patients with respect to both donor/recipient selection and post-transplant management.

RMPS staff noted the existence of liquid scintillation equipment at the University of Hawaii. The amount budgeted for similar equipment in this project is about \$15,775. Further, it was noted that there has been some conflict regarding the reluctance of Kuakini Hospital, which has done only two transplants since 1971, to agree to support St. Francis Hospital as the only PHS funded tertiary center for the treatment of end-stage renal disease on the Islands. Before funds are made available the relationship of both hospitals to the project should be clarified.)

RMPS/WOB
9-19-72

RMPS STAFF BRIEFING DOCUMENT

REGION: HAWAII

OPERATIONS BRANCH: Western

NUMBER: 00001

Chief: Richard Russell

COORDINATOR: Masato Hasegawa, M.D.

Staff for RMP: Calvin L. Sullivan

LAST RATING: _____

TYPE OF APPLICATION:

/ Triennial / 3rd Year Triennial
 / 2nd Year Triennial / Other

Regional Office Representative: _____

Management Survey (Date):

Conducted: May 15-18, 1972
or
Scheduled: _____

Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)

August 7-8, 1972

Mr. Edwin Hiroto
Leonard Scherlis, M.D.
Mr. Kenneth Barrows
William I. Holcomb, M.D.

RMPS Advisory Council
RMPS Review Committee
Consultant
Consultant

Staff Visits in Last 12 Months:

(List Date and Purpose)

Dr. Harold Margulies - Met with RMPH RAG, November 1971.

Mr. Richard Russell and Mr. Ron Currie - Met with RMPH Program Staff, November 1971.

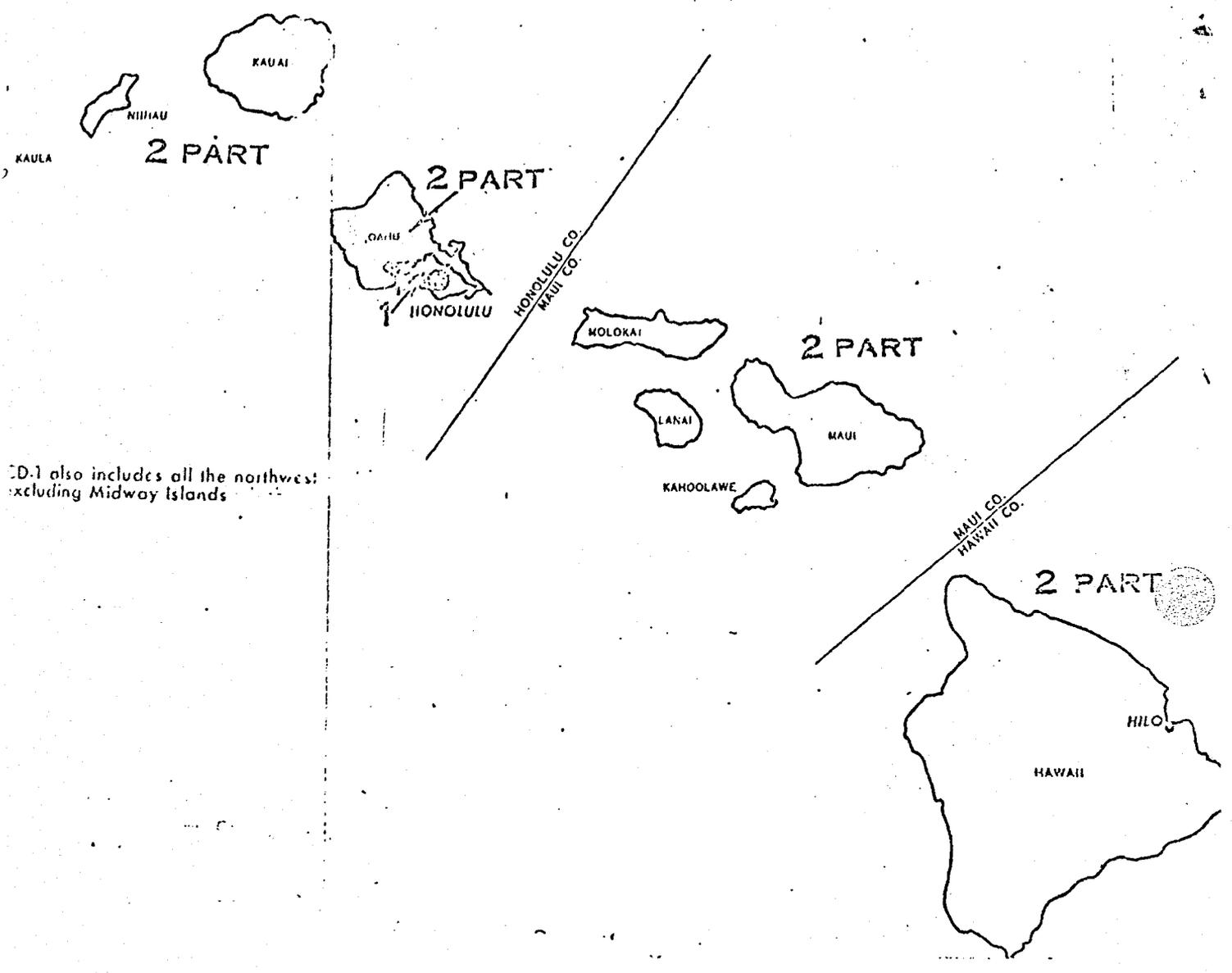
Management Assessment Visit - May 15-18, 1972

Review Verification Visit - May 15-18, 1972

DPTD site visit to limited care facility of St. Francis Hospital, Honolulu and to U. of H. School of Medicine to discuss RMPH plans for kidney diseases.

Recent events occurring in geographic area of Region that are affecting RMP program:

GEOGRAPHY



CD-1 also includes all the northwest
excluding Midway Islands

HEW Regional Office IX
 Regional Delineation:
 State: Hawaii, American Samoa, Guam and Trust Territory
 Counties: 5 (Hawaii)
 Congressional Districts: 2
 Subregions: Territories
 Overlap/interface

DEMOGRAPHIC INFORMATION

Population

Hawaii	769, 900	
Guam	86,900	approximately 900,000
American Samoa	27,800	
Trust Territories	(approximate 97, 600)	

Age Distribution

Percent of Total by Specified Age Group, 1970

<u>Age Group</u>	<u>Hawaii</u>	<u>U.S.</u>
Under 18 yrs.	38	35
18 - 65 yrs.	56	55
65 yrs. & over	6%	10

Population Density

104 per sq. mile
 % Urban - 83
 % Non-White - 61
 (mainly polynesian)
Metropolitan Area Populatio
 *Honolulu - 613.1

INCOME - Average Income per Individual, 1969 & 1970

	<u>1969</u>	<u>1970</u>
State (of RMP)	\$3882	\$4530*
United States	3680	3910

*State of Hawaii ranks 6th

MORTALITY RATES, CY 1967 & 1968

Deaths per 100,000 population **

<u>Cause</u>	<u>RMP (Hawaii)</u>		<u>U.S.</u>
	<u>1968</u>	<u>1967</u>	
Heart Disease	168.3	162.8	364.5
Cancer	98.5	98.5	157.2
Vasc. lesions (aff. CNS)	46.3	44.2	102.2
All causes, all ages		519.4	935.7
45-64 yrs.		827.6	1143.5
65 & over		5102.6	6042.5

** Rates generally atypical because of age distribution (much younger population).

REGIONAL CHARACTERISTICS (Cont'd)FACILITIES AND RESOURCESSCHOOLS

Schools	No.	Enrollment (1969/70)	Graduates (1969/70)	Location
Medicine (and Osteopathy)	(1)			
University of Hawaii		75	--	Honolulu
Sch. of Medical Sciences	--			
(2 yr. school of basic med. sci.)		<u>1970/71</u> 86	--	

Nursing Schools

Professional Nursing
Number

2:1 at Univ; 1 at community college.

Practical Nursing
Number

3:1 at community college.

Allied Health Schools (Approved Programs)*

Cytotechnology
Number

Medical Technology
Number

5 (incl. 1 at Army MC-Tripler)

Radiologic Technology
Number

2 (Honolulu)

Physical Therapy

Medical Record Librarian

I. REGIONAL CHARACTERISTICS (Cont'd)FACILITIES AND RESOURCES (Cont'd)HOSPITALSNon Federal Short and Long-term general hospitals, 1969 & 1970

	<u>Number</u>		<u>Number of Beds</u>	
	<u>1969</u>	<u>1970</u>	<u>1969</u>	<u>1970</u>
Short term	21	22	2384	2453
Long term (and special)	7	6	932	872
V.A. General hospitals	0			

Number of Hospitals with
Special facilities

	<u># of facil.</u>
Intensive CCU	8
Cobalt therapy	3
Isotope facility	6
Radium therapy	7
Renal Dialysis in patient	5
Rehab-in patient	3

Source: Amer. Hospital Assoc. 1970 Guide Issue August 1970

NURSING AND PERSONAL CARE HOMES, 1967

	<u>Number</u>	<u>Number of Beds</u>
Skilled Nursing Homes	12	909
Personal care Homes with Nursing Care	24	178
Long term care units	8	541

Source: NCHS - A Master Facilities Inventory County
and Metropolitan Area Data Book PHS - Number
2043 - Section 2, Nov. 1970

I. REGIONAL CHARACTERISTICS (Cont'd)FACILITIES AND RESOURCES (Cont'd)MANPOWER

<u>Profession</u>	<u>Number</u>	<u>%Total</u>	<u>Ratio per 100,000</u>
Physician - active (pt. care)	934	100.0	
general practice		20.0	
medical specialties		21.0	
surgical specialties		27.0	
other (active)	82		130
Physician - inactive			
Osteopath			
<hr/>			
Total active MD & DO			
<hr/>			
Professional nurses			
active	2334		321
inactive	204		
<hr/>			
Lic. Pract. Nurses			
actively empl. in nurs.	1319		176
not empl. in nurs.	244		
<hr/>			
Medical technologists			
Radiologic technologists			
Physical therapists			
Medical record librarians			

GROUP PRACTICES

Sources: Distribution of physicians, Hospitals, and Hospital Beds in the U.S., 1969; American Medical Association, Chicago, 1970.

Health Manpower Source Book, Section 20, PHS-NIH-BEMT, 1969

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>04</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF (Pacific Basin)	\$ 517,297	\$ 692,244	\$ 717,456	\$ 743,929			
CONTRACTS	24,705	(107,700)	(110,880)	(114,219)			
DEVELOPMENTAL COMPONENT	0	0	0	0			
OPERATIONAL PROJECTS	537,553	287,583	287,583	287,583			
Kidney	X	1,284,467	1,101,907	696,924			
EMS		(90,488 ^{1/})	(39,213)	(20,577)			
hs/ea		(<u>2/</u>)					
Pediatric Pulmonary		(-0-)					
Other		(82,285)	(77,335)				
TOTAL DIRECT COSTS	\$1,079,555	(192,007)	\$2,264,294	\$2,106,946	\$1,728,436		
COUNCIL RECOMMENDED LEVEL							

^{1/} Application submitted August 1, 1972.

^{2/} \$1,470,645, currently available for a 2-year period.

AUGUST 18, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIODREGION - HAWAII
RM 00001 10/72PAGE 1
RMPS-CSM-JTCGR2-1

IDENTIFICATION OF COMPONENT	(5) CCNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
C000 PROGRAM ADMINISTRATION		\$584,544			\$584,544	\$78,948	\$663,492
C001 PACIFIC BASIN ADMINISTRATION		\$107,700			\$107,700	\$11,395	\$119,095
C00 PROG STEE TOTAL		\$692,244			\$692,244	\$90,343	\$782,587
D000 DEVELOPMENTAL COMPONENT				\$287,583	\$287,583		\$287,583
011 A REGIONAL APPROACH TO PEDIATRIC PULMONARY CARE		\$82,285			\$82,285	\$21,677	\$103,962
015 COOPERATIVE CHEMOTHERAPY PROGRAM	\$64,046				\$64,046	\$17,805	\$81,851
020 CONSTANT CARE UNIT	\$21,866				\$21,866		\$21,866
027 KOOLAULOA DIETARY CONSULTING AND OUTREACH SERVICE			\$41,587		\$41,587		\$41,587
028 HEALTH INFORMATION NETWORK OF THE PACIFIC		\$62,831			\$62,831		\$62,831
029 INTENSIVE CARE NURSING		\$43,232			\$43,232	\$6,528	\$49,760
030 MAIANAE COAST COMPREHENSIVE HLTH CENTER		\$169,916			\$169,916		\$169,916
031 UPGRADING OF RURAL NURSING CARE		\$14,300			\$14,300		\$14,300
032 PHYSIOLOGICAL DATA MONITORING SYSTEM		\$63,178			\$63,178		\$63,178
037 IMPROVEMENT OF HEALTH CARE THROUGH OTIOLOGY		\$26,148			\$26,148		\$26,148
038 HEALTH ASSISTANT TRAINING PHASE II		\$101,695			\$101,695		\$101,695
039 HLTH INFO SYS FOR COMPREHENSIVE PERS HLTH SERV		\$42,298			\$42,298		\$42,298
041 HAWAII MEDICAL CARE REVIEW ORGANIZATION				\$245,000	\$245,000	\$69,934	\$314,934
042 HEALTH SCREENING FOR THE ELDERLY				\$68,196	\$68,196		\$68,196
043 MOLOKAI HOME HEALTH SERVICE				\$48,531	\$48,531		\$48,531
044 OAHU PATIENT ORIGIN AND UTILIZATION STUDY				\$13,820	\$13,820		\$13,820
045 IMPROVED MANPOWER UTILIZATION IN A HOSP SYSTEM				\$85,050	\$85,050		\$85,050
047 REGIONAL RENAL DIALYSIS AND TRANSPLANT CENTER				\$90,488	\$90,488	\$15,596	\$106,084
TOTAL	\$85,912	\$1,298,127	\$41,587	\$838,668	\$2,264,294	\$221,883	\$2,486,177

AUGUST 18, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIODREGION - HAWAII
RM 00001 10/72PAGE 2
RMPS-OSM-JTOGR2-1

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
C000 PROGRAM ADMINISTRATION		\$606,576			\$606,576
C001 PACIFIC BASIN ADMINISTRATION		\$110,880			\$110,880
C00 PROG STEE TOTAL		\$717,456			\$717,456
D000 DEVELOPMENTAL COMPONENT				\$287,583	\$287,583
011 A REGIONAL APPROACH TO PEDIATRIC PULMONARY CARE		\$77,335			\$77,335
015 COOPERATIVE CHEMOTHERAPY PROGRAM					
020 CONSTANT CARE UNIT					
027 KOOLAULOA DIETARY COUNSELING AND OUTREACH SERVICE			\$47,350		\$47,350
028 HEALTH INFORMATION NETWORK OF THE PACIFIC		\$41,581			\$41,581
029 INTENSIVE CARE NURSING		\$43,232			\$43,232
030 WAIANAE COAST COMPREHENSIVE HLTH CENTER		\$178,412			\$178,412
031 UPGRADING OF RURAL NURSING CARE					
032 PHYSIOLOGICAL DATA MONITORING SYSTEM		\$65,041			\$65,041
037 IMPROVEMENT OF HEALTH CARE THROUGH CTICLOGY		\$26,148			\$26,148
038 HEALTH ASSISTANT TRAINING PHASE II		\$106,780			\$106,780
039 HLTH INFO SYS FOR COMPREHENSIVE PERS HLTH SERV		\$44,413			\$44,413
041 HAWAII MEDICAL CARE REVIEW ORGANIZATION				\$249,457	\$249,457
042 HEALTH SCREENING FOR THE ELDERLY				\$70,895	\$70,895
043 HOLOKAI HOME HEALTH SERVICE				\$25,000	\$25,000
044 OAHU PATIENT ORIGIN AND UTILIZATION STUDY					
045 IMPROVED MANPOWER UTILIZATION IN A HOSP SYSTEM				\$87,050	\$87,050
047 REGIONAL RENAL DIALYSIS AND TRANSPLANT CENTER				\$39,213	\$39,213
TOTAL		\$1,300,398	\$47,350	\$759,198	\$2,106,946

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT CCSTS	TOTAL ALL YEARS DIRECT COSTS
C000 PROGRAM ADMINISTRATION		\$629,710			\$629,710	\$1,820,830
C001 PACIFIC BASIN ADMINISTRATION		\$114,219			\$114,219	\$332,799
C00 PROG STFF TOTAL		\$743,929			\$743,929	\$2,153,629
D000 DEVELOPMENTAL COMPONENT				\$287,583	\$287,583	\$862,745
011 A REGIONAL APPROACH TO PEDIATRIC PULMONARY CARE						\$159,620
015 COOPERATIVE CHEMOTHERAPY PROGRAM						\$64,046
020 CONSTANT CARE UNIT						\$21,866
027 KOOLAULOA DIETARY COUNSELING AND OUTREACH SERVICE			\$55,540		\$55,540	\$144,477
028 HEALTH INFORMATION NETWORK OF THE PACIFIC						\$104,412
029 INTENSIVE CARE NURSING						\$86,464
030 WAIANAE COAST COMPREHENSIVE HLTH CENTER						\$348,328
031 UPGRADING OF RURAL NURSING CARE						\$14,300
032 PHYSIOLOGICAL DATA MONITORING SYSTEM						\$128,219
037 IMPROVEMENT OF HEALTH CARE THROUGH OTIOLOGY		\$26,148			\$26,148	\$78,444
038 HEALTH ASSISTANT TRAINING PHASE II		\$112,119			\$112,119	\$320,594
039 HLTH INFO SYS FOR COMPREHENSIVE PERS HLTH SEBY		\$46,634			\$46,634	\$133,345
041 HAWAII MEDICAL CARE REVIEW ORGANIZATION				\$256,881	\$256,881	\$751,338
042 HEALTH SCREENING FOR THE ELDERLY				\$73,975	\$73,975	\$213,066
043 MOLOKAI HOME HEALTH SERVICE				\$15,000	\$15,000	\$88,531
044 OAHU PATIENT ORIGIN AND UTILIZATION STUDY						\$13,820
045 IMPROVED MANPOWER UTILIZATION IN A HOSP SYSTEM				\$90,050	\$90,050	\$262,150
047 REGIONAL RENAL DIALYSIS AND TRANSPLANT CENTER				\$20,577	\$20,577	\$150,278
TOTAL		\$928,830	\$55,540	\$744,066	\$1,728,436	\$6,099,676

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMPS-OSM-JTOFHL-20

REGION 01 HAWAII RFF SUPP YR 04 OPERATIONAL GRANT (DIRECT COSTS ONLY) ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED	
		01	02	03	04	TOTAL	05	06	07	TOTAL	
		10/71-12/72					01/73-12/73 01/74-12/74 01/75-12/75				TOTAL
C000	PROGRAM STAFF	3929CC	3835CC	38CCCC	577712	1734112	**	584544	606576	629710	1820830
CC01	PACIFIC BASIN A				5016C	50160	**	10770C	110880	114219	332759
D000	DEVELOPMENTAL C						**	287583	287583	287583	862749
CC2	TRNG REHAB CAST	40300	76200	62CC0		178500	**				
003	PROMOTION AND E	10000	15300	16500		45800	**				
004	CONEC NURS KUAK	29500	20200			45700	**				
CC7	CARDIC-PLLMCAF	48700	70000	55600		174300	**				
008	CC TR MD N QUEE	53000	120300	97100		270400	**				
009	CCU EQUIP AND T	38000	9000			47600	**				
010	CCL EQUIP TRN M	44600	11000			55600	**				
011	REGIONAL AFFRCA	210900	114600	62700	54853	503053	**	82285	77335		159620
013	RHAB CATSTRPHC		2100	3700		5800	**				
015	REG COOPERATIVE		37700	52000	123375	253079	**	64046			64046
C20	CONSTANT CARE U		50200	46100	59114	155414	**	21866			21866
021	CERVICAL CANCER				268480	26848	**				
022	HEALTH ASSISTAN				23862	23862	**				
027	KCCCLALLCA DIETA						**	41587	47350	55540	144477
028	MEDICAL LIBRARY				46808	46808	**	62831	41581		104412
029	INTENSIVE CARE				85615	85615	**	43232	43232		86664
030	WAIANAE COAST C				154593	154593	**	165516	178412		348328
031	UPGRADING OF RU				14715	14715	**	14300			14300
032	PHYSIOLOGICAL D				47274	47274	**	63178	65041		128219
037	IMPROVEMENT OF				15252	15252	**	26148	26148	26148	78444
038	HEALTH ASSISTAN				60000	60000	**	101695	106780	112119	320594
039	HLTH INFO SYS F				25000	25000	**	42258	44413	46634	133345
040	EMERGENCY MEDIC				1470645	1470645	**				
C41	HAWAII MEDICAL						**	245000	249457	256881	751338
042	HEALTH SCREENIN						**	68196	70895	73575	213066
043	MCKICKAI FCHE FE						**	48531	25000	15000	88531
044	CAHU PATIENT CR						**	13820			13820
045	IMPROVED MANPOW						**	85050	87050	90050	262150
047	Kidney						**	90488	39213	20577	
- TOTAL -		E67900	914700	835700	2875830	5494130	**	2264294	2106946	1728436	6099676

DATE PRINTED: 11/11/72

HISTORICAL PROGRAM PROFILE OF REGION

The RMP of Hawaii, Trust Territories, Guam and American Samoa was established with a planning grant under the University of Hawaii School of Medicine in July 1966. Little progress was made in the first year as the Coordinator, Dean Windsor Cutting, was unable to spend time on RMP activities. During the 02 planning year, the RMPH offices were moved out of the University's Leahi Hospital and into a "neutral" building at the Queens Medical Center. The need for a new Coordinator became apparent. In April 1968, Dr. Masato Hasegawa became Coordinator. Dr. Hasegawa is a pediatrician and prominent member of the medical community with an interest in community medicine.

In October 1968, the grantee changed to the Research Corporation of the University of Hawaii, since the developing school of medicine did not have the staff and time to devote to establishing a fully operative RMPH.

The RMP became operational in September 1968, and had continuing education as its major thrust, using regional resources in the absence of a fully developed medical school. The RMPH goals also included development of "advanced health systems" which would improve the delivery of health care.

Dr. Hasegawa, in only a few months, began to involve diverse elements, overcome earlier hostility and develop a separate identity for RMPH. At the end of the first operational year increased involvement of the medical society, hospitals and paramedical personnel had been accomplished. Further, program staff had become stronger, but it was evident that the Coordinator required administrative assistance. The RAG had become more representative, however, there was diminishing involvement of the previously vigorous chairman. Planning activities in the Pacific Basin had been initiated as a result of a \$30,000 award specifically for activities in the Basin.

During its first two years of operation, (9/68-9/70), the RMPH made considerable progress. The RAG's role and influence, however, was still not clear. Established policies and procedures plus an Ad Hoc Evaluation Committee provided hope that RAG effectiveness would be improved. The Executive Committee was the strong force, as were the categorical committees which appeared to have veto powers that weakened the role of the RAG.

Progress continued to be made toward developing the general principles of regionalization. The RMPH had developed a frame work for planning the achievement of goals and objectives. Methods of evaluation were being developed. Also, there was increased sophistication, which allowed the RMPH to look at program rather than projects and to realistically consider program priorities. There appeared to be a broadening and deepening involvement of RMPH with providers of health

services and with the community. In 1971, however, RMPH appeared to be making little progress toward the solution of problems noted during the previous year. It appeared that the RMPH had failed to follow through on past recommendations from RMPS. In August 1971, therefore, the National Advisory Council recommended that the RMPH not be approved for triennial status. Funding was approved for one year only to support program staff and operational projects. Although, a developmental component had been approved for the previous year, the Council believed it should not be approved again until the following conditions were met:

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 bylaws and assume their responsibility for directing the planning and operational activities of the RMPH.
3. That a deputy or associate director to help administer 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 to 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.

In November 1971, as a result of a visit by the Director, RMPS, the RAG became more aware of its role and new directions and responded by re-budgeting some of its funds to provide greater support to activities more in keeping with its goals and priorities.

In May 1972, RMPS staff conducted a Management Survey Visit and a Review Process Verification Visit to the RMPH. Staff found that both the review process and the management process would require considerable strengthening before they could be fully certified by RMPS.

There was a clear need for revised bylaws which would spell out the duties and responsibilities of the RAG and each of its committees, including a clear statement on the role of the RAG as the policy and decisionmaking body of the program.

In June 1972, the RMPH was awarded \$1,470,645 for support of a two-year Emergency Medical Services System Project to be conducted by the Hawaii Medical Association.

The RMPH may participate in the testing and evaluation of the Management Reporting and Evaluation System (MRES) developed by the Washington/Alaska RMP. MRES is designed to aid the RMP in identification of health needs and plans; evaluation and fiscal and technical procedures.

The RMPH submitted a kidney proposal to RMPS on August 1, 1972. An extended deadline was granted for this submission.

Historical Profile: Pacific Basin

By invitation of the RMPH in 1968, the governments of Guam, American Samoa and the Trust Territory joined Hawaii in creating a Pacific Basin Area. A chief of Planning and Operation was added to program staff in January 1969. The proposal to implement RMPH in the Pacific Basin was not totally funded by RMPH, instead \$30,000 was earmarked for planning purposes.

With a small budget and a staff of one, the thrust during the first three years was to ascertain whether the Pacific Basin areas could utilize RMP programs. Five project proposals were submitted. One was funded, Constant Care Unit-Guam. The project "Rehabilitation in Catastrophic Diseases" was extended to Guam and the trust territory.

In 1971 the RMPH RAG approved funds for two previously approved, but unfunded projects (#21,22). \$156,412 were made available in April 1972 for the Pacific Basin Area. The future thrust of the RMPH in the Pacific Basin will be to improve total health care services.

Problems areas might be seen as the level of funding and how this money is shared by the sub-regions of the Pacific Basin, recruitment of qualified personnel for funded projects and the distance between the island units. Further, there appears to be some reluctance on the part of the RMPH RAG to allocate funds for the Basin. CHP-RMPH relationships on Guam are strained.

In April 1972, the Pacific Basin Council was created. Program directors and priorities are made in consultation with this group.

STAFF OBSERVATIONS

Principal Problems:

- 1) Management and Review Process needs considerable strengthening:
 - a) Bylaw revision
 - b) Definition of role of RAG and of committees (see reports)
- 2) Cooperation with CHP agencies

Principal Accomplishments:

- 1) Increased programing in Pacific Basin
- 2) Coordination of the development of an EMS system
- 3) Strengthening of Staff competencies
- 4) Changing emphasis of program from categorical to a total health care system.
- 5) Strengthening RAG

Issues Requiring Attention of Reviewers:

- 1) Issues of concern per MSV and RVV reports

Region Indiana RMP
Review Cycle Sept/Oct 1972
Type of Application: Annly.
Prior to Triennium

Recommendations From

Rating - 222



SARF



Review Committee



Site Visit



Council

RECOMMENDATIONS:

The National Review Committee concurred with staff in recommending a two year funding for the Indiana RMP. Since the region is going through a transition period, reviewers agreed that IRMP would probably need the two years to rebuild a strong program. However, the region may submit a triennial application next year if they feel ready. A mini site visit or a staff assistance site visit should be held next year.

The total request and funding recommendations are as follows:

<u>Year</u>	<u>Requested</u>	<u>Recommended</u>
05	\$1,526,696	\$1,200,000

The breakdown of funding as recommended by Committee for the 05 year is as follows:

Program Staff	\$500,000	Continuation Projects	\$200,000
Contracts	\$300,000	New Projects	\$200,000

This funding would allow the region to increase their program staff and to further develop the regionalization activities that appear to be the new direction the region is now moving.

CRITIQUE:

A site visit was not held in Indiana, although, an August visit was scheduled but was cancelled by RMPS for the following valid reason:

Dr. Stonehill, the Coordinator of IRMP, resigned effective April 30, 1972. The triennial application that was submitted, without really the assistance of a coordinator, was reviewed by RMPS staff, did not present a three year plan, thus the site visit was cancelled. RMPS recommended to the region that they resubmit a one year anniversary application, which would lead to a much stronger triennial application next year, and this has been done.

The reviewers concluded that the strengths of the region, such as, the new relationships with the Medical Society and other health agencies since the interim appointment of Dr. Beerling as Acting Coordinator, and the impressive efforts of subregionalization, which have already culminated with very strong effects, can be used to rebuild the program.

The weaknesses, such as, broad goals, a weak RAC, small ineffective program staff, inadequate minority representation and others, must be resolved immediately in order to complete the transition the region is now in.

The revitalization of RAC and the restructuring of their committees is crucial to the success of IKMP. The proposed increase in program staff and its reorganization must be dealt with immediately in order to rebuild the program.

Committee reiterated the need for strong RMPS staff support in taking to the region the concerns and recommendations of the reviewers.

SCOB/DOD

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION BEFORE TRIENNIUM

Region: India
Review Cycle: Oct. 1972

Component	Current Annualized Level <u>04</u> Year	Request For <u>05</u> Year	Request Funding For
			<u>05</u> Year <input type="checkbox"/> SARP <input checked="" type="checkbox"/> Review Committee
PROGRAM STAFF	\$ 379,442	\$ 417,890	\$500,000
CONTRACTS	100,000	505,000	300,000
DEVELOPMENTAL COMPONENT	----	----	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
OPERATIONAL PROJECTS	641,969	603,806	400,000*
Kidney	X	(11,532)	(11,532)
EMS		(----)	(----)
hs/ea		(----)	(----)
Pediatric Pulmonary		(----)	(----)
Other		(----)	(----)
TOTAL DIRECT COSTS	\$1,121,411**	\$1,526,696	\$1,200,000
COUNCIL-APPROVED LEVEL	\$1,100,000	* Continuation Projects \$200,000 New Projects \$200,000 ** Fy 71 Annualized Level	

RMP'S STAFF BRIEFING DOCUMENTREGION: IndianaOPERATIONS BRANCH: South CentralNUMBER: RM-00043Chief: Lee E. Van WinkleACTING
COORDINATOR: Steven Beering, M.D.Staff for RMP: William Torbert, PHA, SCOBLorraine M. Kytte, PHA, SCOBCharles Barnes - Grants Mgmt.LAST RATING: 244Eugene Piatek - P&E

TYPE OF APPLICATION:

 / Triennial / 3rd Year
Triennial

Regional Office Representative:

Maurice Ryan

Management Survey (Date):

Conducted: April 6-8, 1970

or

Scheduled: _____

 / 2nd Year
Triennial / Other
Anniversary
Prior to
TrienniumLast Site Visit:

September 30 - October 1, 1971

Alexander Schmidt, M.D. - Chairman - Member of Committee

C. H. Adair, Jr., Ph.D. - Consultant

Luther G. Fortson, Jr., M.D. - Consultant

W. Fred Mayes, M.D. - Consultant

Staff Visits in Last 12 Months:

<u>DATE</u>	<u>PURPOSE</u>
Apr. 4-5, 1972	Staff Assistance
May 2-3, 1972	Staff Assistance
July 27-28, 1972	Staff Assistance

Recent Events Occurring in Geographic Area of Region that are Affecting RMP Program:

- Dr. Stonehill, Coordinator, resigned, effective April 30, 1972
- Dr. Steven Beering became Acting Coordinator May 1, 1972
- Acceptance and growth of the AAGs (Area Action Group) around the State. This has incorporated many kinds of health providers throughout the region.

- Formalization of relationship with the 5 existing CHP(b) agencies, the Tuberculosis and Respiratory Disease Association and the Indiana Heart Association.
- Formation of 2 new CHP(b) agencies with IRMP assistance.
- Expansion of Statewide plan for Medical Education to include new center around the State (an increase from 7 to 9 with the 10th projected).
- Increase acceptance of IRMP by various Health agencies, especially the Indiana State Medical Association.
- A large influx of health dollars in Indiana (several million) especially in Indianapolis and Gary.
- Transfer of large funded projects to local funds, e.g., coronary care and stroke projects.

DEMOGRAPHIC INFORMATION

The region encompasses the entire state; interfaces with Ohio Valley to the south;

Counties: 92 Congressional Districts: 11

Population: (1970 Census) - 5,193,700

Urban: 65% Density: 143 per sq. mile
Rural: 35%

			U.S.
Age Distribution:	Under 18	- 36%	35%
	18 - 65 yrs.	54%	55%
	65 & Over	10%	10%

Average per capita income - \$3,691 (Compared with \$3,680 for U.S.)

Metropolitan Areas: (8) Total Population - 3,061,000

Anderson	- 137.5	Lafayette	- 108.3
Evansville	- 230.7	Muncie	- 127.9
Gary Hammond	- 629.0	South Bend	- 277.9
East Chicago	- 629.0		
Indianapolis	- 1,099.6	Terre Haute	- 172.7

Race: White - 4,830,141 93%
Non-White - 363,559 7%

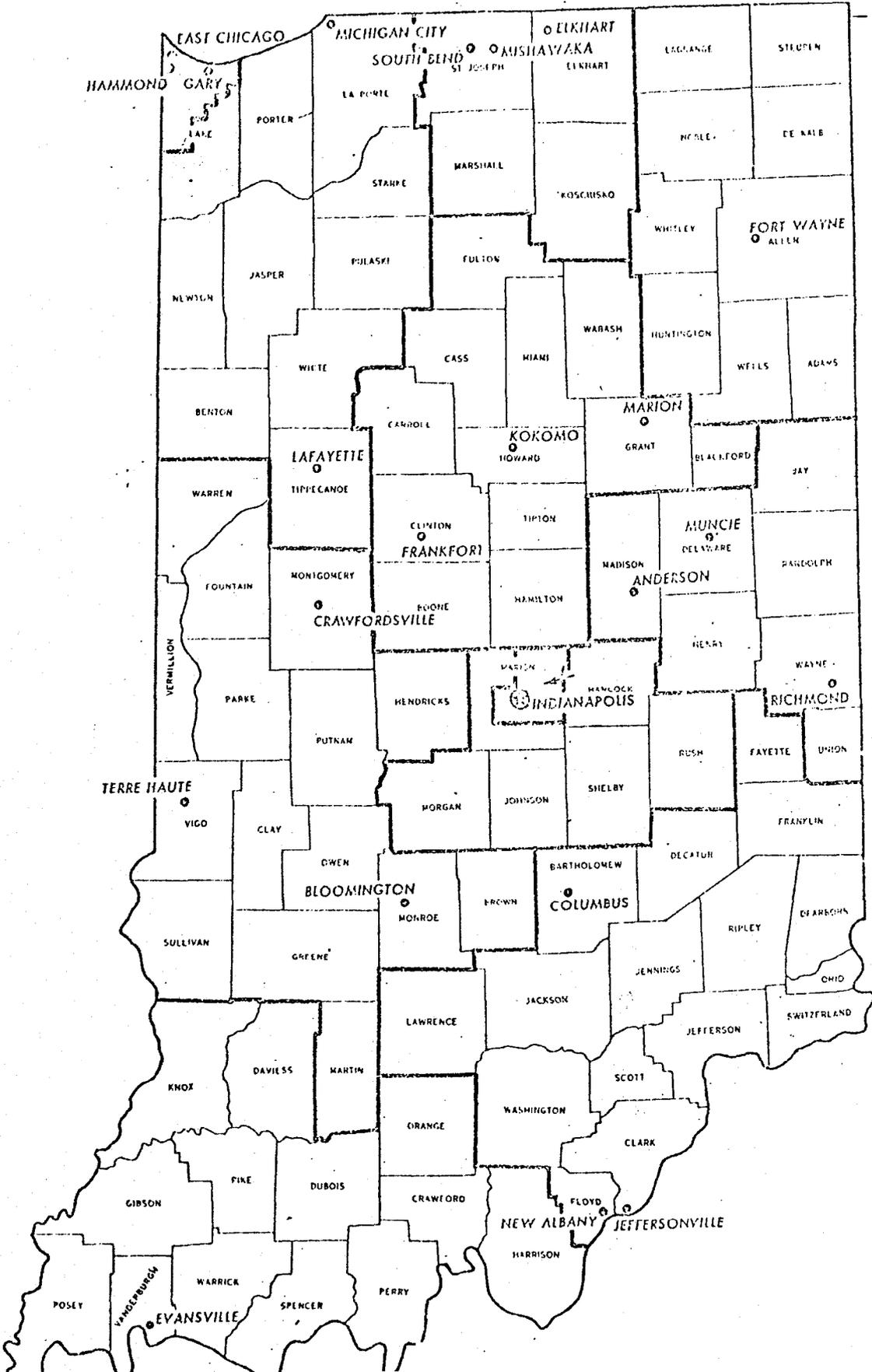
Resources and Facilities

		<u>Enrolled</u>	<u>1969/70 Graduate</u>
Medical School - Indiana University School of Medicine	Indianapolis	885	214
Dental School - Indiana University School of Dentistry		391	89
Pharmacy - Purdue at Lafayette and Butler at Indianapolis			
<u>Allied Health School</u> - Indiana University Medical School,	Division of Allied Health Sciences Indianapolis		

Accredited: Cytotechnology - 2
 Medical Technology - 20
 Radiologic Technology - 26
 Physical Therapy - 1
 Medical Record Librarian - 1

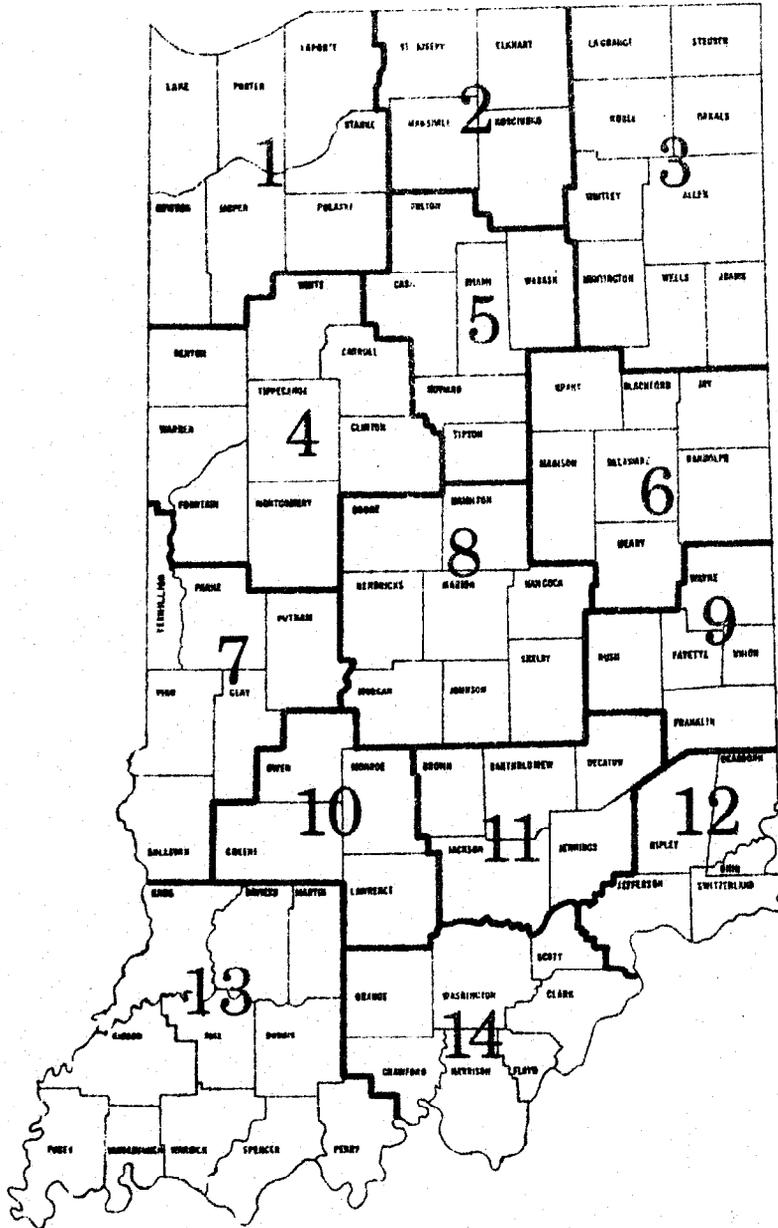
Professional Nursing Schools
28-(17 are University of College Based)

Practical Nursing
17-(Mostly Vocational and Technical)



Planning and Development Regions

State of Indiana



Established by Executive Order No. 18-68 and
Approved by Governor Roger D. Branigin on Dec. 4, 1968.

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION BEFORE TRIENNIUM

Component	Current Annualized Level	Request For	Request Funding For
	<u>04</u> Year	<u>05</u> Year	<u> </u> Year <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee
PROGRAM STAFF	379,442	417,890	
CONTRACTS	100,000	505,000	
DEVELOPMENTAL COMPONENT	----	----	<input type="checkbox"/> Yes <input type="checkbox"/> No
OPERATIONAL PROJECTS	641,969	603,806	
Kidney	X	(11,532)	()
EMS		(----)	()
hs/ea		(----)	()
Pediatric Pulmonary		(----)	()
Other		(----)	()
TOTAL DIRECT COSTS	1,121,411 ^u	1,526,696	
COUNCIL-APPROVED LEVEL	1,100,000		
	^u Fy 71 annualized level		

AUGUST 21, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIODREGION - INDIANA
RM 00043 10/72PAGE 1
RMPS-OSM-JTOGR2-1

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
000 PROGRAM STAFF		\$922,890			\$922,890	\$176,700	\$1,099,590
009 NEIGHBORHOOD HEALTH CENT ERS		\$150,000			\$150,000		\$150,000
024 RENAL ALLOGRAFT		\$11,532			\$11,532	\$772	\$12,304
025 NURSE PRACTITIONER		\$9,516			\$9,516	\$4,800	\$14,316
027 PROGRAM DEVELOPMENT SOUT WEST INDIANA				\$23,150	\$23,150		\$23,150
028 COMMUNITY PLANNING PROGR AM N W I				\$50,000	\$50,000		\$50,000
029 STICKLE CELL MANAGEMENT U NII				\$86,639	\$86,639	\$22,362	\$108,996
030 HOME CARE DEMONSTRATION				\$63,686	\$63,686		\$63,686
031 OCCUPATIONAL THERAPY CON SULTANCY				\$64,585	\$64,585	\$27,960	\$92,545
032 EMERGENCY MEDICAL SERVIC E VIGO COUNTY				\$44,600	\$44,600		\$44,600
033 EMS TRAINING DEMONSTRATI ON				\$47,416	\$47,416		\$47,416
034 CONTINUING EDUCATION TEC HNICAL SUPPORT		\$52,687			\$52,687	\$16,200	\$68,887
TOTAL		\$1,146,625		\$380,071	\$1,526,696	\$248,794	\$1,775,490

MS

AUGUST 31, 1972		REGIONAL MEDICAL PROGRAMS SERVICE					FUNDING HISTORY LIST				RMPS-OSM-JTOFHL-20	
REGION 43 INDIANA		PMP SUPP YR 04		OPERATIONAL GRANT (DIRECT COSTS ONLY)			ALL REQUEST AND AWARDS AS OF JUN 30, 1972					
COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	** REQUESTED	REQUESTED	REQUESTED	REQUESTED	TOTAL	
		01	02	03	04	TOTAL	** 05	06	07			
				01/71-12/71	01/72-12/72	TOTAL	** 01/73-12/73	01/74-12/74	01/75-12/75	TOTAL		
C000	COORDINATORS OF	479400	230200	275463	475442	1469105	**	922890		922890		
C001	PROGRAM CANCER			51700		51700	**					
C002	PROGRAM CHARACT		230200	31942	53668	355810	**					
C003	PROGRAM COMM ED			40437	40044	80481	**					
002	MULTIPHASIC SCR	225000	265000	196000		686000	**					
003	REGIONAL STRIKE	222100	281200	223500	114153	840953	**					
004	NETWORK OF CCU	132900	157300	150500	59314	590014	**					
005	HEALTH MANPOWER		25000			25000	**					
006	HEALTH HAZARD		20700		25000	45700	**					
009	RESEARCH/COMM HE	159600	165600		110700	449900	**	150000		150000		
010	FEAS CA RESTR C	72600				72600	**					
011	NURSING AND ALL		51400	44500	20000	115900	**					
013	NURSING IN COMM	12000	40400	22000	36115	110515	**					
014	EXPANSION OF ME		26700	21800	27193	75193	**					
015	CHRONIC PULMONA		15000			15900	**					
021	RADIATION THER				34000	34000	**					
024	RENAL ALLOGRAF				13250	13250	**	11532		11532		
025	NURSE PRACTITI				18932	18932	**	9516		9516		
026	GATEWAY HEALTH				9700	9700	**					
027	PROGRAM DEVELOP						**	23150		23150		
028	COMMUNITY PLANN						**	50000		50000		
029	SICKLE CELL MA						**	86634		86634		
030	HOME CARE DEMON						**	63686		63686		
031	OCCUPATIONAL TH						**	64585		64585		
032	EMERGENCY MEDIC						**	44600		44600		
033	EMS TRAINING DE						**	47416		47416		
034	CONTINUING EDUC						**	52687		52687		
- T O T A L -		1363600	1513700	1061842	1121411	5060553	**	1526696		1526696		

2025 RELEASE UNDER E.O. 14176

HISTORICAL PROGRAM PROFILE OF REGION AND PRINCIPAL PROBLEMS

- Indiana Regional Medical Program's initial planning grant was awarded January 1967. The operational grant was awarded January 1969.
- The region requested triennial status to begin January 1972, but was denied this request by the Oct./Nov. 1971 Committee and Council. The application submitted had been written before the region had developed its data base and a set of objectives. The action plan for subregionalization had not been described and discrete activities could not be evaluated. There was a lack of overall planning and the activities and projects proposed did not constitute a sound program.
- The region is currently funded at \$1,121,411.
- The region has always been weak in the areas of planning and evaluation, and this weakness still remains.
- There has been a lack of involvement by IRMP with other health agencies in Indiana receiving federal funding. There is concerted effort by the staff to rectify this situation.
- The program staff has been small and very fragmented, but RMPS staff feel confident this will be resolved by the new leadership of IRMP.
- The RAG has never been as committed to or involved in IRMP as is required. The RAG needs to be restructured.
- Proposed activities and projects were never based on a scientific study of needs and resources. The region has always relied on the "bubbling up" of activities and projects.
- There has been a lack of strong leadership and supervision for the program staff.
- IRMP has, in the past, been dominated by the Medical School.
- The region's review process is inadequate and does not meet all of the RMPS minimum standards and requirements. However, the staff has already begun to revise and update the review process.
- The region submitted a triennial application for this current review cycle. RMPS staff reviewed the application and concluded that it did not present a 3 year plan. Staff recommended to Dr. Margulies that the August 1972 site visit be cancelled and

that the region be advised that instead of going with a weak triennial, they should resubmit a strong anniversary application that would lead up to a much stronger triennial request next year. Dr. Margulies concurred with staff's recommendations and the region was so advised. (It should be noted, however, that the triennial application was prepared without the direction of a coordinator.) IRMP and the Indiana Regional Advisory Group accepted our advice and resubmitted an anniversary application.

Accomplishments:

- The subregionalization effort is taking Indiana RMP out from Medical School domination.
- The region has begun to move from being a categorical program to activities addressed to health care delivery and regionalization.
- A new and much stronger working relationship with the State Medical Society is beginning to develop.
- Appointment of Dr. Steven Beering as Acting Coordinator.
- Reorganization of program staff, currently underway.

Issues Requiring Attention of Reviewers:

- The region is requesting continuation funding for one year based on RMPS staff recommendations. They are currently funded at \$1,121,411 which is the NAC approved level. The region is requesting \$1,526,696 which includes an increase for program staff salaries, continuation of three projects and request for funding of eight new projects. Contractural services in the amount of \$505,000 in the program staff budget for feasibility studies, central region services and planned programs to support the subregionalization activities and to build for a strong triennial application next year are also requested.
- RMPS staff feel that the region should not have funds to support sickle cell projects other than small amounts for planning and feasibility studies.
- An increase is needed in program staff salaries to hire staff to fill some key vacancies.
- Staff recommends a funding level of \$1,200,000 for the one year continuation. A suggested breakdown is:
 - \$500,000 for salaries and wages, fringe benefits etc.
 - 300,000 contractural services
 - 200,000 for continuation projects
 - 200,000 for new operational activities

RMPS STAFF BRIEFING DOCUMENT

REGION: Maine

OPERATIONS BRANCH: Eastern

NUMBER: 00054 10/72

Chief: Frank Nash

COORDINATOR: Manu Chatterjee, M.D.

Staff for RMP: Constance Woody

Spencer Colburn

Lyman Van Nostrand

Charles Barnes

LAST RATING: 373

TYPE OF APPLICATION:

/ Triennial / 3rd Year
 / Triennial / Triennial

/ 2nd Year /
 / Triennial / Other

Regional Office Representative:
William McKenna

Management Survey (Date):

Conducted: _____

or

Scheduled: _____

Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)

October 26-27, 1970

Sister Ann Josephine, Review Committee, Chairwoman

Mr. Michael Brennan, Council

Dr. William Vaun, Consultant

Staff Visits in Last 12 Months:

(List Date and Purpose)

May 1-2, 1972 - Verification Review Process

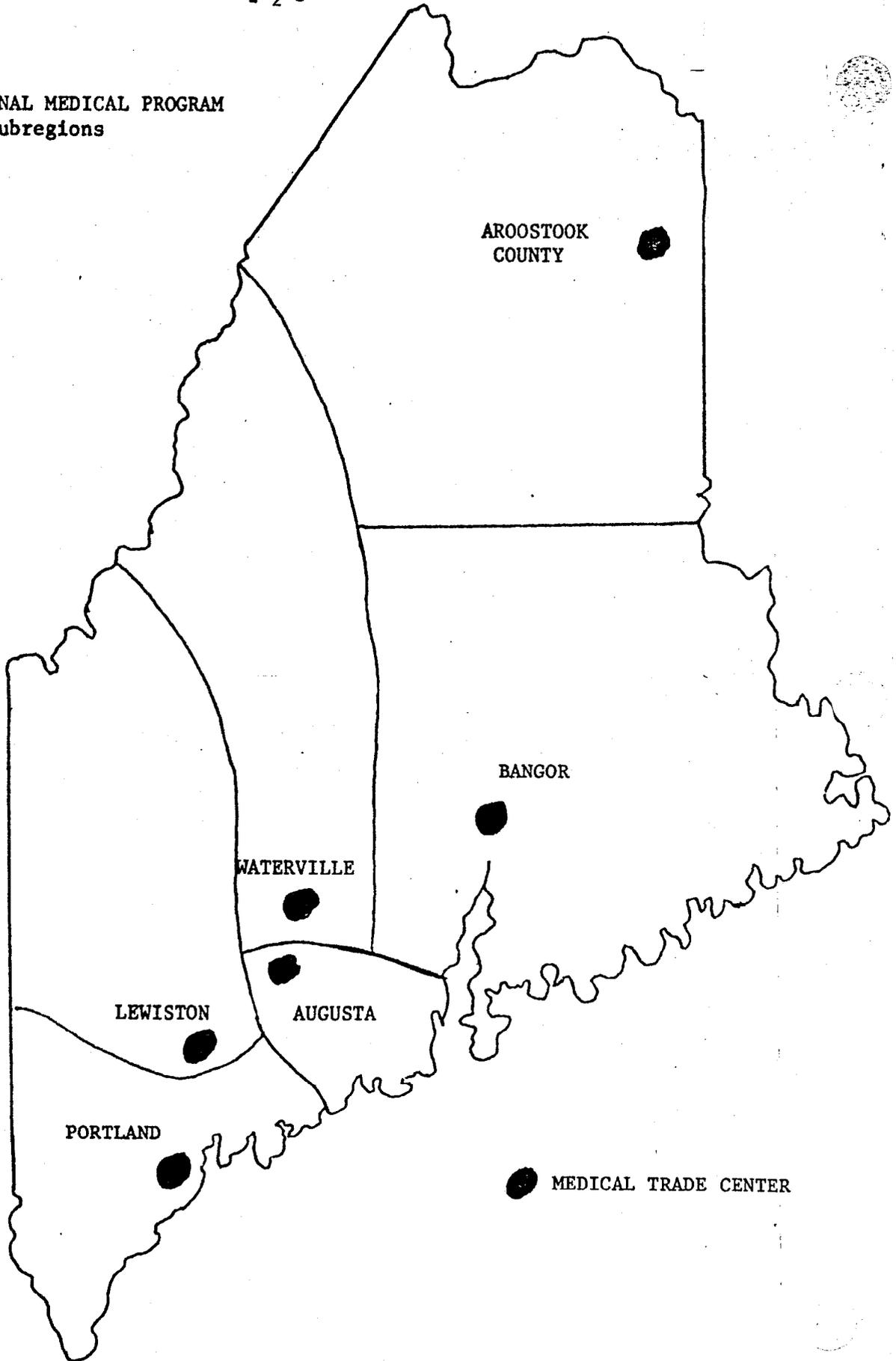
May 17, 1972 - RAG meeting

Recent events occurring in geographic area of Region that are affecting RMP program:

The MRMP complete involvement in the College of Physicians terminated in March 1972. The State Legislature granted an additional \$72,000 to continue the Program until the University of Maine takes complete leadership.

The Lubec activity was funded at \$20,000 as a developmental component and funded at a level of \$85,000 for the first year of planning.

MAINE REGIONAL MEDICAL PROGRAM
Six Subregions



III. DEMOGRAPHY

- 1) Population: The estimated 1970 population is 992,048
 - a) 51% urban
 - b) Roughly 99% white
 - c) Median age: 31.6 (U.S. average 29.5)
- 2) Land area: 31,012 square miles
- 3) Health statistics:
 - a) Mortality rate for heart disease--463/100,000 (high)
 - b) Rate for cancer--182/100,000 (high)
 - c) Rate for CNS vascular lesions--126/100,000 (high)
- 4) Facilities statistics:
 - a) No medical schools
 - b) Seven Schools of Nursing, one is university-based and one is based at a junior college.
 - c) Three Schools of Medical Technology
 - d) No Schools of Cytotechnology
 - e) Eight Schools of Xray Technology
 - f) There are 58 hospitals, five are federal and 53 are non-federal. Of the non-federal hospitals, 45 are short term with 3,508 beds and eight are long term with 4,802 beds. The five federal hospitals have a total of 1,189 beds.
- 5) Personnel statistics:
 - a) There are 1,078 MDs (110/100,000) and 221 DOs (22.5/100,000) in Maine.
 - b) There are 3,856 active nurses (393/100,000) in Maine.
- 6) Per Capital Income (1970): \$3,257

1970 Population

<u>Maine</u>	<u>U.S.</u>
992,048	203,211,926

Region: Maine
 Review Cycle: October 1

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>04</u>	Council-Approved Level For TR Year <u>05</u>	Region's Request For TR Year <u>05</u>	Recommended Funding For TR Year ____ <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
	960,000				
PROGRAM STAFF	462,492	X	\$785,720		X
CONTRACTS	2,000		(75,000)		
DEVELOPMENTAL COMP.	78,653		96,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	
OPERATIONAL PROJECTS	416,855		794,376		
Kidney	X		()	()	
EMS			()	()	
hs/ea			()	()	
Pediatric Pulmonary		()	()		
Other		()	()		
TOTAL DIRECT COSTS	\$960,000		\$1,676,096		
COUNCIL-APPROVED LEVEL	1,503,872	\$1,646,394			

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMPS-OSM-JTOFHL-20

REGION 54 MAINE RMF SUPP YR 04 OPERATIONAL GRANT (DIRECT COSTS ONLY) ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED 01	AWARDED 02	AWARDED 03	AWARDED 04 10/71-12/72	AWARDED TOTAL	REQUESTED C5 01/73-12/73	REQUESTED 06 01/74-12/74	REQUESTED 07 01/75-12/75	REQUESTED TOTAL
C000	PROG PLAN	5014CC	5611CC	3785CC	6596CC	2101CC	** 785720	** 864292		** 1450012
C002	PROGRAM FEASIBI			10700		10700				**
C004	MAINE MEDICAL S			40000		40000				**
D000	DEVELOPMENTAL				20238	8000	** 56000	** 56000		** 192000
D01B	COMPUTER PROGRA				8000	8000				**
D01C	COMPUTER PROGRA				7561	7941				**
D02A	REHABILITATION				12500	12500				**
D03B	INHALATION THER				3000	3000				**
D04C	YARMOUTH MODEL				8000	8000				**
D05A	PROJECT LUPEC				20000	20000				**
D06A	FENCUIS CENTER				15503	15503				**
D07C	COMPUTER ASSIST				9945	9945				**
E08A	CANCER STUDY CE				3000	3000				**
001	GLEST RESIDENT	47200	36400	18900		102500				**
002	KENNEBEC VALLEY	239800	241700	150600		632100	** 57333			** 57333
002A	KENNEBEC VALLEY				68483	68483				**
002B	KENNEBEC VALLEY				39550	39550				**
002C	KENNEBEC VALLEY				20966	20966				**
004	SMOKING CONTRL	31300	48600	36100		116000				**
005	CORONARY CARE	26500	195500	131800		393800				**
005A	CORONARY CARE				37680	37680				**
005B	CORONARY CARE				31107	31107				**
005C	CORONARY CARE				55779	55779				**
006	PHYSICIANS CONT	11700	76200	50100		138000				**
006A	PHYSICIANS CONT				7390	7390				**
006C	PHYSICIANS CONT				23704	23704	** 35000	** 38500		** 73500
008	EST THIRD FACUL		27100			27100	** 30500	** 33550		** 64050
008C	DIRECTORS OF ME					62000				**
009	REGIONAL LIBRAR		42800	20000		6636	** 29195	** 32115		** 61310
009B	REGIONAL LIBRAR				22364	22364				**
009C	REGIONAL LIBRAR				11550	11550				**
017A	DEPARTMENT OF C				3050	3850	** 44500			** 44500
017B	DEPARTMENT OF C				3850	3850				**
017C	DEPARTMENT OF C				4467	4467				**
018A	NURSING AND ALL				4467	4467	** 25000	** 27500		** 52500
018B	NURSING AND ALL				13402	13402				**
018C	NURSING AND ALL				45600	45600	** 28000	** 107000		** 135000
019A	INTERACTIVE TEL				11400	11400				**
019B	INTERACTIVE TEL				27900	27900				**
02C	FAMILY NLFSE AS			27900						**
024A	AREA HEALTH EDU									**
024B	AREA HEALTH EDU									**
024C	AREA HEALTH EDU									**
025A	REGIONAL BLOOD				20000	20000				**
026B	EMERGENCY MEDIC				165920	165920				**
027B	MAINE HEALTH ED				102225	102225				**
027C	HEALTH ED IN				102227	102227				**
028B	HEALTH SCI				173250	173250				**
028C	HEALTH SCI				173250	173250				**
029B	HEALTH FAMILY PFA				151110	151110				**
030B	HEALTH PEDIATRIC				65000	65000				**

10112

FORM 10-68 (REV. 1-72)

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMPS-CSP

L-20

REGION 54 MAINE

RMP SUPP YR C4

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NC	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1	C2	C3	C4	C5	C6	C7	TOTAL
						01/73-12/73	01/74-12/74	01/75-12/75	TOTAL
031B	HSEA FAMILY NUR				181526				181526
032B	HSEA NURSE WICH				135750				135750
033B	HSEA TEAM NURSI				31791				31791
034C	REGIONAL APPROA				97661				97661
035C	HSEA YARMLTH P				31660				31660
036C	HSEA HEALTH EDU				203845				203845
037C	HSEA HEALTH ED.				51250				51250
038C	COMPUTER PROGRA					20000	22000		42000
039B	REHABILITATION					50083	50091		100174
039C	REHABILITATION					50000	50092		100092
040B	INHALATION THER					36579	35526		72105
041A	MEDICAL INTENSI					123325	110511		233836
041B	MEDICAL INTENSI					100502	110511		211013
042A	FENCUIS CENTER					46075	50000		96075
043A	PROJECT HANGCOCK					00120	40000		40120
044A	OPERATION HEALY					33000	36300		69300
045A	FAMILY PLANNING					24764			24764
- TOTAL -		857900	1225500	865000	2866465	5818865	1676056	1704068	3380164

14118

12
11
10
9
8
7
6
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4
3

Form 1-68 (Rev. 11-15-68)

JULY 17, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - MAINE
RM 00054 10/72

PAGE 1
RMP5-05M-JTOGR2-1

IDENTIFICATION OF COMPONENT	EST. 1972 APPR. PERIOD OF SUPPORT	EST. 1971 APPR. PERIOD OF SUPPORT	EST. 1970 APPR. NOT PREVIOUSLY FUNDED	EST. 1969 APPR. PERIOD PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF	\$785,720				\$785,720		\$785,720
0000 DEVELOPMENTAL	\$96,000				\$96,000		\$96,000
002A KENNEBEC VALLEY REGIONAL HEALTH AGENCY	\$57,333				\$57,333		\$57,333
006C PHYSICIANS CONTINUING EDU CATION	\$35,000				\$35,000		\$35,000
008C DIRECTORS OF MEDICAL EDU CATION	\$30,500				\$30,500		\$30,500
009C REGIONAL LIBRARY	\$29,195				\$29,195	\$3,001	\$32,196
017B DEPARTMENT OF COMMUNITY MEDICINE MSC	\$44,500				\$44,500		\$44,500
018B NURSING AND ALLIED HEALT H PERSONNEL EDUCATION	\$25,000				\$25,000		\$25,000
019A INTERACTIVE TELEVISION	\$28,000				\$28,000		\$28,000
034C COMPUTER PROGRAMMED EDUC ATION AGH				\$20,000	\$20,000		\$20,000
034B REHABILITATION PROGRAM N ORTHEASTERN MAINE				\$50,083	\$50,083		\$50,083
035C REHABILITATION PROGRAM N ORTHEASTERN MAINE				\$50,000	\$50,000		\$50,000
035 COMPONENT TOTAL				\$100,083	\$100,083		\$100,083
040B INHALATION THERAPY EDUCA TION				\$36,579	\$36,579		\$36,579
041A MEDICAL INTENSIVE CARE				\$123,325	\$123,325		\$123,325
041B MEDICAL INTENSIVE CARE				\$100,902	\$100,902		\$100,902
041 COMPONENT TOTAL				\$224,227	\$224,227		\$224,227
042A PENQUIS CENTER FOR HEALT H ACTION				\$46,075	\$46,075		\$46,075
043A PROJECT HANCOCK				\$60,120	\$60,120		\$60,120
044A OPERATION HEALTHMOBILE				\$33,000	\$33,000		\$33,000
045A FAMILY PLANNING				\$24,764	\$24,764		\$24,764
TOTAL	\$1,131,248			\$544,848	\$1,676,096	\$3,001	\$1,679,097

JULY 17, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - MAINE
RM 00054 10/72

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DESCRIPTION OF PROGRAM	APPR. PERIOD OF SUPPORT	APPR. PERIOD OF SUPPORT	APPR. (NOT PREVIOUSLY FUNDED)	APPR. (NOT PREVIOUSLY APPROVED)	ANNUAL YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF	\$864,292				\$864,292	\$1,650,012
0000 DEVELOPMENTAL	\$96,000				\$96,000	\$192,000
002A KENNEBEC VALLEY REGIONAL HEALTH AGENCY						\$57,333
006C PHYSICIANS CONTINUING EDU CATION	\$38,500				\$38,500	\$73,500
008C DIRECTORS OF MEDICAL EDU CATION	\$33,550				\$33,550	\$64,050
009C REGIONAL LIBRARY	\$32,115				\$32,115	\$61,310
017B DEPARTMENT OF COMMUNITY MEDICINE MMC						\$44,500
018B NURSING AND ALLIED HEALTH PERSONNEL EDUCATION	\$27,500				\$27,500	\$52,500
019A INTERACTIVE TELEVISION	\$107,000				\$107,000	\$135,000
038C COMPUTER PROGRAMMED EDUC ATION AGH				\$22,000	\$22,000	\$42,000
039B REHABILITATION PROGRAM NI W-HIEASTERN MAINE				\$50,091	\$50,091	\$100,174
039C REHABILITATION PROGRAM NI W-HIEASTERN MAINE				\$50,092	\$50,092	\$100,092
039 COMPONENT TOTAL				\$100,183	\$100,183	\$200,266
040B INHALATION THERAPY EDU CATION				\$35,526	\$35,526	\$72,105
041A MEDICAL INTENSIVE CARE				\$110,511	\$110,511	\$233,836
041B MEDICAL INTENSIVE CARE				\$110,511	\$110,511	\$211,413
041 COMPONENT TOTAL				\$221,022	\$221,022	\$445,249
042A PENQUIS CENTER FOR HEALTH ACTION				\$50,000	\$50,000	\$96,075
043A PROJECT HANGDCK				\$40,080	\$40,080	\$100,200
044A OPERATION HEALTHMOBILE				\$36,300	\$36,300	\$69,300
045A FAMILY PLANNING						\$24,764
TOTAL	\$1,198,957			\$505,111	\$1,704,068	\$3,380,164

HISTORICAL PROGRAM PROFILE OF REGION

1966

The possibility of Maine's becoming part of a New England RMP was discussed, when early interest regarding Regional Medical Programs was generated. Maine chose autonomy and an appropriate grantee organization was formed, Medical Care Development, Inc. The Bingham Associates Fund and the Maine Medical Center were particularly active in pre-planning phases.

The first planning request was submitted to the Division of Regional Medical Programs in December. It designated Medical Care Development, Inc., as the applicant 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.

1967

Under the 01 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 an overlap of membership, and an operational proposal was developed.

1968

The first operational request was submitted in February. A May site visit team was satisfied as to the Region's readiness for an operational award. It was noted that, initially, emphasis was given to development of the regional medical program rather than to establishment of priorities among unmet needs.

1969

During the 02 year the Region continued to fund program staff and the original projects. The Region rebudgeted and utilized unexpended funds to initiate new projects; the Directors of Medical Education activity and the Regional Library project for which supplemental funds were not available. The Region requested continued funding for program staff and six ongoing projects and developmental funding for the 03 operational year.

1970

The Region was site visited in October to assess its readiness for a developmental component. Developmental funds were approved by the November Council. The site visit team considered, the evolution of Maine's Regional Medical Program was being consistent with that of the program at the national level. The RMP started with a categorical emphasis but expanded to include a commitment to the development of an integrated system of medical care to provide access to medically depressed populations, as well as improvement of availability of care to the community at large. The six program objectives reflect this emphasis, and are also geared to the unique needs of Maine itself.

1971

The August Council recommended triennial status for the RMP and developmental funding be approved. The increase in program staff was a concern of the Review Committee and Council.

RAG decided that the three broad operational objectives should be given priority as far as the Maine Program.

1972

The RMP submitted an emergency medical services and health services/ education activities (MEHEIA) proposals for supplemental funding. The EMS proposal developed, which is regionwide in scope, as a result of the close working relationship between CHP Agencies and the program staff. The program staff stimulated the MEHEIA project by working with the University of Maine.

The June Council approved both of these Proposals for supplemental funding. The VA has supplemented partial funding for the MEHEIA Proposal.

During the verification review visit on May 2, the team found the Maine RMP Review Process exceeds the minimum standards in some areas, but there are others in which it does not meet them. The RMP's review process was conditionally certified until the areas of concern have met the requirements:

- (1) The bylaws of the RAG be revised to reflect the responsibility of the Board of Directors of the Medical Care Development, Inc. in the review process as being limited to fiscal and administrative affairs, and the RAG being fully responsible for program policy and decisionmaking;
- (2) A more specific outline of the review process be developed and made available to applicants, and a conflict of interest statement be developed which coincides with Federal policy;

- (3) A priority ranking and funding system which is applied by the RAG to all approved operational activities be established;
- (4) An evaluation capability, which includes assistance and surveillance, be established.

STAFF OBSERVATIONS

Principal Problems:

The RAG bylaws are to be revised to reflect the responsibility of the Board of Directors of the Medical Care Development, Inc, in the review process as being limited to fiscal and administrative affairs; and the RAG being fully responsible for program policy and decisionmaking.

The grantee has been requested to provide the rationale for the projected staff increase.

The RMP should establish a priority ranking and funding system.

The RAG needs to establish a conflict of interest policy.

Principal Accomplishments

As a result of a close working relationship with VA, Model Cities, CHP Agencies and the University of Maine; the RMP developed (1) MEHEIA, (2) EMS, (3) Kennebec Valley Regional Health Agency, (4) Lubec, (5) Community Action Program, and (6) The Summer Student Program for further development of primary care in underserved areas.

The RMP was completely involved in the study of the College of Physicians until March 1972.

The MRMP received \$400,000 in funds from other sources to help develop these activities.

The negotiated contract with Harold Keairnes, M.D. for evaluation supervision.

Issues requiring attention of reviewers

Maine's RMP should continue systematic studies of the interest, use, and adaptation of problem oriented medical records.

There are no minorities involved in the program in any capacity.

There is no specific policy in the application delineating a MRMP policy or long-term support.

MEMORANDUM

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

: Director
Division of Operations & Development

DATE: September 7, 1972

RC
9/8/72

FROM : Director, Regional Medical Programs Service

SUBJECT: Action on September 5-6 Staff Anniversary Review Panel
Recommendation Concerning the Maine's Regional Medical
Program Application RM 00054 10/72.

Accepted

Ham

9/14/72
(date)

Rejected

(date)

Modifications.

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>01</u>	Council-Approved Level For TR Year <u>02</u>	Region's Request For TR Year <u>02</u>	Recommended Funding For TR Year <u>02</u> <input checked="" type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium	
PROGRAM STAFF	\$ 462,492	X	\$ 785,720	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	X	
CONTRACTS	2,000		(75,000)			
DEVELOPMENTAL COMP.	78,653		96,000			
OPERATIONAL PROJECTS	416,855		794,376			
Kidney	X		()			()
EMS			()			()
hs/ea			()			()
Pediatric Pulmonary		()	()			
Other		()	()			
TOTAL DIRECT COSTS	\$ 960,000		\$1,676,096	\$1,200,000		
COUNCIL-APPROVED LEVEL	\$1,503,872	\$1,646,394				

Region Maine
Review Cycle 10/72
Type of Application:
Anniversary within
Triennium
Rating 335

Recommendations From

SARP

Review Committee

Site Visit

Council

The members of the Staff Anniversary Review Panel recommended that Maine's Regional Medical Program be supported at the level of \$1,200,000 direct costs for the second year of triennium. These funds will provide support for program staff, operational activities and a developmental component. This represents an increase over the Region's current annualized level of funding. An increase was considered justified by the SARP because of the Region's current stage of development.

The Staff Anniversary Review Panel was impressed with the Region's continuing to refine its objectives to: (1) conduct experiments in new methods for delivering health services; (2) develop new health manpower; and (3) update level of medical knowledge for health professional and public.

The objectives are directed toward solving Maine's unique problems, and yet are still in keeping with national priorities. The priorities reflect a realistic assessment of needs and appear to be functional as guidelines for operating the program. These reflect input from providers, consumers, and low-income members of the RAG. MRMP has continued to establish its leadership role throughout the State. The Program has been successful in providing services to underserved, urban and rural areas of the State.

A substantial amount (\$1,666,465) was awarded during the latter part of the current year to support supplemental activities in emergency medical services and health services/education activities over a three year period and although this was a plus for the Region, reviewers were somewhat concerned about the capability of program staff to adequately manage such a tremendous increase in the Region's overall budget. Although their fears were somewhat relieved by the information that one member of the staff would be responsible for the administration of the hs/ea (MEHEIA), staff was urged to express this concern to the Region. Somewhat paradoxically, there was concern about the large projected staff increase from 25 to 32 positions; and the lack of information supporting the rationale for the projected increases. The SARP showed concern for the one to one ratio of professional and clerical positions; and the Coordinator's salary as being disproportionate to the remainder of staff. RMPS Management Assessment Unit will work with the Region to resolve these issues.

Maine includes 6772 racial minorities, and there are no minorities presently on program staff or the RAG. The SARP members were interested in knowing whether an effort had been made for the inclusion of minorities on staff or RAG and to pursue this issue with the Region.

The Region readily admits its efforts to develop an evaluation capability have not been very productive. As a result of its lack of productivity, the Region is planning to augment a contract with Harold Keairnes, M.D., Tri-State RMP, and a recommendation was made to RMPS staff to keep a close surveillance on the process.

Generally, SARP's impression of the Region was favorable but showed concern with the points raised above. RMPS staff was urged to work closely with MRMP during the coming year.

EOB: 9/7/72

Region: Memphis RMP
Review Cycle: Oct/Nov 1972
Type of Application: Anniv.
within Triennium

Recommendations From:

Rating - 281

SAMP

Review Committee

Site Visit

Council

RECOMMENDATIONS:

From a recommended funding level of \$2,000,000, Review Committee stipulated that a \$100,000 developmental component be supported, as well as selected activities under a contract account not to exceed \$200,000. The level of total funding and the developmental component authority prevail for the remaining two years of the region's triennium. The Committee agreed with the staff recommendation that no further increases in the program staff were warranted except the presently budgeted but vacant Program Director position.

Requested
\$3,267,527

Staff Recommendation
\$2,252,000
with conditions

Committee Recommendation
\$2,000,000
with conditions

CRITIQUE:

This anniversary application within an approved triennium was considered by the Review Committee because the region was reapplying for developmental component authority. When triennial status was conferred last year, developmental component authority was withheld because of the complicated Regional Advisory Group structure.

At that time, some reviewers questioned the propriety and possibly the legality of the Mid-South Medical Center Council (151 members meeting twice a year) serving as the Regional Advisory Group for the Memphis Regional Medical Program. MMCC was and is a well established, powerful and beneficial influence on health care in the Memphis medical trade area. However, its geographic mandate is confined to 14 counties spanning west Tennessee, Arkansas, and Mississippi, and reviewers agreed it did not represent a valid decisionmaking body for the 75 counties served by the Memphis RMP.

In June of this year, the full membership of MMCC voted to accept a resolution presented by the Board of Directors which disenfranchised itself as the MRMP Regional Advisory Group. A new body of 36 members was created, and all powers formerly held by the Board of Directors of MMCC, with regard to RMP matters, were vested in the new Council. Committee agreed that the newly

constituted Regional Advisory Council satisfied the disqualifying factor and recommended that developmental component authority be approved for the remaining two years of the region's millennium. The geographic distribution of the new Council members, the range of health interests and expertise, as well as representation of minorities (9 of 36) and of women (6 of 36) were viewed favorably.

At the time of this current review, the new RAC was three months old and had met three times. Bylaws have been approved, Committee assignments have been made, and task forces have been formed. However, the newness of this decisionmaking body and the realization that much of the plan for the upcoming year described in the application document was developed without specific inputs from all members of the new Council, led Review Committee to conclude that the funding level recommended by staff (\$2,252,000 against a \$3,267,827 request) was higher than should be approved.

Much of the discussion regarding funding levels centered on the \$1,000,000 contract request. The two large segments of this request that were explored were; 1) \$400,000 to expand Memphis' concept of Community Health Service Education Activities (building from a "model learning center" in a hospital and then reaching out to develop a consortium, rather than the reverse), and 2) \$500,000 to implement emergency medical services activities (Memphis submitted an EMS proposal in the spring of this year competing for supplemental funds and received a \$67,000 award to further survey and plan total EMS needs. The region now tells us in this application that this will have been completed by January 1973, which is the beginning of its next operational year, and it is requesting operational EMS dollars.) In the final analysis, Committee believed a \$200,000 contract component was adequate to launch the region in selected activities described under the contract portion of the application.

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Region: Me
Review Cycle: Sept/Oct 1972

Component	Current Annualized Funding 1st TR Year <u>04</u>	Council-Approved Level For 2nd TR Year <u>05</u>	Region's Request For 2nd TR Year <u>05</u>	Recommended Funding For 2nd TR Year <u>05</u> <input type="checkbox"/> SARP <input checked="" type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
PROGRAM STAFF	\$ 812,000	X	\$ 998,298	\$ 800,000	X
CONTRACTS	---0---		1,012,624	200,000	
DEVELOPMENTAL COMP.	---0---		162,700	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 100,000	
OPERATIONAL PROJECTS	815,000		1,034,205	900,000	
Kidney	X		()	()	
EMS (contract)			(: 506,000)	()	
hs/ea (contract)			(400,000)	()	
Pediatric Pulmonary		()	()		
Other		()	()		
TOTAL DIRECT COSTS	\$1,627,000	\$3,267,827	\$2,000,000	\$2,000,000	
COUNCIL-APPROVED LEVEL	\$1,627,000	\$1,627,000			

RMP'S STAFF BRIEFING DOCUMENTREGION: MemphisOPERATIONS BRANCH: South CentralNUMBER: 00051Chief: Mr. Lee E. VanWinkleCOORDINATOR: James Culbertson, M.D.Staff for RMP: Lorraine Kytte (SCOB)Bill Torbert (SCOB)LAST RATING: 285Larry Pullen (GMB)Gene Nelson (P & E)

TYPE OF APPLICATION:

 / Triennial / 3rd Year TriennialRegional Office Representative:
Ted Griffith / 2nd Year Triennial / Other

Management Survey (Date):

Conducted: none

or

Scheduled: early 1973Last Site Visit: June 1971 (in response to triennial application)Mrs. Florence R. Wyckoff (National Advisory Council)Bruce Everist, M.D. (National Advisory Council)Robert R. Carpenter, M.D., Director, Western Pennsylvania RMPPaul Dygert, M.D., private practitioner, Vancouver WashingtonStaff Visits:

March 28, 1972: To explore the relationships between MRMP and the Mid South Medical Center Council (MMCC). The organizational structure of these two bodies was cited by previous reviewers as a complication that prohibited granting developmental component authority.

April 20, 1972: (1) To meet with members of MMCC board to ascertain if question of MRMP's Regional Advisory Group could be brought before full MMCC membership at its May meeting.

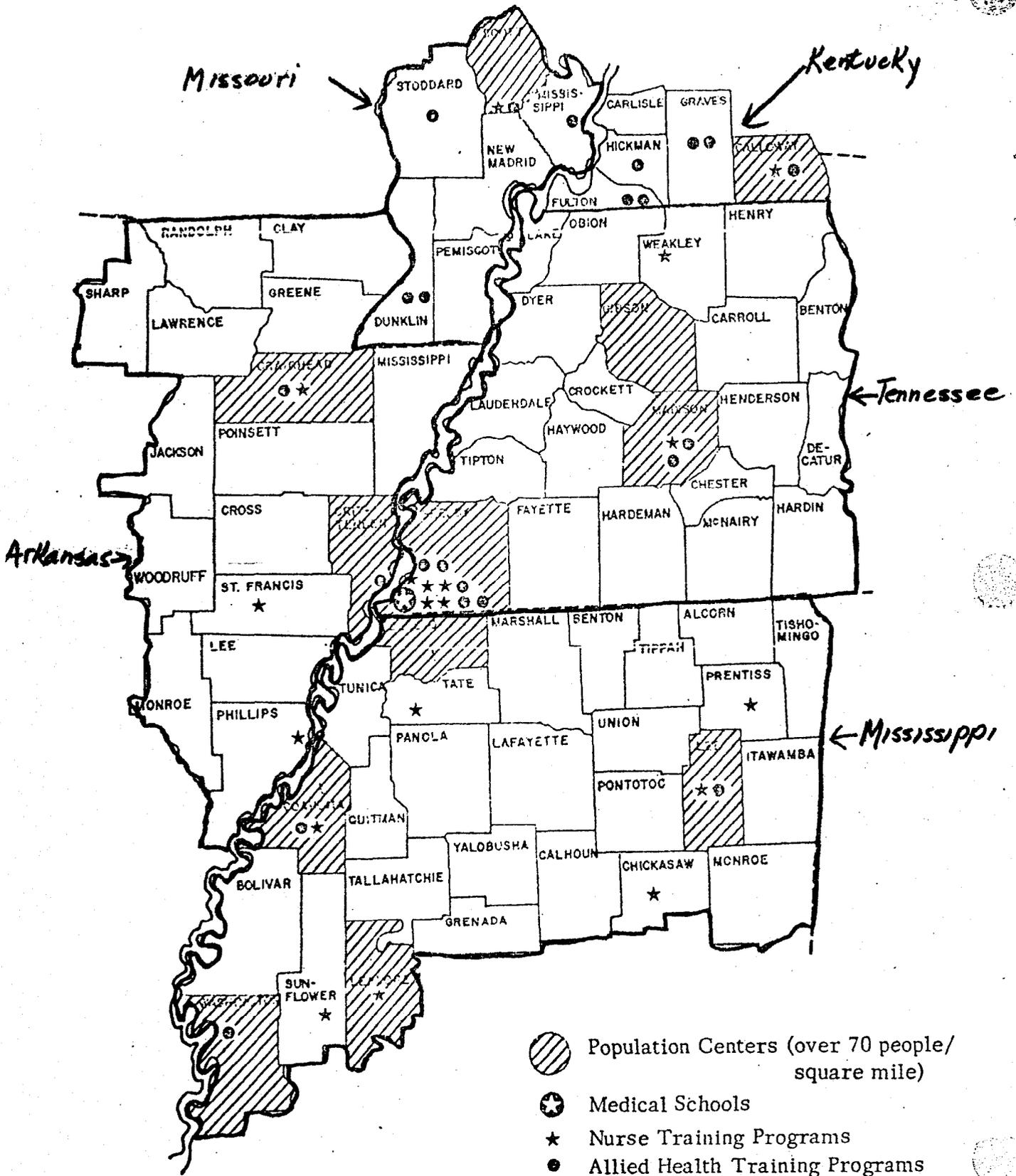
(2) To discuss funding plans for extended 04 operational year.

Recent events occurring in geographic area of Region that are affecting RMP program:

The Higher Education Commission in its second study (1971) again recommended that the need for a new medical school was not substantiated at that time. The study also found that Knoxville should be the selected site when the need was further developed. The Trustees of the University of Tennessee have formally adopted the findings of the report.

The need to clarify the geographic relationships involving the programs in Arkansas, Mississippi and Western Tennessee (Memphis RMP) is under discussion by Drs. Silverblatt, Lampton and Culbertson.

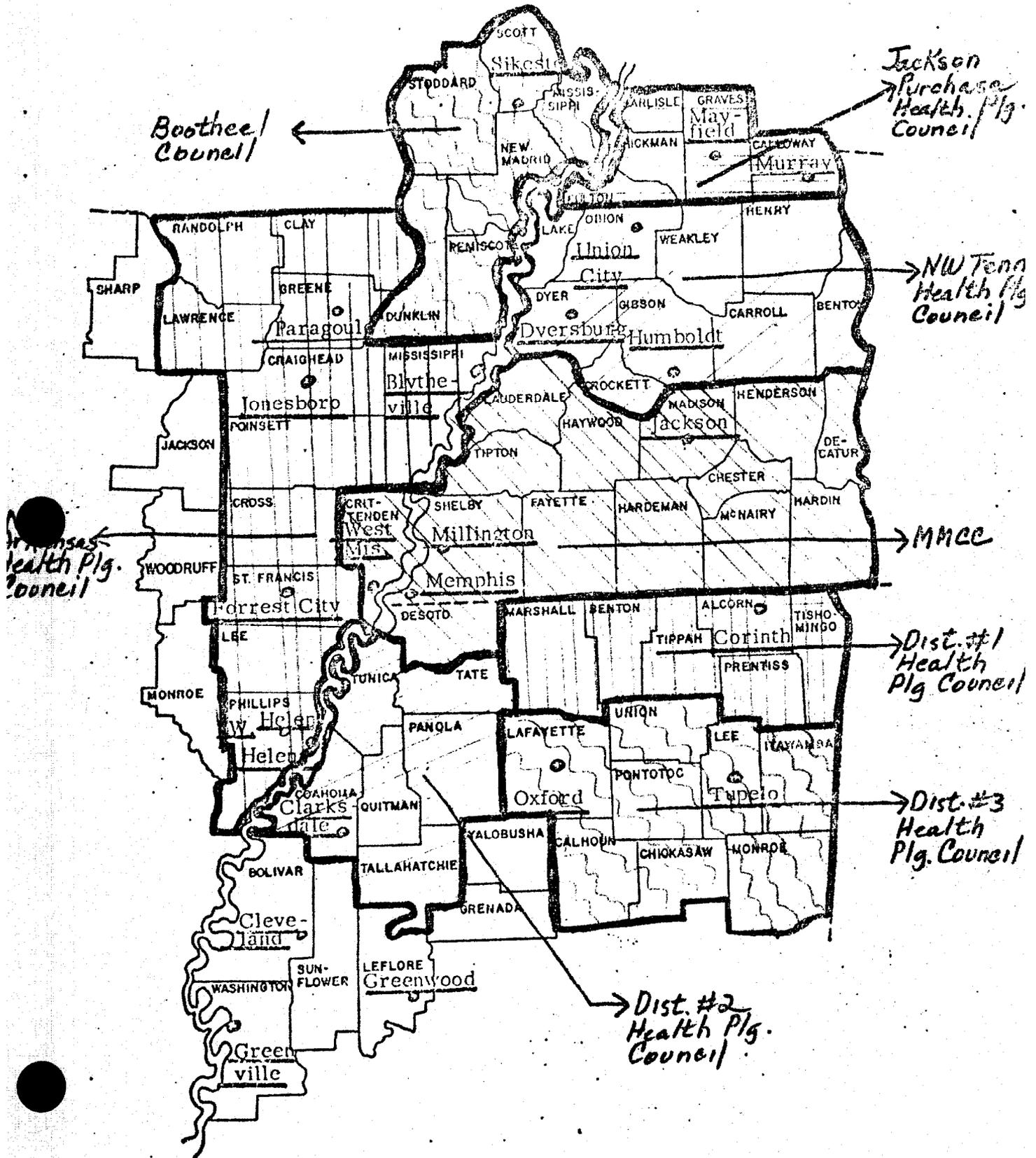
MID-SOUTH POPULATION CENTERS AND MEDICAL TRAINING PROGRAMS



-  Population Centers (over 70 people/square mile)
-  Medical Schools
-  Nurse Training Programs
-  Allied Health Training Programs

Comprehensive Health Planning

B Agencies



Comprehensive Health Planning
B Agencies

The Bootheel Council (Missouri): This is MRMP's Area Advisory Council as well as the funded CHP(b) agency. Through contract funds and program staff subsidy, MRMP assisted with identification of needs and development of priorities.

The Jackson Purchase Council (Kentucky): MRMP provided data base as this council was forming.

NW Tennessee Council: MRMP prepared portions of this council's application; did the leg work to start the office; presently is budgeting contract dollars to assist in identification of needs.

MMCC: Formerly MRMP's Regional Advisory Group; new Regional Advisory Council has excellent overlap; products of joint efforts have been outstanding and are expected to continue under new arrangement.

District #1 Council (Mississippi): Not yet funded for operations--MRMP did leg work in establishing; budgeted \$15,000 contract dollars through A agency to catalyze.

District #2 Council (Mississippi): Still in process of organization. Activities under requested Developmental Component include completion of work in this area.

District #3 Council (Mississippi): Funded through Appalachia--MRMP contributed \$4,000 for survey work; included in MRMP's EMS plans.

NE Arkansas Council: MRMP assisted with planning funds and development of data base.

JULY 25, 1972

BREAKOUT OF REQUEST
OF PROGRAM PERIOD

REGION - MEMPHIS
PM 00051 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF	\$2,010,922				\$2,010,922	\$146,615	\$2,157,537
0000 DEVELOPMENTAL COMPONENT				\$162,700	\$162,700		\$162,700
017 PREV OPPV PAT DIS CA STR CKE AND BEL DIS	\$55,500				\$55,500	\$21,219	\$76,719
018 MOBILE MULTIPHASIC HEALTH SCREENING IN BO MISS	\$60,500				\$60,500	\$8,874	\$69,374
019 NORTH MISSISSIPPI CARDIO VASCULAR CLINICS	\$14,157				\$14,157	\$2,442	\$16,599
021 HIGH RISK INFANT PROGRAM	\$218,165				\$218,165	\$116,543	\$334,708
025 HOPE HEALTH CARE	\$16,425				\$16,425		\$16,425
032 MODEL HOSPITAL LEARNING CENTER	\$31,029				\$31,029		\$31,029
035 PROGRAM IMPROVE DEATH S IDENTIFICATION	\$52,203				\$52,203	\$19,242	\$71,445
034 DEVELOPING LEADERSHIP IN HEALTH EDUCATION	\$34,527				\$34,527	\$16,615	\$51,142
036 IMPROVE UTILIZATION NURS ING SERVICES	\$45,066				\$45,066	\$20,227	\$65,293
037 EXPANSION TOTAL	\$78,571				\$78,571	\$36,421	\$115,000
038 EXPANSION OF NEIGHBORHOOD HEALTH CENTER			\$80,000		\$80,000	\$14,067	\$94,067
039 MULTIDISCIPLINARY TRAINI NG FOR CASE CASE	\$28,032				\$28,032		\$28,032
040 HYPERTENSION CONTROL PRO GRAM	\$42,951				\$42,951	\$7,442	\$50,393
041 PATIENT SAFETY AND ELECT RICAL SURVEILLANCE				\$72,849	\$72,849	\$16,481	\$89,330
042 SATELLITE CLINIC PROGRAM				\$58,482	\$58,482		\$58,482
043 REGIONAL BLOOD BANKING P ROGRAM				\$237,641	\$237,641	\$44,512	\$282,153
TOTAL	\$2,618,155		\$80,000	\$569,672	\$3,267,827	\$434,280	\$3,702,107

5

Demographic Information

I. The Region's Coverage:

Consists of parts of five states traditionally known as the Memphis trade area on the basis of hospital referral patterns.

Made up of 75 counties:

21 in West Tennessee
16 in Arkansas
27 in Mississippi
6 in Missouri
5 in Kentucky

II. The Region's Population:

Contained 2,560,032 people in 1970

Most populous subregion is the Tri-County area containing Shelby County, Tennessee (Memphis); Crittenden County, Arkansas; DeSoto County, Mississippi with 802,000 residents--nearly one-third of the region's population.

The other subregions contain the following population:

North Mississippi	662,559
West Tennessee	459,404
East Arkansas	374,909
SE Missouri } SW Kentucky }	329,626

Although there is a shift from rural to urban areas, the region remains essentially rural, characterized by an agricultural economy.

Density

With the exception of the city of Memphis, with a population of 624,000, the largest city has a population of less than 50,000 (Jackson, Tennessee).

The East Arkansas subregion has the lowest population density; even Western Kentucky, the most densely populated subregion, falls below the national average.

Only 13 of the 75 counties in this region have as much as half of their population residing in towns of 2,500 or more persons.

Race

31% of the region's population is Negro; there is a small American Indian and Oriental population. However, the distribution of the Black population within subregions and by county is significant.

Blacks comprise 73% of the population in Tunica County, Mississippi while the Ozark area makes a striking contrast to the rest of the Arkansas subregion with a very high white and elderly population. Nine of the 27 counties in the Mississippi subregion have populations of more than half Black.

Age

The subregion with the highest ratio of persons over 65 is Kentucky; the lowest is North Mississippi. Tunica County, Mississippi, for instance, has a 12.9% under age 5 average as compared to the national average of 8.6%.

Infant Mortality

The infant mortality rate of the region is 28.9 compared with the national average of 21.7. Seven counties in the Mississippi subregion have rates at least twice the national average.

Distribution of Physicians:

In this region there is one physician for every 1,206 people. The Benton County, Mississippi ratio is 1/7,505 and DeSoto County, Mississippi has a total of 5 physicians--1 for every 7,177 people.

Income

The Mississippi subregion has the lowest income level. Of the 4 counties in the MRMP territory with a family income of under \$4,000, 3 are in Mississippi.

HISTORICAL PROGRAM PROFILE

MRMP's early years were spent under the watchful eyes of its parents-- The University of Tennessee Medical Units (the grantee) and the Mid-South Medical Center Council (the board of which served as the MRMP Regional Advisory Group). As the program developed, its relationship to MMCC evolved into an exceedingly fruitful partnership; UT has proven to be an excellent grantee--vigilant but without co-opting tendencies.

This region first received operational funding in 1968, activating 10 projects basically representing an extension of the medical center rather than a deliberate pursuit of regionalization. One of the 10, however, was a linkage and sharing of resources between hospitals in Paragould, Arkansas, and Kennet, Missouri.

Reviewers of the second operational year application kept in mind that MRMP had developed its operational plan under considerable pressure from DRMP to assume operational status and realized it had submitted readily available, attainable proposals for its debut.

Initially, the second year continued the ongoing activities with the addition of an ICU project in Jonesboro, Arkansas.

Supplemental funding in the second year (June 1970) allowed the region to activate 5 new projects and Memphis' regionalization was underway. A mobile health screening activity in Northeast Mississippi was begun; cardiovascular clinics, operated by the Mississippi St. Board of Health, received funding; a demonstration program in home health care seated in Paragould, Arkansas was started; and the expansion of the geographic bases of West Tennessee activities beyond Memphis/Shelby County lines began. Also during this operational year, a series of events occurred that created a crisis for MRMP, its grantee, and MMCC--a sanitation employees strike, a hospital employees strike (both of which were of very long duration), and the assassination of Dr. Martin Luther King. The majority of the Memphis medical center manpower was devoted to keeping the complex operational under great stress and RMP expansion temporarily took a back seat.

The question of other continuing sources of funds after RMP support terminated arose in the review of Memphis' 3rd year operational application. Staff felt the region had not really addressed this issue and MRMP went into its 3rd year with the message to start building continuity for its successful activities elsewhere.

The triennial application submitted by the region the following year was a combination of:

- . A requested Developmental Component authority
- . The continuation of 5 projects for their previously specified life
- . 3 additional years of funding for Program Services and for 7 projects beyond their previously specified life
- . The termination (at the specified time) of 3 projects
- . 12 new proposals

The application requested \$2.7 for the 04 year; site visitors recommended \$2.0 for each of the 3 years; Committee and Council recommended \$1.6 for each of the 3 years; the Director, RMPS allocated \$1.3 for the 04 year. None of the reviewers recommended approval of the developmental component authority.

The site visitors, Committee and Council assessed the following pluses and minuses:

- +The working relationships between MMCC and RMP had indeed created a unique interface between Comprehensive Health Planning and Regional Medical Programs and both organizations were taking full advantage of the opportunities.
- The organizational identification of the MRMP Regional Advisory Group as the board of MMCC has created an administrative (and possibly legal) complication that needs to be clarified.
- +MRMP staff had developed a good role as "broker" for joint efforts of several organizations, but
- Paradoxically, did not have a good record of spinning off the successful activities it generated.
- The Coordinator appeared to be overextending himself and needed a good #2 man. (Dr. Charles McCall had left for the Texas RMP and a replacement still has not been found.)
- +The region, nevertheless, has the potential of becoming one of the better programs.

Total RMPS budgetary restrictions permitted funding only at the \$1.3 level. True to form, Memphis allocated these dollars to the 7 activities seeking 3 year renewals, but promised that this would be their terminal year; the 5 continuation activities were also supported; 2 of the 12 new proposals were activated. One of the two, the Model Hospital Learning Center, had strong subregionalization potential.

In June of this year, Memphis received supplemental funds which brought it up to the approved \$1.6 level for an extended 16 month 04 year.

True to its promise, it did not allocate any extension time or dollars to the projects scheduled for termination; it gave basically extension time dollars only to the continuing components; and it activated 3 previously approved but unfunded activities, one of which represented a combination of 2 proposals. Collectively, these activities display a good combination of training and service. In developing its budget for the extended current year, the region paid good attention to its future year budget needs and has not boxed itself in by activating projects that cannot reasonably be continued within the existing level. Conversely, it has learned to project turn over dollars rather well, and it is this type of projection that will support the existing program's continuation needs.

Memphis submitted an EMS proposal in April 1972, competing for \$762,898 to fund for 18 months the first "year" of a 2 year activity. Memphis role had been identified in both the Tennessee and Mississippi state plans for a partnership of federal, state, community and private framework, as the lead program charged with the involvement of hospitals and medical schools to upgrade emergency room services. An award of \$67,038 was granted for further planning and surveying needs.

The region also competed in June, 1972 for supplemental funds for health services/education activities but the applications were not recommended for funding.

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding 1st TR Year 04	Council-Approved Level For 2nd TR Year 05	Region's Request For 2nd TR Year 05	Recommended Funding For 2nd TR Year 05 <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium	
PROGRAM STAFF	812,000	X	998,298	<input type="checkbox"/> Yes <input type="checkbox"/> No	X	
CONTRACTS	---0---		1,012,624			
DEVELOPMENTAL COMP.	---0---		162,700			
OPERATIONAL PROJECTS	815,000		1,094,205			
Kidney	X		()			()
EMS (contract)			(506,000)			()
hs/ea (contract)			(400,000)			()
Pediatric Pulmonary			()			()
Other		()	()			
TOTAL DIRECT COSTS	1,627,000		3,267,827			
COUNCIL-APPROVED LEVEL	1,627,000	1,627,000				

12

STAFF OBSERVATIONS

Principal Problems:

Please see attached staff memorandum

Principal Accomplishments

Please see attached staff memorandum

Issues requiring attention of reviewers

Please see attached staff memorandum

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

Date: August 17, 1972
Reply to
Attn of:
Subject: Staff Review of the Memphis Anniversary Application
To: Mr. Lee E. Van Winkle
Acting Chief, RMPS, South Central Operations Branch
From: Ms. Lorraine M. Kytte
Public Health Advisor

On August 3rd the following staff met to review the Memphis anniversary application for the purpose of identifying issues for the attention of reviewers:

Mr. Larry Pullen, Grants Management Branch
Mr. Gene Nelson, Planning and Evaluation
Mr. Ted Griffith, Region IV, HEW
Ms. Lorraine Kytte, South Central Operations Branch

Remembering the concerns of previous reviewers of this region, staff elected first to consider the effects of the recently created Memphis Regional Advisory Council which is now organized as a body free-standing of the Mid-South Medical Center Council. As early as 1969, site visitors questioned the complicated organizational arrangement under which MRMP was operating vis a vis the MMCC. The 151-member MMCC was officially designated as the MRMP Regional Advisory Group, and the full membership met only twice a year. The real decision-making authority was vested in a 45-member Board of Directors, which met 8-10 times a year. MMCC was and is a powerful and beneficial influence on health care in the Memphis medical trade area. It is the CHP(b) agency for the 14-county area covering west Tennessee; Crittendon County, Arkansas; and DeSoto County, Mississippi, and as such represents a valuable ally for RMP. The working relationships between RMP and MMCC (CHP) are exquisite.

However, the 14-county mandate vested in MMCC gave rise to questions of the legality of that body holding the decision-making authority for a program serving 75 counties and actively supporting (both with professional assistance and grant funds) activities beyond MMCC's geographic sphere. Beyond the possible legal issue, reviewers challenged the cumbersome administrative structure such an arrangement had spawned. A Policy and Review Committee within the RMP structure had been created and was acting like a RAG in most ways, but was not vested with the proper decision-making authority; there was also an RMP Planning Board which the Coordinator had established to advise him and which usually met in joint sessions with the Policy and Review Committee.

The complications of these arrangements led previous reviewers to withhold developmental component authority when according triennial status to this region last year. At that time it was acknowledged that the advantages of close ties to MMCC-CHP were important and that Memphis RMP was utilizing these opportunities well, but the Region was given the message that its organizational structure at the decision-making level.

On June 28, 1972, the full membership of MMCC voted to accept a resolution presented by the Board of Directors which disenfranchised itself as the RMP Regional Advisory Group. It created a Regional Advisory Council for Memphis Regional Medical Program composed of 36 persons and vested in that body all of the powers formerly held by the Board of Directors of MMCC with regard to RMP matters.

The new body is not simply a selection of 36 MMCC members (although it is difficult to assemble a group interested in health care delivery in the Memphis area and not have them be MMCC members). When Dr. Culbertson made his first moves seeking a free-standing RAG, he proposed the establishment of a committee within MMCC to explore solutions, and he involved Dr. Bland Cannon, a consultant to both MMCC and UT; Dr. Joseph Johnson, Chancellor of UT and an MMCC member, and Mr. Norman Casey, Executive Director of MMCC and the CHP(b) agency. MMCC did create such a committee and all of the persons named above were included in the 7-member body. The committee reviewed the activities of MRMP, considered nominations for a new RAG, and developed a working paper for guides to bylaws.

The new membership reflects a good geographic distribution of the territory served; a 5-member overlap of MMCC board members; and a Chairman, Dr. Francis Cole, who certainly knows his way around MMCC, UT, CHP, R&D, and the health needs and interests of the region. Dr. Cole was the chairman of the Policy & Review Committee and his confirmation by the grantee is assured.

Proposed bylaws developed by the 7-member committee mentioned above are up for discussion at the initial meeting of the new RAC on August 16. The development of revised administrative and review procedures is also on the agenda. Drafts of both documents have been reviewed by staff and the preliminary work done by MRMP and the new RAC is excellent.

Staff concluded that the region has satisfied the disqualifying factor concerning developmental component authority and recommends its approval for the last two years of the triennium.

Goals & Objectives:

In January 1972, MRMP sharpened and redefined its goals and objectives. (This need was cited by 1971 site visitors). The 4 goals are still broadly stated: (1) increasing the availability of care; (2) improving accessibility to care; (3) enhancing its quality; and (4) moderating its costs. It was difficult to distinguish strategies, priorities and objectives, but among the four statements MRMP has attempted to cover the full spectrum. These are explicitly stated; our difficulty was in attempting to digest the several different treatments of them in this application. Staff concluded that the pursuit MRMP had described of the first 3 goals did little to accomplish the fourth, but this we felt was common to most regions. The new goals are directly reflected in funding decisions recently made by MRMP.

Accomplishments and Implementation:

It is in the area of program staff services and cooperative relationships with other organizations that this region probably excels in performance but does not report on well. In addition to the Forms 9 (20 pages of them) there are references throughout other sections of the application to MRMP's inputs to other regional health efforts. This has made it difficult to get a sense of the total contribution MRMP staff has made in the role of catalyst as well as architect. The expanded health care offered by Wesley House (inner city Memphis--funded by OEO) stems from a proposal generated and partially written by MRMP staff; the experimental health care delivery system funded by a NCHS R & D contract originated from MRMP staff work; the recently awarded Sickle Cell Anemia grant from NIH had a heavy component authored by this staff; a family planning center proposal recently competed successfully for HSMHA funds and had its genesis in MRMP. Planning groups and institutions have become quite accustomed to looking to RMP for technical assistance and consultation, and MRMP has filled this role commendably.

Continued Support:

This has been an area of concern for previous reviewers. Until last year, the region evidenced only a vague concept of spinning off successful operational components. They appear to have learned a lot in a hurry. Specific inquiry about the fate of the original 10 operational projects, which either have just terminated or will terminate by April 1973 resulted in the following:

- 1 project terminated with no continuation of the activity
- 2 projects continued under other sponsoring but on a restricted basis
- 5 projects continued either at full range or nearly full range by other funding
- 2 projects (which will not terminate until April 1973) have tentative agreements for future support, 1 of which the Mississippi State Board of Health plans to fully fund.

Minority Interests:

Of the 36-member new Regional Advisory Council, 9 members are Black and 6 are women. Staff noted that one of the minority members is the controversial Mr. Ollie Neal, Administrator of the Lee County Cooperative Health Clinic in Marianna, Arkansas. Mr. Neal is known in the area as an outspoken proponent of the need for change in the health care delivery system.

Since the submission of the Equal Opportunity Employment form 7 included in the application, the lone minority professional (a female) has resigned. MRMP is recruiting a black, female nutritionist for her replacement. At this time, the replacement candidate is the only minority professional on a program staff in a region where 31% of the population it serves is Black.

The activities MRMP supports reach the rural poor, which, in most of the subregional areas includes large numbers of Negroes, to an extent much greater than the complement of the program staff would indicate. The cardiovascular clinics supported in North Mississippi cover counties with high percentages of Blacks; the high risk infant component, which is regional, will target the minority population (it is just starting up); the proposal to expand the services of existing Memphis neighborhood health centers to primary care (and is a good combination of training and service) primarily serves the indigent; the hypertension control component operating in 3 northern Mississippi counties operates in an area where more than half the population is Black; and the arrangements entered into with the Lee County Cooperative Clinic (Marianna, Arkansas) for on-the-job training of nurse practitioners is an activity targeted to minorities.

Grantee Organization:

There has been no problem of grantee interference with RAG's decision-making role in the past under the MMCC arrangement and none is expected under the new arrangement. Dr. Joseph Johnson, Chancellor of UT Medical Units is an MMCC member, is a member of the new RAC, and keeps himself well-informed on MRMP affairs.

UT as the grantee is a proven partner without co-opting tendencies.

Process:

Staff believes the Coordinator is overextended and whereas he gives good overall leadership, the need for specific mastership sometimes makes MRMP miss the mark insofar as responding to specific signals from RMPs is concerned. He needs, and has needed for some time, a strong Program Director. The position has been budgeted for quite some time but not filled.

The Forms 6 and 7 regarding the Program Staff give information that does not agree--the listing of personnel was updated later than the Equal Employment Opportunity report. As of August, 1972 there were 44 employees on Program Staff. 26 are classified professionals and 18 clerical and secretarial. The entire Program Staff Services budget (Salaries & Wages, Travel, Consultation, etc.) currently approximates one-half of their total program budget. When the last tally of RMP percentages was made (FY 1971) two-thirds of the regions were budgeting from 31 to 60 percent of their total funds on program staff and staff activities. MRMP provides a tremendous staff resource service to the health groups and institutions in its region--grant proposal writing being only one.

The proposed Program Staff budget Memphis submits for next year still stays within the one-half mark if you delete the \$1 million contract category. Staff realizes that both the grantee and MMCC have informally advised Dr. Culbertson to stay below 51%. With the exception of the Program Director vacancy (the needed #2 slot) staff unanimously recommends that the region be advised no further

expansion of program staff is deemed warranted.

The personnel listing in the application reflects 13 vacancies and 36 filled positions, so some additions have already been effected since the application was prepared. We realize that this is a region in a triennial status with certain budgetary prerogatives, but a recommendation regarding no further expansion of program staff included in an advice letter which reaches both RAC and the grantee would be potent.

Memphis RMP has assembled a staff of essentially full-time competent people who move very well in the health community. They are well-credentialed, but Dr. Culbertson is the only full time M.D. on staff.

Participation and Local Planning:

It is this area, staff believes, in which MRMP has excelled. The interests of the key health groups are woven through MRMP's activities (particularly its staff services) and conversely MRMP is a partner in most undertakings of other organizations. Its superb collaboration with Health Systems Management, Inc. (the organization developed to administer the NCHS - R & D experimental systems contract); MMCC; CHP; UT and the Health Departments of most of the states involved in its territory, forms a productive coalition.

Assessment of Needs and Resources:

Staff resources are involved in almost a preoccupation with systematic identification and analysis of needs and resources. But this staff has developed an eminence in this region as a resource for data and analysis that has proven to be the springboard for some excellent joint ventures. For example, staff's studies on emergency rooms was utilized by the state Department of Transportation and was one of the reasons for MRMP's identification as a component in the state's emergency medical system. Much of this type of activity (analysis of data) is reflected in the activities of other health interests in the region as well as MRMP.

Management and Evaluation:

The order and scope of activities appear to be well-defined and understood by staff. A management assessment visit is planned for this region early next year which will provide more specific evaluation on this point. This past year, the staff has increased its vigilance, both fiscal and programmatic, over operational activities.

Like many regions, the results of MRMP's evaluation efforts are still fragmented but they are aware of this and are attempting to get at the whole thing. This area, as well as improved reporting via application preparation, has been identified by staff as targets

for working toward with the region in the upcoming year.

Since attaining triennial status, Memphis has instituted more sophisticated budgeting mechanisms to identify projected funds so that new activities may be initiated. The administrative procedures covering the developmental component are in the process of revision and the work staff has done in this regard for presentation to the new RAC looks good.

Program Proposal:

There is a \$1 million contract proposal under the Regional Staff Services portion of this application which breaks out as follows:

. Inter-Regional Information Exchange Program	\$ 4,000
. Ambulatory Health Care Centers	\$100,000
. Community Health Service Educational Activities	\$400,000
. Emergency Medical Services Program	\$500,000
. Tennessee Nursing Association Manpower Feasibility Study	\$ 2,600

The ambulatory health care centers portion builds from keystone component #36, Expansion of Neighborhood Health Centers, an approved but unfunded activity of highest priority which is proposed for activation in this application. Basically, the \$100,000 contract request is for the purpose of extending the Memphis/Shelby County concept of utilizing a nurse in an expanded role to the rural areas of the subregions. Endorsements of the concept have already been secured from local physicians and early implementation is promised.

The community health services education component proposes the expansion of the model hospital learning center recently funded at Jackson-Madison County Hospital, Jackson, Tennessee (component #32) to a network of eight such learning centers. The expansion proposes a second center in Tennessee (at Union City), one in Kentucky, one in Arkansas, one in Missouri and 3 in Mississippi. Although they would be patterned basically as the Jackson station is, the individual programs would be determined by local conditions. Based in an active community hospital, the proposal seeks to:

- . develop learning centers which provide instructional materials, trained personnel and organized channels of communication with the UT Medical Center Library and the UT Audiovisual Department--
- . create a MRMP regional development liaison office that can be a focus for RMP activities in the area--
- . train local in-service leaders to respond to regional requests for assistance--
- . encourage residency and intern training programs, working collaboratively with university medical centers--

- . improve arrangements with local vocational and community colleges to expand allied health manpower training--
- . encourage quality control systems such as PAS/MAP--
- . initiate consumer education programs.

The emergency medical services program is essentially a resubmission of an activity Memphis proposed in the spring of this year competing for supplemental funds. At that time, \$67,038 was awarded to the region to further survey and plan total EMS needs. The region tells us that by January 1, 1973 (the beginning of this region's next operational year) this will have been accomplished and it again requests operational monies. Staff recommends that should MRMP budget operational dollars into this proposal, preliminary consultation should be arranged with the Division of Professional and Technical Development.

Briefly, the new activities are:

- #41, Patient Safety and Electrical Surveillance proposes education to promote awareness of electrical hazards and safety measures; a regional pacemaker referred clinic (at UT) and registry; a regional cardiovascular health delivery team to upgrade the knowledge of the general practitioner concerning his cardiac patients.
- #42, The Satellite Clinic Program proposes the training of nurse practitioners in two settings: (1) on-the-job training at the Lee County Cooperative Clinic (Marianna, Arkansas) carried out on a one-to-one basis with Clinic physicians; and (2) intensive sessions at the Arkansas Medical Center or at UT, whichever proves to be more expedient. This proposal has encountered some political controversy since the original clearances were secured (a local health professional who ran unsuccessfully for governor included the danger of this type of activity in his platform). However, the Marianna Community Hospital's new administrator is working with MRMP hopefully to implement the activity under the auspices of the county medical society.
- #43, Regional Blood Banking proposes to link the small community hospitals in the region to the Baptist Hospital Blood Bank in Memphis. The region estimates that RMP support will be needed for 2 years, after which the project should be self-supporting.

The descriptors covering the 15 components proposed for funding reflect:

- . 67% of the component dollars are in activities that combine training with patient services
- . 12 of the 15 offer multicategorical pursuits
- . 9 activities (35% of component dollars) are subregionally based

- . 4 activities (56% of component dollars) are regional activities with ties to central services
- . 2 activities (8% of component dollars) are a network of central and satellite units
- . two-thirds of the activities are sponsored by other than the single medical school in the region.

The \$1,381,870 requested for operational component funding is complemented by \$1,044,781 funds from other sources (\$23,000 state funds, \$911,781 local funds and \$110,000 other federal sources).

STAFF RECOMMENDATIONS:

This application requests \$3,267,827 direct costs for the second triennial year (the region's 05 operational year). The current annualized level of funding is \$1,627,000.

Staff recommends an increase in the approved level to permit funding at \$2,252,000 based on the following rationale:

\$1,627,000--to support current program for the upcoming year which is rather tightly budgeted on projected turnover dollars to continue activities initiated in the extension period.

\$ 162,700--for developmental component

\$ 237,300--to support selected new activities including the keystone component #36

\$ 225,000--to pursue selected activities under the contract request

\$2,252,000

RMPS STAFF BRIEFING DOCUMENT

REGION: MICHIGAN

OPERATIONS BRANCH: South Central

NUMBER: RM 00053

Chief: Lee E. Van Winkle

COORDINATOR: Robert Tupper, M.D.

Staff for RMP: William Reist (SCOB)

Backup Rep. - Jeanne Parks (SCOB)

Grants Officer - Charles Barnes (GMB)

Planning & Evaluation - Gene Platek

LAST RATING: .376 - A

TYPE OF APPLICATION:

Triennial 3rd Year Triennial

2nd Year Triennial Other

Regional Office Representative:
Maurice Ryan - Program Director (Region V)

Management Survey (Date):

Conducted: September 1970

Review Process Verification Visit
conducted July 25, the Region
was certified.

Last Site Visit:

(June 9-10, 1971) Alexander McPhedran M.D., Review Committee (Chairman)
Robert Brown, M.D., Coordinator, Kansas RMP
Jack Hall, M.D., Methodist Hospital Indianapolis

RMPS STAFF: George Hinkle, Grants Management Branch
Joseph Jewell, Grants Review Branch
Elsa Nelson, Continuing Education and Training Branch
Jeanne Parks, Grants Review Branch
Eugene Platek, Office of Planning and Evaluation
Maurice Ryan, Program Director, Region V

Staff Visits in Last 12 Months:

- 7/71-12/71 Attended two RAG Meetings and visited the MARMP Staff once (Pgm. Dir.)
- 1/27/72 Board and RAG Meeting (Program Director)
- 4/13-14/72 Attend RAG Meeting - met Dr. Tupper (Program Director & SCOB Staff Rep.)
- 6/7-10/72 Attend RAG Retreat - Consult on preparation of anniversary application (Program Director & South Central Operations Branch Staff Representative.)
- 6/27/72 Accompany Dr. Hirman, DPTD, on his visit to consult with major health providers interested in developing a state kidney plan (Program Director & Staff Representative)

Visit (Program Director & Staff Rep.)

RECENT EVENTS OCCURRING IN GEOGRAPHIC AREA
OF REGION

Appointment by Governor Milliken of Irving A. Taylor as Director of the Office of Comprehensive Health Planning.

Coverage of entire state by CHP areawide (b) agencies.

Beginning development of an emergency medical services state plan. (A cooperative effort between MARMP, CHP, Department of Public Health and Office of Highway Safety Planning.)

Initial meeting (June, 1972) of all individuals and organizations interested in the development of a state plan for the prevention, detection and treatment of kidney disease. (Co-sponsored by MARMP, the State Office of CHP and the Michigan Kidney Foundation.)

Development of a "State Plan for Nursing Education in Michigan, Phase II: Planning for Licensed Practical Nurse Education" (Provisional).

Formal incorporation of Area Health Education Centers in Grand Rapids and Flint.

Passage of certificate of need legislation for acute care general hospitals.

In May, 1972, Michigan became a member of the National Institutional Television Consortium in order to promote health education for 8-10 year olds.

Selection of two Detroit agencies (the Detroit Health Facility, the Detroit Medical Foundation) for receipt of Health Maintenance Organization Planning funds.

Michigan receiving four assignees from the National Health Services Corps.

Within the Academic Sphere

Michigan State University:

1. Formal institution of on-campus headquarters of the College Osteopathic Medicine; first on-campus classes held; an increase from 36 to 64 students entering the 1972 class.
2. The School of Human Medicine graduated its first class of medical students.

Wayne State University:

1. Entering into phase II in the development of a large scale ambulatory facility to be located in the Detroit Medical Center Complex where students will be able to receive training in an ambulatory and multidisciplinary setting; the opening of Scott Hall, the basic science unit for the Medical School that permits admission of 256 medical students; establishment of a Department of Family and Community Medicine under Dr. Ruben Meyer (RAG member).

University of Michigan:

Redesign of the Post Graduate School of Medicine to provide for community extension.

Among the most recent results stemming from the consortium of the Deans of the four medical schools is the capacity for a student in any of the four schools to take elective courses for credit in any of the other schools.

I. REGIONAL CHARACTERISTICS

FACILITIES AND RESOURCES

SCHOOLS

Schools	No.	Enrollment (1969/70)	1970- 1971	Graduates (1969/70)	70/ 71	Location
<u>Medicine and (Osteopathy) (4)</u>						
Univ. of Michigan Med. School		(812)	846	(189)	201	Ann Arbor
Wayne State Univ. Sch. of Med.		(537)	570	(132)	141	Detroit
Mich. State Univ. College of Human Medicine		(85)	109	---		E. Lansing
Mich. Coll. of Osteo. Med.		1st yr.	20			Lansing
Dental	2	696		139		Ann Arbor Detroit

Pharmacy (1967/68)	3	486		152		
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Nursing Schools

Professional Nursing Number	39					22 College or Univ. based
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Practical Nursing Number	32					Many at Junior Colleges; some Ed. of Education
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Allied Health Schools (Approved Programs) *

(1) Univ. Based- Cytotechnology Number	3	Northern Mich. U.				Marquette
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Medical technology Number	37	(incl. 1 at V.A. Hosp. Allen Pk.)				
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Radiologic Technology Number (appr. 1970)	33					
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Physical therapy Number	2					U. of Mich. Wayne State
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Medical Record Medical Record Technician	1					
	1					

I. REGIONAL CHARACTERISTICS (Cont'd)

FACILITIES AND RESOURCES (Cont'd)

MANPOWER

Profession	Number	% Total	Ratio per 100,000
Physician - active	9515		
general practice	1635		
medical specialties	1448		
surgical specialties	2190		
other specialties	1313		
Physician - inactive	598		
Osteopath	1932		
Total active MD & DO	11,447		
Professional nurses			
active	23,441		
inactive	13,212		
Lic. Pract. Nurses			
actively empl. in nurs.	10,781		
not empl. in nurs.	3,778		
Medical technologists			
Radiologic technologists X-ray	2427		
nucl. technol.	42		
Physical therapists	390 FT		radiation therap. 14
Medical record librarians			

GROUP PRACTICES: Total - 260

Single specialty - 156; general practice - 24; multi-specialty- 80.

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Michigan RMP
Review Cycle October/72

Component	Current Annualized Funding TR Year <u>04</u>	Council-Approved Level For TR Year <u>05</u> 2,100,000	Region's Request For TR Year <u>05</u>	Recommended Funding For TR Year <u>05</u> <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
PROGRAM STAFF	280,184		425,940		
CONTRACTS	-0-		-0-		
DEVELOPMENTAL COMP.	160,598		192,350	<input type="checkbox"/> Yes <input type="checkbox"/> No	
OPERATIONAL PROJECTS	1,483,784		2,379,189		
Kidney			(-0-)	(/)	
ENS			(-0-)	()	
hs/ea			(-0-)	()	
Pediatric Pulmonary		(-0-)	()		
Other		(-0-)	()		
TOTAL DIRECT COSTS	1,924,566		2,997,479		
COUNCIL-APPROVED LEVEL	2,100,000	2,100,000	<p>*The Region identifies two projects (#45 & #46) as Health Service Education Activities, when in fact they do not meet RMPs' definition of such an activity. The titles of these projects will be changed.</p>		

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
C000 PROGRAM STAFF	\$425,940				\$425,940		\$425,940
D000 DEVELOPMENTAL COMPONENT	\$192,350				\$192,350		\$192,350
005 MSU PLANNING	\$163,275				\$163,275	\$42,397	\$205,672
014 WAYNE ST PLAN	\$125,000				\$125,000	\$57,463	\$182,463
015 ZIEGER BOTSFORD HOSP PAR TICIPATION	\$128,472				\$128,472	\$19,300	\$147,772
017 STROKE BASE CENTER	\$52,410				\$52,410	\$10,730	\$63,140
019 STROKE DEMONSTRATION UNI T	\$95,000				\$95,000	\$15,720	\$111,720
021 PUBLIC EDUCATION FOR STR OKE	\$50,125				\$50,125	\$4,226	\$54,351
027 COMPREHENSIVE HEALTH CAR E URBAN POOR	\$207,000				\$207,000	\$41,605	\$248,605
029 COOPERATING STROKE CENTE R	\$145,886				\$145,886	\$13,579	\$159,465
030 SOUTHEASTERN MICHIGAN RE G CANCER PROGRAM	\$209,620				\$209,620	\$44,374	\$253,994
031 MODEL NEIGHBORHOOD HLTH SERV. COORD	\$173,777				\$173,777		\$173,777
032 LAKESIDE COMPRE HLTH SER V DEL SYSTEM	\$150,000				\$150,000	\$48,000	\$198,000
033 STROKE DAY CARE CENTER	\$129,000				\$129,000	\$22,083	\$151,083
039 IMPROVE THE CALIBER OF L ABORATORY WORK				\$27,240	\$27,240	\$6,180	\$33,420
040 COMPUTER LINKAGE TO COMM UNITY HOSPITALS				\$92,492	\$92,492	\$21,852	\$114,344
041 NEW BORN CARE IN COMMUNI TY HOSPITALS				\$72,694	\$72,694	\$33,323	\$106,017
042 MODEL BURN CARE TRAININ PROGRAM				\$109,049	\$109,049	\$55,229	\$164,278
044 TELEPHONE INFORMATION SY STEM				\$151,412	\$151,412		\$151,412
045 GRAND RAPIDS HLTH SERV E DUC ACTIVITY				\$105,000	\$105,000		\$105,000
046 UPPER PENINSULA HLTH SER V EDUC ACTIVITY				\$75,537	\$75,537		\$75,537
047 UPGRADING NURSING HOME C ARE				\$116,200	\$116,200		\$116,200
TOTAL	\$2,247,855			\$749,624	\$2,997,479	\$437,761	\$3,435,240

AUGUST 8, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - MICHIGAN
RM 0053 10/72

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	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF	\$456,000				\$456,000	\$881,940
0000 DEVELOPMENTAL COMPONENT	\$195,000				\$195,000	\$387,350
005 MSU PLANNING	\$159,000				\$159,000	\$322,275
014 WAYNE ST PLAN	\$100,000				\$100,000	\$225,000
015 ZIEGER BOTSFORD HOSP PAR TICIPATION	\$123,000				\$123,000	\$251,472
017 STROKE BASE CENTER	\$56,700				\$56,700	\$109,110
019 STROKE DEMONSTRATION UNI T						\$95,000
021 PUBLIC EDUCATION FOR STR OKE						\$50,125
027 COMPREHENSIVE HEALTH CAR E URBAN POP	\$300,000				\$300,000	\$507,000
029 COOPERATING STROKE CENTE R	\$146,000				\$146,000	\$291,886
030 SOUTHEASTERN MICHIGAN RE G CANCER PROGRAM	\$242,700				\$242,700	\$452,320
031 MODEL NEIGHBORHOOD HLTH SERV CTR	\$179,000				\$179,000	\$352,777
032 LAKESIDE COMPRE HLTH SER V DEL SYSTEM	\$150,000				\$150,000	\$300,000
033 STROKE DAY CARE CENTER	\$106,000				\$106,000	\$235,000
039 IMPROVE THE CALIBER OF L ABORATORY WORK				\$28,668	\$28,668	\$55,908
040 COMPUTER LINKAGE TO COMM UNITY HOSPITALS						\$92,492
041 NEW BORN CARE IN COMMUNI TY HOSPITALS				\$47,000	\$47,000	\$119,694
042 MODEL BURN CARE TRAINING PROGRAM				\$110,000	\$110,000	\$219,049
044 TELEPHONE INFORMATION SY STEM				\$274,370	\$274,370	\$425,782
045 GRAND RAPIDS HLTH SER E DUC ACTIVITY				\$105,100	\$105,100	\$210,100
046 UPPER PENINSULA HLTH SER V EDUC ACTIVITY				\$96,500	\$96,500	\$172,037
047 UPGRADING NURSING HOME C ARE				\$165,400	\$165,400	\$281,600
TOTAL	\$2,213,400			\$827,038	\$3,040,438	\$6,037,917

APR 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST
OPERATIONAL GRANT (DIRECT COSTS ONLY)

RMPS-CSM-JTCFHL-20

REGION 53 MICHIGAN

FHF SUPP YR C4

ALL REQUEST AND AWARDS AS OF JUNE 30, 1971

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1 7/68-6/69	C2 7/69-8/70	C3 09/70-09/71	C4 09/71-12/72	TOTAL	C5 01/73-12/73	C6 01/74-12/74	C7 01/75-12/75	TOTAL
0000	PROGRAM STAFF	266800	349000	249275	371578	1238657	425940	456000		881940
0001	HEALTH CITY PLAN	44100				44100				
0000	DEVELOPMENTAL				89378	89378	152350	195000		387350
0001	SICKLE CELL ANE				2000	2000				
0002	SUBREGIONAL APP				39788	39788				
0003	PROGRAM TO IMPR				38800	38800				
0004	MANAGEMENT OF S				11500	11500				
0005	NCCARE				8000	8000				
0006	MANAGEMENT OF S				12000	12000				
0007	ANTI-CANCER DRG				5450	5450				
0008	INNER CITY HEAL				7216	7216				
003	DATA COLLECTION	252900	334200	227500		834600				
004	CORONARY CARE	54300	171100	103000		368400				
005	FL CCEP ARR EC	190900	266700	163100	163285	783985	163275	159000		322275
006	EST CTR MD ED H	25800	61300			87100				
007	COORD CTR U MICH	90700	82200	23500		196400				
008	PG NLR EC DEV T	51700	112400	92700		256800				
009	PILOT DRUG INFO	58900	128500	75500		262900				
010	DEV TR PPG TECH	27700				27700				
011	PILOT EVAL DEL	87200	166600			273800				
012	DATA TR NEEDS C	24800	36900	28900		90600				
013	MD ATTITUDE CON	64700	50900			115600				
014	SUB REGIONAL PL	116700	167500	145900	211666	641826	125000	100000		225000
015	STDY CSTECD MD C	85600	45700	64800	154423	350523	126472	123000		251472
016	SLPVY ELECTRON	12400	35900	53000	8625	119825				
017	STROKE BASE GEN		13400	16000	44324	73724	52410	56700		109110
018	DETROIT GENERAL		144400	80000		224400				
019	STROKE DEMONSTR		114800	84800	111666	311266	95000			95000
020	SPARROW HOSPITA		104400	56593		160993				
021	PLBLIC EDUCATIO		65000	83246	29708	177954	50125			50125
022	CARDIOVASCULAR		34400	28900	16530	79830				
023	COMPREHENSIVE H				255000	255000				
025	WESTERN MICHICA			39225	35000	74229				
026	INNER CITY PHYS		112800	77015		189815				
027	HEALTH CARE TO			150000		150000	207000	300000		507000
029	CARE OF STROKE			39600		39600	145896	146000		291896
030	SOUTHEASTERN MI				123628	123628	205620	242700		448320
031	COMPREHENSIVE F			16000	165728	181728	173777	179000		352777
032	LAKESIDE COMPRE				163462	163462	150000	150000		300000
033	COMPREHENSIVE S				161355	161355	129000	106000		235000
034	HEALTH CARE DEL				45000	45000				
039	IMPROVE THE CAL						27240	28668		55908
040	COMPUTER LINKAG						92492			92492
041	NEW BORN CARE I						72694	47000		119694
042	MCCEL BURN CARE						109045	110000		219045
044	TELEPHONE INFOR						151412	274370		425782
045	GRAND RAPIDS HL						105000	105100		210100
046	UPPER PENNSILLA						75537	96500		172037
047	UPGRADING NURSI						116200	165400		281600
- T C T A L -		1455200	2662000	1898825	2566087	8622113	2997479	3040438		6037917

HISTORICAL PROGRAM PROFILE
OF THE MICHIGAN ASSOCIATION
FOR REGIONAL MEDICAL PROGRAMS

- Nov. '65 - Governor's Council on Heart, Cancer, and Stroke met to discuss PL 89-239; Albert Heustis, M.D., Chairman.
- Dec. '65 - Dr. Marston, NIH, met with health providers to discuss a RMP in Michigan.
- June '66 - The Michigan Association for RMP was incorporated.
- June '67 - The region's first planning award was granted.
- Sept. '67 - Albert Heustis, M.D. was appointed full-time Coordinator.
- June '68 - A pre-operational site visit was conducted. The region was considered to be viable, cooperative arrangements were being formed and operational projects were likely to lead to desirable regionalization. (No negative findings were revealed.)
- June '68 - The region became operational. The first year operational program consisted basically of the Central Planning Staff, subregional planning projects (at Wayne State, Michigan Dept. of Health, Michigan State Univ. and Univ. of Michigan) and continuing education activities, a large portion of which were sponsored by the University of Michigan. The ten operational type activities were almost entirely sponsored by major health institutions (medical schools, Department of Public Health and the Heart Association). Zieger/Botsford Hospitals sponsored a continuing education project which was to become, in the 03 year, identified as a subregional planning activity. The overall program placed no emphasis on a particular disease category.
- July '69 - The region was awarded 2nd year operational funding. National reviewers found the region had exhibited growth and maturity under excellent leadership. The region's review system appeared superb. No negative findings were revealed.

The second year operational program continued along the lines of the first, but with some exceptions. Support of the Department of Public Health subregional planning project was discontinued and stroke began to emerge as a major emphasis with the funding of four related projects. Sponsorship of projects remained with major health institutions.

Aug. '70 - The region was awarded 3rd year operational funding. The reviewers believed MARMP was on target. Program staff was considered too small. Both the region and the reviewers expressed concern regarding the contributions and the relationship to the Central office of the four subregional planning offices. Quantitative project evaluation needed strengthening.

While the third year program remained basically the same as the second, the region took more interest in the underserved and funded a related project. Also, more projects sponsored by other than the traditional institutions were funded. The continuing education project at Zieger/Botsford was identified as a subregional planning project under the central program.

June '71 - A pre-triennium site visit was conducted. The region received a favorable review by the site visit team, Committee and Council, and was approved for triennium and developmental component. Issues raised by this review are elaborated on in the Staff Observation Section of this document.

Sept. '71 - The region began its 04 year of operation with an award of \$1,923,509 for program staff, developmental component, three subregional planning projects (University of Michigan is discontinued) and 11 operational projects, most of which were initiated in 02 and 03 years. Additional emphasis was placed on delivery of services to the underserved with the funding of three related projects. Also, the MSU planning office took on the new look of a project designed to improve services to a specific underserved population.

Sept. 1, 1971 - Albert Heustis, M.D. resigned as Coordinator and Gaetane Larocque, Ph.D., the Association Coordinator, became Acting Coordinator.

Jan. 1, 1972 - Gaetane Larocque, Ph.D. resigned and Theodore Lopushinsky, Ph.D., a Program Representative, became Acting Coordinator.

May 1, 1972 - Robert Tupper, M.D., Director of Medical Education at Pontiac General Hospital, became permanent Director. (Title changed from Coordinator to Director.)

June '72 - The region's 04 program period was extended 4 months (9/71-12/72) and with supplemental funds the region's award is increased to \$2,566,087 for the 16 month period.

July 6, 1972 - Region submitted current application for RMPS review.

STAFF OBSERVATIONS

Principal Problems Previously Identified & Achievements toward their Solution

The site visitors' concern of a year ago regarding the future of the program upon Dr. Heustis' resignation was justified. It took the Board of Directors eight months to recruit and hire a new Director, during which time the program progressed at a slow rate due to a lack of leadership, resignations of staff (at one point there were only two professionals on staff) and an accompanying morale problem. Since Dr. Tupper's appointment and the hiring of additional staff, there is a new enthusiasm and vitality throughout Michigan RMP. After being aboard only a short time, Dr. Tupper became aware of how accurately the national reviewers of a year ago identified the more significant problems of the Region which demand immediate attention.

Following are concerns identified a year ago and relevant comments.

Concern: Goals and objectives were not stated explicitly in quantifiable terms nor were they related to identifiable time-frames.

The retreat scheduled for a year ago to deal with this problem never took place. The new planner/evaluator has worked out with Dr. Tupper a specific concept to deal with the problem. This concept was presented to and accepted by the RAG at a June '72 retreat. The RAG has identified some general areas of possible program direction. Based on these staff is presently developing a specific program, with alternatives, to be presented to the RAG for endorsement.

Concern: A need was identified for a more systematic evaluation system.

A new planner/evaluator has been hired who has an excellent background in evaluation. He is currently site visiting every project and in cooperation with the Project Director is working out an agreeable evaluation mechanism. His concept for planning and the development of goals and objectives has program evaluation built into it.

Concern: A lack of depth of program staff was noted particularly in the areas of allied health.

Three people have been added to the professional staff which now totals five. Of these, two are specialists, the other three are generalists. Dr. Tupper tentatively sees a total of about 13-15 professional staff most of whom will be generalists. Specialists and allied health people will be considered in relation to the new program look once it is developed.

Concern: The salary structure for central program staff should be more equitable to that of institutional program staff.

Central program staff salaries have been increased in an attempt to make them more equitable. Salaries are for the most part now equitable with those of institutional positions with the exceptions of the Director at Wayne State (\$32,000), his Deputy (\$27,000), and the Director at Zieger/Botsford at (\$30,000). Most salaries are comparable to those of other regions.

Concern: The relationship of CHP to MARMP was unclear.

In June 1972, MARMP and CHP held a combined retreat to improve dialogue and planning efforts. Since that time, Dr. Tupper and the CHP (a) Director have established close working relationships as have the two staffs. They are working closely in the development of a state kidney plan and a state emergency system plan which will be jointly funded. Dr. Tupper has attended CHP (b) meetings which appears to be the first step in continuous dialogue. Plans include assigning staff members as liaison to specific (b) agencies.

Concern: The region should refine its mechanism to insure more realistic budgeting and financial control of funds.

Dr. Tupper is aware of the problem in this area, and he expresses his awareness of the need to frequently monitor program expenditures so as to use rebudgeting more fully in promoting efficient program expansion.

Concern: Consideration should be given to how MARMP might improve its image and visability to both the professional and lay constituency.

New organization plans include a Director of Communications. Responsibilities of this position will include the publication of periodic newsletter and other, unspecified means of promoting MARMP and its mission.

Recommendation: Staff supported in the three subregional planning offices be identified with MARMP and be identified with programs and activities which are directly related to MARMP goals, objectives and priorities.

Recommendation: The budgeting for subregional personnel and functions be separate from other programs which may be carried on in the institution.

Recommendation: A line of authority be established between the central office and the staff of the subregional offices and be so reflected in an organizational chart.

During the past year considerable change has occurred with respect to the functions of the subregional offices and their relationships to the central office. This change represents a phasing out of subregional planning as it has been functioning in the past.

The Michigan State University planning component has been altered so that it no longer serves as a subregional office conducting many diffuse activities, which due to overlap, confuses evaluation. While it maintains the same title it in fact is a project having the specific mission of developing, in cooperation with 314 (e) grant, a family health center, and continuing care models for the underserved of a rural area, Cass County. This, in turn, will serve as a model for the rest of the state. Project staff includes personnel serving in the center. The project is consistent with the region's goals and objectives and will be considered as any other project including the expectation that it will terminate by 8/74.

With the submission of this year's application, the Wayne State Planning Component now represents a specific project designed to develop prototype family-centered, hospital-based, primary health care organization in Mt. Sinai Hospital, which has the potential of becoming an HMO capable of serving a low-income population of 10,000. As with the MSU component, while the title remains the same, the project will be subject to the same conditions and evaluation as any other operational project and will be expected to terminate by 8/73.

The Zieger/Botsford Hospital participation activity has not undergone much change. It remains basically the same emphasizing an effort to document the quality of care being delivered to the underserved, and through the use of PAS and peer review improve services. To date, no progress has been made to incorporate this activity as a part of program staff or completely isolate it as a separate project with a limited period of support. Dr. Tupper has a strategy for terminating the project, but it will necessitate a trade off for a smaller staffed osteopathic subregional office which will be directly responsible to him.

Problems Not Previously Identified but which are Recognized and being Resolved by the Region.

Problem: The region's bylaws are in bad disarray and are not consistent with the RMPS statement on Grantee-RAG relationships.

Dr. Tupper, the board and RAG are working together to develop bylaws which do comply with the RMPS statement and incorporate other suggestions made by RMPS staff.

Problem: Few minorities (1) and no women are employed on program staff in professional positions.

Dr. Tupper is aware of the problem and intends to make special efforts to recruit both minorities and women to professional positions.

Problem: MARMP activities are limited to the southern and particularly the southeastern part of the state.

Dr. Tupper is aware of the situation and will be making special efforts to develop activities relative to the needs of the northern rural communities.

Issues Requiring the Attention of Reviewers

The basic issue is whether or not the reviewers believe the Michigan program is deserving of having its NAC approved level raised from its current level of \$2,100,000.

If the region is approved and awarded the amount requested, it will allow it to continue its basic program outlined for this triennium, employ additional program staff, and initiated eight new activities which for the most part relate to the region goal #IV- General Professional Continuing Education to Improve the Quality of Health Services.

Since the region is almost funded (\$1,924,566) at its current NAC level (\$2,100,000) an increase in the NAC level would allow RMPS more flexibility in the future to raise the region's level of support.

There does not appear to be any other issues which are not already spoken to in this document, however, a staff review of MARMP is scheduled for August 29 and any issues resulting from that review, not previously identified, will be the subject of a separate document.

MEMORANDUM

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

TO : Director *CP 9/10/72*
Division of Operations and Development

DATE: September 7, 1972

FROM : Director
Regional Medical Programs Service

SUBJECT: Action on September 5-6 Staff Anniversary Review Panel Recommendation concerning the Michigan Association for Regional Medical Programs Application.

Accepted *AS*

9/10/72

(Date)

Rejected _____

(Date)

Modifications

Region: Michigan RFP
Review Cycle: October 7 2
Type of Application: Anniversary
within Triennium
Rating: 290

RECOMMENDATIONS FROM

SARP

REVIEW COMMITTEE

SITE VISIT

COUNCIL

RECOMMENDATIONS:

1. That the Michigan RFP funding level be approved for the 05 operational year at \$2,250,000, rather than the \$2,997,479 requested.
2. The recommended level exceeds the 05 year National Advisory Council approved level of \$2,100,000 by \$150,000.

RATIONALE FOR RECOMMENDATIONS:

The panel was impressed with the program's progress which has been made since Dr. Tupper became Program Director on May 1, 1972. Dr. Heustis, the former Director, resigned as of September 1, 1971. Therefore, the region was essentially without leadership for eight months. In view of the many problems which remain to be resolved, hiring of additional staff, necessary reorganization, etc., SARP concluded that it would be premature at this time to make any substantial increase in the region's level of support. The level of support being recommended is believed to be a reasonable compromise which will allow MARMP to continue its ongoing program and provide an additional sum to expand program staff. In addition, this reduced level may provide incentive for MARMP to speed up the phasing out of institutional planning offices and to recoup dollars for use in initiating new activities.

CRITIQUE:

While slippage in programming and initiative have occurred over the past year, the Michigan program remains basically sound and consistent with national priorities. Systems for delivery of health services to the underserved remains as MARMP's basic program thrust, an emphasis to which most project activities relate. Activities being undertaken for the most part involve communication, transportation, and disease prevention components. In addition, they more fully use existing

facilities and improve productivity of physicians and other allied health personnel. In most instances these projects have the potential to moderate costs to the patient.

Since Dr. Tupper's appointment, he and his small, but highly competent, staff have demonstrated their ability to relate to issues raised by the site visit team a year ago.

- . A RAG retreat was held in June, 1972, as a first step toward refining goals and objectives in quantifiable terms related to specific time frames. Using the guidelines evolving out of that retreat, staff is currently reworking goals and objectives for consideration by the RAG at a mid-winter retreat.
- . A new planner/evaluator with excellent credentials has been employed. He is currently involved in developing a more systematic evaluation system.
- . Reorganization of program staff is underway, which is to give special consideration to the need for a depth of disciplines as well as employment of minorities and women.
- . Recent salary increases for central program staff makes the salary structure more equitable to that of the institutional program staff.
- . Relationships with OHP agencies are being strengthened not only by improving dialogue through participation in meetings, but also with joint planning efforts, such as EMS and a state kidney proposal.
- . New organizational plans include a position of Director of Communication who will be responsible for improving the image and visibility of MARMP to both the professional and lay constituency.
- . Institutional subregional planning offices are being phased out by the end of the 05 year and will be replaced by new offices, which will be basically free of institutional ties. The new offices will have a direct line of authority to the central office.

The region is taking action to resolve other program deficiencies.

- . Dr. Tupper and a bylaws committee of the RAG, are revising MARMP bylaws to be consistent with RMPS policy regarding grantee-RAG relations and responsibilities.
- . A special effort is to be made to assess the needs of the residents of northern Michigan and to develop relevant programs. Consideration is being given to establishing field offices to serve this area.

SARP, in its review, identified only two new issues to which HANSP should give consideration.

- . A need for expanded allied health, minority, and northern state representation on both the BAC and the Executive Committee.
- . A need to more closely coordinate stroke activities.

COMPONENT AND FINAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Michigan RMP
Review Cycle October

Component	Current Annualized Funding TR Year <u>04</u>	Council-Approved Level For TR Year <u>05</u>	Region's Request For TR Year <u>05</u>	Recommended Funding For TR Year <u>05</u> <input checked="" type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium	
CGRAM STAFF	280,184	X	425,940	X Yes <input type="checkbox"/> No	X	
CONTRACTS	-0-		-0-			2,250,000
DEVELOPMENTAL COMP.	160,598		192,350			
OPERATIONAL PROJECTS	1,483,784		2,379,189			
Kidney			(-0-)			(-0-)
EMS			(-0-)			(-0-)
hs/ea			(-0-)			(-0-)
Pediatric Pulmonary			(-0-)			(-0-)
Other			(-0-)			()
TOTAL DIRECT COSTS	1,924,566					2,997,479
COUNCIL-APPROVED LEVEL	2,100,000	2,100,000	*The Region identifies two projects (#45 & #46) as Health Service Education Activities, when in fact they do not meet RMP's definition of such an activity. The titles of these projects will be			

Recommendations From

Rating - 288

- SARP Review Committee
- Site Visit Council

RECOMMENDATIONS:

The Review Committee recommended approval of the triennial application with the following funding levels:

	<u>Requested</u>	<u>Recommended*</u>
04 Year	\$2,340,618	\$1,500,000
05 Year	2,439,588	2,110,000
06 Year	2,445,891	2,325,891

The kidney project is excluded from the 04 year level but is included in the 05 and 06 year levels.

CRITIQUE:

Committee accepted the recommendations of the site visit team with the exception of the funding level for the first year of the triennium.

The 04 year funding level reflects the concerns reviewers had about some of the projects MRMP has chosen to fund and the fact the first year budget period for the triennial is only for 10 months.

Committee was aware that these projects were developed prior to the rethinking of the region and the restructuring of RAG and program staff, and feel that the region should be restricted during the first year funding, and they should reevaluate the proposed activities and be very selective in the ones they decide to fund. The projects should reflect the new direction of MRMP and coincide with the new goals and objectives.

It was noted by the reviewers that MRMP has made a significant turnaround since the September 1971 site visit, and have answered all the criticisms of that visit. The RAG has become actively involved in directing the program and the new staff appear to be competent and dedicated.

The leadership and management of MRMP has dramatically improved and it was felt by the reviewers that the region has the maturity and ability to move forward and should be awarded triennial status.

* The recommended amounts include Developmental Component monies in the amounts of \$90,000, \$100,000, and \$100,000 for the 04, 05, and 06 years respectively.

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Region: Mississippi RMP
 Review Cycle: Oct 1972

Component	Current Annualized Level 03 Year 7/71 - 6/72*	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$411,097	\$ 513,823	\$ 633,842	\$ 666,387	\$ 513,823	\$ 633,842	\$ 666,387
CONTRACTS	---	---	---	---			
DEVELOPMENTAL COMPONENT	---	96,315	196,000 250,000	250,000	90,000	100,000	100,000
OPERATIONAL PROJECTS	485,133	1,730,480	1,555,746	1,529,504	896,177	1,376,158	1,559,504
Kidney	X	(183,634)	(161,915)	(120,403)			
EMS		(---)	---	---			
Hs/ea		(116,745)	(137,743)	(150,341)			
Pediatric Pulmonary		(---)	---	---			
Other		(---)	---	---			
TOTAL DIRECT COSTS	\$896,230	\$2,340,618	\$2,439,588	\$2,445,891	** \$1,500,000	\$2,110,000	\$2,325,891
COUNCIL RECOMMENDED LEVEL	\$1,095,428	* Region requested a four month extension and was awarded \$321,053 for continuation. This extended their 03 operational year to 10/72. ** Ten month Budget					

SITE VISIT REPORT
MISSISSIPPI REGIONAL MEDICAL PROGRAM
JACKSON, MISSISSIPPI
JUNE 29-30, 1972

Site Visitors

Joseph W. Hess, M.D., Detroit, Michigan, Chairman, Site Visit Team, Member of RMPS Review Committee
John P. Merrill, M.D., Boston, Massachusetts, Member of RMPS National Advisory Council
Claude E. Nichols, Jr., M.D., Harrisburg, Pennsylvania, Practicing Physician, Member of Susquehanna Valley RAG
Mr. Donald Trantow, Evaluation Consultant, Director of Assessment, Georgia RMP

Regional Medical Programs Service

Lee Van Winkle, Acting Chief, South Central Operations Branch
William Torbert, Public Health Advisor, South Central Operations Branch
Vernie Ashby, Public Health Advisor, South Central Operations Branch
Eugene Nelson, Office of Planning and Evaluation
Earle Belue, Division of Professional and Technical Development
T. H. Griffith, HEW Region IV Representative for RMPS

Mississippi Regional Medical Program Staff

T. D. Lampton, M.D., Coordinator
Pat L. Gilliland, Assistant Director for Administration
Guy T. Gillespie, M.D., Assistant Director for Planning and Evaluation
James B. Moore, Ed.D., Assistant Director for Community Liaison and Program Development
Bob Cotten, Communications Specialist
Betty Zimmerman, Grants Management Officer
Jack Gordy, B.S., Planning and Evaluation Assistant
Tom Brooks, M.A., Health Planner
Nita Gunter, M.A., Sociologist - Demographer
Al Betts, Program Specialist
Carlyle Baker, Program Specialist

Mississippi Regional Medical Program Regional Advisory Group

Lewis Nobles, Ph.D., President of Mississippi College,
Chairman of Regional Advisory Group
Guy D. Campbell, M.D., Member of RAG
David B. Wilson, M.D., M.P.H., Chairman of RAG Planning
Committee

Participants

Robert E. Blount, M.D., Dean and Director, University Medical
Center
Charles W. Flynn, Mississippi Hospital Association
Cyril A. Walwyn, M.D., Mississippi Medical and Surgical
Association, Minority Group Representative
Richard E. Barba, Mississippi Division of American Cancer
Society
Miss Lucile Little, Mississippi Heart Association
Frank M. Wiygul, M.D., Mississippi State Board of Health
Arthur A. Derrick, Jr., M.D., Mississippi State Medical
Association
Miss Wynema McGrew, Mississippi Nurses' Association
Alton B. Cobb, M.D., M.P.H., Medicaid Commission Representative
Phil Laird, CHP "A" Agency

Purpose of the Site Visit

The site visit was to review the Mississippi Regional Medical Program's Triennial Application request and to ascertain the progress made by the region since the previous staff assistance site visit of September 1971.

This site visit report is a compilation of observations and conclusions from all members of the site visit team and follows the outline of the RMPS Review Criteria.

A. Performance

Since the Staff Assistance Site Visit of September 1971, the Mississippi Regional Medical Program has taken many positive steps in developing a program that is now a major contributor and a very important leader in the delivery of health care to the people of Mississippi.

The goals and objectives were expanded and delineated during a retreat of the Regional Advisory Group in December of 1971. These are the basis for the new direction MRMP is now moving. The RAG and program staff were also restructured during that retreat which has resulted in a cohesive and dedicated working group. MRMP has not only answered and dealt with all of the criticism and recommendations of the 1971 site visit team, but has moved forward in the accomplishment of other goals.

The coordination between the University Medical Center and the MRMP appears extremely good. MRMP has been instrumental in setting up a School of Allied Health at the University Medical Center for which a Dean has just been appointed.

The number of midwives in the County Health Improvement Program has increased, resulting in a reduction of neonatal deaths in Holmes County. In 1968 the neonatal death rate was 28.0 per 1000 live births. This was reduced to 19.8 in 1970 and 7.0 in 1971. Previously, the neonatal death rate was the highest in the country. Also in Holmes County, a number of pediatric nurse assistants have been trained under the auspices of MRMP and medical care has reached out to the urban community with the establishment of a satellite medical clinic in a trailer.

Renal satellite units have been set up around the state which has significantly reduced the cost of dialysis. In the University Medical Center the approximate cost per patient is \$19,500 per year. In the trailer units (4 currently operational), the cost per patient dialysis has been reduced to \$3,500 for units with 3 or more patients.

Similarly, heart clinics have been set up which have resulted in care being given to patients outside of the hospital, again resulting in cost moderation.

The initial establishment of a stroke care demonstration center has been expanded and clinics outside the hospital have now been set up where neurologists are available for consultation. An average of 100-150 patients per year are being treated. Courses have been developed for physicians and they have been invited to spend 5 days on the ward with a neurologist in the stroke care demonstration center. Some 20 physicians attended the course last year. In addition, nursing care for the stroke patient has been implemented by the development of courses for nurses. Some 15-20 nurses from various parts of the state attended courses last year.

A pulmonary training program in inhalation therapy has been established and a number of inhalation therapy aides trained, who may now function effectively outside hospitals. The 20-week program has trained 38 aides and was designed for the disadvantaged unemployed persons with 30 percent of the ones trained being minorities.

The original coronary care unit, funded by MRMP at UMC, which at the time was the only one in the state, has trained 120 nurses in coronary care. This has resulted in the establishment of a number of other units in hospitals around the state staffed by individuals trained at UMC. Some 4,000 individuals have been trained in emergency cardiopulmonary resuscitation.

An extremely important activity is the program for the training of dental hygienists. This program appears to be particularly effective since there is no dental school in Mississippi. MRMP staff feel that perhaps this program may contribute to the establishment of a dental school. In addition, real effort has been made at establishing an adequate third party payment base to take over the cost of patient care when RMP monies are phased out. There is a close relationship with medicaid since the present head of medicaid is a member of RAG.

Another example of continued support is with the Hollandale Midwifery Project in which medicaid money is paid into a pool which is to help support service costs of the program.

One possible drawback has been the fact that much of the effort of MRMP has been undertaken by faculty members of UMC. This has been possible through MRMP support, but since other sources of funding to support contributions to continuing education by these individuals is slim, it seems unlikely that in the future they can continue their efforts in this area.

There are specific goals, objectives and priorities dealing with the improvement of health care delivery for underserved minorities. MRMP activities have made primary health care services available in heart clinics, neurology, and active stroke programs in which over 50 percent of the patients in attendance represent minority and underserved groups. This type of care has improved services throughout the state bringing the health care team to the patient in settings close to their home and only those patients who need the more extensive work up in the medical centers are referred. This has resulted in the specialty clinics not being swamped with routine patients that can be seen, diagnosed, and treated in the local area.

The training of inhalation therapy aides has attracted minority groups and other project activities which have employed minority members.

Minority patients have taken advantage of all patient activity services funded by MRMP.

Dr. Lampton and staff have assisted minority professionals in obtaining hospital privileges in several instances. When the Black Hospital was closed in the Yazoo City area and patients were referred to the previously all white hospitals, they assisted in getting the black professionals accepted on the staffs, and have also worked with the hospitals in becoming certified for medicaid and medicare programs.

The program staff has one minority professional and one minority secretary. Further efforts are being made to employ competent minorities in unfilled vacancies.

One outstanding program the MRMP staff are involved in is with Black medical students that are attending school outside of Mississippi. Seminars are being held in which these students are brought back to Mississippi in an effort to interest them in returning to the state upon completion of their studies.

The RMP has been instrumental in assisting minority groups throughout the state in obtaining access to health care services, and access to schooling that is available.

B. Process

Coordinator

On the basis of previous visits by RMPS staff and the comments of a number of MRMP program staff and RAG members, the Coordinator has provided strong leadership and appears knowledgeable and exhibits

enthusiasm. There was further evidence of this in the large number of organizational changes that have occurred since the September 1971 site visit. The program has developed a sense of direction and cohesion, and the Coordinator has succeeded in gathering about him a young, dedicated program staff who appear to have the potential for functioning effectively. There is evidence that some further maturity as Coordinator is yet to be developed, but there seems to be little question that Dr. Lampton has made substantial progress as a program manager.

The working relationships with the RAG seem to be cordial and satisfactory as determined from the formal and informal statements of members of RAG. A position of Deputy Coordinator has been created but has not been filled. Dr. Lampton indicated that he is concerned about finding a well-qualified person to fill this position.

Program Staff

The program staff does reflect a relatively broad range of professional and discipline competence although some of them are new and as yet untested in an RMP setting. Unquestionably, there has been substantial improvement in this regard since the September 1971 site visit. A number of the older members of the staff have demonstrated effective administrative management capability although there is substantial room for improvement, particularly in the area of planning. The Assistant Director for Planning and Evaluation is a physician who is half time with MRMP, the only half time position on program staff, and he does not appear to be very sophisticated in the area of program planning. His Chief Planning Assistant is a recent graduate with a master degree in Urban and Rural planning and lacks the necessary experience to provide strong support at this time.

The program staff appears to be adequate, except for the planning section. There was concern on the part of the site visitors regarding the salary level for several key members of the program staff. It was felt that the level was too low to retain competent staff for a long period of time. The new goals and objectives and the general orientation of the program staff appear to be appropriate, but projects which have evolved out of the goals and objectives have yet to be developed.

Regional Advisory Group

The site visitors felt that most of the key health interest in institutions within the region are represented on the RAG, and RAG members appear to be geographically distributed on the planning and executive committees and the task forces.

Dr. Nobles, Chairman of RAG, is the president of Mississippi College and has a broad background in pharmacy. His presentation to the site visitors exhibited intelligence, experience, and practicality. He also has maintained contact with the State Legislature and has been active in lobbying for legislation to increase support for training paramedical personnel.

Most impressive has been the restructuring of RAG. They have become more involved in the activities of MRMP. The RAG is scheduled to meet 3 times per year, but in the last 6 months more frequent meetings have been held with a special retreat in December 1971, to reorient the program based on recommendations of the September 1971 site visit and to develop the current set of goals and objectives.

Attendance at RAG meetings have been running over 50 percent. There is a bylaw's requirement that if a member misses more than 3 meetings he is dropped from RAG membership. There are 11 RAG members classified as consumers out of a total of 37. The consumers actively participate in the deliberation as shown by the RAG minutes.

Since the 1971 site visit, there has been a marked change in the role which RAG plays in the decisionmaking process. The RAG is much more actively involved in planning committee and task force work, and a system is being implemented that involves RAG members on monitoring teams established for each project that is approved and funded.

The Executive Committee meets between RAG meetings, and the RAG has delegated to it authority for approving small projects and grants not over \$2,000. The Executive Committee is geographically representative of the total RAG.

Grantee Organization

The grantee organization (University Medical Center) provides adequate administrative support and there appears to be a good working relationship with MRMP. In general, it permits sufficient freedom and flexibility and does not appear to be interfering with RAG's policy making role. However, MRMP may need some special consideration by the University in terms of personnel policy and the establishment of salary levels for program staff in order to assure appropriate working conditions to retain competent program staff.

Participation

The major health interests in the state appear to be participating and working well with MRMP. Members of these health interests, including the Nursing Association, Medical Association, Black Medical Community, Heart Association, Cancer Society, State Board of Health, Veterans Administration and general practitioners from the rural community, were unanimous and enthusiastic about the aims and accomplishments of MRMP.

Local Planning

MRMP has worked closely with CHP in developing "b" agencies. There are currently 3 operating "b" agencies in Mississippi and MRMP has been involved in getting each of them operational. One of the program's stated objectives for the coming year is to assist in developing "b" agencies in other local areas.

With the cooperation of MRMP, 10 local planning areas throughout the state have been identified. Much of the data used in defining these areas was supplied by MRMP. Active discussions are going on concerning organizations in 9 of the 10 areas and 5 of these are in the active planning stage at this time.

There is an adequate mechanism for obtaining CHP review and comment, and the existing "a" and "b" agencies have input and comment on program proposals.

Assessment of Needs and Resources

The MRMP has participated in and/or has available to it a rather large data base documenting the health needs and resources of Mississippi. However, there has been, thus far, an apparent lack of the expertise needed to move from available data to program development. The needs of Mississippi are so extensive in the health area, that almost any type of project could find some rationale or justification. This situation would seem to make it even more urgent that a careful review and analysis of the available data be made to provide the context for an overall program plan of action which will be most cost effective and efficient in addressing the unmet health needs of the people as a whole. A systematic planning activity remains a weak point in MRMP at this time.

All of the projects in the current triennial application were developed concurrently with the rethinking of the goals and objectives and the restructuring of the RAG and program staff. Consequently, the current set of projects have not evolved as a result of the rethinking which has gone on during the last 10 months, although several of the projects are compatible with the directions expressed by the new goals and objectives.

Management

The coordination of program staff activities has improved substantially since MRMP moved into its new quarters in which staff are in one location and in close physical proximity to one another. None of the dissatisfaction which characterized the program in September 1971, and was rather freely voiced by program staff at that time, was found on this site visit. However, an exception to this general rule was the concern of the site visitors in having a half time person as Assistant Director for Planning and Evaluation. Since this is the one weak area of the program, it was felt that this position should be full-time since new staff members working in this section will need guidance and consultation in directing the activities of the program.

A plan has been developed for regular systematic monitoring of individual projects by both written reports and by site visits of project monitoring teams, which include program staff, RAG members, and other consultants as necessary. Periodic progress and financial reports are also required.

Evaluation

The program has a full-time evaluator who appears to have the potential to improve the evaluation activities of MRMP. He had been with the program only 4 months prior to the site visit. The projects which are currently ongoing, and the new projects in this application, did not have the benefit of his expertise, and the site visit team did not have a basis upon which to judge his performance, although their prognosis was optimistic. His plans for evaluating and monitoring projects, as well as for organizing total program evaluation, appears well conceived and practical. The site visit team was impressed with his presentation and felt that his input to the region will have a positive effect. He plans to build more effective evaluation into new projects, including those which are proposed in the triennial application.

A particular problem which was identified in the application is the difference in evaluative criteria between the stated objectives, project development guidelines, technical review criteria, developmental component priorities, the RAG rating form, and the program evaluation statement form 14. This was called to the attention of the region during the site visit.

C. Proposal

The priorities of MRMP have been established and complement the need for health care in Mississippi. The priorities were established during a retreat of the Regional Advisory Group in December of 1971. The priorities are congruent with the national goals and objectives. In general, the activities proposed for the triennial application relate to the stated goals and objectives, although, for the most part, they were initiated prior to the RAG retreat.

The methodology for monitoring and evaluating the current list of activities were outlined by the Program Evaluator during the site visit. The approach the region has chosen to pursue is both realistic and practical and the site visit team has confidence that the intended results proposed in the activities will be accomplished.

In view of the fact that the University Medical Center is the only institution of higher medical training in the state, and with their program of continuing education, it is felt that the knowledge gleaned by MRMP will be adequately disseminated to the medical and allied health fields throughout the state.

The communications specialist of the program staff has developed methods to keep RAG members, health care providers, and the general public informed on the various activities and the mission of MRMP. His input to the triennial application and his presentation to the site visit team is evidence that his knowledge of the region and of MRMP's mission will be a great asset to MRMP in the area of information and communication.

The program staff feel that because of the paucity of manpower and facilities, the maternal and childcare facilities, which are the spin off of other projects, will help to improve the utilization of manpower and facilities. The project for black physicians preceptorship will be a very necessary prerequisite, since 37% of the population in Mississippi is black, with 41 black physicians practicing in the state. In the view of the inherent problems of "separate but equal," which are not maintained on the surface but are, however, maintained in the mores and customs of the people, programs of this nature have an increasing bearing on the welfare of the entire state.

With the School of Allied Health at UMC and active recruitment of both black medical students and allied health personnel, there can be marked improvement in the number of physicians and allied health personnel who will be serving the community.

MRMP has shown, through the midwifery program, that individuals can be taken care of in outlying areas and that paramedical facilities will be developed, as proposed in the current application to increase the availability of care.

There are ten planning and development districts in the state. MRMP recognizes the fact that health care generally follows trade patterns in Mississippi and that these ten districts form the basis of any approach to improving the health delivery systems, as well as the care that people receive in the region. MRMP is actively involved with CHP to regionalize the health care in Mississippi. The current list of projects proposed in the triennial application is by no means the utopia for regionalization, but the site visit team believes that plans and methods for doing this can be achieved by MRMP.

Although the performance generally has been good, there is a lack of agreement on the part of the program staff, with the precept that "evidence of support for continuation of successful activities in program by community organization or other Federal or State agencies after RMP funding has been phased out," should be provided. In many instances, staff argued that even though no evidence for continuing support is available and in all probability will not be available, the project should be launched and supported in and of itself.

A number of projects, particularly the kidney project, have been partially funded by agencies other than MRMP, and it is felt that each project will, in turn, be reviewed and evaluated with other funding sources being investigated.

Recommendations

1. The site visit team recommends that the Mississippi Regional Medical Program be awarded triennial status, and that the triennial application be approved for funding as follows:

04 Operational Year	\$1,926,984
05 Operational Year	2,200,000
06 Operational Year	2,445,891

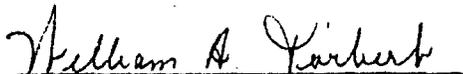
The triennial application includes a request for developmental component.

2. Strengthening of the Planning Staff:
 - a. There should be a full-time director of the planning and evaluation section.
 - b. Extensive training is needed for the new planning staff, including training visits to RMPs which have well organized and operational planning. Suggested RMPs are:

Florida
Georgia
Northlands
Ohio Valley
Tennessee Mid-South

3. Emphasis should be placed, in the immediate period ahead, on the development of written program statements for each of the goals, 1 through 5, with priority and implementation schedules based on the goals and objectives agreed upon. Then these statements could be used as the basis for reevaluating currently developed projects and assessing the need for new project development appropriate to the goals and related program statements.
4. Better documentation of need, based on need assessment studies appropriate to local areas, which relate to program goals and objectives, is necessary.
5. Improved Technical Review input to the RAG and its subcommittees with greater emphasis on Technical Review in the decisionmaking process is essential to the program.

6. The program staff and the planning committee of RAG should coordinate the evaluative criteria with the stated objectives, project development guidelines, technical review criteria, developmental component priorities, the RAG rating form, and the program evaluation statement form 14. The following is a list of the statements that should be coordinated:
 - a. Guidelines--page 83--1st paragraph, Items 1-7
 - b. Technical Review and Rating Form--features 1-5
 - c. Developmental Component Priorities--page 100,1-5
 - d. Goals and Objectives--page 72A & B, I-V
 - e. Criteria #2--page 146, "New Modalities."
 - f. RAG rating form criteria
 - g. Application information for project applicants, 1-3
 - h. General Principles--page 82,1-5
7. MRMP should work to obtain CHP and State funding of ongoing health planning data collection and movement toward placing the data collection project into the State Board of Health or the CHP(a) agency.
8. MRMP program staff salaries should be reviewed with the UMC administration to see if a mechanism can be developed for more adequate program staff compensation.


William A. Torbert

RMP'S STAFF BRIEFING DOCUMENT

REGION: Mississippi RMP

OPERATIONS BRANCH: South Central

NUMBER: RM 00057

Chief: Lee E. Van Winkle

COORDINATOR: Theodore D. Lampton, M.D.

Staff for RMP:

William Torbert - PHA - SCOB

Eugene Nelson - P. & E.

Lawrence Pullen - Grants Mgmt.

LAST RATING: _____

TYPE OF APPLICATION:

Triennial 3rd Year Triennial

2nd Year Triennial Other

Regional Office Representative:

Theoda H. Griffith

Management Survey (Date):

Conducted: May 22-25, 1972

or
Scheduled: _____

Last Site Visit:
September 16-17, 1972 - Staff Assistance

- Chairman - Dr. Joseph Hess, Committee
- Dr. Anthony Komaroff, Council
- Dr. McCall, Consultant
- Dr. Levenson, Consultant
- Dr. Vaun, Consultant

Staff Visits in Last 12 Months:

<u>DATE</u>	<u>PURPOSE</u>
Dec. 1-3, 1971	- RAG Retreat and Staff Assistance
Mar. 22-24, 1971	- RAG Meeting of Project Review
April 1972	- Staff Assistance
May 18-19, 1972	- Verification of Review Process

Recent events occurring in geographic area of Region that are affecting RMP program:

Highlights of activities during the past year involving MRMP program staff:

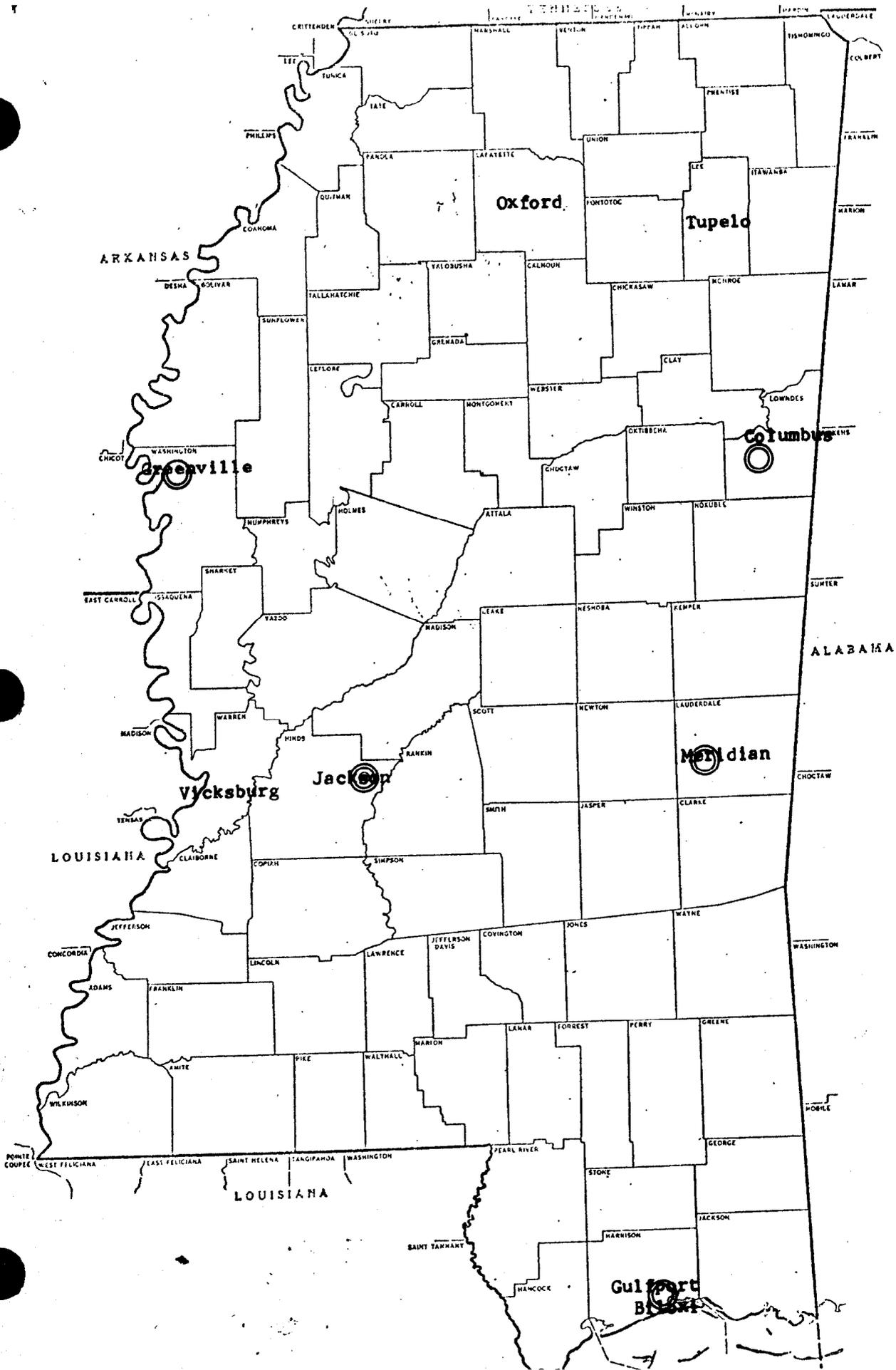
1. In June 1972, Governor Waller appointed Dr. Risher as head of CHP(a) agency.
2. An EMS statewide planning council was established with all agencies involved in Emergency Medical Care participating.
3. Creation of the new School of Allied Health at the University Medical Center. A new Dean was appointed on July 1, 1972.

Handwritten notes:
 1,926,504
 513.823
 96/315
 2,110,158
 DeLong
 Totals



4. The new Riverside Psychiatric Hospital opened -- only privately owned Psychiatric Hospital in Mississippi.
5. Maternal and Infant Care project in Holmes County under the County Health Improvement Program has been expanded to 3 other counties - Warren, Sharkey, Isaquena.
6. Applachian Project became operational and was funded at \$2.4 million.
7. Three Regional Vocational Centers established in Mississippi that included some training for health careers.
8. A New School of Nursing established at the Mississippi State College for Women in Columbus, Mississippi.
9. Legislation has been passed and the Board of Trustees have approved a new dental school for Mississippi.
10. A Nurse Anesthetist program was established at the University Medical Center.
11. The Legislature passed a sickle cell screening program for the public schools.
12. Moorehead Junior College, in the Delta, has initiated a new program for upgrading LPNs to RNs.
13. Tri County Comprehensive Health Program (Yazoo, Madison and Leake Counties) funded at \$416,000 under the Experimental Health Delivery Services.
14. Five National Health Corp personnel assigned to Mississippi.
15. Full-time director of family planning appointed in the State Board of Health.
16. First class of dental hygenists graduated in June of 1972.
17. New Helicopter ambulance service in Hattiesburg. The only one in the state.
18. MRMP was the sponsor of Mississippi's first "Health Expo" held during the first three days of October, 1971, which drew throngs of interested people from all areas of the state.





DEMOGRAPHIC INFORMATION

POPULATION: (1970 Census)

Total Population: 2,216,912 % Urban: 44.5
Population Density: 46.9 per sq. mile % Non-white: 37

ETROPOLITAN AREAS

AGE DISTRIBUTION

Name of SMSA	Pop. in 000's	Percent of Total by Specified Age Group, 1970		
		Age Group	State	U.S.
Total (2)	393.5			
Biloxi-Gulfport	134.6	Under 18 yrs.	38	34
Jackson	258.9	18 - 65 yrs.	52	56
		65 yrs. & over	10	10

Source: Bureau of the Census - PC(1)-A26 and PC(1)-B26 1970 - 1970 Census of Population; State and County #26

INCOME - Average Income per Individual, 1969

State (of RMP)	\$2,192
United States	\$3,680

Source: State data from Statistical Abstract of the U.S., 1970 (Dept. of Commerce)

HOSPITALS

Non-Federal Short and Long-Term General Hospitals, 1971

	<u>Number</u>	<u>Number of Beds</u>
Short-Term	115	9,262
Long-Term	0	0
<u>V.A. General Hospitals</u> (One has long-term unit)	2	1,576

Source: Mississippi Hospitals With License Status and Governing Bodies, February 1, 1971, Mississippi Commission on Hospital Care

REVISION SYSTEM _____

COMPONENT AND FINANCIAL SUMMARY
TRIENNIAL APPLICATION

Component	Current Annualized Level 03 Year 7/71 - 6/72*	Request for Triennial			Committee Recommendation fo Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd ye
PROGRAM STAFF	411,097	513,823	633,842	666,387			
CONTRACTS	----	----	----	----			
DEVELOPMENTAL COMPONENT	----	96,315	190,000	250,000			
OPERATIONAL PROJECTS	485,133	1,730,480	1,555,746	1,529,504			
Kidney	X	(183,634)	(161,915)	(120,403)			
EMS		(----)	----	----			
hs/ea		(116,745)	(137,743)	(150,341)			
Pediatric Pulmonary		(----)	----	----			
Other		(----)	----	----			
TOTAL DIRECT COSTS		896,230	2,340,618	2,439,588	2,445,891		
COUNCIL RECOMMENDED LEVEL	1,095,428	*Region requested a 4 month extension and was awarded \$321,053 for continuation. This extended their 03 operational year to 10/72.					

JULY 17, 1972

BREAKDOWN OF REQUEST PERIOD

REGION - MISS
RM 00057 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
000 MISS REGIONAL MEDICAL PLANNING		\$513,823			\$513,823	\$66,130	\$579,953
0000 RAMP DEVELOPMENTAL COMPUTERS				\$96,315	\$96,315		\$96,315
001 STROKE CARE DEMONSTRATION AND TRAINING	\$122,951				\$122,951	\$47,718	\$170,669
013 EMERGENCY NURSING IN CRITICAL ILLNESS	\$35,400				\$35,400	\$5,897	\$41,297
015 CERVICAL CYTOLOGY SCREENING			\$42,707		\$42,707	\$6,087	\$48,794
017A RENAL DISEASE DIALYSIS CLINICS	\$103,039				\$103,039	\$38,226	\$141,265
017B RENAL DISEASE TRANSPLANTATION				\$80,595	\$80,595	\$34,510	\$115,105
017 CERVICAL ILLNESS	\$103,039			\$80,595	\$183,634	\$72,736	\$256,370
0193 COMMUNITY HEALTH WORKER SYSTEMS OPERATIONAL				\$116,745	\$116,745	\$24,591	\$141,336
020 CONTROL OF INFECTIONS IN HOSPITALS				\$32,465	\$32,465	\$7,528	\$39,993
021 REGIONAL CANCER PROGRAM				\$81,850	\$81,850	\$33,886	\$115,736
022 FOSTER HOME CHILDREN SERVICES				\$50,734	\$50,734		\$50,734
023 CONT. EDUCATION IN MATERNAL INFANT CARE				\$230,261	\$230,261	\$19,715	\$249,976
024 MISS COOP HEALTH STATISTICS SYSTEM				\$87,451	\$87,451	\$25,739	\$113,190
025 PULMONARY THERAPY PROGRAM COMMUNITY HOSPITALS				\$88,259	\$88,259	\$25,230	\$113,489
026 REGIONAL RURAL MATERNAL INFANT CARE				\$80,784	\$80,784		\$80,784
027 STROKE REHABILITATION SYSTEM				\$58,808	\$58,808		\$58,808
028 CONT AND INSERVICE EDUCATION NURSING FACILITIES				\$46,087	\$46,087		\$46,087
029 REGIONAL NEWBORN CARE				\$144,362	\$144,362	\$32,461	\$176,823
030 ELECTRICAL HAZARDS SAFETY DEMONSTRATION				\$79,364	\$79,364	\$22,136	\$101,500
031 RADIOTHERAPY INT PLANNING CONSULTANTS				\$80,041	\$80,041	\$3,625	\$83,666
032 EDUCATION QUALITY SERVICES FOR MENTALLY ILL SERVED				\$38,938	\$38,938		\$38,938
033 PRECEPTOR TRAINING BLACK MEDICAL AND DENTAL STUDENTS				\$20,220	\$20,220		\$20,220
034 PATIENT AND STAFF EDUCATIONAL CLINIC DISEASES				\$67,149	\$67,149	\$8,452	\$75,601
035 CONT ED HLTH PROV USE				\$42,270	\$42,270	\$13,413	\$55,683
TOTAL	\$261,390	\$513,823	\$42,707	\$1,522,698	\$2,340,618	\$415,344	\$2,755,962

JULY 17, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - MISS
RM 00057 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
C000 MISS REGIONAL MEDICAL PROGRAM		\$633,842			\$633,842
0000 MRMP DEVELOPMENTAL CORPUS				\$250,000	\$250,000
001 STROKE CARE DEMONSTRATION					
013 EMERGENCY NURSING IN CRITICAL ILLNESS	\$39,596				\$39,596
015 CERVICAL CYTOLOGY SCREENING			\$50,441		\$50,441
017A RENAL DISEASE DIALYSIS	\$100,276				\$100,276
017B RENAL DISEASE TRANSPLANTATION		\$61,639			\$61,639
017 COMBINES TOTAL	\$100,276	\$61,639			\$161,915
019B COMMUNITY HEALTH WORKER SYSTEMS OPERATIONAL				\$137,743	\$137,743
020 CONTROL OF INFECTIONS IN HOSPITALS				\$35,738	\$35,738
021 REGIONAL CANCER PROGRAM				\$108,455	\$108,455
022 FOSTER HOPE CHILDREN SPECIAL SERVICES				\$103,034	\$103,034
023 CONT EDUCATION IN MATERNALITY CARE				\$66,732	\$66,732
024 MISS COOP HEALTH STATISTICS SYSTEM				\$121,218	\$121,218
025 PULMONARY THERAPY PROGRAM COMMUNITY HOSPITALS				\$95,920	\$95,920
026 REGIONAL RURAL MATERNAL INFANT CARE				\$74,059	\$74,059
027 STROKE REHABILITATION SYSTEM				\$37,157	\$37,157
028 CONT AND INSERVICE EDUCATION NINE CITIES				\$47,924	\$47,924
029 REGIONAL NEWBORN CARE				\$169,078	\$169,078
030 ELECTRICAL HAZARDOUS SAFETY PROGRAM				\$100,459	\$100,459
031 RADIOTHERAPY TRI PLANNING CONSULT					
032 EDUCATION QUALITY SERVICES EMP. MENTALLY RETARDED				\$39,774	\$39,774
033 PRECEPTOR TRNG BLACK MEDICAL AND DENTAL STUDENTS				\$50,440	\$50,440
034 PATIENT AND STAFF EDUCATION RELATED CHRONIC DISEASES				\$84,395	\$84,395
035 CONT ED HLTH PRGV USE				\$31,668	\$31,668
TOTAL	\$139,872	\$695,481	\$50,441	\$1,553,794	\$2,439,588



JULY 17, 1972

BREAKDOWN OF REQUEST
06 MONTH AM PERIOD

REGION - MISS
RM 00057 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
000 MISS REGIONAL MEDICAL PROGRAM		\$666,387			\$666,387	\$1,814,052
000 MRMP DEVELOPMENTAL COMPONENT				\$250,000	\$250,000	\$596,315
001 STROKE CARE DEMONSTRATION AND TRAINING						\$122,951
013 EMERGENCY NURSING IN CRITICAL ILLNESS						\$74,996
015 CERVICAL CYTOLOGY SCREENING			\$38,310		\$38,310	\$131,458
017A RENAL DIALYSIS		\$98,099			\$98,099	\$301,414
017B RENAL DIALYSIS TRANSPLANTATION				\$22,304	\$22,304	\$164,538
017 CEMENTUM TREATMENT		\$98,099		\$22,304	\$120,403	\$465,952
019B COMMUNITY HEALTH WORKERS SYSTEMS OPERATIONAL				\$150,341	\$150,341	\$404,829
020 CONTROL OF INFECTIONS IN HOSPITALS				\$37,642	\$37,642	\$105,845
021 REGIONAL CANCER PROGRAM				\$117,779	\$117,779	\$308,084
022 FOSTER HOME CHILDREN SPECIAL SERVICES				\$150,553	\$150,553	\$304,321
023 CONT. EDUCATION IN MATERNITY CARE				\$70,482	\$70,482	\$367,475
024 MISS COOP HEALTH STATISTICS SYSTEMS				\$130,440	\$130,440	\$339,109
025 PULMONARY THERAPY PROGRAM IN COMMUNITY HOSPITALS						\$184,179
026 REGIONAL MENTAL MATERNAL HEALTH SERVICES				\$62,919	\$62,919	\$217,762
027 STROKE REHABILITATION SYSTEMS				\$17,579	\$17,579	\$113,544
028 CONT AND INSERVICE EDUCATION FOR NURSES				\$44,424	\$44,424	\$138,435
029 REGIONAL NURSING CARE				\$247,505	\$247,505	\$560,945
030 ELECTRICAL HAZARDOUS SAFETY PROGRAMS				\$101,650	\$101,650	\$281,473
031 RADIOTHERAPY TREATMENT PLANNING CONSULT						\$80,041
032 EDUCATION QUALITY SERVICES FOR MENTALLY RETARDED				\$38,921	\$38,921	\$117,633
033 PRECEPTOR TRAINING BLACK MEDICAL AND DENTAL STUDENTS				\$70,660	\$70,660	\$141,320
034 PATIENT AND STAFF EDUCATION IN SELECTED CHRONIC DISEASES				\$102,129	\$102,129	\$253,673
035 CONT. ED HLTH PROV USE				\$27,767	\$27,767	\$101,705
TOTAL		\$764,486	\$38,310	\$1,643,095	\$2,445,891	\$7,226,097

JUNE 8, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMPS-DSM-JTOFHL #20

REGION 57 MISS RMP SUPP YR 03 OPERATIONAL GRANT (DIRECT COSTS ONLY) ALL REQUEST AND AWARDS AS OF MAY 31, 1972

COMPONENT NO	TITLE	AWARDED 01	AWARDED 02	AWARDED 03 07/71-06/72	AWARDED TOTAL	REQUESTED 04	REQUESTED 05	REQUESTED 06	REQUESTED TOTAL
C000	PROGRAM STAFF	306900	401800	411097	1119797	**			
001	COMPR STRK DET	62600	119800	91627	274027	**			
002	TRN DXRX CHR PU	200300	178000	93784	472084	**			
003	MISS PG INST IN	38500	57200	62790	158490	**			
004	RECR HLTH MNPW	70000			70000	**			
005	CVA CLNCS INDIG	29000	31200	33592	93792	**			
006	EST COORD SYS C	164600	109300	54470	328370	**			
008	COMPR PRG CPR T	39000	47000		86000	**			
010	RAD RX TRN CONS	204900	45400	31110	281410	**			
011	REG COMPR NEURO	67500	71000	52332	190832	**			
012	COMPR REN DIS T	46300	34700		81000	**			
013	EMRGY N CRTCL I			25210	25210	**			
017	RENAL DIS PROG			30218	30218	**			
018	HYP CONTL DEM A			10000	10000	**			
- TOTAL -		1229600	1095400	896230	3221230	**			

HISTORICAL PROGRAM PROFILE OF REGION

- One Medical School located in Jackson serving the entire state.
- For the most part, medical care is available to all citizens, but the real problem is in educating the people to take advantage of medical services.
- Upgrading and increasing health manpower is the major goal for this region and positive steps are being taken to alleviate this problem. The region was awarded supplemental funds to begin planning for health services/educational activities.
- Mississippi has only one physician per 1,350 people, which is half the average for the U.S. This figure includes all urban areas. In many rural districts of Mississippi, the ratio reaches almost astronomical proportions.
- The region's emphasis in the past has been categorical in heart, cancer, and stroke, and in continuing education with activities centering around the Medical School.
- The new thrust is regionalizing the activities with the major emphasis on improving the health care delivery system access and availability to all persons.
- Projects being submitted by the region have been designed for outreach into all areas of the state.
- The region is requesting funds for 2 continuation projects. All other projects are new. Ten old projects are being terminated.
- The developmental component is intended to provide MRMP with funds to move rapidly and expeditiously in responding to emerging or unique program development activities.
- The internal problems that plagued the region a year ago no longer exist.
- The program has moved to new quarters outside of the Medical School complex.
- The program staff has been reorganized and new staff have been hired to fill needed vacancies.
- The RAG has been restructured and is no longer a reactionary group but now exert good leadership and strong influence on the program and are actively involved in directing the activities of MRMP.

- The Mississippi RMP, a year ago was just beginning to turn the corner in becoming a strong and important leader in the development and delivery of health services to all people of Mississippi. During the past year they have "put it all together" so to speak and are now a cohesive, dedicated and enthusiastic group who are looked on by the health professionals of Mississippi as strong and reliable leaders in developing programs that are innovated and challenging, but are designed to meet the health needs of the region.

STAFF OBSERVATIONS

Principal Problems:

Review of the region during last year's review cycle revealed the following problems:

1. Goals and objectives were broad, giving the region little direction.
2. No Black professionals on program staff.
3. Program staff needed further strengthening in both planning and evaluation skills.
4. RAG needed to be restructured and become more involved in directing the program.
5. The region was relying quite heavily on the "bubbling up" technique as opposed to a balance between this and a RAG and program staff stimulated system of project development.
6. Evaluation had not consisted of more than progress reporting.

Principal Accomplishments:

1. Program staff has moved to new facilities away from the Medical Center, resulting in a new identity for MRMP throughout the State.
2. RAG and program staff has been restructured and reorganized and RAG is now more involved and is directing the program instead of being a reactionary group.
3. Goals and objectives have been refined and further delineated, and RAG and program staff are developing programs to meet the goals and objectives rather than waiting for activities to bubble up.
4. Additional staff have been hired to fill vacancies in planning and evaluation. A Black professional has also been hired to work in the program development area.
5. Evaluation techniques have been developed for evaluating projects and overall programs.

Issues Requiring Attention of Reviewers:

The region is requesting triennial status and developmental component.

Much of the effort of MRMP has been undertaken by faculty members of the University Medical Center. This has been possible through MRMP support, but since other sources of funding to support contributions to continuing education by these individuals is slim, it seems unlikely that in the future they can continue their efforts in this area.

MRMP may need some special consideration by the University in terms of personnel policy and the establishment of salary levels for program staff in order to assure appropriate working conditions to retain competent program staff.

RECOMMENDATIONS FROM REVIEW COMMITTEE

application request, they suggested that more time is needed to concentrate on initiating comprehensive activities and programmatic thrusts.

Review Committee noted that the Program has made excellent progress in increasing minority involvement on the Executive Committee, RAG and its committees. The Coordinator has already responded to the site visitors concerns regarding the employment of minority members on program staff. It was noted that the Coordinator has hired three additional minority staff members thus resulting in a total of six minority program staff members.

Committee noted that the NMRMP's program objectives are commendable. However, the proposed use of funds appeared to be a continuation of old-line activities. Concern was expressed regarding the proposed continuation of ongoing activities for a fifth consecutive operational year. In this connection, there was extended discussion concerning the request for continued funding for the cancer registry. The site visit team had dealt with this issue and had strongly urged the Program as well as the project director to seek other sources of support for this activity during the next year. Reviewers agreed with site visitors that the \$118,000 requested should be budgeted and monitored as an operational project rather than as a program staff activity. Reviewers were made aware of several of the outstanding qualities of this particular program and were informed of the partial support being made available from the National Cancer Institute.

Reviewers also noted the request for a substantial increase in the number of personnel needed to implement project activities under program staff direction. It was felt that this strategy should be discouraged since it would probably lead to further prolongation of activities beyond a maximum three-year time-limit. They recommended that the Region should consider supporting additional staff through the use of operational project funds rather than pursuing continued assistance through its program staff budget.

Review Committee disagreed with the site visit report statement "if the Program is interested and seriously intends to facilitate HMO planning, it should bring onto the program staff people with appropriate experience in the managerial and financial aspects of HMO planning. Committee noted that two organizations in Albuquerque have funded HMO activities and could be called upon to offer consultation to other applicants upon demand.

Committee further discussed the overall staff complement and agreed that the Community Health Services Response System was particularly outstanding. Recognition was made of the number of demands from communities which were being responded to from this section. In spite of this commendable effort, reviewers believed that this staff should concentrate more of its efforts in stimulating programmatic activities rather than responding solely to the incoming single, isolated project requests.

RECOMMENDATIONS FROM REVIEW COMMITTEE

Even though the health related resources of the Region were recognized as being limited, major emphasis should be exerted for developing other sources of support for the continuation of activities initiated by the Program. Incremental funding concepts should be encouraged at the inception of each activity. The reviewers also suggested that more input and assistance could/should be recruited and exchanged with the Lovelace Foundation.

Finally, Committee noted that RMPS policy, adopted in August 1969 by the NAC, does not permit support of basic training in established health professions. Therefore the proposed activities for dental assistants, medical lab technicians and inhalation technicians were considered to be ineligible for RMPS operational grant support.

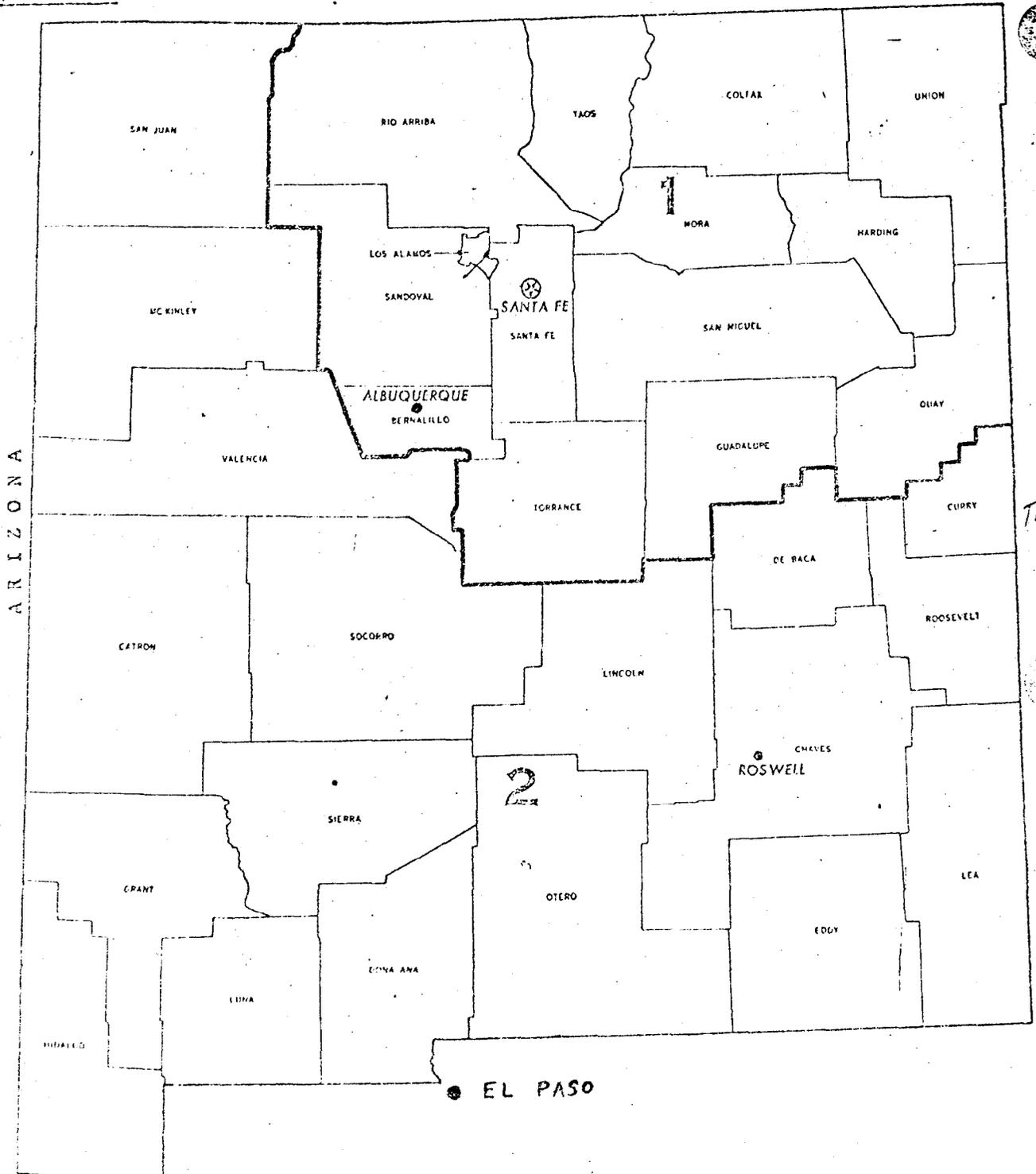
COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>04</u> Year 1,036,719	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year 05	2nd year 06	3rd year 07	1st year	2nd year	3rd year
PROGRAM STAFF	610,682	1,201,263 118,459 <u>1,319,722</u>	1,381,452 84,825 <u>1,466,277</u>	1,441,515 56,550 <u>1,498,065</u>	1,070,000**	1,120,000	1,170,000
CONTRACTS							
DEVELOPMENTAL COMPONENT		138,228	158,968	165,974	80,000	80,000	80,000
OPERATIONAL PROJECTS	426,037*	232,305	135,906	55,390			
Kidney	X	()					
EMS		()					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	1,036,719	1,690,255	1,761,151	1,719,429	1,150,000	1,200,000	1,250,000
COUNCIL RECOMMENDED LEVEL		*Includes Project #6 - Emergency Medical Services funded at \$61,274 **Program staff and operational projects combined.					

REGIONAL CHARACTERISTICS

GEOGRAPHY

NEW MEXICO



TEXAS

Regional Delineation:

NEW Regional Office VI

State/ States - State of New Mexico

Counties - 32

Congressional Districts- 2

Subregions ---

Overlap / interface - with portion of Navajo Indian Reservation, Arizona

I. REGIONAL CHARACTERISTICS (Cont'd)

2yr but less than 4 yr.
beyond high school

Schools of Higher Education: Total 11
8 Public; 3 private.

2 (Public)

FACILITIES AND RESOURCES

SCHOOLS

Schools	No.	Enrollment 1970- (1969/70)	71	Graduates 1970- (1969/70)	71	Location
<u>Medicine and (Osteopathy)</u>						
University of N.M. School of Medicine	(1)	(115)	154	(21)	26	Albuquerque
Dental	0					
Pharmacy (1967/68)	1	102		32		Univ. of N.M. Albuquerque
<u>Nursing Schools</u>						
Professional Nursing Number	3	291		32		(all Univ. based)
Practical Nursing Number	6					(2 college or Univ. based)
<u>Allied Health Schools (Approved Programs) *</u>						
Cytotechnology Number	1					Univ. of N.M. Albuquerque
Medical technology Number	5	(1 at V.A. hospital)				
Radiologic Technology Number	7	(1 at PHS Indian MC, Gallup)				
Physical therapy Number	--					

Note: See Manpower Table for sources - page 8.

Sources: * Directory of Approved Allied Medical Educational Programs, Council on Medical Education, Amer. Med. Assoc. Chicago 1971.

I. REGIONAL CHARACTERISTICS (Cont'd)DEMOGRAPHY

POPULATION:

Total Population : 1,016,000
 Population Density: 8 per sq. mile

% Urban - 69
 % Non-white - 10
 (large proportion
 Indian and Sp. surname)

METROPOLITAN AREAS

Name of SMSA	Population (in 000's)
Total	313.8
Albuquerque	313.8

AGE DISTRIBUTION

Percent of Total by Specified Age Group, 1970		
Age Group	State	U.S.
Under 18 yrs.	42	35
18 - 65 yrs.	51	55
65 yrs. & over	7	10

Source: Bureau of the Census- PC (V1 & V2) 1970 - 1970 Census
 of Population; State and County # 33
 Bureau of the Census - PC (P3) - 3, U.S. Population
 of Standard Metropolitan Statistical Areas, 1970.

INCOME - Average Income per Individual, 1969 & 1970

State (of RMP) N.M.	\$2894	1970	
United States	\$3680	NM 3044	rank 44th
		US 3910	

Source: State data from Statistical Abstract of the U.S., 1970
 (Dept. of Commerce)

REGIONAL CHARACTERISTICS (Cont'd)

FACILITIES AND RESOURCES (Cont'd)

HOSPITALS

Non Federal Short and Long-term general hospitals, 1969 & 1970				
	Number 1970		Number of Beds 1970	
Short term	41	39	3423	3351
Long term	2	3	430	462
V.A. General hospitals	1		409	430
			430	

Bed-size (general hospitals) incl. osteop.	# of hospitals	Number of hospitals with Special Facilities	
			# of facil.
Under 50	12	Intensive CCU	14
50 - 100	13	Cobalt therapy	4
100 - 200	7	Radium therapy	9
200 - 300	3	Renal Dialysis	1
300 - 400	1	in patient	
400 - 500		Rehab-in patient	6
500 and over	-----	Isotope facility	10
(others newly registered; no data)			
Source: Amer. Hospital Assoc. 1970 Guide Issue August 1970			

NURSING AND PERSONAL CARE HOMES, 1967

	Number	Number of Beds
Skilled Nursing Homes	20	1358
Long term care units	11	493
Personal care Homes with Nursing Care	9	188

Source: NCHS - A Master Facilities Inventory
 County and Metropolitan Area Data Book
 PHS- Number 2043 - Section 2, November 1970

I. REGIONAL CHARACTERISTICS (Cont'd)FACILITIES AND RESOURCES (Cont'd)MANPOWER

Profession	Number	% Total	Ratio per 100,000
Physician - active	895	100.0	
general practice	235	20.0	
medical specialty	204	17.0	
surgical specialty	281	25.0	
other			
Osteopath - active			
Total active MD & DO	970		120
Physicians - inactive	80		
Dentists - active	344		
Professional nurses			
- active	2511		251
- inactive	1095		--
Lic Pract. Nurses			
active	712		70
inactive			
Medical technologists			
Radiologic technologists	223		
Physical therapists			
Medical record librarians			
* GROUP PRACTICES- Total	26		
Single Specialty	9		
General practice	4		
Multispecialty	13		

* Medical Groups in the U.S., 1969 ; A.M.A., Chicago, 1971

Sources: Distribution of Physicians, Hospitals, and Hospital Beds
in the U.S. 1969, Amer. Medical Assoc., Chicago, 1970.

Health Manpower Source Book, Section 20, PHS-NIH-BEMT, 1969

The Health Professions Educational Assistance Program,
Report to the President and the Congress, Sept. 1970
(PHS-NIH-BEMT)

NEW MEXICO

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>04</u> Year 1,036,719	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year 05	2nd year 06	3rd year 07	1st year	2nd year	3rd year
PROGRAM STAFF	610,682	1,201,263	1,381,452	1,441,515			
CONTRACTS		118,459	84,825	56,550			
DEVELOPMENTAL COMPONENT							
OPERATIONAL PROJECTS	426,037*	232,305	135,906	55,390			
Kidney	X	()					
EMS		()					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	1,036,719	1,690,255	1,761,151	1,719,429			
COUNCIL RECOMMENDED LEVEL							

*Includes Project #6 - Emergency Medical Services funded at \$61,274.

JULY 18, 1972

BREAKOUT OF REQUEST
BY PROGRAM PERIOD

REGION - NEW MEXICO

PM 00034 10/72

PAGE 1

NO. OF PAGES 1

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
COCO PROGRAM STAFF		\$1,201,263			\$1,201,263	\$273,018	\$1,474,281
DOOO DEVELOPMENTAL COMPONENT				\$138,228	\$138,228	\$37,039	\$175,267
OCIA TUMOR REGISTRY		\$118,459			\$118,459	\$34,621	\$153,080
004 LABORATORY SCIENCES MANP OWER DEVEL		\$33,052			\$33,052	\$10,947	\$43,999
006 PRIORITY MEDICAL SERVICE		\$63,969			\$63,969	\$19,098	\$83,067
007 CONTINUING EDUCATION		\$20,461			\$20,461	\$1,801	\$22,262
008 HEALTH SCIENCES INFORMAT IGN CENTER		\$36,846			\$36,846	\$12,667	\$49,513
010 CARDIOPULMONARY EVALUATI ON LABORATORY		\$10,000			\$10,000	\$1,997	\$11,997
015 STREPTOCOCCAL THROAT CUL TURE PROJECT		\$23,247			\$23,247	\$6,411	\$29,658
017 LEUKEMIA LYMPHOMA		\$44,730			\$44,730	\$15,787	\$60,517
TOTAL		\$1,552,027		\$138,228	\$1,690,255	\$413,386	\$2,103,641

JULY 18, 1972

BREAKOUT OF REQUEST
0% PROGRAM FUNDING

REGION - NEW MEXICO
RM 00034 10/72

PAGE 2

00034 10/72 1

IDENTIFICATION OF COMPONENT	(10) CNT. WITHIN APPR. PERIOD OF SUPPORT	(12) CNT. BEYOND APPR. PERIOD OF SUPPORT	(14) APPR. NOT PREVIOUSLY FUNDED	(11) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
0000 PROGRAM STAFF		\$1,381,452			\$1,381,452
0000 DEVELOPMENTAL COMPONENT				\$158,968	\$158,968
001A TUMOR REGISTRY		\$84,825			\$84,825
004 LABORATORY SCIENCES MANP OWER DEVEL					
006 PRIORITY MEDICAL SERVICE S		\$47,925			\$47,925
007 CONTINUING EDUCATION					
008 HEALTH SCIENCES INFORMAT ION CENTER		\$42,366			\$42,366
010 CARDIOPULMONARY EVALUATI ON LABORATORY					
015 STREPTOCOCCAL THROAT CUL TURE PROJECT		\$23,250			\$23,250
017 LEUKEMIA LYMPHOMA		\$22,365			\$22,365
TOTAL		\$1,602,183		\$158,968	\$1,761,151



JULY 18, 1972

BREAKOUT OF REQUEST
07 PROGRAM PERIOD

REGION - NEW MEXICO
RM 00034 10/72

PAGE 3

PHO 5-064-11062 1

IDENTIFICATION OF COMPONENT	CENT. WITHIN APPR. PERIOD OF SUPPORT	CENT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF		\$1,441,515			\$1,441,515	\$4,024,230
0000 DEVELOPMENTAL COMPONENT				\$165,974	\$165,974	\$463,179
001A TUMOR REGISTRY		\$56,550			\$56,550	\$259,834
004 LABORATORY SCIENCES MAINT OWER LEVEL						\$33,052
006 PRIORITY MEDICAL SERVICES						\$111,894
007 CONTINUING EDUCATION						\$20,461
008 HEALTH SCIENCES INTERNATIONAL CENTER		\$44,208			\$44,208	\$123,420
010 CARDIOPULMONARY EVALUATION LABORATORY						\$10,000
015 STREPTOCOCCAL THROAT CULTURE PROJECT						\$46,497
017 LEUKEMIA LYMPHOMA		\$11,182			\$11,182	\$78,277
TOTAL		\$1,953,455		\$165,974	\$1,719,429	\$5,170,835

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FUNDING HISTORY LIST

RMPSP-CSP-JTCFHL-20

REGION 34 NEW MEXICO

RMP SUPP YR 04

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 197

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED	
		01	02	03	04	TOTAL	05	06	07	TOTAL	
		09/71-12/72					01/73-12/73 01/74-12/74 01/75-12/75				
0000	PROGRAM STAFF	364300	466000	385200	651473	1868973	**	1201263	1381452	1441515	4024230
0001	PROJECT 1 A TCM				162774	162774	**				
0000	DEVELOPMENTAL C						**	138228	158968	165974	463170
001A	TUMOR REGISTRY						**	118459	84825	56550	259834
002	MODEL CARDIAC C	143900	170400	97800	16381	428481	**				
003	CORONARY CARE N	21500	63800	42300	5721	173721	**				
004	LARCRATRY SCIE	104200	98600	70500	50275	323575	**	33052			33052
005	STROKE PROGRAM	178000	178900	144600	89432	528932	**				
006	EMERGENCY MEDIC	30600	59500	50500	87103	227703	**	63969	47925		111894
007	CIRCLIT RIDING	44700	38400	19800	53308	176208	**	20461			20461
008	HEALTH SCIENCES	25000	38700	33200	50694	147594	**	36846	42366	44208	123420
009	PEDIATRIC PULMC	56600	95700	73700	66900	255500	**				
010	CARDIOPULMONARY	15000	21000	17500	21086	74586	**	10000			10000
014	MONITORING REMD				51000	23302	**				
015	STREPTOCOCCAL T				19100	29994	**	23247	23250		46497
016	HEART SOUND AND				16000	19070	**				
017	LEUKEMIA LYMPH				24700	54775	**	44730	22365	11182	78277
018	E M S IN RURAL				564721	564721	**				
019	AHEC 2 COMMUNIT				20500	20500	**				
020	AHEC 2 COMMUNIT				20500	20500	**				
021	AHEC 2 COMMUNIT				20500	20500	**				
022	AHEC 2 COMMUNIT				20500	20500	**				
- T O T A L -		965200	1253000	1045900	2029009	5293109	**	1640255	1761151	1719429	5170835

HISTORICAL PROGRAM PROFILE OF REGION

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 Dean of the School of Medicine was appointed RMP Director, as well as chairman of the Executive Committee of the RAG.

The first planning grant was awarded for the period October 1, 1966 to November 30, 1967. A seven month grant period was awarded for the second year planning continuation because of disapproval by the National Advisory Council of the Region's first operational application. Reasons for disapproval were:

- 1) no justification for expenditures of 01 year funds;
- 2) over commitment of Dr. Fitz, the Coordinator;
- 3) planning activities for the 02 year were vague and seemed operational in nature; and
- 4) no RAG involvement.

The Region resubmitted an improved operational application described as "Phase I" program with five operational projects. The Review Committee (January 11-12, 1968) recommended deferral and a site visit to determine the real needs of the region with appropriate translation into a unified comprehensive proposal with a truly regional orientation.

Prior to the site visit, the NM/RMP submitted a Phase I supplement which included a number of changes in the proposal. The National Advisory Council of May 27-29, 1968 recommended approval in a reduced amount and a grant was made in the amount of \$965,305 for Core and seven projects.

The progress report for the first year indicated some organizational improvements with a notable shift away from the medical school. The region identified \$355,612 in unspent balances and was granted \$1,252,911 (D.C.) for a fourteen month period.

The continuation application for the 03 year requested Core and nine projects (\$1,053,537) and carryover balances in the amount of \$174,902. The continuation award for the third operational year was made effective September 1, 1970 for twelve months with a direct cost amount of \$1,170,171.

On May 1, 1971 the New Mexico RMP submitted its triennial application (including a developmental component) request for the 04 year, \$1,003,503, for the 05 year \$985,603 and for the 06 year \$886,971.

On June 8-9, 1971 the NM/RMP was site visited. The site visit team identified the major strengths to be the good relationships that exist between the NM/RMP and other professional groups, and the Dean of the Medical School supportive role in the RMP. However, major weaknesses in the Region still existed. These were: 1) an excess dependency of the Medical School on the resources of NM/RMP; 2) lack of a good coordinator; 3) need for strengthening of Program Staff; 4) better representation of the Executive Committee of the RAG; and 5) lack of progress in the kidney disease area. The program received \$796,312 for its 04 year (only one additional year) with a follow-up site visit in a year to evaluate a revised triennial application.

In July 1971, James R. Gay, M.D. became new Coordinator. During the past year, Dr. Gay has reorganized the New Mexico RMP, hired new Program Staff, enlarged the New Mexico RAG from 41 to 116 members, increased the number of its committees, revised by-laws, and revised organizational structure from traditional mode (vertical hierarchical pattern) to matrix system where everyone is in a co-equal position on an organizational chart.

In April, 1972, the budget period for the program was extended an additional four months to December 31, 1972. An amount of \$1,382,288 was made available for the 16 month period (9/1/71-12/31/72).

The June, 1972 RMPS National Advisory Council approved Project #18- Statewide Emergency Medical Services for \$425,675 for 01 year, and \$139,046 for 02 year. Also projects #'s 19-22 were approved for \$82,000 for only one year. The Program is presently supported in the amount of \$2,029,009 for the 04 year budget period.

On July 1, 1972 the New Mexico RMP has submitted its revised triennial application (including developmental component) request for its 5th, 6th and 7th years of financial support.

STAFF OBSERVATIONS

Principal Problems:

1. Program Staff budget request is large i.e. requesting 34 additional staff members.
2. Large proportion of Program Staff budget for equipment
3. Program Staff being project directors could become conflict of interests.
4. Other areas of continued financial support after the withdrawal of RMP support.
5. Why does NM/RMP continue to fund Project #1A- Tumor Registry when on pge. 10, item 9 - it states... continues objections to Tumor Registry...
6. Does a three year plan really exist?
7. Program did not submit any new projects as part of its triennial application
8. RMPS policy prohibits more than 5 years of financial support for projects #6 and #8.

Principal Accomplishments:

1. Assisted Home Education Livelihood Program (H.E.L.P.) to assume responsibility for the Migrant Health Program in New Mexico.
2. NM/RMP has reorganized total Program.
3. Provided assistance to small clinics throughout New Mexico.
4. Provided excellent assistance to communities for obtaining National Health Service Corps placement of assignees.
5. Program Staff has responded to many community requests for assistance
6. Excellent representation of minorities on Executive Board, RAG, and Committees.

Issues requiring attention of reviewers:

1. RMPS policy, adopted in August 1969 by NAC does not permit support of basic training in "established health professions. Therefore training programs for dental assistants (p.45), medical laboratory technicians (p.95) or inhalation therapy technicians (p.119) are ineligible for RMPS operational grant support.
2. NM/RMP states on p. 42, item 10, that it plans program disengagement and recycling of funds. How does the transfer of some of the staff positions and activities of the Community Rehabilitation activity at a cost of \$95,000 fit in with this plan?

STAFF OBSERVATIONS (continued)

Part 5 - Regional Characteristics

Three outstanding features of these publications are the instructive nature of the content, the easy readability of the style of writing and the ingenuity in analysis of sociological factors. Part 5, Appendix I and II provide a beautiful education on social factors, their relation to disease, and their use as indices of health especially where direct measures of health are not available. The discussion on infant mortality, longevity, and educational level lay the foundation for their use as indicators of health.

Appendix III and Appendix IV are based on a mathematical technique known as Factor Analysis. The entire analysis and interpretation is based on the assumption that the sociological concept of "Factors" is valid. A more serious question can be raised about the "statistical significance" of some of the findings. In Appendix III, they use County Data which are gross and in Appendix IV they use Enumeration District Data which are inadequate and the results in the two reports differ as a result.

Part 10 - Manpower Development

The New Mexico RMP states that the State Senate Bill 71, which requires M.D.'s and O.D.'s to participate in continuing education activities, has given new impetus to RMPs's continuing education activities. The stated purpose of the Act is to "protect the health and well being of the citizens of the State." If continuing education is to have an effect on people's health, continuing education needs should be determined by identified deficits in patient care rather than on what the provider would like to learn, and evaluation of continuing education activities should focus on provider performance and changes in care rather than on provider satisfaction with the program. New Mexico RMP mentions hospital medical audit procedures as one kind of input into program planning. There should be increased emphasis on this and similar kinds of need determination. On page 8 of the Manpower Development section, Part 10, the applicant mentions that a proposal to develop evaluation criteria and a controlled study of outcomes has been submitted but does not elaborate any further.

The Nursing component of the Manpower Development section states that the New Mexico RMP is reinforcing efforts of health care organizations in measuring quality of care provided. How are they doing this?

STAFF OBSERVATIONS (continued)

The Allied Health Component of Manpower Development mentions team approach to management of health problems as one of its functions, The Nursing Section does likewise. Do the teams consist of mixtures of educational levels of nursing or allied health personnel or are they talking about teams made up of several different disciplines? Elaboration is needed.

What are the interrelationships between the many educational activities proposed in this triennial application? For example, how does the health aide training described in the Home Health Network (page 49, triennial application) fit in with the Community Rehabilitation proposal on page 43? Will the planning for dental health training, at Eastern New Mexico University (page 46) be coordinated with or incorporated into the planning for a health education system for that section of the State, a health services/education activity which was approved June 1/72 for supplemental funding? Indeed, how does the RMP plan to relate all of its already existing education activities to the four consortia for health services/education activities being planned throughout the State? If manpower development is to be considered as extending along a continuum of recruitment, production, distribution, utilization and continuing education, then the region should be considering the interrelationships and coordination of all of its ongoing and projected educational activities. This kind of coordination would also help fulfill one of the Region's stated objectives-- to manage programs more efficiently and moderate costs.

Part 11 - Health Care Delivery Systems

Staff was impressed with the comprehensiveness as well as the direction of the initiative. This activity is entirely appropriate for an RMP and indeed, is very optimistic in scope.

Part 12 - Selected Characteristics of New Mexico Culture

Selected characteristics of New Mexico culture stresses the sociological factors in discussing the health problems because of the three different cultures within the state, namely Anglo, Chicano and Indian.

Part 14 - Cancer Programs

These documents are descriptions of plans and activities. In order to evaluate their proposals as segments of a program one needs more information

STAFF OBSERVATIONS (continued)

about the problems they address, the alternative solutions to those problems from which these approaches were chosen and the reason for the priorities accorded these plans.

For example, the ratio of annual cancer deaths to annual incidence or new diagnoses appears to be 1100 to 2500. Perhaps New Mexico already is approaching the American Cancer Society goal of saving 50% of cancer patients. A total of 2500 cases, even without correction for patients with multiple cancers is .0025% of the population, perhaps somewhat lower than the national average.

The forthcoming development of new unusual radiation therapy resources and a related cancer center are calling attention to cancer in New Mexico. It is clear that these facilities will require patients and that their existence will change the patient referral patterns in the state and adjacent areas. The new centers will not reduce the State's medical resources, and they will pick up only a small fraction of the workload of the existing medical care system. For all of these reasons, one must question the RMP priority of projects whose principal beneficiaries to date seem to be future University-related oncological activities, and drug testing.

The plans for both projects appear to have been designed along admirable lines. Both strive to involve practicing physicians and existing hospitals. Both are thoughtfully detailed in procedure. The leukemia-lymphoma program seems to be developing its own registry, which seems to suggest that the Statewide registry cannot serve all the needs of therapists.

The registry project seems to be rather costly. With a dozen accessions, and fewer than half as many deaths per working day, and its basic, tabulations and printouts designed, the organization seems over-staffed at thirteen full-time and two part-time people. The account of the registry program gives little information on its performance. The usability and reliability of the data collected by its field workers, the performance of hospitals in providing the records, the trends in accession and losses to follow-up would be helpful parameters for assessment of the registry's chances of success. It would also be useful to know whether any changes in stage at diagnosis or patient referral patterns have occurred in the hospitals that have participated for two years or more.

The leukemia-lymphoma project also is costly. It would add \$90,000 to an unknown current annual expenditure for a patient load of 225 now

STAFF OBSERVATIONS (continued)

registered to an estimated 400 or so. Not all of these patients would benefit from this added cost, and much of the treatment would be experimental, with investigational new drugs. It appears that the project must rely heavily upon its clinical trial and research values to justify its costs. If this is true, should it not be supported by research interests, rather than by a Regional Medical Program?

Part 15 - Priority Health Care

No information is presented regarding several critical areas: Methods to provide continuing support following expiration of RMP grant; Effectiveness of existing model system in addressing the target health problem; Local verification of the acceptability of the proposed approach; Evaluation criteria.

Part 16 - Health Information Center - provides general information.

Part 17 - Community Rehabilitation Program

This program seeks to enlarge the awareness of rehabilitation among existing social and medical workers. To do this, it employs a five-specialist team which seeks to impart both awareness and skills to local work-forces, on a community-by-community basis. In one area the team has demonstrated to its own satisfaction that it can improve a community's awareness and utilization of consciously planned and administered rehabilitative techniques. No before and after data are given to show the situation the team found and the changes that allowed it to disengage with conviction that its mission was accomplished.

The objective is admirable. As an improvement of the performance of existing resources, it appears to be a legitimate RMP objective. There is some doubt that the approach employed in the experiment recounted should be continued, because it seems to this reviewer to be one that would take a long time to cover the State.

The State-directed agencies should have been performing this function all along. Could not the RMP reach more localities sooner by concentrating its efforts on helping the State agencies to be more aggressive.

SITE VISIT REPORT

NORTHERN NEW ENGLAND REGIONAL MEDICAL PROGRAM

AUGUST 9-10, 1972

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M. Dawson Tyson, M.D., Represented RAG Member, Yasinski, Director,
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* Members of the Executive Committee

Others

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Joan Blankenship, R.N., Project Director, Ambulatory Pediatric Program;
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Richard Bouchard, M.D., Director RMP Heart Management Committee
Stanley Burns, M.D., Director RMP Cancer Management Committee
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David Miller, Executive Director, Vermont VHSI
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II. INTRODUCTION

The site visit was in response to a triennial application from the **NERMP**. The purposes of the site visit were to assess the program's overall progress, its current quality, its readiness for triennium status and a developmental component, and to arrive at a funding recommendation for consideration by the National Review Committee and the National Advisory Council on RMPs.

Prior to January, this program devoted a great majority of its time and energy to developing a data base for health planning and also in planning a single management system for RMP and CHP. With the data base, problems of accreditation and utilization continually occurred. With the management system complicated administrative structures were considered but no administrative structure could be created that would allow linking the two organizations in a manner which would preserve each program's intended purpose, at least in the opinion of the Federal Government. To complicate the organizational problems even further, Vermont was the recipient of an Experimental Health Services Delivery System contract in excess of \$900,000 for a two year period.

Realizing that an acceptable management system could not be readily developed and that continued RMPs support for such a massive data collection effort was unlikely, the program began formulating a more "traditional" RMP in January under the new leadership of Mr. Danielson.

A reader of this document should keep in mind the infancy of the new program at the time of this site visit and the influence this stage of maturity has on the findings, opinions, suggestions, and recommendations contained within this report.

III. PERFORMANCE

1. Goals, Objectives and Priorities

Due to the infancy of the **NNE** Program as a "program", goals, objectives and priorities have not yet been developed and explicitly stated. The bylaws of the RAG, and the application for triennial support refer to program goals as being ones of improving accessibility to medical care, enhancing quality of care, and increasing efficiency and efficacy of medical care delivery. These are considered as areas of concern stated in a very broad and global sense that cannot be interpreted, or accepted, as standards against which to make policy and funding decisions.

It is considered, however, that the program is now on the fringe of making a constructive move in this area and a significant impact within the next 90 to 120 days should occur. They have data from which a problem list is presently being developed, the "beginnings" of what appears to be necessary for the establishment of an active and effective RAG, and a program staff cognizant of the immediate need for explicit but appropriate goals, objectives and priorities. These are all positive factors which should lead to improvement soon in this area. This is not to say, though, that the site team is not without concern for in discussing this subject during the visit, it became apparent that RAG, the technical committees as well as staff in the region, do not share a common concept of how goals, objectives and priorities are to function. The program staff seems to understand how goals, objectives and priorities should be used in policymaking, decisionmaking, evaluation, etc., but some (the Chairman of the RAG in particular) did not appear to have this same understanding. There was extensive discussion about this point both during the formal and informal sessions and there is reason to believe that a unanimity of understanding will soon develop.

Even though it is mentioned above that the RAG has the "beginnings" of being an effective group, it also is not an area without concern. As discussed later in this report under Regional Advisory Group and Minority Interest, there is concern that the present RAG membership is not representative of all desired factions. Notably, consumer and community groups, and allied health personnel are lacking representation.

If the goals, objectives and priorities are to accurately reflect the region's needs and problems, all desired factions should be represented in their formulation.

2. Accomplishments and Implementation

The major accomplishments have been the development of the Regional Disease Management approach and the development of a data base for health planning. Regional Disease Management is a committee approach to heart disease, cancer, and respiratory disease. Of these three committees, heart is the most developed, data has been collected, professionally analyzed, and standards and guidelines have been developed for treatment for coronary care.

When considering the effectiveness of the disease management committees, it is encouraging to note the acceptance of the committee's recommendations by providers as well as acceptance of "updating" changes recommended by the committees through their continuing evaluation and updating of standards process.

Each committee is free to organize itself into subcommittees and task forces, but generally develop along the lines of standards and guidelines for treatment, educational requirements, and information systems.

Additional committees in emergency medical service systems, kidney disease, and other problem areas of disease and health care delivery are planned.

The Regional Disease Management approach is considered a substantial program accomplishment because it serves as mechanism for stimulating worthwhile activities, provides a vehicle through which to replicate successful accomplishments, and functions as a means for promoting wider application of new knowledge and techniques. However, these committees need a functional operating plan, bylaws, and a definite scheme for approaching their mission. In the past, the management committees have been the influential force in the RMP advisory structure so it is anticipated that with their predominate categorical emphasis, difficulties will develop as the "new" RAG now begins to assume its leadership role in formulating a total program designed with a comprehensive emphasis. In the absence of a functioning RAG, these committees were the only way of obtaining "provider" input in the RMP. It is important that the management committees understand the strengths and limitations of their role in policy development and decisionmaking.

The data base for health planning unquestionably holds a potential for enabling more rational decisions as to how the health care system should be managed and what standards and guidelines for treatment are more efficacious. The data base has been the source for many reports, papers, and the like, published by the program (a list of which is appended to this report). Also, there is evidence that the data has been used by others concerned with health care problems such as Comprehensive Health Planning "a" and "b" agencies, the Experimental Health Services Delivery System (HSI), a developing HMO, etc. Yet, in this same connection there is evidence that a number of parties concerned with health care delivery problems are not users of the data and in fact in some instances may not even be aware of its existence.

The site visit team is aware that the data will soon (September 1972) be funded and maintained by a separate independent organization; but, nevertheless, believe the RMP has to assume some continuing responsibility in solving the problems of developing a utilization strategy for the data.

In many ways this program is considered to be one in which

accomplishments have been few; there has been little effect on monitoring costs, and aside from the program emanating from the management committees, there has been little impact on the improvement of the quality of care. Again, however, the site team is comfortable with the impression that progress will be achieved in the future.

3. Continued Support

There is not a firm policy on continued support. The issue of continued support is formally addressed in the technical review criteria and there is substantial evidence that emphasis is given to continued support during the planning, developing and reviewing of proposals.

4. Minority Interests

Due to the fact that there is no significant ethnic minority in Vermont, the reviewers chose to use the term "minority", divested of racial connotations, and to refer to the poor and medically underserved sector of its population. The total minority population (Blacks, Indians, Japanese, Chinese, and others) constitutes 0.4 of 1% of the total population. From census data it is estimated that one-fourth of the population of the State have French as their first and in many cases, only language. Regardless of the small number of minorities, the site visit team feels that the RAG should be more representative of the total population served by the program.

It was indicated by the RMP that the membership of the RAG will probably be increased by ten in the near future. The team, therefore, suggested that these additions should be chosen with the idea of adequate representation of all aspects of the population as well as other local interests in mind.

On the program staff there are no minorities and there are no women in top-level decisionmaking positions.

Probably more surveys have been done in this region than in any other to assess the health needs, problems, and utilization of services of minority groups, but very few "true" consumers have been consulted in formulating study designs of interpretation of the data, or in action plans.

IV. PROCESS

1. Coordinator

Considering the process of transition through which the Northern New England RMP has been going, the new Coordinator seems to have done a commendable job. Donald Danielson was appointed Director of NNERMP in January of 1972. The previous Director, John Wennberg, resigned to become Director of Research and Development of Health Systems Incorporated, the recipient of HSMHA Experimental System's contract.

During the following months, Mr. Danielson has reorganized the Regional Advisory Group to make it a separate functioning body for RMP, has revised the program staff structure and begun to hire some new people, and put together the current application.

He seems to have developed a good working relationship with the Regional Advisory Group and there was generally good interaction with the Chairman of the RAG, Dr. John Mazuzan.

It did seem apparent to the site team that a deputy director was needed. Mr. Danielson said he was in the process of recruiting for such, and that he would be a health professional rather than a management-type, as this seemed to be where the staff structure needed strengthening.

2. Program Staff

The program staff has been reorganized to reflect the movement of the large data effort to Health Systems, Inc. The data base staff of 11 people plus secretaries has been dissolved, with some moving into other positions in RMP and some going to HSI.

The reorganized structure now includes two major staff functions and two major line functions. Staff functions include planning and evaluation, making use of the data base built by the RMP, and educational activities support, which will help in educational design and evaluation in support of local project efforts.

The two major line divisions are:

- (a) Health System Development and Demonstration Staff - Designed to put together a community health development support

capability which can work with local areas in developing coordinated health services. A young M.D., Anthony Robbins, has been hired to head this division.

- (b) Regional Program Development Staff - Responsible for staffing the disease management committees and task forces, which currently include heart disease, cancer, and respiratory disease. Others proposed are in emergency medical systems and kidney disease. This staff is also responsible for the program management of the projects in this area.

The site team felt that the program staff at present is heavily management-oriented, and that there is a significant need for nursing and allied health personnel on the staff, to provide a broader range of professional and discipline competence.

The team also thought that staff was needed in the areas of health system development and community organization, to provide a stronger alternate focus to the categorical interests. Efforts at keeping the medical community and public informed of RMP activities might also be strengthened. The program staff currently employed was essentially full time.

3. Regional Advisory Group

The process of reshaping the Regional Advisory Group seems to be moving along well. The RAG was merged with the State Comprehensive Health Planning Board in December 1970, to form a single planning and management decision group for the state. This proved to be unacceptable to RMPS at the national level, so that in the latter half of 1971, RMPS and HSMHA specifically indicated that functions assigned to RMP, CHP, and the Experimental Delivery System (HSI) must be separated so that each could be given appropriate attention. An RMP Study Committee then went to work to re-establish a separate RMP Advisory Group, and adopted bylaws for the new RAG in February 1972.

The new RAG currently has a membership of about 30, with the expectation that it will be expanded to 40 in the near future.

The site team noted that specific areas of representation that need strengthening are nursing and allied health personnel, consumers, VA Hospital and possibly some of the economic and local political interests, and representation of the areawide CHP agencies.

In this connection, the site team also brought up the question of the status of the three New York counties around Plattsburgh which the Vermont RMP sometimes claims responsibility for. The team stated that

if this area was to be considered part of the NNERMP, then they should be represented on the RAG. On the other hand, if it was determined that they really related more to the Albany RMP, it might be better to make that clear, so the situation did not remain in limbo. The team made it clear that from a RMPS standpoint, there was no objection to the NNERMP releasing its partial claim to that New York area.

The RAG is structured to meet four times annually and to date the meetings are very well attended. The new RAG has played a very active role in setting program policy. The site team made it clear, however, that both the RAG and the staff needed to initiate a much more definitive process of setting specific objectives and priorities. Otherwise, the objectives are tending to be set by the Regional Disease Management Committees, which are strictly categorically-oriented, rather than looking at the problems across-the-board.

The RAG does have an Executive Committee which has been meeting frequently and which has a wide base of representation.

4. Grantee Organization

The University of Vermont is the Grantee Institution for the NNERMP. Relationships seem to be generally good with the grantee permitting sufficient freedom and flexibility to the RMP. There was some question raised about the policy of submitting the names of proposed RAG members to the President of the University for concurrence, especially in light of the new RMPS policy statement on RAG/Grantee relationships.

The RMP, concerned about the overhead charged the program (currently 70.2% of salaries and wages), is moving its offices to an off-campus site to achieve a lower rate (46.7% of salaries and wages). The grantee supports this move.

The site team also noted errors in the method of filling out Form 15 (Operational Activity Summary) and Form 16 (Financial Data Record) of the RMPS application form. On most of these forms, the NNERMP listed the University of Vermont as the sponsor institution, and on many listed a program staff person as project director. This gives the distorted picture that most funds are flowing to the University of Vermont, which is not the case. The RMP was requested to correct these forms to show who was actually running the project.

An additional question was brought up on the advisability of asking for specific medical school review and comment on project applications. This seemed to duplicate in some ways the work of the technical review committee structure.

5. Participation

There seemed to be evidence of close interaction with some health groups and interests, but a lack of involvement with others. It was noted that particularly on the Regional Disease Management Committees, physician influence was dominant. It was suggested that these groups in particular needed a broader range of representation, including nursing and allied health interests, and possibly some public or consumer involvement. Although the voluntary health agencies are participating, it was felt that this aspect could be strengthened, as well as greater involvement of the State Health Department. It was also felt that the economic and local political elements could be more significantly involved.

6. Local Planning

The NNERMP seems to have developed good working relationships with the two areawide CHP agencies that exist in Vermont: the Northern Counties Health Council (Northeast Kingdom), and the Connecticut Valley Health Compact. It is expected that three more planning areas will be developed in the future.

The large data base which RMP developed proved to be a helpful rationale in the definition of medical trade areas. The data on patient flow patterns and utilization of services was particularly useful in defining appropriate sub-regions for planning purposes.

There seems to be an adequate mechanism for obtaining CHP review and comment on RMP proposals. Both the State CHP agency and the two areawide agencies provided comments. It is not quite certain the extent to which the RAG took these comments into account in making their final priority rankings.

7. Assessment of Needs and Resources

The data base developed by NNERMP is probably one of the best in the country. The general analytical approach was the development of the following indices: population needs and characteristics; community characteristics; resource investments (manpower, facilities, expenditures); utilization of services; and end results.

This base has provided a good source for identification of problem areas and resources available. It has been particularly useful in development of categorical programs by disease management committees, particularly so in the area of heart disease.

The major concern is now that the data effort is being moved into Health Systems Incorporated, will the RMP develop a working linkage so that the data continues to be available for a more action-oriented approach to using it. The site team mentioned that some mechanism should be established to make certain that the data continued to prove useful to the RMP in its planning and development activities.

8. Management

A RMP staff member is assigned management responsibility for each project. Each manager must work with the project director and the Director of Planning and Evaluation to develop a work schedule and the points at which project activity may be measured and evaluated.

Periodic progress and expenditure reports are required at least quarterly for all projects. If difficulties are noted in development of the project, the Director of Planning and Evaluation and other staff are to provide assistance to get these solved. If the rate of expenditure is low for a project, funds will be diverted to other uses.

It is difficult to tell at this point how well the program staff activities are coordinated. This component of the program may be analyzed more easily after the RAG sets some more specific objectives and priorities, and after existing staff vacancies are filled.

9. Evaluation

In addition to the management reporting process, an evaluation process has also been designed. It has not really been tested to date, however, so it is rather early to judge it. The program does have a full-time staff person for planning and evaluation, and will probably be hiring an assistant in this area.

Two mechanisms are used to provide feedback on progress to RAG and other appropriate committees. The first is that a project director submits a quarterly report to the RAG stating progress made concerning project objectives for that period. The second involves peer review site visits which may be called for by: (a) the Director of Planning and Evaluation; (b) a disease management committee; (c) the Executive Committee; or (d) the RAG.

There is also an annual evaluation of each project, whether or not the project is subject to renewal during the following year. On the basis of the proposer's annual report and materials provided by staff, evaluations will be made by the appropriate disease management

committee and the Executive Committee. These groups, after examining characteristics of the project which contributed to its success or failure, will be asked to recommend whether or not such activities should be replicated in the region, and whether similar projects should be considered for future funding.

There appears to be no line of direct responsibility from those conducting the overall ongoing evaluation to the Director of Evaluation. Such an organizational arrangement would clarify the responsibility for the continuing evaluation activity.

Considering the reorganization of the NNERMP review process and RAG, it is too early to determine whether this mechanism will convert unsatisfactory results into program decisions and modifications. The RMP needs to develop for both its own benefit and for that of project directors, a specific procedure relating to the phasing out of unsuccessful or ineffective activities.

V. PROGRAM PROPOSAL

1. Action Plan

The NNERMP has not, as yet, established goals, objectives and priorities. However, they recognize the need and understand the importance of developing a framework of goals, objectives and priorities. The site visit team stressed the need to convert to a program related to the RMP's mission statement. Mr. Donald Danielson, Director of NNERMP, stated that ranking of priorities will occur in the very near future and that these priorities will be congruent with national goals and objectives.

The activities now being proposed by the region do relate to their approach toward new priorities, objectives and needs. However, the team is concerned that though the 20 proposed projects have several common objectives, there is need to tie these related efforts together so that the resources have a greater potential for changing the health care system than if they are left as isolated activities. For example, all seven cancer proposals have a high proportion of effort devoted to cancer education of the health professions and the public, but they are proposed as seven separate independent activities. Likewise, the five heart proposals have a high proportion of effort to education of health manpower and the public, but they are also independent of each other as well as of other RMP proposed activities. Infant and Mother Care which carries the top priority ranking by the region does not relate to other RMP activities.

Seven discrete categorical areas are to be used as part of a consumer education program using the extension service network, but there is no consolidated approach or strategy by the health providers to use this resource to achieve maximum benefit.

In four categorical areas, i.e., respiratory disease, cancer, heart, and cerebrovascular rehabilitation plans are proposed to establish and adopt procedures to improve patient care management within community hospital. No interface, exchange, or strategy is suggested or considered. In summary, this RMP is in danger of fragmenting its staff effort and its resources by its heavy concentration on categorical approaches and thereby losing the promise of a program change to improve the system of health care delivery. Attention to the whole instead of individual bits and pieces is essential if the change promised in the reorganization is going to be fulfilled. The Regional Management Committees on a categorical base must interface and interlock with RMP goals and objectives or there is danger of a traditional old-line chronic disease program being developed. The program might well consider consolidation of some of its proposed activities when the actual program to be implemented is determined.

The planned and proposed activities are realistic in view of the resources available and past performance. Abundant data exists on the region's health problems and resources so that criteria for setting priorities becomes all the more important in this region.

The team was told that methods for reporting accomplishments and assessments have been proposed. Evaluation teams plus managers have a commitment to the reporting process so that accomplishments and results can be easily measured. The Director also indicated that though priorities had not previously been viewed and updated periodically, it will be done in the future.

2. Dissemination of Knowledge.

In regard to including other groups or institutions that will benefit from data, the team finds that these groups have been targeted and that they will be further involved in the future.

Knowledge, skills, and techniques to be disseminated have been identified in some areas, but not yet developed in relationship to community affairs with the exception of the ambulatory pediatric program. Once implemented and developed, there is little doubt that they be disseminated in the region.

The site visit team is concerned that the RMP seems to be operating singularly and not in conjunction with other organizations and research

institutions in the area excepting the University of Vermont and those hospitals with coronary care units. Other health and education providers have not yet become involved and there is evidence that they had not really been interested in becoming so. This, most likely is because the past RMP strategy has been preoccupied with data gathering and not action. Improvement is expected in this area under the new program thrust.

The team is in concordance in thinking that while the RMP has not shown any evidence of improving quality of care other than in coronary care or moderating costs, this will be a by-product as the program moves on. The approach to dissemination of knowledge about applicable, practical techniques is very significant at this point in time. For example, the use of referral centers has been well established and help by RMP should continue in the future.

3. Utilization Manpower and Facilities

Utilization programs are not yet far enough along within the region to comment on except to say that there are a limited number of programs in a limited number of community health facilities. These are all well utilized and will most likely improve in the future.

We saw no evidence that there has been increased productivity of health manpower other than physicians and possibly the utilization of nurse practitioners. The region, however, understands utilization problems and is beginning to move in this area, although, implementation has not actually occurred.

4. Improvement of Care

The RMP has identified the problems of expansion of ambulatory care and the geographic areas requiring attention. Current and proposed activities will expand ambulatory care and other needs.

In reference to communication, transportation services, and others, the RMP is doing well as can be expected. They are available but often are not well used nor do people understand how to use them. The EMS is an excellent example of what can be done.

Problems of access have been identified and solutions are in project form. Current and proposed activities will strengthen primary care. Underserved areas are beginning to receive attention in one or two projects. As the RMP moves more fully into a services, more involvement of the underserved areas will occur.

There are some health maintenance and disease prevention components, but these are not yet a major emphasis in this particular RMP. We

can see that they will be in the very near future. Health maintenance and disease prevention components and plans are considered realistic in reference to the present state of the knowledge.

5. Short-Term Payoff

Operational activities will increase the availability and access to services over the next two to three years. The need for feedback to measure payoff is understood, is documented, and is well established in the new evaluation mechanism.

It is reasonable to expect that RMP support can be withdrawn over the next three years in most instances.

6. Regionalization

With respect to regionalization, the team found that plans and activities are aimed at assisting provider groups and institutions. Greater sharing of facilities, manpower and other resources is definitely envisioned in their planning and projects at this point in time. Existing resources and services will be extended and made available to other areas. New linkages will be established among health practitioners and institutions. Progressive patient care is also a definite part of their planning and has already been demonstrated with coronary patients.

7. Other Funding

There is little question but that the region has already attracted funds other than RMP and will continue to do so. Most of those have been state and federal, but some local and private funds have been involved. The region has, it was indicated, definite plans for bringing in others. RMP activities have been definitely related to other federally funded health programs and have furnished the base for much of their activity to date. This is particularly evident with Comprehensive Health Planning, Experimental Health Service Delivery Systems, Health Maintenance Organizations, and the Federal-State-Local Health Statistic Center.

SUMMARY

Taking into consideration the history of this program with its preoccupation on data gathering and efforts to organizationally merge RMP and CHP, the site visitors were favorably pleased with developments since January when the RMP decided to devote its energy to developing a viable RMP.

The site team recognized the infancy of the program reviewed, the fact that many elements of the program are untested, and that for the most part the NNERMP is a "paper" organization. Yet, based on the quality of the materials assembled and with an insight to the management capabilities of the program staff, the visitors were impressed with the progress to date and believed prospects for continued development are good.

In light of the above remarks, however, the site team has the following suggestions:

- . The goals and priorities need to be further defined and more explicitly stated. Ideally, the time frame on this is for accomplishment in the next 90-120 days.
- . The Regional Advisory Group needs to expand its membership to include better representation of youth, minorities (as interpreted under Minority Interests of this report), the medically underserved, areawide planning agencies, allied health, and representatives from the bordering areas of New Hampshire and New York if it is established that these areas are indeed appropriate territories of the NNERMP. Consideration should also be given to the appropriateness of the economic and local political interest having representation.
- . The RAG should consider establishing a subcommittee structure aligned with goals, once goals have been developed.
- . The composition of the disease management committees, ad hoc groups, and technical review committees should be examined closely to insure appropriate representation. At this time, there is concern for over representation of physicians, thus limiting constructive input from other providers or persons knowledgeable on health care problems.
- . Also, measures should be taken to assure that these groups are supportive of the program's evaluation plan.
- . The disease management committees should have bylaws, or another similar management tool, to align their functional operation plans with the total program.

- . Consideration should be given to developing management committees for non-disease areas of interest to RMP such as community health.
- . The approval and disapproval mechanisms for projects should be more clearly delineated.
- . The evaluation scheme should be re-examined to give further assurance that the RAG and program staff each understands its respective roles in review, evaluation, and feedback. This should minimize potential conflicts. Also, organizational changes should be made coordinating all program staff performing any evaluation with the Director for Evaluation.
- . The vacant program staff positions should be filled with persons that will provide the program with a broader range of professional and discipline competence. Nursing, allied health, health system development, and community organization are specific suggestions.
- . The program should look at all their proposed projects and relate common objectives so that the resources have a greater potential for effecting constructive change of the health care system.
- . The RMP still needs to assume some continued responsibilities for making the region aware of available data, and to assist in the development of a data utilization strategy.
- . A formal policy on continued support should be established.
- . The surveillance and monitoring devices of projects should include a method for prematurely phasing out unsuccessful or ineffective projects.

Each of the above points were discussed at the feedback session at which the Program Staff, the Dean of the Medical School, the Chairman of the RAG and several other RAG members were in attendance.

In addition to presenting the above points at the feedback session, the following advice was given with the belief that it may serve to improve the program's presentation in future applications:

- . The forms 15 and 16 should each reflect the same project sponsor, and this should not necessarily be the grantee institution but the institution or agency at which the project is being coordinated and actually implemented.
- . Program staffs' discipline, professional competency, speciality, or area of interest be identified.

- . A problem-solution chart be included in the program report.
 - . The role of the project managers and the project directors be clearly identified so that potential areas of conflict for decisionmaking are handled in advance.
-

RECOMMENDATION

It is the site visit team's recommendation that triennial status not be granted at this time, but that the program receive two-year approval, with developmental component rights, at the level of \$850,000 each year. It is further recommended that there be a site visit next year to determine progress, re-evaluate the second year funding level, and again determine the program's readiness for triennial status if in fact triennial status is again requested.

With this recommendation there is one restriction and it is with the continuation request for Project #6, A Program in Kidney Disease. The presently approved levels for this project's second and third years are \$37,900 and a \$25,400 respectfully; the requested levels are \$78,740 and \$70,000 respectfully. Because there is no change of scope of the activity and there has been no re-evaluation by a technical review group that would satisfy review-of-kidney-proposal-requirements as set forth in the May 3, 1972 NID, it is the recommendation of the site visit team that the present level of approval remain. If RMPS wishes to investigate this situation further and it is decided further evaluation of this situation is merited, the site visit team has no objection.

APPENDIX I

NORTHERN NEW ENGLAND REGIONAL MEDICAL PROGRAM PUBLICATIONS LIST

A. Published by the Program

"A Comparison of Utilization of Selected Health Services by Various Age, Income and Education Groups in the CVHC Area." January 1971. A Connecticut Valley Health Compact Report.

"A Layman's Look at the Working Paper of Health and Medical Care Resources." Spring 1970.

"A Report on Cancer in the Vermont Region." February 1971.

"A Report on Kidney Disease in the Vermont Region." May 1971.

1. A Report on Prepayment in Vermont
2. A Report on Respiratory Disease in the Vermont Region 12/71
3. A Report on Stroke in the Vermont Region
4. A Report on Vermont Hospitals 7/71

"A Report to the State Health Planning Advisory Council." April 1971. Basic demographic data.

"A Working Paper of Health and Medical Care Resources." November 1969. Connecticut Valley Health Compact Report.

1. An Inventory of Health Manpower in the State of Vermont 6/72
2. An Inventory of Health Related Educational Programs in The State of Vermont 6/72

"Background and Methodology of the CVHC Area." August 1971. A Connecticut Valley Health Compact Report.

"Children's Immunizations in the CVHC Area." August 1971. A Connecticut Valley Health Compact Report.

"CVHC Results: Mental Retardation." July 1971. A Connecticut Valley Health Compact Report.

"Coronary Care Network Newsletter." Published bimonthly; first issue: October 1970.

"Demographic Characteristics of the CVHC Area." January 1971. A Connecticut Valley Health Compact Report.

"Family Planning Patterns in the CVHC Area." August 1971. A Connecticut Valley Health Compact Report.

1. Identification of Major Health Problems and Needs in Vermont 5/72
2. Thirteen Individual Home Health Agency Reports 9/71
3. Eighteen Individual Hospital Reports

"Infant Mortality in the CVHC Area." August 1971. A Connecticut Valley Health Compact Report.

1. Inventory of Health Care Services and Facilities in Vermont

"Knowledge, Need and Use of Home, Health, Mental Health and Related Services." January 1971. A Connecticut Valley Health Compact Report.

"NNE/RMP Health Planning Data Base." Winter 1970.

"Northern New England Regional Medical Program" (newsletter). Published bimonthly; first issue: February 1967.

"Patterns & Utilization of Health Services and their Economic Implications in the CVHC Area." August 1971. A Connecticut Valley Health Compact Report.

"Patterns of Use of Hospitals & Preferences for Hospitalization." April 1971. A Connecticut Valley Health Compact Report.

1. Physician Manpower in Vermont 10/71

"Projected Impact of Health Maintenance Legislation in Vermont." May 1971.

1. Report on Health Care in Vermont (Layman's Version of "Status Report..") 8/72 Revised
2. Report on Vermont Home Health Agencies 9/71

"Setting of Health Goals in Vermont: Problem in Political Science and Technology of Planning," presented at the 11th Annual Institute of Management Sciences, Los Angeles. October 1970.

"Smoking History and Behavior of the CVHC Population." August 1971. A Connecticut Valley Health Compact Report.

1. Standards & Guidelines: Vermont Coronary Care Network

"State Health Planning Advisory Council By-Laws." January 1970. For the Combined Regional Medical Program and Comprehensive Health Program Boards.

"Status Report of the Community Health Systems of Vermont." (Technical Version) August 1971.

"The Consumer's View of the Health Care System and Health Insurance." April 1971. A Connecticut Valley Health Compact Report.

"The Northern New England Regional Medical Program Health Planning Data Base." Paper presented at the Northern New England Regional Medical Program Conference and Workshop on Evaluation, Chicago, September 1970.

"Utilization of Dental Services in the CVHC." January 1971. A Connecticut Valley Health Compact Report.

"Variations in Patterns of Medical Care in the Vermont Region for the American College of Surgeons, Regional Meeting." September 10, 1971. Burlington, Vermont.

B. Published Nationally and Locally

"HMO Hearings Begin," Legislative Roundup. July 23, 1971.

"HMO Strategy Would Increase Cost of Care in Vermont, Study Shows," NHI Newsletter. June 7, 1971.

"How One Regional Program Looks," Modern Medicine. March 1966.

RMPS STAFF BRIEFING DOCUMENTREGION: Northern New EnglandOPERATIONS BRANCH: EasternNUMBER: 00003Chief: Frank NashCOORDINATOR: Mr. Don DanielsonStaff for RMP: Spencer ColburnLAST RATING: Unrated

TYPE OF APPLICATION:

3rd Year

 Triennial Triennial

2nd Year

 Triennial Other
Regional Office Representative:
William McKenna

Management Survey (Date):

Conducted: _____

or

Scheduled: October 1972Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)

October 1968 - (Program Site Visit) Dr. Proger, Chairman, Dr. Storey,
Robert LawtonDecember 1970 - (Technical Assistance Visit) Dr. Mark, Chairman, Drs. Delon,
Keller, and KomaroffStaff Visits in Last 12 Months:

(List Date and Purpose)

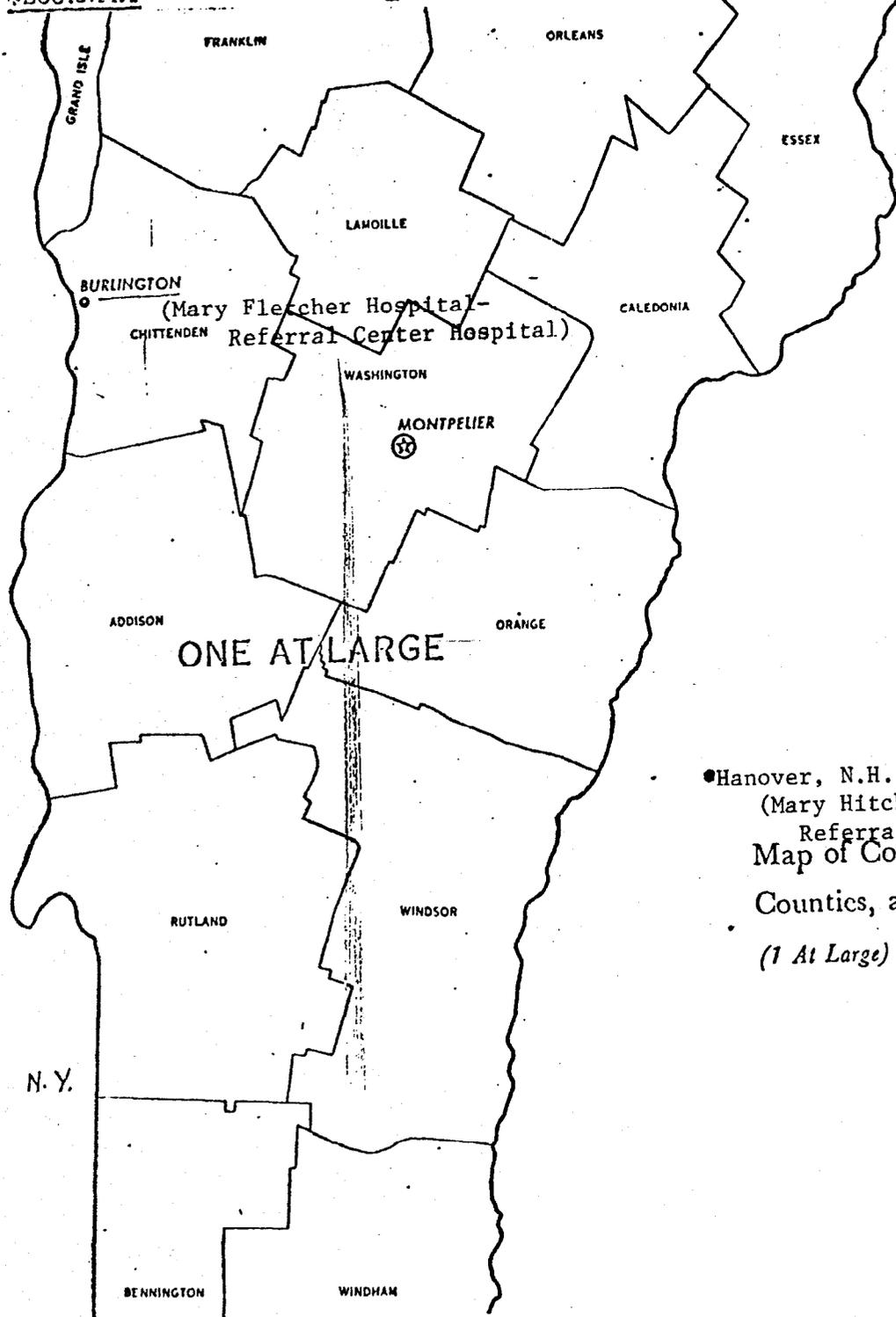
February 1972 - To establish a channel of communication with the new
coordinator, discuss regional development plans as well as coming site
visit.June 1972 - To attend first meeting of new RAG, and to clarify questions
regarding the scheduled August site visit, review verification visit
and management assessment visit.Recent events occurring in geographic area of Region that are affecting
RMP program:

EHSDS Contract

F-S-L Statistic Grant (presently under consideration)

I. REGIONAL CHARACTERISTICS

GEOGRAPHY



● Hanover, N.H.
 (Mary Hitchcock Hospital-
 Referral Center Hospital)
 Map of Congressional District,
 Counties, and Selected Cities
 (1 At Large)

HEW Regional Office I
Regional Delineation

State/ States: Vermont and 3 N.Y. counties
 Counties: 14
 Congressional Districts: 1
 Counties/ Interfaces: 3 counties Albany RMP.

POLITICAL INFORMATION

Governor: Deane C. Davis (R)
 Senators: George D. Aiken (R)
 Robert T. Stafford (R)
 Representative: Richard Mallory (R)

DEMOGRAPHIC INFORMATION

Population characteristics:

Total: 444,732
 % Urban: 32
 % Non-white: 0.4 of one percent
 Age Distribution (%) VT. U.S.
 Under 18 yrs. 35 35
 18-65 yrs. 54 55
 65 yrs and over 11 10
 Average Income per Individual \$3,267 \$3,680

Mortality Rates (CY 1967)

Heart Diseases 435.5 364.5
 Cancer 173.9 157.2
 Vasc. Lesions 117.5 102.2
 All Causes, all ages 1085.4 1143.5

Facilities and Resources:

<u>Schools</u>	<u>Number</u>	<u>Enrollment (71/72)</u>	<u>Graduates (72)</u>
Medicine (UVM)	1	288	66
Nursing	4	523	108
Practical Nursing	2	106	94
Cytotechnology	1	(Med. Center Hospital, Burlington)	
Medical Technology	1	(UVM)	
Radiologic Technology	2		

* * * * *

<u>Hospitals</u>	<u>Number</u>	<u>Number of Beds</u>
Nonfederal Short Term	18	2,244
Nonfederal Long Term	3	2,325*
V.A. General Hospital	1	200

*Plus 42 beds in respiratory disease unit at the Med. Center Hospital, Burlington.

* * * * *

Special Hospital Facilities

Number

Intensive CCV	11
Cobalt Therapy	1
Isotope Facility	3
Radium Therapy	3
Renal Dialysis, in patient	1
Rehabilitation, in patient	3

* * * * *

Nursing and Personal Care Homes (1972)

Type	Number of Beds
Skilled Nursing Home	869
Personal Care Homes with Nursing Care	1311
Long Term Care Units	1043

* * * * *

Manpower

Profession	Number
Physician - Active	644
Inactive	32
General Practice	218
Medical Specialties	150
Surgical Specialties	69
Other	207
Osteopath	33
Nurses - Active	2373
Inactive	955
LPN - Active	1067
Inactive	316

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>03</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 397,578	\$ 462,368	\$ 480,000	\$ 500,000			
CONTRACTS							
DEVELOPMENTAL COMPONENT		114,617	114,617	114,617			
OPERATIONAL PROJECTS	328,389	683,804	451,720	416,636			
Kidney	X	(78,740)	(70,000)				
EMS		()					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	725,967	\$1,260,789	\$1,046,337	\$1,031,253			
COUNCIL RECOMMENDED LEVEL							

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RMPS-OSM-JTCFFH-20

REGION 03 N NEW ENG

RMF SUPP YR 03

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NC	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1	02	03	TOTAL	04	05	06	TOTAL
				09/71-12/72	TOTAL	01/73-12/73	01/74-12/74	01/75-12/75	TOTAL
000	PROGRAM STAFF	556700	389200	659978	1645878	462300	480000	500000	1442368
000	DEVELOPMENTAL C					114617	114617	114617	343851
002	PROGRESSIVE CPR	194400	120000	156423	470823				
004	PROJECT IN CONT	124500	81000	96261	301761				
006	KIDNEY PROJECT			55250	55250	78740	70000		148740
007	EMS INCREASING			72060	72060				
009	HIGH RISK INFAN					70298	55350	46402	172050
010	REGIONALIZED CE					33200	38527	38440	110567
011	REGIONALIZED RE					85752	85216	53410	224378
012	AMBULATORY PECT					47616			47616
013	CANCER PROTOCOL					11055			11055
014	REGIONALIZED RE					19714	37285	31559	88558
015	PAP SMEAR FEASI					29238			29238
016	CONTINUITY OF C					30427	20367	20064	70858
017	REGIONAL CANCER					47204	28199	29952	105355
018	PUBLIC EDUCATIO					24364	29735	31452	85595
019	ELECTRICAL SAFE					31797			31797
020	EARLY IC OF CAR					22648	42506	67152	132306
021	PROFESSIONAL ED					50239	40522	43416	134577
022	UPGRADING EFERE					20030	39515	22959	82504
023	NEW TECHNIQUES					50920			50920
024	COMMUNICATIONS					1750			1750
025	STREETCROSSING C					3680			3680
026	CARDIAC I'D CAR					3050	4000		7050
027	HEALTH EDUCATIO					22082	29654	31790	83566
- TOTAL -		515600	590200	1040012	2545812	1260789	1116337	1031253	3402379

RMPS-OSM-1111-1111

1111

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
000 GENERAL PROGRAM STAFF		\$462,368			\$462,368	\$216,267	\$678,635
000 DEVELOPMENTAL COMPONENT				\$114,617	\$114,617		\$114,617
006 KIDNEY DISEASE	\$78,740				\$78,740	\$28,782	\$107,522
009 HIGH RISK INFANT AND MUT HERS PROGRAM				\$70,298	\$70,298	\$18,041	\$88,339
010 REGIONALIZED CEREBROVASC ULAR DISEASE PROGRAM				\$33,200	\$33,200	\$17,550	\$50,750
011 REGIONALIZED RESPIRATORY DISEASE PROGRAM				\$85,752	\$85,752	\$22,324	\$108,076
012 AMBULATORY PSYCHIATRIC CAR E				\$47,616	\$47,616		\$47,616
013 CANCER PROTOCOLS FOR PAT IENT MANAGEMENT				\$11,055	\$11,055	\$1,327	\$12,382
014 REGIONALIZED REHABILITAT ION PROGRAM				\$19,714	\$19,714	\$10,600	\$30,314
015 PAP SMEAR FEASIBILITY ST UDY				\$29,238	\$29,238	\$7,813	\$37,051
016 CONTINUITY OF CARE FOR C ARDIAC PATIENTS				\$30,427	\$30,427	\$9,161	\$39,588
017 REGIONAL CANCER REGISTRY				\$47,204	\$47,204	\$18,722	\$65,926
018 PUBLIC EDUCATION CANCER				\$24,364	\$24,364	\$8,345	\$33,209
019 ELECTRICAL SAFETY				\$31,797	\$31,797	\$14,777	\$46,574
020 EARLY ID OF CARDIACS				\$22,648	\$22,648	\$7,511	\$30,159
021 PROFESSIONAL EDUCATION C ANCER				\$50,239	\$50,239	\$15,242	\$66,181
022 UPGRADING EMERGENCY ROOM CARDIAC SKILLS				\$20,030	\$20,030	\$6,669	\$26,699
023 NEW TECHNIQUES OF CANCER DETECTION				\$50,920	\$50,920		\$50,920
024 COMMUNICATIONS SYSTEM FO R CANCER				\$1,750	\$1,750		\$1,750
025 STREPTOCOCCAL CONTROL PI LOT PROJECT				\$3,680	\$3,680		\$3,680
026 CARDIAC I D CARD				\$3,050	\$3,050		\$3,050
027 HEALTH EDUCATION FOR VER MONTNERS				\$22,082	\$22,082	\$11,443	\$33,525
TOTAL	\$78,740	\$462,368		\$719,681	\$1,260,789	\$416,474	\$1,677,263

JULY 17, 1972

DEPARTMENT OF HEALTH
US PROGRAM PERIOD

REGION - N NEW ENG
ON BUDGET 1972

PAGE 3
RAPS-USM-11002-1

IDENTIFICATION OF COMPONENT	(3) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
000 GENERAL PROGRAM STAFF		\$480,000			\$480,000
000 DEVELOPMENTAL COMPONENT				\$114,617	\$114,617
006 KIDNEY DISEASE	\$70,000				\$70,000
009 HIGH RISK INFANT AND MOTHERS PROGRAM				\$55,350	\$55,350
010 REGIONALIZED CEREBROVASCULAR DISEASE PROGRAM				\$38,927	\$38,927
011 REGIONALIZED RESPIRATORY DISEASE PROGRAM				\$85,216	\$85,216
012 AMBULATORY PEDIATRIC CARE					
013 CANCER PROTOCOLS FOR PATIENT MANAGEMENT					
014 REGIONALIZED REHABILITATION PROGRAM				\$37,285	\$37,285
015 PAP SMEAR FEASIBILITY STUDY					
016 CONTINUITY OF CARE FOR CARDIAC PATIENTS				\$20,367	\$20,367
017 REGIONAL CANCER REGISTRY				\$28,199	\$28,199
018 PUBLIC EDUCATION CANCER				\$29,739	\$29,739
019 ELECTRICAL SAFETY					
020 EARLY ID OF CARDIACS				\$42,506	\$42,506
021 PROFESSIONAL EDUCATION CANCER				\$40,922	\$40,922
022 UPGRADING EMERGENCY ROOM CARDIAC SKILLS				\$39,515	\$39,515
023 NEW TECHNIQUES OF CANCER DETECTION					
024 COMMUNICATIONS SYSTEM FOR CANCER					
025 STREPTOCOCCAL CONTROL PROJECT					
026 CARDIAC I C CARD				\$4,000	\$4,000
027 HEALTH EDUCATION FOR VENTRICULAR MONITORS				\$29,694	\$29,694
TOTAL	\$70,000	\$480,000		\$566,337	\$1,116,337

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
000 GENERAL PROGRAM STAFF		\$500,000			\$500,000	\$1,442,368
001 DEVELOPMENTAL COMPONENT				\$114,617	\$114,617	\$341,451
005 KIDNEY DISEASE						\$148,740
009 HIGH RISK INFANT AND MOTHERS PROGRAM				\$46,402	\$46,402	\$172,050
010 REGIONALIZED CEREBRAL VASCULAR DISEASE PROGRAM				\$38,440	\$38,440	\$110,567
011 REGIONALIZED RESPIRATORY DISEASE PROGRAM				\$53,410	\$53,410	\$224,378
012 AMBULATORY PEDIATRIC CARE						\$47,616
013 CANCER PROTOCOLS FOR PATIENT MANAGEMENT						\$11,055
014 REGIONALIZED REHABILITATION PROGRAM				\$31,559	\$31,559	\$88,558
015 PAP SMEAR FEASIBILITY STUDY						\$29,238
016 CONTINUITY OF CARE FOR CHRONIC PATIENTS				\$20,064	\$20,064	\$70,858
017 REGIONAL CANCER REGISTRY				\$29,952	\$29,952	\$105,355
018 PUBLIC EDUCATION CANCER				\$31,492	\$31,492	\$85,595
019 ELECTRICAL SAFETY						\$31,797
020 EARLY ID OF CARDIACS				\$67,152	\$67,152	\$132,306
021 PROFESSIONAL EDUCATION CANCER				\$43,416	\$43,416	\$134,577
022 UPGRADING EMERGENCY ROOM CARDIAC SKILLS				\$22,959	\$22,959	\$82,504
023 NEW TECHNIQUES OF CANCER DETECTION						\$50,220
024 COMMUNICATIONS SYSTEM FOR CANCER						\$1,750
025 STREPTOCOCCAL CONTROL PROJECT PROJECT						\$1,680
026 CARDIAC I D CARD						\$7,050
027 HEALTH EDUCATION FOR VERMONTERS				\$31,790	\$31,790	\$83,566
TOTAL		\$500,000		\$531,253	\$1,031,253	\$3,408,379

HISTORICAL PROGRAM PROFILE OF REGION

July , 1967

- John E. Wennberg, M.D. became Program Coordinator (100% time).

Site Visit:

The role of systems analysis activities in RMP is discussed. Visitors felt that systems had helped them organize the planning process but questioned its use in other than planning activities.

Fiscal Year 1968

- During FY 68 the RMP accomplishments were:

- 1) Participated in development of the Connecticut Valley Health Compact whose overall goal is to examine the possibilities for the provision of total health care in the Connecticut Valley Health Compact region.
- 2) A physician attitude study is initiated.
- 3) Heart inventory is completed.
- 4) A survey was made of existing medical records to evaluate time involved in history taking and recording of data from the viewpoint of completeness and retrievability.
- 5) A state-wide education program is conducted in external cardiopulmonary resuscitation.
- 6) Possibilities of a cervical cancer screening program are explored.
- 7) Involvement with three projects related to information systems.

June, 1968

- First Operational grant request received requesting support of four projects as follows:

- Project #1 - RMP office
- Project #2 - Progressive Coronary Care
- Project #3 - Emergency Health Care
- Project #4 - Continuing Education for Health Professionals

In early September a project #5 - Evaluation Protocol for Coronary Care System Inclusive Emergency Health Services was submitted and

October, 1968

- Site Visit to discuss O1 operational request:

Major concerns of the visitors:

- 1) Slow rate of maturity;
- 2) Lack of involvement of RAG - especially in the decisionmaking process;
- 3) Degree of influence of Executive Committee or RAG;
- 4) Lack of Medical Society involvement in generating program ideas;
- 5) Lack of a clearly defined conceptual strategy for the region.

All projects were reviewed and visitors felt this had merit but additional planning was needed.

November, 1968

- Council concurs with site visit team and Review Committee and O1 operational grant is deferred for additional information and clarification.

December, 1968

- Dr. Wennberg request (granted) permission to meet with DRMP to discuss November Council's recommendation. He asked for permission to revise the operational application and be allowed to submit it for the January-February 1969 review cycle. His justification for requesting this was that a delay to the April-May cycle would be extremely detrimental to NNERMP.

February, 1969

- Council approved operational request and authorized funding of Projects Nos. 2-- Progressive Coronary Care, and 4--Continuing Education for Health Professionals.

May, 1970

- The RMPS staff review of the O2 year operational request 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 its planning experience, i.e., concentrating on problem identification, epidemiology studies, data analysis, etc., without a clear-cut operational plan of action.

August, 1970

- RMPS staff reviewed a revised O2 operational request, approved it, and recommended a site visit to 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.
 - 3) Whether there has been any major reallocation of regional resources.

December, 1970

- Site Visit:

The findings and recommendations were generally as the following:

The major emphasis on data acquisition and analysis strategies was reasonable, however, some of the region's resources should now 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 systematic 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, these visitors reported problems in communication with members of these institutions. The relationship with the practicing community was also a question.

May, 1971

- RMPS staff was unable to grasp accomplishments of the region and requested that the National Review Committee and Council be requested to assess its program approach before the region begins preparation of its three year application.

August, 1971

- National Advisory Council expressed concern over the program of the region and requested a staff assistance visit to the region.

October, 1971

- Dr. Margulies, Director RMPS, sent a letter to Dr. Luginbuhl, Dean, College of Medicine, UVM, expressing concern over the status of RMP in Vermont, the portion of RMP resources going for support of the Experimental Delivery System and conversely the portion going toward program development consonant with the Mission Statement.

January, 1972

- Mr. Don Danielson is appointed Program Coordinator and the effort to rebuild NNERMP along "traditional" lines is started.

STAFF OBSERVATIONS

Principal Problems:

The principle problems have been this program's failure to:

- 1) establish a RAG active in decisionmaking,
- 2) develop a clear-cut operational plan of action,
- 3) coordinate RMP, CHP and EHSDS into one management system acceptable to both Vermont and the Federal Government, and
- 4) develop a systematic data utilization strategy for RMP or other potential data users.

Principal Accomplishments:

The principal accomplishments have been:

- 1) development of the Regional Disease Management approach
- 2) development of a data base for health planning, and
- 3) publishing of reports in heart, cancer, kidney and respiratory diseases.

Issues requiring attention of reviewers:

1. Present and future organizational relationships between RMP, CHP and EHSDS?
2. Relationships with the medical school with particular attention to the Medical Review and Comment provision in the review process?
3. Correlation between the activities and the stated program's goals, objectives and priorities, and determination of which is the product of what?
4. Composition of the RAG (CHP a and b?) and its Executive Committee?
5. The RMP plans for future support and/or utilization of the data base?
6. Compliance with the CHP review and comment regulations?
7. The plans for involvement and development of the three counties in New York State considered a part of this region?

The Committee recognized the infancy of the program reviewed, the fact that many elements of the program are untested, and that for the most part the NNERMP is a "paper" organization. Yet, based on the quality of the materials assembled and with an insight to the management capabilities of the program staff, particularly the new Director, Mr. Danielson, it is believed prospects for continued development are good.

The following suggestions emanated from the review:

- . The goals and priorities need to be further defined and more explicitly stated.
- . The RAG needs to expand its membership to include better representation of youth, the medically underserved, areawide planning agencies, allied health, and representatives from the bordering areas of New Hampshire and New York if it is established that these areas are indeed appropriate territories of the NNERMP. Consideration should also be given to the appropriateness of the economic and local political interest having representation.
- . The RAG should consider establishing a subcommittee structure aligned with goals, once goals have been developed.
- . The composition of the disease management committees, ad hoc groups, and technical review committees should be examined closely to insure appropriate representation. Also, measures should be taken to assure that these groups are supportive of the program's evaluation plan.
- . The disease management committees should have bylaws, or another similar management tool, to align their functional operation plans with the total program.
- . Consideration should be given to developing management committees for non-disease areas of interest to RMP such as community health.
- . The evaluation scheme should be reexamined to give further assurance that the RAG and program staff each understands its respective roles in review, evaluation, and feedback. This should minimize potential conflicts. Also, organizational changes should be made coordinating all program staff performing any evaluation with the Director for Evaluation.
- . The vacant program staff positions should be filled with persons that will provide the program with a broader range of professional

and discipline competence. Nursing, allied health, health system development, and community organization are specific suggestions.

- . The program should look at all their proposed projects and relate common objectives so that the resources have a greater potential for effecting constructive change of the health care system.
- . The RMP still needs to assume some continued responsibilities for making the region aware of available data, and to assist in the development of a data utilization strategy.
- . A formal policy on continued support should be established.
- . The surveillance and monitoring devices of projects should include a method for prematurely phasing out unsuccessful or ineffective projects.

It was emphasized that the transition the NNERMP is presently going through is not the traditional project-to-program transition most RMPs experience, but one of changing from an organization primarily interested in data collection to one more in concert with the present RMPS mission statement. In fact, the few categorical activities of the program have a comprehensive flair with definite considerations for broader problems.

Dr. Luginbuhl of the University of Vermont was not present during these deliberations.

EOB/DOD/9/29/72

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>03</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 397,578	\$ 462,368	\$ 480,000	\$ 500,000			
CONTRACTS							
DEVELOPMENTAL COMPONENT		114,617	114,617	114,617	10%	10%	
OPERATIONAL PROJECTS	328,389	683,804	521,720	416,636			
Kidney	X	(78,740)	(70,000)		(37,900)	(25,400)	
EMS		()					
hs/ea		()					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	725,967	1,260,789	1,116,337	1,031,253	850,000	850,000	
COUNCIL RECOMMENDED LEVEL							

Region Rochester
Review Cycle 10/72
Type of Application:
Anniversary before
Triennium
Rating 269

Recommendations From

SARP

Review Committee

Site Visit

Council

RECOMMENDATION: The Committee agreed with the site visitors in recommending an approved level of \$935,000 for the Rochester RMP's 05 operational year. In arriving at this level it was necessary to balance the numerous and promising changes made during the year against the considerable work yet to be done. The base level of \$900,000, plus \$35,000 earmarked for the kidney program, was considered appropriate because it would represent an increase over the current approved level and a moral encouragement to the Region and would permit the RRMP a sufficient allocation for program staffing, developmental and planning activities, as well as an increase in project activities beyond those initiated during the 04 extension period.

Requested

\$1,035,000

Recommended

\$935,000

Critique - The Committee agreed with the site visit team that over the last year the Rochester Regional Medical Program has seen dramatic organizational, functional, and programmatic changes, particularly:

1. The resignation of the previous Coordinator and the hiring of Dr. Peter Mott.
2. The dissolution of the previous large program staff in terms of functions and people and the beginnings of the new.
3. The change in the character of the program with the termination of sixteen ongoing projects and the initiation of new directions in concert with newly-established goals.
4. The change in RAG composition, interest, and responsibility.

5. The closer working arrangements with the CHP (b) agency.

Time has not yet permitted the Region to complete the change process, however, and many areas still need a substantial amount of work; especially:

1. The further development of goals, short-term objectives, and priority setting mechanisms.
2. Completion of the organization of RAG committees and delineation of their functions, with an awareness of the need for minority representation. There is a necessity too, which the Region recognizes, to diminish the power of the Executive Committee and increase the responsibilities of the RAG.
3. Development of program staff as a high program priority. There was the suggestion that the Region may wish to increase program staff over that now projected.
4. The immediate development of by-laws and procedures, with the proviso that these documents must be furnished to RMPS staff for review, and that the January 1st award be contingent on their completion. It was stressed that there must be a clear definition of the differing roles of program staff and RAG.

The Committee agreed, too, that the numerous other points of advice the site visitors relayed to the Region (which are contained in the site visit report) be formalized and relayed to the Region after Council consideration.

EOB/DOD
9/26/72

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION BEFORE TRIENNIUM

Component	Current Annualized Level <u>04</u> Year	Request For <u>05</u> Year	Request Funding For <u>05</u> Year <input type="checkbox"/> SARP <input checked="" type="checkbox"/> Review Committ
PROGRAM STAFF	\$ 259,855	\$ 415,000	\$935,000 combined
CONTRACTS	--	-0-	
DEVELOPMENTAL COMPONENT	---	-0-	<input type="checkbox"/> Yes <input type="checkbox"/> No
OPERATIONAL PROJECTS	598,951	620,000	
Kidney	X	(35,000)	(35,000)
EMS		(-0-)	()
hs/ea		(-0-)	()
Pediatric Pulmonary		(-0-)	()
Other		(-0-)	()
• TOTAL DIRECT COSTS		\$ 858,806	\$1,035,000
COUNCIL-APPROVED LEVEL	\$ 871,308	*	

* Only Council approval for the 05 year is \$35,000 for the Regional Kidney Program.

~~\$ 800,000~~ \$900,000
~~35,000~~ 35,000
~~\$ 82,000~~ \$93,000
 RMP STAFF BRIEFING DOCUMENT
 Review Cycle: 10/72
~~\$ 900,000~~ Kidney
~~+ 35,000~~ D.C.
~~\$ 93,000~~

REGION: Rochester

OPERATIONS BRANCH: Eastern

NUMBER: RM 00025

Chief: Frank Nash

COORDINATOR: Peter Mott, M.D.

Staff for RMP: Eileen Faatz

LAST RATING: "C"

TYPE OF APPLICATION:

- Triennial 3rd Year Triennial
 2nd Year Triennial Other

Regional Office Representative: Robert Shaw

Management Survey (Date):

Anniversary prior
 to Triennial-05
 Operational year

Conducted: November 1970
 or
 Scheduled: _____

Last Site Visit: June 1971

- (List Dates, Chairman, Other Committee/Council Members, Consultants)
 Alexander M. Schmidt, M.D., Dean, Abraham Lincoln School of Medicine,
 University of Illinois - Review Committee Member
 Robert Lawton, Deputy Director, Tri-State RMP - Consultant
 Richard Cross, M.D., Chairman of NJRMP RAG - Consultant
 Richard Haglund, Associate Coordinator for Administration, Intermountain RMP -
 Consultant

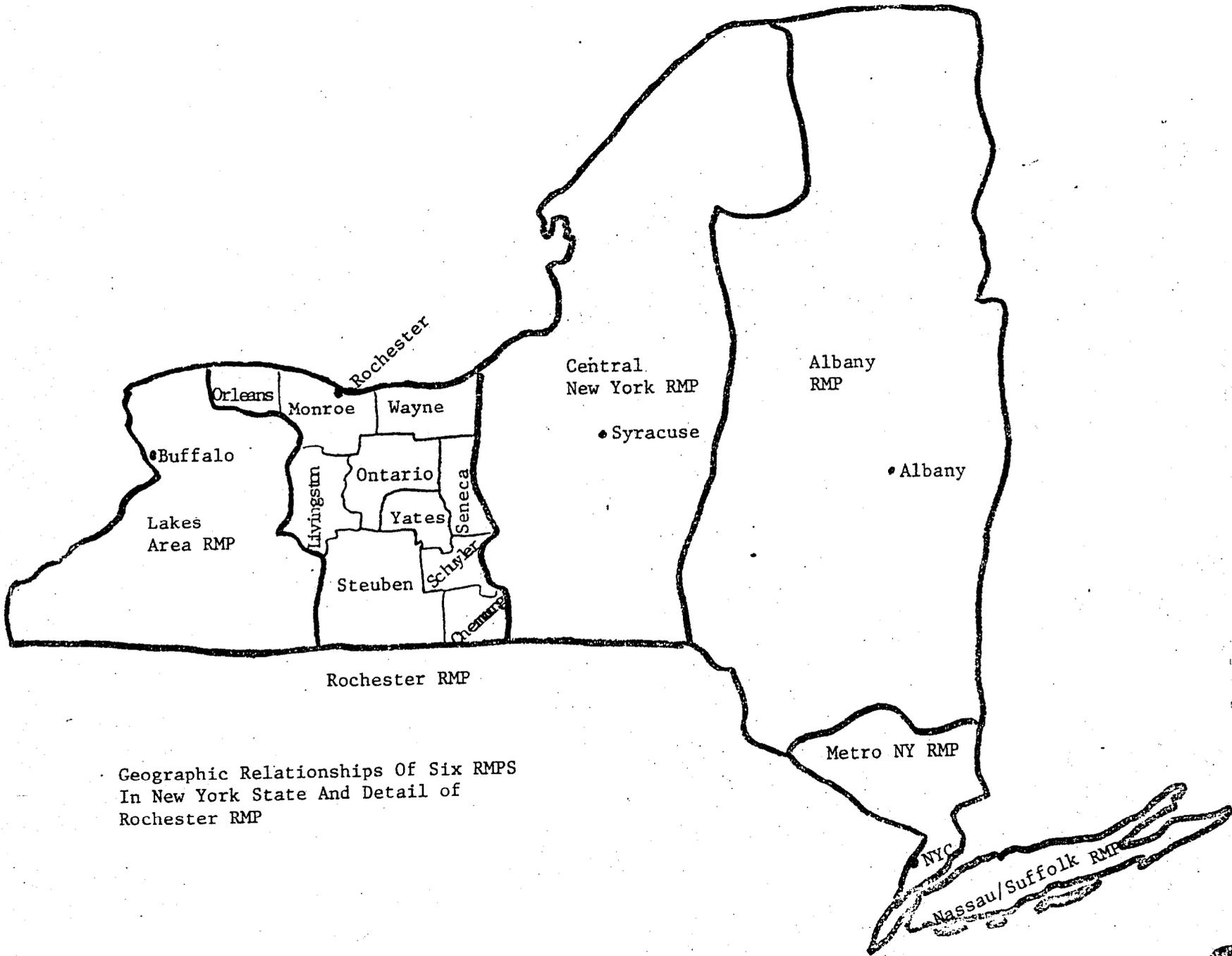
Staff Visits in Last 12 Months:

(List Date and Purpose)

- October 1971 - Dr. Orbison (Dean, Med. Sch.) and Dr. Saward (Assoc. Dean Extra-
 mural Affairs) visit Rockville to discuss RRMP problems with Dr. Margulies.
 February 1972 - Dr. Pahl, Mr. Peterson, Mr. Simonds, Mr. Shaw, Ms. Faatz -
 to review the changes/progress made since the June 1971 site visit, discuss
 the Rochester situation with all key people involved, and recommend
 necessary changes for the Region in the future.
 June 1972 - Ms. Faatz - review recent progress and discuss upcoming application
 and site visit.

Recent events occurring in geographic area of Region that are affecting RMP program:

- All year. Continuing conflict between Blue-Cross sponsored pre-paid group
 practice plan and many area physicians who oppose the idea - with Blue
 Cross the victor.
 Fall 1971. Unsuccessful attempt by CHP (b) agency and others to establish
 a Rochester health authority.
 Winter-Spring 1972. Employment of Assistant Director of CHP (b) agency
 and concomitant increase in close working relationships between CHP and
 RMP.
 June 1972. Tropical Storm Agnes wreaks havoc on the Corning-Elmira area -
 both cities inundated - possibly two of four community hospitals beyond
 repair and many private physicians' offices wiped out. Since this area
 has been rife with duplication and gaps in health delivery system, there
 exists the possibility for some restructuring of the system in the



Geographic Relationships Of Six RMPs
 In New York State And Detail of
 Rochester RMP



DEMOGRAPHIC INFORMATION

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 Lakes Area RMP (Buffalo) and on the east by the Central New York RMP (Syracuse), on the north by Lake Ontario, and the south by Pennsylvania.

The city of Rochester is the third largest in New York and is the industrial, commercial, educational, and cultural center of the area covered by the RRMP. More than half the city's people earn their livings in manufacturing industries. Eastman Kodak and the Xerox Corporation employ large numbers. The second largest city in the RRMP area is Elmira, a manufacturing center in the south-central part of the State. The remainder of the Region can be characterized as small town/rural, including the beautiful Finger Lakes area, and has fruit growing, truck gardens, dairy farms, and vineyards.

The approximate population served by the Region is 1.2 million. Although statistically the population of the ten-county area is 66 percent urban, this is a result of the large urban population in the two most populous counties of the area: Monroe County (Rochester) and Chemung County (Elmira). The other eight counties in the Rochester Region are overwhelmingly rural. The non-white population of the area comprises 5.5 percent of the total, with the largest concentration in the city of Rochester where 17.5 percent of the population (52,115) is non-white. Many Blacks and Puerto Ricans in Rochester, though, feel that the census figures are considerably lower than the actual population figures. The RRMP area contains 271 registered migrant camps - one-third of the New York State total - and during the peak season there are somewhere between 12-15,000 migrants in these camps, mostly Blacks. The median age of the area is approximately 28 years with eleven percent of the population over 65. There is a generalized out-migration in the age ranges 20-35 and an in-migration at ages under 20 and over 65. The average family income in the area is somewhat lower than that of the rest of New York State and the percentage of people eligible for public assistance is higher.

There are 27 general acute care hospitals in the Region with a total of 4,153 beds. Of these, seven hospitals and 50 percent of the total beds are in the Monroe County (Rochester) area. Elmira has two hospitals of about 250 beds each. The remaining eight counties contain at least one community hospital each. The Region houses 1,798 licensed and registered MDs and 10,435 RNs, with 70 percent of the physicians and 50 percent of the nurses in Monroe County. Appendix A to the RAG Report shows, though, that in the ten counties there are only 800 active, non-institutional primary care physicians (GP, internal medicine, pediatricians, and OB/GYN) under 65 years of age.

The health education institutions in the area include the University of Rochester School of Medicine and Dentistry, eight professional nursing schools and three for practical nurse training, one cytotechnology and six radiologic technology programs, as well as two hospital-based programs for medical technology.

Region: Rochester RMP
 Review Cycle: 10/72

COMPONENT AND FINANCIAL SUMMARY
 ANNIVERSARY APPLICATION BEFORE TRIENNIUM

Component	Current Annualized Level <u>04</u> Year	Request For <u>05</u> Year	Request Funding For <u> </u> Year	
			<input type="checkbox"/> SARP	<input type="checkbox"/> Review Committee
PROGRAM STAFF	\$ 259,855	\$ 415,000		
CONTRACTS	--	-0-		
DEVELOPMENTAL COMPONENT	--	-0-	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OPERATIONAL PROJECTS	598,951	620,000		
Kidney	X	(35,000)	()
EMS		(201,500)	()
hs/ca		(-0-)	()
Pediatric Pulmonary		(-0-)	()
Other		(-0-)	()
TOTAL DIRECT COSTS	\$ 858,806	\$1,035,000		
COUNCIL-APPROVED LEVEL	\$ 871,308	*		

* Only Council approval for the 05 year is \$35,000 for the Regional Kidney Program.

AUGUST 29, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

RHPS-OSM-JTCFHL-20

REGION 25 ROCHESTER

RMP SUPP YR 24

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	** REQUESTED	REQUESTED	REQUESTED	REQUESTED
		01	02	03	04	05	06	07	TOTAL	
		09/71-12/77				TOTAL	** 01/73-12/73	01/74-12/74	01/75-12/75	TOTAL
000	PROGRAM STAFF	244805	303908	436400	326043	1311156	**	415000		415000
001	PECCASTR EQUIP	26400				26400	**			
002	POSTGRADUATE TR	83500	77000	110600	54209	325709	**			
003	RGST GEN MSP AC	21200	8800	11000		41000	**			
004	REGIONAL COAGUL	69400	45100	65600	16681	196781	**			
006	CARDIOVASCULAR	71300	62100	83400	33339	250139	**			
007	EARLY DISEASE C	202200	262200	363700	127992	977692	**			
008	CONED MNS COV S	30900	40000	51600		124500	**			
009	CANCER CLEARING	19500	22500	22300	23096	97396	**			
010	STATISTICAL AND	71600	58400	81900	42012	255912	**			
011A	TELEPHONE EXG C		30100	43200	3342	76642	**			
013	DECENTRALIZED C		36900	53000	14679	104779	**			
014	EST SINK TRMS		20700	27700		48400	**			
015	NEUROLOGIC AND		9100	13100	8957	31157	**			
016	PHYSICIAN TRAIN		6100	9700	7119	22919	**			
017	CHRONIC RENAL D		3100	11000	16613	30713	**			
018	DIABETES MELLIT		20500	33800	26629	81129	**			
021	MEDICAL ORGAN						**	35000		35000
021A	REC ORGAN PROCL				9546	9546	**			
021B	REC ORGAN PROCU				22067	22067	**			
021C	REC ORGAN PROCL				27193	27193	**			
022	PRIMARY CARE AN				50476	50476	**	37500		37500
023	FAMILY COLASFLC				17333	17333	**	13000		13000
024	CONSULTANT SERV				24483	24483	**			
025	HEALTH EDUCATIC				30244	30244	**			
026	CHRONIC NERLPCMU				59374	59374	**			
030A	EMS SOUTHERN TI				33333	33333	**	100000		100000
030B	EMS SOUTHERN TI				16667	16667	**	50000		50000
030C	EMS HEALTH INFO				54160	54160	**	51500		51500
030D	EMS PLANNING AN				67172	67172	**			
031	HEALTH EDUCATIONA				16000	16000	**	48000		48000
032	RURAL FAMILY ME				20492	20492	**			
033	NURSING CONTINU				40000	40000	**	60000		60000
034	FINGER LAKES HC				11667	11667	**	50000		50000
035	RURAL PEDIATRIC				7787	7787	**			
036	DELIVERY SYSTEM				16667	16667	**	80000		80000
037	RURAL NURSE PRA				8333	8333	**	35000		35000
038	BILINGUAL ALLIE				12705	12705	**			
039	ENRICHMENT PROG						**	30000		30000
040	ADOLESCENT MATE						**	30000		30000
- T O T A L -		841205	1008108	1452900	1266810	4568123	**	1035000		1035000

SHAW-WALKER, INC.

JULY 17, 1972

DEPARTMENT OF HEALTH
AND PROGRAM SERVICES

REGION - ROCHESTER
FISCAL YEAR 1972

PAGE 1
RHS-038-1100-1

IDENTIFICATION OF COMPONENT	(1) CONT. WITHIN APP. PERIOD OF SUPPORT	(2) CONT. BEYOND APP. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
0000 PROGRAM STATEMENT		\$412,000			\$415,000	\$169,270	\$584,270
021 REGIONAL URBAN PROGRAMS NT SHARING TRAINING	\$35,000				\$35,000	\$16,444	\$51,444
022 PRIMARY CARE ANALYSIS		\$37,500			\$37,500	\$8,414	\$45,914
023 FAMILY COUNSELOR PROGRAM		\$13,000			\$13,000	\$3,809	\$16,809
030A SOUTHERN TIER EMERGENCY NETWORK		\$100,000			\$100,000		\$100,000
030B SOUTHERN TIER CRISIS PHU SE SERVICE		\$50,000			\$50,000		\$50,000
030C MONROE CRISIS PHONE SERV ICE		\$51,500			\$51,500		\$51,500
030 COMPONENT TOTAL		\$201,500			\$201,500		\$201,500
031 EDUCATIONAL ALLIANCE		\$48,000			\$48,000		\$48,000
033 NURSING CONTINUING EDUCA TION		\$60,000			\$60,000	\$27,333	\$87,333
034 FINGER LAKES HOME CARE		\$50,000			\$50,000		\$50,000
036 DELIVERY SYSTEMS EVALUAT ION		\$80,000			\$80,000	\$19,890	\$99,890
037 RURAL NURSE PRACTITIONER		\$35,000			\$35,000		\$35,000
039 ENRICHMENT PROGRAM FOR D EPRIVED INFANTS				\$30,000	\$30,000	\$10,714	\$40,714
040 ADOLESCENT MATERNITY SER VICE PROJECT				\$30,000	\$30,000	\$15,401	\$45,401
TOTAL	\$35,000	\$940,000		\$60,000	\$1,035,000	\$267,275	\$1,302,275

HISTORICAL PROGRAM PROFILE OF REGION

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. These growing concerns spurred numerous visits to the Region.

The first was a site visit in April 1970. 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. This visit and a subsequent management assessment visit in November 1970 resulted in recommendations to the Region that the RAG assume its responsibilities for direction and that the program hire a strong Deputy for the Coordinator and provide administrative assistance to the program.

The Spring of 1971 saw the submission by the RRMP of a Triennial Application which exhibited the same chronic problem areas, and another site visit was scheduled for June. Although in many ways the 1971 visit was merely a replay of that in 1970, the site visitors were optimistic about the recent creation of an interested and active Executive Committee of the RAG, and in this Committee the visitors saw a possible hope for

bringing the RRMP out of the doldrums. The program still remained, though, a conglomeration of individual projects, and the primary problems identified continued to be:

1. Problems in program staffing and lack of administrative leadership.
2. Lack of integration of goals and objectives into a coordinated program approach with attendant priorities for determining program activities.
3. The inadequate review and decisionmaking process and the failure of the RAG to assume its responsibilities.

The many concerns of the site visitors were relayed clearly to the Region and emphasized by a recommendation to fund RRMP for only one additional year, and at a reduced level. The Region was told that there would be a follow-up site visit in a year to check progress.

Within a few months of the site visit Dr. Orbison (Dean of the Medical School) and Dr. Saward (Associate Dean for Extramural Affairs) visited Dr. Margulies in Rockville for a frank discussion of the Region's problems.

For some time after this, the Region appeared to continue business as usual, stretching its 04 year award to cover all approved projects, which by this time numbered 17, primarily categorical and dominated by nurses' and physicians' continuing education activities. Then, on January 1, 1972, Dr. Parker's resignation was announced and interim direction was assumed by Mr. Jonathan Rudolph, a young man who had come with the program only a few months before as assistant to the Coordinator.

A rather large team of RMPS staff members (five) visited Rochester in late February 1972 and were rather disappointed to find that other than Dr. Parker's resignation and the search for a new Coordinator, the situation was as stagnant as it had been for the last two years. Two days were spent discussing necessary changes with the numerous people involved with the program. Although the messages delivered by RMPS staff at that time were not new, perhaps the degree of receptivity was, because after the February visit, a number of things happened in rather quick succession (including the appointment of a new Coordinator). These are described briefly on the next page under Principal Accomplishments.

Meanwhile, an RMPS administrative decision to implement a three-cycle review year, caused Rochester's 04 year to be extended four months from 8/31 to 12/31/72. RRMP was asked to justify an award of \$266,672 (a pro-ration of the present level of funding) with the understanding that during the four-month extension new activities could be implemented with RMPS staff approval. These activities, though, could not be continued beyond 12/31/72 without approval of the National Advisory Council. In June, the RRMP submitted an application for \$266,672 for the four-month extension. Support for program staff activities and thirteen projects was requested. Of the thirteen projects, ten were completely new and evidenced a new trend in Rochester, away from continuing education and categorical activities. On the strength of the major programmatic, functional, and organizational changes which had occurred in the Region in the last months, and on the basis of the new look represented by these projects, Dr. Margulies and RMPS staff gave Rochester the authority and funds to implement these activities for four months.

STAFF OBSERVATIONS

Principal Problems:

Main problem is the insufficient time since Dr. Mott became Director for all the necessary restructuring:

- a. Essentially, at this point, the Director and the Assistant Director are running the program by themselves, a rather difficult task.
- b. The RAG bylaws and other procedures need revision.
- c. The RAG committee membership (selected before the new RAG members were appointed) needs to include minorities and other new members.
- d. In filling future RAG vacancies, the program should consider whether the present composition of seven women on the 36-member group represents adequate sexual parity.
- e. The RAG must continue to take on increasing responsibility and relieve the Executive Committee.

Principal Accomplishments:

In this last year there have been considerable organizational, functional, and programmatic changes:

- a. New Director - Dr. Peter Mott
- b. Changed composition of RAG to increase minority and consumer representation, and election of a new RAG Chairman (the second in the Region's history).
- c. Establishment of goals, termination of old program, and initiation of new directions.
- d. Closer working arrangements with CHP and development of relationships with groups not formerly involved, such as inner-city and migrant organizations.
- e. Plans for complete reorganization and reorientation of program staff.

Issues requiring attention of reviewers:

- a. Goals - Does regional experience since the formulation of goals suggest that they should be modified?
- b. Is the review process adequate?

STAFF OBSERVATIONS (Continued)

Issues requiring attention of reviewers (continued).

- c. Are the Region's ideas about the organization and functions of the new program staff reasonable, and are recruitment activities meeting with success?
- d. Is the proposed evaluation process for individual projects going to be handled in a coordinated fashion? (There is no proposed position for evaluator of program staff.)
- e. With the change in program direction, is the previous base of community support being maintained, or is a new constituency being developed, or both?
- f. How has the University/RRMP relationship withstood the recent program changes?

Recommendations From



SARP



Review Committee



Site Visit



Council

RECOMMENDATION: The Review Committee concurred with the site visitors that the Regional Medical Program of Texas be approved for triennial status including a developmental component. However, the Committee recommended reduced funding. Amounts requested and recommended are as follows:

	<u>Direct Costs</u>	
<u>Years</u>	<u>Requested</u>	<u>Recommended</u>
05	\$2,178,470	\$1,900,000
06	2,340,225	2,100,000
07	2,400,508	2,300,000

The recommendation includes the condition that maximum funds be budgeted for the developmental component (05-\$158,000, 06-\$190,000, and 07-\$210,000).

RATIONALE FOR FUNDING RECOMMENDATION: Recommended funding should be adequate to increase program staff, provide flexibility to support imaginative developmental activities, and fund some of the worthwhile projects. This action should force the Region to sharpen its priorities and reallocate project dollars. Maximal discretionary developmental funds should strengthen their hand in stimulating activities which are more in keeping with the Region's needs.

CRITIQUE: The recommendation was decided upon after a great deal of discussion and debate about the Region's progress.

As reported by the site visitors, RMPT has made considerable progress since the previous July 1971 site visit. Most of the major concerns cited in the August 11, 1971 advice letter had been addressed. Objectives and priorities have been established, but need to be developed in more measurable terms. There was now evidence of central office support and assistance to subregions. Progress and projected staffing of subregions seemed good. The Region's plan of cooperation with and being responsive to local CHP(b) planning groups, rather than of formation of local RMPT

advisory groups appeared practical at this time. The visitors also believed the proposed activities reflect peripheral involvement. Expansion of more allied health representation in the decisionmaking groups has been limited, but sincere beginning efforts were noted. Of major concern to the visitors, progress in minority involvement on the program staff and in the decisionmaking process has been slow. However, attention was drawn to RMPT's written plan for recruiting minority program staff. The site visit team believed the application request to be modest for what RMPT proposed doing and recommended approval for the period of time and in the amount requested. The visitors also went on record recommending a continued rating of "A" for RMPT.

The Review Committee expressed concern that the RAG is still dominated by providers of health services, and noted only minimal change in minority involvement. It was also believed that many of the projects seemed to be self-serving to producers of services. It was expressed that a program which has to deal with the kind of issues in Texas, particularly Blacks, Mexican-Americans, migrants, etc., can only do so with the kind of experience they can get from people who are involved with these problems.

The Committee noted the relatively modest request submitted by the RMPT and wondered why the program wasn't bigger in view of the size of the state and the magnitude of the problems. On the other hand, the reviewers were not impressed by many of the proposed projects and questioned how much impact they would have on the health care delivery system.

The Committee recognized some progress in Texas and the keen ability of the Coordinator. However, it was believed that the Region should involve many more minorities and consumers, and sharpen its focus on priority needs.

Dr. Brindley and Mrs. Flood were not present at the discussion of this application.

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>04</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 579,999	\$ 754,129	\$ 822,762	\$ 877,970			
CONTRACTS	138,280	--	--	--			
DEVELOPMENTAL COMPONENT	90,000	160,000	200,000	225,000	(\$158,000)	(\$190,000)	(\$210,000)
OPERATIONAL PROJECTS	771,761	1,264,341	1,317,473	1,297,538			
Kidney		(337,157			(\$337,157)	(\$309,640)	(294,640)
EMS		(---)					
hs/ea		(153,200					
Pediatric Pulmonary		()					
Other		(773,984					
TOTAL DIRECT COSTS	\$1,580,040	\$2,178,470	\$2,340,235	\$2,400,508	\$1,900,000	\$2,100,000	\$2,300,000
COUNCIL RECOMMENDED LEVEL							

REPORT
OF
REGIONAL MEDICAL PROGRAM OF TEXAS
SITE VISIT

August 1-2, 1972, Austin, Texas

By

REGIONAL MEDICAL PROGRAMS SERVICE

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I. SITE VISIT TEAM

A. Consultants

Miss Elizabeth E. Kerr (Chairman)
Review Committee Member
Director, Program in Health Occupations Education
Division of Health Affairs
University of Iowa
Iowa City, Iowa

Mrs. Mariel S. Morgan
National Advisory Council Member
Chief Medical Technologist
Presbyterian Hospital
Albuquerque, New Mexico

1/ George E. Miller, M.D.
(former member of Review Committee)
Director of Research in Medical Education
College of Medicine
University of Illinois
Chicago, Illinois

1/ Alfred Popma, M.D.
(former member of National Advisory Council and past
Director of the Mountain States RMP)
Boise, Idaho

John A. Lowe, M.D.
Director
South Dakota Regional Medical Program
Vermillion, South Dakota

B. RMPS Staff

1/Michael J. Posta
Acting Chief
Mid-Continent Operations Branch
Division of Operations and Development

Joseph de la Puente
Acting Deputy Director
Office of Planning and Evaluation

Jimmy L. Roberts, M.D.
Health Consultant
Division of Professional and Technical Development

Luther J. Says, Jr.
Operations Officer
Mid-Continent Operations Branch
Division of Operations and Development

C. DHEW VI Regional Office Staff

David Eubanks
Program Representative
Dallas, Texas

II. REGIONAL MEDICAL PROGRAM REPRESENTATIVES AND OTHERS

A. Executive Committee and Regional Advisory Group

2/ Richard T. Eastwood, Ph.D., Chairman
Director, Houston Medical Center
Houston

2/ Arthur H. Dilly
University of Texas System
(Chairman of Capital Area Planning Council - CHP(b)
Austin

Robert K. Bing, Ed.D.
President, Occupational Therapy Association
University of Texas Medical Branch
Galveston

Levi V. Perry, M.D.
(Coronary Care Project)
Private Practice
Houston

N. C. Hightower, M.D.
Past Chairman, RAG
Chairman of Nominating Committee
Scott and White Clinic
Temple

George J. Race, M.D.
Chairman, Technical Advisory Committees
Baylor University Medical Center
Dallas

2/ Elizabeth Jones, R.N.
Chairman, Continuing Education Committee
Associate Dean, University of Texas School of Nursing
Houston

2/Executive Committee Members

Edward L. Baker
Texas Pharmaceutical Association
Dallas

2/ S. R. Greenwood
Chairman, Availability Committee
Member, Program Development Committee
Temple National Bank
Temple

2/ James. E. Bauerle, D.D.S.
Texas Dental Association
San Antonio

Martha N. Bobbitt, R.N.
Texas Nurses Association
Amarillo

Burton G. Hackney
Executive Director, CHP(a)
Austin

Billye Brown, R.N.
Member, Evaluation Committee
Associate Dean, University of Texas School of Nursing
Austin

Vance Terrell, M.D.
Program Development Committee
Private Practice
Stephenville

V. J. Belda (ex officio)
Director, V.A.
Temple

Charles Corley
President, Texas Society of Medical Technologists
Abilene

John M. Smith, Jr., M.D.
Texas Medical Association
Private Practice
San Antonio

2/ Grover Bynum, M.D.
Vice Chairman, Evaluation Committee
Private Practice
Austin

2/ Executive Committee Members

2/ J. G. Cigarroa, M.D.
Private Practice
Laredo

B. Grantee

Charles A. LeMaistre, M.D.
Chancellor
University of Texas System
Austin

R. L. Anderson
Comptroller
University of Texas System
Austin

C. Program Staff

Charles B. McCall, M.D.
Coordinator

Stanley Burnham, D.Ed.
Director, Professional and Community Programs

Louise Miller, B.A.
Chief, Administrative Services

David K. Ferguson, M.S. -
Deputy Coordinator

Robert O. Humble, M.A.
Deputy Director for Community Programs

Beverly Drawe, M.J.
Chief, Information Service

Thomas V. Sander, B.B.A.
Accountant

Hubert Reese
Data Management Specialist

John Donbroski
Program Development

Linda Johnson
Technical Information Specialist

2/ Executive Committee Member

John G. Dailey
Director of Education Programs (effective 9/1/72)

Central Office Based Operations Officers

Robert L. Anderson, M.B.A.
Gerald Mussey, M.Ed. (EMS Specialist)
Billy D. Gwartney, M.B.A.

Subregional Representatives

Samuel D. Richards, Ph.D.	#2 Lubbock
Maria Elena Flood	#3 El Paso
James C. Karsch, M.S.	#4 Abilene
Grady Faulk, Jr., M.Ed.	#7 Tyler
N. Don Macon	#8 Houston
Sister Marion Strohmeier, R.N., M.P.H.	#10 Harlingen

D. Others

Floyd Norman, M.D.
Assistant Regional Director for Health and Scientific Affairs
DHEW Region VI
Dallas

Garabed Eknayan, M.D.
Baylor College of Medicine
(Renal Disease Project, Director)

Forrest Ward, Ph.D.
Coordinating Board
Texas College and University System
Austin

Lincoln Williston
Executive Director
Texas Medical Association
Austin

Ray Hurst
Texas Hospital Association
(TRMP Health Careers and Electrical Safety Projects)
Austin

Lewis A. Leavitt, M.D.
Baylor College of Medicine
(TRMP Rehabilitation Projects)

Robert Mickey
Office of Medical Health Manpower
Texas Medical Association

Frederick Fleming
Executive Director
Houston-Galveston Planning Commission - CHP(a)
Houston

Velma T. Faulk, Ph.D.
Project Director
GRO Projects 54 A-E

Jo Ann Hinson
GRO

Verna Hancock
GRO

III. BACKGROUND INFORMATION

A. Purpose of the Site Visit

1. To assess program progress, processes and proposed Triennial Application. The RMPS Review Criteria constituted major factors taken into account by the site visit team.
2. As recommended by the August 1971 National Advisory Council the site visit team was charged to provide specific information on progress in the following areas which were enumerated in RMPS' Advice Letter of August 11, 1971 to RMPT.
 - a. "The RMP of Texas needs to establish priorities under its new program direction. Although the review system appears to be satisfactory at the present time, reviewers felt that it cannot be fully tested until priorities are established. Only then can the Region expect to concentrate on funding patterns which relate to the real health needs of the Region.
 - b. "The subregional staff members need more assistance and support from the central staff and RAG members in the development of specific programmatic activities. Local advisory groups, either in conjunction with CHP(b) agencies or under the auspices of RMP of Texas, would also further the enhancement of progressive action in the subregional areas.

"The approval of the developmental component request should also assist the Region in the further development of more peripheral involvement.
 - c. "More representation from allied health groups is needed on the major policy making bodies, especially the Executive Committee and the Regional Advisory Group. Reviewers felt that those who are now serving on task forces and committees could/should be considered for election into policy making positions and continue to use the subcommittee structure as a "training ground" for additional nonphysician health professionals and consumers.

- d. "Similarly, additional minority group members should be included on the RAG and Executive Committee. Reviewers noted the commitment of RMP of Texas to the health care needs of the Blacks and Mexican-American populations which together comprise 30% of the population of the Region. Although there is representation from professional members on these groups, reviewers urge the Program to consider the nonprofessional's involvement in proposed activities soon enough for them to be constructive in their participation. This would seem appropriate, especially in the subregions where activities will be planned for ghetto residents and migrant workers. By utilizing minority groups, especially those with bilingual talents, at the local level, a more extended RMP orientation could be offered which could provide a source for better selection of those who could be considered for election into the Regional Advisory Group.

"It was noted that there were no minority representatives on four of the major subcommittees of the RAG or any serving in professional positions of Core staff. The Program should strive to improve these weaknesses. Perhaps employment opportunity on the Core staff might be improved by inserting a recruitment suggestion into the operational objectives of the Administrative Service Division (note page 68 of the Triennial Application).

- e. "In giving attention to the assessment of regional needs and problems, some reviewers felt that the process seemed to be more of a central office academic review rather than peripheral involvement and input—a theoretical rather than pragmatic approach. Reviewers agreed that the Core staff theoreticians are most capable but may need to have increased input from the emerging subregional organizations. These statements might be considered as a corollary to item #2 found above.
- f. "Reviewers felt that overall Program accomplishments to date have been relatively modest. It was noted that some projects, such as the Cancer Registry, have not progressed as rapidly as others. The

relatively high funding priority given to the Registry activities was most perplexing to the reviewers. On the more positive side, the coronary care program was cited as having had a real impact on the health delivery system. Other project activities, per se, were not discussed by the reviewers other than how they were ranked for funding consideration. It is assumed that this apparent short-coming will be rectified when short-term objectives and program priorities become finalized by the Regional Advisory Group."

B. Pre-Site Visit Meeting

1. As part of the verification of RMPT's review process, Messrs. Posta and Says visited and interviewed representatives of the CHP(a) , two CHP(b) Planning Commissions and sponsors of four projects (2 approved and 2 disapproved) July 28 & 31, 1971 in Houston and Austin. On this phase of the verification, they found RMPT in compliance with the RMPS' Review Process Requirements and Standards.
2. The site visit team met the evening of August 31, 1972 to review the purpose of the site visit as outlined above. At the suggestion of Dr. Miller (chairman of the June, 1971 site visit), it was agreed that most of the discussions should be directed toward the concerns of the August, 1971 Council; and that little would be gained in rediscovering most of what was learned during the previous site visit. For these reasons RMPT agreed to last minute changes in the agenda to allow adequate time to get at the major issues during the first day. Also, for this reason some RAG and Committee members originally scheduled to attend during the second day were not present. However, RAG and Committee representatives present were satisfactory to the conduct of the visit.

Other issues to be explored as presented by RMPS staff were:

- Utilization of consumer groups in establishing objectives and priorities.
- Relationships with CHF(a) and (b) agencies in planning and project development; particularly since only 5 of 21 (b) agencies have been funded and TRMP local advisory groups have not be activated.

- Why are no planning and/or feasibility studies included in the application?
- What is the current status of emergency medical services and what is TRMP's role?
- Of those projects where TRMP support is to be phased out in the 04 year, how many will continue?
- Proposed budgets indicate only minimal support from other sources. If successful, what are the assurances of their continuation after cessation of TRMP support?
- In the long range planning, what will the relationships be between GRO projects and Area Health Resource Information Centers?
- With regard to GRO projects, what are the cost-sharing services other than education?
- Explore rationale of funding of the many new projects for one year only, as well as unspecified growth funding in the 06 and 07 years.

IV. CONCLUSIONS, GENERAL IMPRESSIONS AND RECOMMENDATION

The Regional Medical Program of Texas has developed priorities which were the basis for the development of the proposed three year program. Objectives and priorities should be further developed in measurable terms; hence the critical need for rapid employment of a qualified evaluator. There was new evidence of central office support and assistance to the subregions. Progress and projected staffing of subregions is good. Their plan of cooperation with and being responsive to local CHP (b) planning groups rather than formation of local RMPT advisory groups appears practical at this time. The proposed programs reflect peripheral involvement. Expansion of more allied health representation in the decision-making groups has been limited, but sincere beginning efforts were noted, however. Progress in minority interest involvement has also been slow in the transition and this issue must be addressed more rapidly. Evidence of overall progress is clear and proposed action should now be tested. The request is modest for what they want to do and approval is recommended for the period of time and in the amounts requested. The site visitors also strongly wished to go on record recommending a continued rating of A for RMPT.

Supplemental documents requested from RMPT (appended to this report) are as follows: 1) a discussion of program elements relative to 1974 and 1975 plans for new activities; 2) Recruitment Plan 1973-74; and 3) Non-RMPT Project Funding.

At the request of RMPS staff RMPT also provided supplemental information on the renal disease project with a cover letter dated August 14, 1972.

V. REVIEW DETAIL

A. Performance

1. Goals, Objectives and Priorities

This was one of the major concerns of the previous site visitors as stated in the advice letter. Specific long-term and short-term objectives have since been established. Priorities have been delineated and coincide with both RMPT and national objectives.

The objectives as evidenced by testimony during the site visit are understood by all those participating in the process. The paucity of measurable objectives inherent in the priority statements, however, was noted. The Chairman of the RAG, the Coordinator and his Deputy shared this concern and intend to develop measures of effectiveness. A Chief of Program Development and Evaluation is to be employed and more expert consultation will be sought in strengthening the Evaluation Committee.

It is clear that the subregional offices are now providing more input into the system. This was supported by all subregional office representatives. The issue of the advisability of developing local advisory groups was discussed and the consensus was that CHP(b) consumer oriented planning councils are being developed and that potential activities of local RMP advisory bodies would constitute wasteful duplication of effort. This would also be detrimental to community efforts, particularly in Texas, because not all of the potentially effective, articulate, and well-informed consumers have been introduced to the system. Perhaps RMPT could assist in developing more expertise in council consumer participation, as suggested by one of the subregional representatives.

A joint effort to train consumers in council participation is presently being supported by Migrant Health and RMPS. In addition, five contracts for developing an environment for Chicano Health Consumer Participation are being supported by RMPS in Texas, Arizona, Colorado, and California in the hope to alleviate this need for effective council participation. Mrs. Maria Elena Flood, subregional representative in the El Paso area has been appointed by RMPT to spearhead the latter in Texas.

The site visitors believe some real progress has been made toward establishing priorities under the new program directions. The stated priorities, when appropriate, have been followed in the funding of operational activities. Priorities are addressed to regional needs and reflect the possibility and instrumentality for continuous development and improvement. While their objectives and priorities reflect the result of a study process, there is little evidence that other than "studied opinions" entered into the priority determination mechanism.

2. Accomplishments and Implementation

There is evidence of continued accomplishment stimulated by Program Staff and RAG Committees. For example, the support of a planning effort towards a comprehensive proposal addressed to renal disease has resulted in a promising activity. If this program is successfully funded and implemented, it will bring to Texas one of the first efforts addressed to comprehensive care of a particular patient group on a regional basis. Project GRO and their Area Health Education Resource Programs (AHERP) are other examples of likely successful activities.

While "traditional" projects had been supported in previous years, these are now being terminated. A new generation of projects, as presented, promise to deliver improved accessibility. The thrust of these activities toward the wider application of knowledge is not yet visible.

Quality of care has not yet been addressed with emphasis, particularly in terms of providing opportunities to measure these objectives.

Representatives of various multi-disciplined professional organizations testified favorably on behalf of RMPT. Salient among these was the Texas Medical Association, the Texas Nursing Association, and the Texas Pharmaceutical Association.

It was recognized that the Region is serving an effective role towards the delivery of health services by being a bridge between the institutional physician, the practicing specialist, and the general practitioner. Here the program is serving as a catalytic agent toward progress addressed to implementation of RMPT priorities.

The visitors saw positive potential reflected in present and scheduled accomplishments.

3. Continued Support

In response to questioning by the visitors, the Regional representatives reviewed the continuing support status of activities funded during 1970-72. Of twenty-two projects supported only two will continue after the close of the current period; eight will be supported by self and/or other support; seven will be discontinued; and continuance of three is questionable.

It is evident that the issue of continued project support may well become an important component in RMPT's decision-making progress. While RMPT feels that past performance in this area could well be improved, the future will bring early consideration of this issue at the proposal development stage. For example, an integral part of the total performance plan for an integrated kidney disease program for Texas will be identification of continued sources of support other than RMPT with particular attention to fee for service.

4. Minority Interests

The lack of adequate minority involvement being a historical problem in RMPT, this review criterion was explored in depth by the site visitors, as will be recognized throughout this report. There are only three minority representatives on the Program Staff, one professional and two clerical (Spanish surnamed), one of whom was added during the past

year. A recruitment effort has been underway for sometime for a qualified Mexican-American to head the San Antonio subregion. Employment of Black subregional representative in Dallas is also a consideration. It was also pointed out that Sister Strohmeier, subregional representative in the Rio Grande Valley, though of German ancestry, identifies extremely well with the Mexican-American in that area. Minority and female representation on the RAG is expressed in the following table:

MINORITY AND FEMALE REPRESENTATION ON RMPT RAG

	<u>1968</u>	<u>1969</u>	<u>1970</u>	<u>1971</u>	<u>1972</u>
SPANISH SURNAME	-	1	1	2	3
BLACK	1	2	3	3	3
FEMALE	<u>1</u>	<u>3</u>	<u>5</u>	<u>6</u>	<u>5</u>
TOTAL OF ABOVE	2	6	9	11	11
TOTAL OF RAG	32	33	44	50	51
% OF RAG MEMBERSHIP	6.3	18.2	20.5	22.0	21.6

Although there is clear evidence of minority input by consumer groups through the subregions, the visitors expressed dissatisfaction with the small number of minority members on RAG and its sub-structure. A plus for the Region is the significant number of minority personnel on project staffs.

The present goals and objectives coincide with areas of minority concern, particularly those addressed to "making quality of care available in those areas where little if any is now available." Planned activities are addressed to the training of members of minority groups in health occupations. RMPT is not satisfied with its performance in minority involvement. The Chancellor of the University of Texas System, Charles A. LeMaistre, M.D., advised that as the grantee institution, the University of Texas indicated awareness of their responsibility to assure compliance by the RMPT.

A proposed "Recruiting Plan" for 1973-74 was presented to the visitors. The plan includes the hiring of Blacks and Spanish Surnamed/Spanish Speaking Americans. It was emphasized that the Recruitment Effort Document includes plans for constructing a talent roster. This documentation was submitted to RMPS as a supplement to the application prior to the Review Committee meeting.

Dr. Cigarroa, a RAG member and a private physician from El Paso, who identified himself as a Mexican-American, advised that all the tokenism in the world would not help without true concern for the needs of minorities. In the RMPT RAG he has clearly seen concern for the needs of the underserved.

B. Process

1. Coordinator

Dr. McCall, the Coordinator, has provided strong leadership to the Texas Regional Medical Program during his three-year tenure. He has assembled a viable Regional Advisory Group and has utilized the diversified talents of its membership in establishing the three-year plan as presented in the Triennial Application. In addition to this task, this Group has been actively involved in responding to the concerns of the August, 1971 National Advisory Council as enumerated in the advice letter August 11, 1971.

Dr. McCall's excellent rapport with the members of the Regional Advisory Group and with the many health agency representatives was overtly apparent to the visiting team.

The Program Staff is outstanding as evidenced by their individual presentations throughout the two-day site visit meeting. The Deputy Coordinator, Mr. David Ferguson has major responsibilities and receives the same degree of loyalty from other members of the staff as does the Coordinator.

2. Program Staff

The current RMPT staff consists of 19 professionals. All but two of them serve 100% time, and there has been very little turnover during the past two years. Six additional professional staff members are requested in next year's budget.

They include a Director of Educational Programs, a Chief of Program Development and Evaluation, a Nursing Educator, and three subregional representatives. The site visitors believe that the additional positions budgeted (approximately \$100,000 annually) in the Triennial are justified. The Chief of the Program Development and Evaluation position is considered essential since Mr. Humble, who had filled this position until recently, has been appointed Deputy Director of Community Programs and will now be more involved in working with the subregional representatives. The site visitors suggested that consultant services also be considered to assure that effective program evaluation plans materialize by the RAG Committee assigned to this function. Aside from program evaluation responsibilities, this Committee will also be expected to assess Program Staff activities.

The Program Staff reflect a high quality and broad range of professional discipline competence. Particularly impressive was the quality of the subregional representatives who demonstrated thorough knowledge about their responsibilities and respective geographical assigned areas. They also described their active involvement with the local Council of Governments and CHP 314(b) agencies who give additional input from the consumer interests in the respective subregional areas.

3. Regional Advisory Group

The 51 member RAG met three times during the past year. The average rate of attendance was 70%. The site visit team noted that most of the key health interests were represented on the RAG. Geographical distribution of its membership was considered to be satisfactory. However, as with many Regional Medical Programs, physician representation is proportionately high while consumer interests remain relatively low. The site visitors gave this deficit considerable attention since the same problem was evident when the Region was assessed in 1971. The RAG Chairman and the Coordinator responded to this concern by stating that progress had been made in the selection of one-third of the members who were replaced during the past year. The site visitors made it clear that the progress was not as good as it should be and strongly urged that this problem be addressed as soon as possible. Dr. Eastwood, RAG Chairman, responded by stating

that the present members of the Advisory Group are outstanding personalities. He also expressed his belief that there is a distinct difference in institutional and practicing physicians; and considering Texas' large population, geography and number of medical institutions, the number of physician RAG members may be minimal. On this premise expanding the RAG membership may be the solution to involving more non-physicians.

The 16 member Executive Committee met 4 times during the past year and provided ample guidance to the Coordinator and staff. This Committee was particularly effective in providing leadership in the total review process and in utilizing the Regional Advisory Group's many (51) committees and task forces. Membership composition of all committees was found to have the same weakness as the RAG.

The Program Development Committee assumed an active role by establishing short-term objectives and program priorities. As a result of its work, seven Program Committees have been formed to identify general program activities relating to the seven priorities identified. The Chairman of each Program Committee is a RAG member and serves on the Executive Committee. General program activities are described for each of the seven priority statements and funding allocations projected for use of growth funds in the second and third year of the proposed Triennial Grant Application. Thus, the Program Staff has a fairly good concept of what kinds of activities should be generated in subsequent years. The Staff will also be able to better employ developmental funds in stimulating activities which have a direct relationship to the short range objectives identified.

4. Grantee Organization

Dr. Charles LeMaistre, Chancellor, University of Texas System, Mr. R. L. Anderson, Comptroller, and Mr. Arthur Dilly, Executive of the UT System assured the site visit team that the grantee does provide freedom and flexibility to the RAG and does not interfere with the programmatic endeavors and the decisionmaking functions of the RAG. The site visitors wished to be assured that compliance was being met in equal employment practices for minority groups and women. When the response to this inquiry indicated that progress had not been as good as it should be, the visitors suggested the need for an affirmative action

plan which would include a recruitment practice calling for the advertisement of the job, its description, the credentials needed, records of interviews conducted and the results of them, upward mobility intents, and the implementation of an applicant file. The visitors were then presented with a recruitment plan which had been prepared by the Program Coordinator which was considered to be a "forthright" response. However, the team expressed the concern that intent should be encompassed far beyond the sole responsibility of the Coordinator and urged that the above mentioned affirmative action plan be considered for draft by the RMPT and ratified by its membership.

It was apparent that the grantee also recognized its responsibility in seeing to it that the minority interest problems are resolved.

5. Participation

Many health interests, institutions and groups are actively participating in RMPT as evidenced by the number of persons who attended the two-day visit. No major group has captured the controlling interests of the program. In comparing the budget request with that of last year, there is a complete turnaround with respect to funding the major universities and institutions. This accomplishment has provided more community resources but has not brought about less cooperation from the major health institutions. Although there remains a high degree of medical society influence on program activity considerations, much progress has been noted. For example, an HMO activity is being funded by HSMHA to the Bexar County Medical Society as a direct result of RMPT involvement and staff assistance in drafting the application. Also, the first three program priorities indicate a marked change in the philosophy of the Texas program in that access, availability and utilization of manpower have replaced the categorical emphasis of yesteryear. There remains strong resentment in implementing new physician extender manpower programs (i.e., physician assistants) on the part of the Texas Medical Association (TMA). This was again emphasized by a TMA Official and progress in this area may be slow unless the four proposed AHERP's (health services/education activities) generate additional strength through the County Medical Societies.

The political and economic power is involved in the RMPT program. Aside from active RMPT physician prominence on the state and national scene (i.e., cancer and heart), the CHP agencies and local Councils of Governments have given endorsements to the Region.

6. Local Planning

CHP(b) planning has developed slowly. There are 21 CHP (b) state planning regions encompassing the entire state (254 counties). Five have received federal funding and almost all of the others have received state funds (\$10,000 to \$20,000 each) for staffing. Nineteen (19) of these agencies now have councils. In Texas, each CHP (b) agency is associated with a Council of Government. The latter are voluntary associations of local governments of which two-thirds of voting members are elected officials. All health proposals for state and/or federal support are reviewed first by the CHP Planning Agency and then by the Council of Government. All proposals applicable to the City of Houston also require review and comment by the Mayor's Office of Planned Variation, one of approximately twenty federally supported programs.

RMPT has defined 10 subregions covering the entire state and six of these have now been staffed. The remaining four will be staffed by the end of the current period with priority given to the San Antonio and Dallas areas. Most of the subregions relate to two or more CHP planning agencies. Unstaffed subregions are currently served by the central office staff. The Region has an excellent interface with local planners and consumer groups.

During the last RMPT review cycle, there was ample evidence that RMPS' Minimum Review Process Requirements and Standards for local review have been carried out in a most satisfactory manner, particularly by the CHP(b) agencies. As reported by RMPS staff the CHP(a) agency has participated in the review of RMPT applications but only through limited staff involvement. The Council has not been involved because it meets only twice annually. CHP(a) staff reported and described their review and comment workload as voluminous (49 agencies have health components); yet they believe they too should have technical review prerogatives. Its staff is limited and the lack of a complete state plan is probably because most of its \$500,000 budget is used in

enhancing the local (b) agency growth. As expressed by one of their officials they are more interested in developing the players before the script.

7. Assessment of Needs and Resources

There was ample evidence that RMPT has conscientiously accumulated a great deal of data as evidenced by its being selected along with 6-7 other RMPs to participate in the Washington/Alaska Management Information System program. The data is utilized, but probably not to its fullest extent in identifying specific and measurable needs. The priorities, as stated, reflect the general mission statements of the national program and are not based necessarily on specific needs as documented by hard data obtained by the RMPT.

8. Management

The management capability of RMPT continues to be excellent. Program Staff and project activities are well coordinated, including monitoring by RAG members, a Program Staff person and other selected ad hoc members. Progress and financial reports are required on a quarterly and monthly basis respectively and shared services are being actively pursued by satellite hospitals participating in the five project GRO activities. The Texas Hospital Association is participating actively through its diversified activities especially in the electrical hazard project and in the shared services program being implemented in 18 hospitals. The latter program has demonstrated a 10% savings in services provided by utilizing the concepts employed by better management techniques.

9. Evaluation

At the present time, there is no full-time Evaluation Director on the Program Staff even though there is evidence of some management assessment in this specialty. Several activities have been rightly terminated due to evaluation and monitoring assessments by staff and the RAG. Some project activities have been evaluated fairly extensively while others have not due to the shortage of staff expertise. Very little consultant services have been procured to more fully provide evaluation to program development and Program Staff activities. The site

visitors were assured that employment of a qualified evaluator would be given high priority and that the RAG Evaluation Committee and consultants would be more highly geared to this effort during the ensuing year. More effective evaluation is critical to the Region's further program development and effectiveness.

C. Program Proposal

1. Action Plan

A comprehensive effort, the priorities have been thoughtfully prepared with much debate and review, and are clearly congruent with national goals and objectives. The proposed activities relate to stated priorities and objectives, with increasing attention to needs. Though modest in terms of identification of areas of highest need, the proposal is much more realistic in light of available resources and past performance. The goals are admirable, but are stated in such a general way, it will be difficult to quantify; and is one of the weakest parts of the program proposal. Methods of reporting accomplishments and assessing results are proposed, but address individual activities more than program achievement. Periodic review and updating of priorities are planned.

2. Dissemination of Knowledge

Most programs have a focus on appropriate provider groups and/or institutions that will benefit. Knowledge, skills and techniques to be disseminated have been identified to varying degrees in some projects. There is a remarkable degree of involvement of health education and medical institutions as evidenced in their widespread support of program proposals. Better care to more people is the goal to which most projects are directed; but some solid measurement of results remains to be seen. Moderation of costs of care is addressed. While RMPT does not necessarily address management of most frequent health problems, those to which attention is given are significant and not rare.

3. Utilization of Manpower and Facilities

The Region's intent to utilize community health facilities is apparent in most projects. At this stage increased productivity of health manpower does appear to be an

objective in most of the projects. Utilization of allied health personnel has improved. Although new types of health manpower is a sensitive issue, further attention is being given. Utilization of manpower and facilities is an identified priority and it is receiving appropriate program focus. Underserved areas and populations is a concern of RMPT as reflected in their proposal.

4. Improvement of Care

There seems to be a very limited degree of studies of ambulatory care, but this data may emerge in next year's program staff activities. Program staff are involved with other groups in attempts to improve Emergency Medical Systems. Access to health care is their first priority and projects are addressed to this issue. Primary care and its access will probably be strengthened since this is an important element in several projects. Less attention is given to health maintenance and disease prevention in the proposed activities.

5. Short-term Payoff

The proposal in part is directed more toward the availability of an access to services, than simply gathering more information about health problems; whether this goal will be achieved remains to be seen. The need for feedback to document actual payoffs is projected but not specifically planned. Support of projects is not planned beyond three years and plans for transition to other sources of support are generally included.

6. Regionalization

Support of multiple groups and institutions is a major goal of the program as reflected in many of the activities. Sharing existing resources, and services and new linkages among providers are indicated in the three year plan. The concept of progressive patient care (e.g., OP clinics, hospitals, extended care facilities, home health services) are only minimally reflected in the application.

7. Other Funding

Contrary to the information in the application, there is ample evidence that the Region has and will attract funds from sources other than RMPT. Though not discussed in detail during the site visit, the RMPT accountant provided RMPS staff with a document which indicates non-RMPT funding as follows: new and continuing projects - \$882,372 and terminating projects - \$150,380.



REGIONAL MEDICAL PROGRAM OF TEXAS

4200 NORTH LAMAR, SUITE 200, AUSTIN, TEXAS 78750

512/451-3555

August 15, 1972

Harold Margulies, M.D., Director
Regional Medical Programs Service
Parklawn Building, Room 11-05
5600 Fishers Lane
Rockville, Maryland 20852

Dear Dr. Margulies:

The attached materials are forwarded in response to discussion with the site visit team on August 1 and 2, 1972.

During that visit we outlined the Regional Advisory Group's work toward definitive program development. The reviewers asked that we reduce to writing, RMPT's 1974 and 1975 plans regarding new activity in each short-range program area. Attachment I. discusses each program element as it has been identified by the committees of the Regional Advisory Group and as presented at the site visit.

Another area of discussion was the minority composition of the staff of the Regional Medical Program of Texas. The discussion centered around the recruiting plan presented to the team as additional information. It was suggested we forward the plan as information supplemental to our application. It is enclosed herein as Attachment II.

Under separate cover and letter we have sent you (August 14, 1972) additional documents in support of the Texas statewide renal proposal. This material was requested by J. L. Roberts, M.D. of your staff.

We hope this information will be useful in the presentation of the RMPT Triennial Application to the review committee and council. If additional clarification is needed or information required please let us know.

Sincerely,

A handwritten signature in dark ink, appearing to read "C. B. McCall".

Charles B. McCall, M.D.
Coordinator

CBM/mj

Enclosure

XC: Miss Elizabeth Kerr
Mrs. Mariel S. Morgan
✓ Mr. Luther Says

Seven ad hoc program committees of the Regional Advisory Group were convened in late 1971 and early 1972 to accomplish three major tasks, (1) development of activity selection criteria, (2) evaluation of potential program strategy, and (3) identification and discussion of particular elements of each program area for emphasis by the Regional Medical Program of Texas. The committees, through the latter assignment, specified several areas of particular concern as a point of departure for further program development and immediate foci for staff effort. The timing of the development process was such that the staff did not have this information available to them when proposals and ideas from the community were being solicited and evaluated in December, 1971 and January, 1972. Therefore, the first opportunity to explore community interest in depth in these areas will come in the 1973 review cycle.

The staff of the Regional Medical Program of Texas is seeking community interest and involvement in those elements set out by the program committees. The fruits of this search will be forthcoming in the 1973 review cycle. In anticipation of new activity in these specific areas, a minimum amount of funds in the 1974 and 1975 budget have been identified. Some of these funds are available from terminating projects. Others have been included on the basis of an estimated number and size of activity anticipated. The actual specific activity to which these funds will be allocated is at this time unknown.

The areas in which ideas will be solicited are known and funds have been estimated accordingly. These areas are described

Access -

Public (patient) education - ideas for the reduction of barriers to health arising from lack of knowledge about illness, the health care system, or financing mechanisms.

Cultural barrier reduction - test methods for overcoming health barriers relating to culture from both the patient and professional viewpoints.

Quality consistency - try mechanisms to assure that the quality of care provided is consistent without regard to economic or social status.

Coordination of referrals - explore ideas for coordinating patient referrals to reduce the confusion and appearance of fragmentation in the health care system.

Simplification of the entry process - aside from cost and information, seek ideas concerning the simplification of the acquisition of care.

Availability -

Emergency service coordination - seek activities whose purpose is the development of linkages and/or coordination of services of communities involved in the delivery of emergency medical treatment.

Community development activity - support interest and community effort in the development of health care or treatment facilities not now available.

Utilization -

Utilization studies - encourage studies of facility and manpower use.

Health care team development - test organizational and management mechanisms that use the team approach to manpower utilization.

Use of "non-direct care" personnel - explore ways to use such "non-direct care" professionals as school nurses and nurses not working as nurses.

Rural resource coordination - support activities that aim for cooperative interaction among rural communities in the efficient and effective use of health care resources.

Health Manpower -

Curriculum coordination - explore means by which articulation and coordination can be expanded in the region's manpower program.

Central reference source development - support further activities that will improve and expand this valuable program.

Continuing Education -

Professional self-assessment - seek methods for re-designing the conventional approach to self-assessment.

Community leadership development - encourage health professionals to become involved in community planning and seek ways to provide some training for the assumption of that role.

Audio-visual techniques - analyze new electronic techniques for potential use in refresher education.

Re-instruction in disease management - test ideas for selecting the appropriate subject areas for re-instruction presentations.

Acquiring common disease information - discover the most common disease entities treated and suggest programs to present latest research information.

Local Cooperation -

Linkages between professional schools and practitioners - encourage attempts to close the communications gap between the "town" professionals and the "gown" professionals.

Involvement of state education agency - try ideas which involve the state education agency staff in RMPT activity.

Extension -

Successful project screening - seek successful ideas from this and other RMP's that might be applicable in Texas.

Publication of successful effort - support the spread of information regarding activities that have successfully contributed to improved patient care.

Publicize project progress regularly - encourage efforts at publicizing the progress of project effort in an attempt to involve the interest of others.

Audio-visual information - maintain a knowledge of available audio-visual packages and how they can be obtained.

ATTACHMENT II
RECRUITING PLAN 1973-1974

At the time of the development of this plan the Regional Medical Program of Texas employed 30.6 full time equivalent staff in seven offices throughout the state. That staff is 44 percent male and 56 percent female. The program employs no Blacks and three Mexican-Americans. This plan is designed to bring the staff of the Regional Medical Program of Texas into reasonable parity with the 1970 census tabulation of major minority groups in Texas. The census identifies 12.7 percent of the Texas population as Black and 17 percent as Spanish surnamed.

Recruiting Goal

The goal of the program regarding minority staffing is presented in the attached table. To meet this goal recruiting efforts will be organized to seek, in the next two years, five Blacks, three Mexican-Americans, and two females. Every effort will be made to find individuals who can meet the professional and other criteria for employment in this program. It is anticipated that this goal can be achieved by the end of 1974.

The following vacancies exist in the present organizational structure of the Regional Medical Program of Texas:

Available Positions

Current Vacancies:

Chief, Program Development and Evaluation
Nurse Education Coordinator
Regional Representative - San Antonio
Administrative Assistant - Houston

Future Vacancies (1973):

Regional Representative - Dallas-Fort Worth
Regional Representative - Amarillo

Clerical positions will be created in each of the regional offices as the professionals are employed. This will add three half-time secretaries to the staff by the end of 1974. One secretary is programmed for the Austin office staff in 1974.

In addition to the planned additional positions shown above there will be vacancies that occur from normal attrition. Recent experience indicates this rate will be approximately two clerical and one professional per year.

Recruiting Program

The Regional Medical Program of Texas has concentrated in the past few months on the search for qualified professionals to fill staff vacancies. Three Spanish surname individuals have been interviewed along with four others. Two were qualified but for various reasons unavailable at this time. Four women, one Black, have been considered for the nursing position but no offers have been extended.

Through the advice and cooperation of Regional Advisory Group members, staff members, and others, the names of several minority recruiting contacts have been collected. Each will be thoroughly explored in the coming months. An Austin employment agency also is supplying good leads to potentially qualified individuals. The entire program staff is aware of the vacancies that exist and is alert to the availability of qualified professionals.

Progress and Evaluation

This recruiting plan will be evaluated in two areas. (1) Records will be developed and maintained on each recruiting contact. A file will be closed only when a final advice letter is written or the individual remove himself from consideration. (2) Progress toward the composite goal will be recorded each three months as a part of the quarterly administrative review process.

PROPOSED

PROGRAM STAFF

MINORITY REPRESENTATION PLAN (1)

	<u>Professional</u>		<u>Clerical</u>		<u>Composite</u>	
	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
Current:						
Black	0	0	0	0	0	0
Mexican/American	1	5	2	18	3	10
Female	6	31	11	100	17	56
Total Staff	19.6		11		30.6	
Goal:						
Black	3	13	2	13	5	13
Mexican/American	4	17	2	17	6	17
Female	6	26	13.5	100	19	50
Total Staff	24.6		13.5		38.1	

(1) Calculated in terms of full time equivalent employment.

MEMORANDUM

- 32 -
SITE VISIT REPORT ATTACHMENT
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

TO : FOR THE RECORD

DATE: August 21, 1972

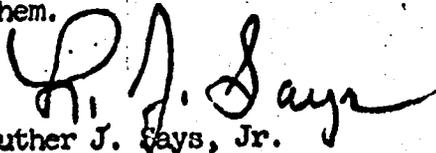
FROM : Operations Officer
Mid-Continent Operations Branch

SUBJECT: Regional Medical Program of Texas - Supplemental Information to the
Triennial Application

During the site visit to RMPT the subject of support from other sources was discussed. Contrary to the information in the Triennial Application under review, there was ample evidence that this criterion is being met. Although not discussed specifically during the visit, RMPT provided this reporter with a listing of non-RMPT support of both new and continuing activities \$882,372, as well as projects to be terminated this period \$150,380.

The Region has subsequently clarified that their figures are for one year and are expected to increase in subsequent years. Also the figures include services of kind.

The budget forms 34-1 will be changed accordingly when the RMPT is advised of funds to be awarded them.


Luther J. SAYS, Jr.

Attachment

NON-RMPT PROJECT FUNDING -- NEW AND CONTINUING PROJECTS

<u>PROJECT</u>	<u>LOCAL</u>	<u>STATE</u>	<u>OTHER FEDERAL</u>	<u>OTHER NON-FEDERAL</u>
TIRR AHRIC	\$ 2,500	\$	\$	\$
AHRIC - Tyler	2,400			
Tyler-Smith County	5,000			
Project REACH		7,000		
Family Medical Resource Center Planning	4,000			
AHERP - Central Texas	2,750			
Electrical Safety Services	100,000			
Continuing Medical Education	22,230			
Project HEARD	55,990		37,400	
Standard Techniques for Home Health Care	--	--	--	--
Rehab Nursing Techniques For Small Hospitals	20,500			
Demo Unit & Continuing Education in Medical Rehab	70,415	33,137		
Project GRO	25,000			
Project MANO			72,800	
Children's Heart Program	43,000			
W. Texas - S.E. New Mexico	6,250			
AHERP - Rio Grande Valley	--	--	--	--
AHERP - South Texas	--	--	--	--
Renal Program		372,000		

NON-FEDERAL PROJECT FUNDING -- TERMINATING PROJECTS

<u>PROJECT</u>	<u>LOCAL</u>	<u>STATE</u>	<u>OTHER FEDERAL</u>	<u>OTHER NON-FEDERAL</u>
Statewide Cancer Registry	\$ 2,400	\$	\$	\$
Reduce Complications Following Radiotherapy		13,500		
Maxillofacial		14,500		
Health Careers	49,832			
Dial Access		3,500		
Stroke Demo Program	--	--	--	--
Medical Physics		5,000		
Inhalation Therapy	2,000			
Electrical Hazards	--	--	--	--
Eradication of Cervical Cancer		14,548		
PASTEX			4,000	
Inter-regional Serial Control		1,100		
Rehab Management - St. Elizabeth's	6,000			
Regional Rehab - Wharton	--	--	--	--
Regional Rehab - New Braunfels	27,000	7,000		

RMPS STAFF BRIEFING DOCUMENTREGION: TexasOPERATIONS BRANCH: Mid-ContinentNUMBER: 00007Chief: Michael J. PostaCOORDINATOR: Charles B. McCall, M.D.Staff for RMP: Luther J. Says, Jr.
Operations Officer, MCOB; JimLAST RATING: ARoberts, M.D., DPTD; Joseph de la
Puente, OPE; Charles Barnes, Grants
Management

TYPE OF APPLICATION:

<input checked="" type="checkbox"/>	Triennial	<input type="checkbox"/>	3rd Year
<input type="checkbox"/>	2nd Year	<input type="checkbox"/>	Triennial
<input type="checkbox"/>	Triennial	<input type="checkbox"/>	Other

Regional Office Representative:

Dale Robertson, (HEW VI, Dallas, Texas)

Management Survey (Date):

Conducted: May '71

or

Scheduled: _____

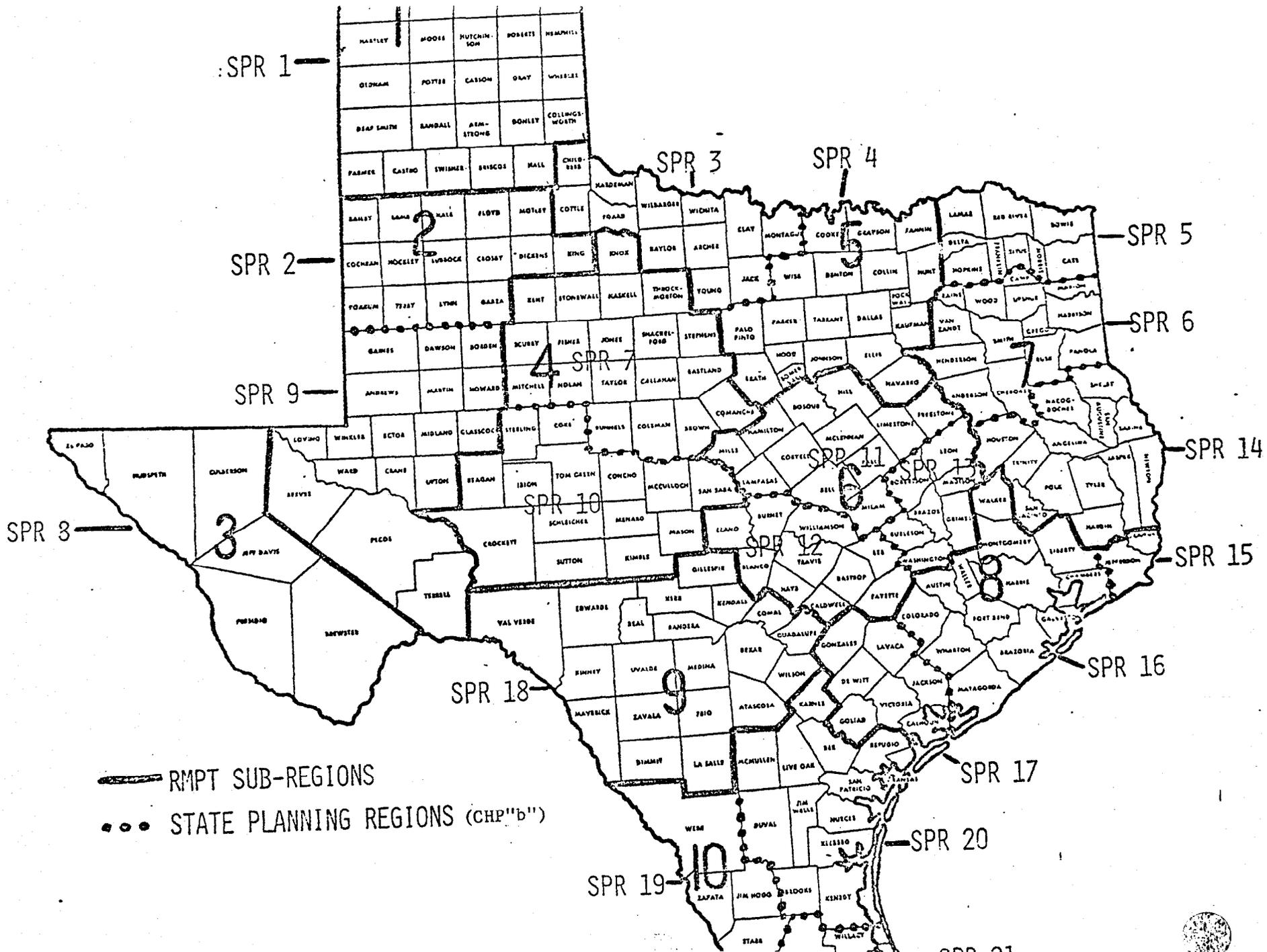
Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)
 July 29-30, 1971 - George E. Miller, M.D., Chairman; Alfred M. Popma, M.D.;
 Joseph J. Smith, M.D. and I. J. Brightman, M.D.

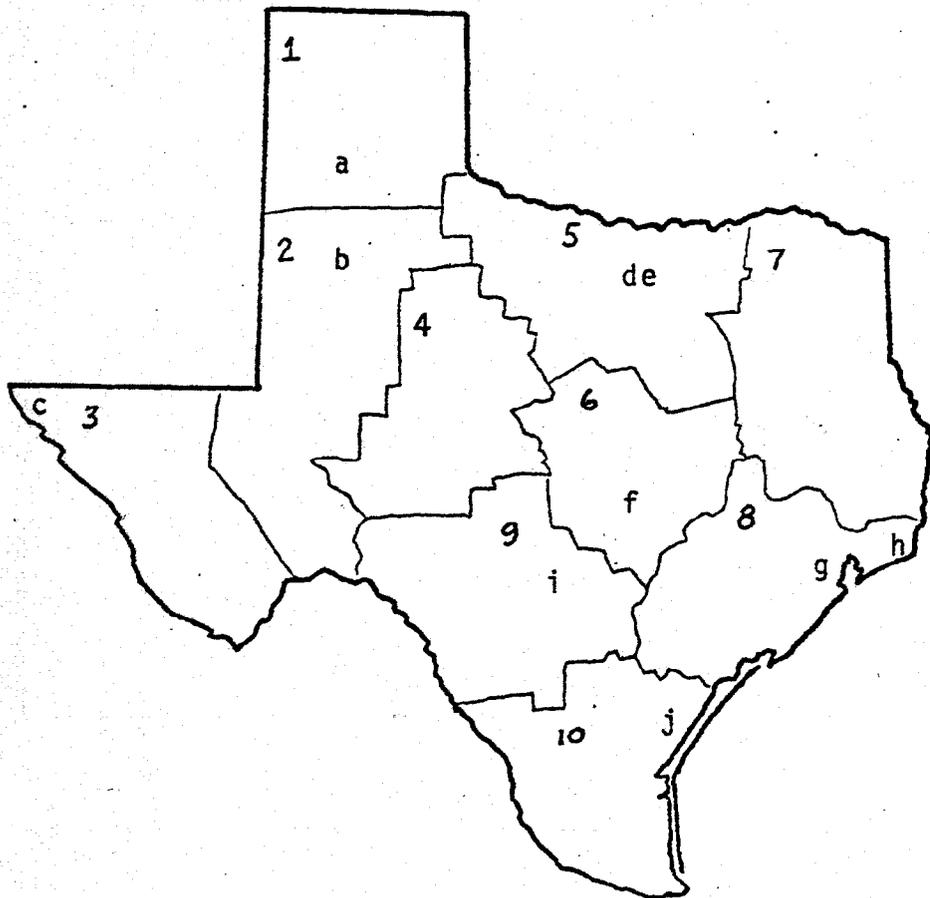
Staff Visits in Last 12 Months:

(List Date and Purpose) Dale Robertson (HEW VI) - Several visits
Luther J. Says, Jr. - 11/16/71 Introductory Visit to TRMP Central Headquarters,
Austin
Francis Van Hee - 11/22/71 Site Visit to Military Assistance to Safety and
Traffic (MAST), San Antonio
Says and Carol Larson - 1/31/72 Consultation regarding AHECs, Harlingen
Says - 5/29-6/2/72 Visits to El Paso and Houston Subregions and to attend RAG
Recent events occurring in geographic area of Region that are affecting meeting.
RMP program:

1. Seven priorities established with an ad hoc committee for each to develop appropriate programs.
2. In addition to the four existing subregional offices (El Paso, Houston, Harlingen, and Tyler), two more were implemented (Abilene and Lubbock). San Antonio and/or Dallas will soon begin.
3. Five representatives of TRMP participated in the RMPS sponsored conference on awareness of the Mexican American culture May 14-17, 1972, Abiquiu, N. M.



TEXAS POPULATION 1970: 11,196,720



TEXAS CITIES with 100,000 or more population (1970) and % change since 1960

CITY	POP.(1970)	% CHANGE
a Amarillo	127,010	- 7.9
b Lubbock	149,101	+15.9
c El Paso	322,261	+16.5
d Fort Worth	393,476	+10.4
e Dallas	844,401	+24.2
f Austin	251,808	+35.0
g Houston	1,232,802	+31.4
h Beaumont	115,919	- 2.7
i San Antonio	654,153	+11.3
j Corpus Christi	204,525	+22.0

NUMBER OF OTHER CITIES OR TOWNS BY SIZE

POP. RANGE	NUMBER
2,500- 9,999	249
10,000-49,999	100
50,000-99,999	17

DEMOGRAPHIC, FACILITIES AND RESOURCES STATISTICAL SUMMARY

07 REGION: TEXAS

Geography and Demography

Encompasses entire State; several subareas.

Counties: 254 Congressional Districts: 23

Population (1970 Census) - 11,197,000

Urban: 80% Density: 43 per sq. mile

Age Distribution:	<u>Texas</u>	<u>U. S.</u>
Under 18 years	37%	35%
18 - 64 years	54%	55%
65 and over	9%	10%

Metropolitan Areas: 17 SMSA's - Total Population 6,268,600

Abilene	Dallas	Galveston	Odessa
Brownsville	El Paso	Laredo	San Angelo
Corpus Christi	Fort Worth	Lubbock	Sherman
Denison - Sherman	Texarkana	Tyler	Waco
Wichita Falls	Houston		

Race: 87% White; 13% non-white

Vital Statistics

Mortality - deaths per 100,000 population, 1967

	<u>Texas</u>	<u>U. S.</u>	<u>Age specific death rates (all causes)</u>
Heart Disease	275.3	364.5	
Malignant neopl.	130.2	157.2	45-64 yrs.-1081.4
Vascular lesions	92.2	102.2	65 & over -5518.8
(aff.CNS - stroke)			
All causes	798.6	935.7	

Other Federal Programs

CHP - A Agency - \$495,000 (13 prof. staff)
 (4) B Agencies - Arlington, Austin, McAllen, San Antonio
 Total funding \$410,000 (11 prof. staff)

#07 Region: Texas

Resources and Facilities

	<u>1969/70</u> <u>Enrollment</u>	<u>Graduates</u>
Medical Schools -		
Baylor U. College of Med., Houston	362	88
U. of Texas, Med. Br., Galveston	598	147
U. of Texas Southwest Med. School Dallas	426	107
U. of Texas So. Texas Med. School San Antonio	216	33
Medical School, U. of Houston (developing)	-	-

Dental School

3 - Baylor, U. of Texas, Houston and U. of Texas, San Antonio

Pharmacy

3 - U. of Texas, Austin; Texas So. U. & U. of Houston, Houston

Professional Nursing Schools

51 - 32 are college or University
based

Practical Nurse Training

153 - majority at college or
special vocational and
technical schools

Allied Health School -- University based:

University of Texas, Med. Br. at Galveston
School of Allied Health Sciences, Galveston

Public Health

University of Texas, Houston - School of Public Health

Accredited Schools

Cytotechnology - 9 (five affiliated with University or Med. Sch.
including one at Brooke Army Med. Center)

Medical Technology - 57 (one at VA Hospital and one at Brooke Army)

Radiologic Technology - 60 (one at Brooke Army Med. Center)

Physical Therapy - 4 (one at Brooke Army Medical Center)

#07 Region: Texas

<u>Hospitals - Community General and V.A. General</u>			<u># Hospitals with selected special facilities</u>
	<u>#</u>	<u>Beds</u>	
Short term	490	44,587	Intensive Care - 139
Long term (special)	14	2,857	X-ray therapy - 78
V. A. (general)	7	2,532	Cobalt therapy - 33
			Isotope - 84
Skilled nursing homes	441	31,587	Renal dial (in pt.) - 48
			Rehab. (in pt.) - 24

Manpower

Physicians* - Non-Federal M.D.'s (1967)

Active	11,279
Inactive	481
Osteopaths (D.O.'s)	721

Ratio of active M.D.'s (per 100,000 pop.): 106

*Percent by specialty: General practice - 31%
 Medical spec. - 21%
 Surgical spec. - 33%

Graduate Nurses, 1966

Actively employed in nursing	20,167	Ratio per 100,000
Not employed in nursing	9,955	188

Licensed Practical Nurses (1967)

Total employed in nursing (adj.)	13,386
Not employed in nursing	-

Region: Texas
 Review Cycle: Sept/Oct 1972

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>04</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 579,999	\$ 754,129	\$ 822,762	\$ 877,970			
CONTRACTS	138,280	—	—	—			
DEVELOPMENTAL COMPONENT	90,000	160,000	200,000	225,000			
OPERATIONAL PROJECTS	771,761	1,264,341	1,317,473	1,297,538			
Kidney	X	(337,157)					
EMS		(—)					
hs/ea		(153,200)					
Pediatric Pulmonary		(—)					
Other		(773,984)					
TOTAL DIRECT COSTS	\$1,580,040	\$2,178,470	\$2,340,233	\$2,400,508			
COUNCIL RECOMMENDED LEVEL							

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BREAKOUT OF REQUEST
05 PROGRAM PERIOD

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF	\$754,129				\$754,129	\$104,120	\$858,249
054A GRO	\$160,000				\$160,000		\$160,000
054B GRO	\$18,476				\$18,476	\$3,579	\$22,055
054C GRO	\$18,476				\$18,476	\$2,545	\$21,021
054D GRO	\$18,476				\$18,476		\$18,476
054E GRO	\$19,572				\$19,572		\$19,572
054 COMPONENT TOTAL	\$37,900				\$37,900	\$14,795	\$52,695
055 ELECTRICAL SAFETY SERVICE	\$112,900				\$112,900	\$20,919	\$133,819
ES	\$50,000			\$166,259	\$166,259	\$25,080	\$191,339
057A COMPREHENSIVE RENAL PROG				\$52,283	\$52,283	\$18,825	\$71,108
EAM				\$31,575	\$31,575	\$10,600	\$42,175
057B COMPREHENSIVE RENAL PROG				\$55,465	\$55,465	\$25,498	\$80,963
RAM				\$31,575	\$31,575	\$10,000	\$41,575
057C COMPREHENSIVE RENAL PROG				\$337,157	\$337,157	\$90,003	\$427,160
EAM							
057D COMPREHENSIVE RENAL PKCG							
RAM							
057E COMPREHENSIVE RENAL PROG					\$38,381		\$38,381
RAM					\$39,200		\$39,200
057 COMPONENT TOTAL		\$38,381			\$39,200		\$39,200
058 AREA HEALTH EDUCATION RE		\$39,200					\$39,200
SOURCES PROGRAM LGVY					\$46,748		\$46,748
059 WEST TEXAS S & NEW MEX A					\$114,170		\$114,170
HEBP							
060 SOUTH TEXAS AREA HEALTH		\$46,748					\$46,748
EDUCATION RESOURCES					\$114,170		\$114,170
061 MAND		\$114,170					\$114,170
062 CHILDRENS HEART PROGRAM		\$86,175			\$86,175		\$86,175
OF SOUTH TEXAS					\$24,071	\$2,565	\$26,636
063 AREA HEALTH RESOURCE INF		\$24,071			\$35,000		\$35,000
G CENTER					\$25,500	\$4,887	\$30,387
064 STD TECHNIQUES FOR HOME		\$35,000					\$35,000
HEALTH CARE SERVICE					\$66,808		\$66,808
065 REACH		\$25,500					\$25,500
066 DEMO UNIT IN MEDICAL REH		\$66,808			\$27,200		\$27,200
AB							
067 BASIC REHAB NURSING TECH		\$27,200					\$27,200
NIQUES							

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
068 DEV AUTO AREA HEALTH RES GRACE INDO CENTER		\$45,000			\$45,000	\$11,949	\$56,949
069 HEARD				\$113,816	\$113,816		\$113,816
070 FAMILY MEDICAL RESOURCE CENTRE				\$14,840	\$14,840		\$14,840
071 AREA HEALTH EDUCATION RE SOURCE PERVASIVE CENT ILL				\$42,000	\$42,000		\$42,000
072 TYLER SMITH COUNTY HEALT H COUNCIL				\$25,375	\$25,375		\$25,375
073 CONTINUING MEDICAL EDUCA TION				\$20,000	\$20,000	\$3,163	\$23,163
UNSPECIFIED GROWTH FUNDS							
TOTAL	\$1,077,029	\$548,253		\$553,188	\$2,178,470	\$242,312	\$2,420,782

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
C000 PROGRAM STAFF		\$822,762			\$822,762	\$2,454,861
D000 DEVELOPMENTAL COMPONENT		\$200,000			\$200,000	\$585,000
054A GRO		\$18,750			\$18,750	\$37,226
054B GRO		\$18,750			\$18,750	\$37,226
054C GRO		\$18,750			\$18,750	\$37,226
054D GRO		\$18,750			\$18,750	\$38,322
054E GRO		\$39,920			\$39,920	\$77,820
054 COMPONENT TOTAL		\$114,920			\$114,920	\$227,820
055 ELECTRICAL SAFETY SERVICE ES						\$50,000
057A COMPREHENSIVE RENAL PROG RAM				\$138,742	\$138,742	\$443,743
057B COMPREHENSIVE RENAL PROG RAM				\$52,283	\$52,283	\$104,566
057C COMPREHENSIVE RENAL PROG RAM				\$31,575	\$31,575	\$63,150
057D COMPREHENSIVE RENAL PROG RAM				\$55,465	\$55,465	\$110,930
057E COMPREHENSIVE RENAL PROG RAM				\$31,575	\$31,575	\$63,150
057 COMPONENT TOTAL				\$309,640	\$309,640	\$646,797
058 AREA HEALTH EDUCATION REI SERVICES PROGRAM LRGV						\$38,381
059 WEST TEXAS S L NEW MEX A HERP						\$39,200
060 SOUTH TEXAS AREA HEALTH EDUCATION RESOURCES						\$66,748
061 MANO		\$102,100			\$102,100	\$285,925
062 CHILDRENS HEART PROGRAM OF SOUTH TEXAS		\$85,000			\$85,000	\$255,675
063 AREA HEALTH RESOURCE INF O CENTER						\$24,071
064 STD TECHNIQUES FOR HOME HEALTH CARE SERVICE		\$35,600			\$35,600	\$95,500
065 HEALTH						\$25,500
066 DEMO UNIT IN MEDICAL REH AB						\$66,808
067 BASIC REHAB NURSING TECH NIQUES		\$24,700			\$24,700	\$51,900

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IDENTIFICATION OF COMPONENT	(1) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
068 DEV AUTO AREA HEALTH RES SERVISED CENTER		\$46,890			\$46,890	\$91,800
069 HEARD				\$118,623	\$118,623	\$296,280
070 FAMILY MEDICAL RESOURCE CENTER						\$14,850
071 AREA HEALTH EDUCATION PE SOURCES PROGRAM LIAISON						\$42,000
072 TYLER SMITH COUNTY HEALT H COUNCIL						\$25,375
073 CONTINUING MEDICAL EDUCA TION						\$20,000
UNSPECIFIED GROWTH FUNDS				\$480,000	\$480,000	\$1,240,000
TOTAL		\$1,431,972		\$908,263	\$2,340,235	\$6,763,315

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF		\$877,970			\$877,970	\$2,454,861
0000 DEVELOPMENTAL COMPONENT		\$225,000			\$225,000	\$585,000
054A GRC						\$37,226
054B GRC						\$37,226
054C GRC						\$37,226
054D GRC						\$38,322
054E GRC						\$77,820
054 COMPONENT TOTAL						\$227,820
055 ELECTRICAL SAFETY SERVICE ES						\$57,200
057A COMPREHENSIVE RENAL PROG RAM				\$138,742	\$138,742	\$443,763
057B COMPREHENSIVE RENAL PROG RAM				\$48,535	\$48,535	\$153,121
057C COMPREHENSIVE RENAL PROG RAM				\$27,824	\$27,824	\$90,974
057D COMPREHENSIVE RENAL PROG RAM				\$51,715	\$51,715	\$162,645
057E COMPREHENSIVE RENAL PROG RAM				\$27,824	\$27,824	\$90,974
057 COMPONENT TOTAL				\$294,642	\$294,642	\$941,437
058 AREA HEALTH EDUCATION RE SOURCE PROGRAM LBGV						\$38,381
059 WEST TEXAS S E NEW MEX A HEBP						\$39,200
060 SOUTH TEXAS AREA HEALTH EDUCATION RESOURCES						\$46,748
061 MAND		\$69,655			\$69,655	\$255,925
062 CHILDRENS HEART PROGRAM DE SOUTH TEXAS		\$84,500			\$84,500	\$255,675
063 AREA HEALTH RESOURCE INF O CENTE?						\$24,071
064 STD TECHNIQUES FOR HOME HEALTH CARE SERVICE		\$24,900			\$24,900	\$95,500
065 REACH						\$25,500
066 DEMO UNIT IN MEDICAL REP AH						\$66,908
067 BASIC REHAB NURSING TECH NIQUES						\$51,000

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
068 DEV AUTO AREA HEALTH RES SOURCE INFO CENTER						\$91,890
069 HEARD				\$63,843	\$63,843	\$296,292
070 FAMILY MEDICAL RESOURCE CENTER						\$14,860
071 AREA HEALTH EDUCATION RE SOURCES PROGRAM CENT TEX						\$42,000
072 TYLER SMITH COUNTY HEALT H CCUACIL						\$25,375
073 CONTINUING MEDICAL EDUCA TION						\$22,000
UNSPECIFIED GROWTH FUNDS				\$760,000	\$760,000	\$1,240,000
TOTAL		\$1,282,025		\$1,118,483	\$2,407,508	\$6,919,213

REGIONAL MEDICAL PROGRAM OF TEXAS SERVICE
 FUNDING HISTORY LIST
 OPERATIONAL GRANT (DIRECT COSTS ONLY)
 May 15, 1972

No	Component Title	01 7/68-9/69	02 10/69-9/70	03 10/70-8/71	04* 9/71-8/72	Total 9/72-12/72
C000	Coordinators office	\$ 232,386	\$ 721,219	\$	\$ 527,617	\$1,481,222
C001	Planning for Renal Disease				20,000 4,000	20,000 4,000
C002	Feasibility of Pastex			580,140		580,140
C21A	Program Staff			15,000		15,000
C21B	Planning Renal			1,743		1,743
C21Z	Feasibility Study					75,135
C220	Planning So. Texas Med.	60,135	15,000			65,856
C230	Planning So. West Med.	62,596	3,260			99,543
C240	Planning Galveston U. T.	95,194	4,349			42,194
C250	Planning Dental Inv.	42,194				56,886
C260	Planning Multi. Med.	45,386	11,500			47,122
C270	Planning Reg. Ca. Program	37,622	9,500			207,842
C290	Planning Baylor Fea.	180,117	27,725			
	Subtotal	755,630	792,553	596,883	551,617	2,696,683
D000	Developmental Component				87,334	87,334
001	Medical Genetics	25,149	26,748	12,570		64,467
003	East Texas Hosp. Teaching Chain	40,164				40,164
004	Comm. Hospital Inhalation	47,500	50,000			97,500
005	Regional Consultation in Radiotherapy	47,500	60,000	30,000		137,500
006	Medical Physics	28,500	49,584	45,000	20,000	143,084
007	Cancer Incidence and Resources in Texas	76,446				76,446
008	Statewide Cancer Registry	38,000	80,000	91,123	108,000	317,123
014	Stroke Demonstration Progressive Program			141,045		141,045
014A	Stroke Demonstration				63,419	63,419

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No	Component Title	01 7/68-9/69	02 10/69-9/70	03 10/70-8/71	04* 9/71-8/72	Total 9/72-12/72
014B	Stroke Demonstration	\$	\$	\$	\$ 36,581	\$ 36,581
015	Area-wide Respiratory	174,388	242,915	80,000		497,303
016	Regional Rehabilitation	107,007	127,063	67,708	20,000	321,778
017	Regional Rehabilitation San Antonio	60,709	67,607	46,185		174,501
017A	Regional Rehabilitation				5,444	5,444
017B	Regional Rehabilitation				14,556	14,556
018	Univ. of Texas Dallas Co.	40,873	74,620	45,049		160,542
019	Rehabilitation Cardiac Work	41,181				41,181
020	Eradication of Cervical Cancer	80,083	90,000	86,700	20,000	276,783
030	Planning for Allied Health Training	51,870	13,000			64,870
031	Long Distance Consultations		35,000	19,395		54,395
033	Extended Coronary Care Nursing Training		84,000	62,550		146,550
035	Reduce Complications	37,000	37,000	38,566	35,000	110,566
036	Serial Control System		28,000	28,001	9,001	65,002
037	Health Careers		29,801	65,762	77,000	172,563
038	Dial Access		16,500	19,963	17,000	53,463
039	Annual Tumor Clinic		15,000	11,520		26,520
042	Continuing Education for Occupational Therapists		24,000	22,826		46,826
043	Instructional Program for Allied Health Educators		17,500			17,500
045	Community Action		160,000	90,977	55,000	305,977
046	Maxillofacial Prosthetic		100,000	106,217		206,217
046A	Maxillofacial Prosthetic				34,878	34,878
046B	Maxillofacial Prosthetic				30,062	30,062
046C	Maxillofacial Prosthetic				35,060	35,060

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No	Component Title	01 7/68-9/69	02 10/69-9/70	03 10/70-8/71	04* 9/71-8/72	Total 9/72-12/72
051	Inhalation Therapy	\$	\$	\$	\$ 26,900	\$ 26,900
054	Project GRO				75,000	75,000
055	Electrical Hazards				68,583	68,583
Total		\$1,615,000	\$2,220,891	\$1,708,040	\$1,390,435	\$6,934,366

* 04 Year Extended to 16 months (9/71-12/72) - See Revised Budget next page.

Regional Medical Program of Texas
04 Yr. Extended 16 Months (9/71-12/72)

	Direct Costs	
Program Staff	\$ 926,818	
Planning Renal Disease	<u>26,500</u>	
Subtotal		\$ 953,318
Developmental	120,000	
06 Medical Physics	20,000	
08 Cancer Registry Bexar Co.	131,939	
14 Stroke Demonstration	100,000	
16 Demonstration Unit	20,000	
17A Demonstration Unit-Registry Rehabilitation	5,444	
17B Demonstration Unit-Registry Rehabilitation	8,556	
20 Cervical Cancer	20,000	
35 Radiotherapy Complications	35,000	
36 Serial Control System	9,001	
37 Health Careers	77,000	
38 Dial Access	24,555	
45 Community Action	55,000	
46 Maxillofacial Prosthetic	100,000	
51 Inhalation Therapy	48,100	
54A GRO - Tarleton State College	22,247	
54B GRO - Sam Houston State University	22,247	
54C GRO - Tyler Junior College	22,847	
54D GRO - Del Mar College	4,992	
54E GRO - Graduate School of Biomedical Sciences	45,912	
55 Electrical Safety Services	<u>52,580</u>	
58 Area Health Education Resources Program	15,000	
59 S. E. New Mexico Health Resources Program	21,000	
60 S. Texas Area Health Education Resources	15,000	
61 MANO - Family Health Service Program	50,000	
62 Children's Heart Program	30,000	
63 Area Health Resources Information Center	8,000	
64 Standard Tech. for Home Health Care	12,000	
65 REACH	8,000	
66 Demonstration Unit in Medical Rehabilitation	22,270	
67 Basic Rehabilitation Nursing Technician	9,000	
68 Dey. Auto Area Health Resources Information Center	<u>17,712</u>	
Total		\$2,106,720

REGIONAL MEDICAL PROGRAM OF TEXAS
HISTORY

FUNDING (DIRECT COSTS):

<u>Planning</u>		
<u>Grant Period</u>	<u>Period</u>	<u>Amount Funded</u>
01	7/66-6/67 (12 mos.)	\$ 969,541
02	7/67-6/68 (12 mos.)	1,039,295
<u>Operational</u>		
01	7/68-9/69 (15 mos.)	1,615,000
02	10/69-9/70 (12 mos.)	2,220,891 <u>1/</u>
03	10/70-8/71 <u>2/</u> (11 mos.)	1,708,040 <u>3/</u>
04	9/71-8/72 (16 mos.)	2,106,720 <u>4/</u> <u>5/</u>

- 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.
- 4/ 04 periods extended from 9/71-8/72 \$1,390,435 to 9/71-12/72 \$2,106,720 to accommodate Three Cycle Review.
- 5/ Reflects a 12% budget reduction imposed in April 1971.

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 operation 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. These funds were divided evenly between operational and planning activities.

A subsequent site visit was held in April 1969 to assess 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 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, the Region received an 02 award including carryover, as well as commitments for the 03 and 04 years.

The 03 continuation application, reviewed by RMPS staff, indicated 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 program staff in Austin. Functional differentiations between the RAG and the program staff had been delineated. The RAG had adopted a set of bylaws 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

Regional Medical Program of Texas

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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 pursued.

On receipt of the Region's Triennial Application for the 04, 05, 06 years, another site visit was conducted during June 1971. The visitors were convinced that TRMP had made considerable progress during the past two years, but in the absence of specific proposed activities for funding for the second and third years of the request, three year funding was not recommended. The Region was complimented on its concerted efforts to develop program activities outside the confines of the medical institutions without losing the support and commitment of these necessary resources. It was recognized that there are still strong proponents for the categorical medical center approach in Texas, but in the opinion of the site visitors, these interests had been neutralized by the support for a program emphasizing the needs of community hospitals and practicing physicians. The focus on subregionalization was also commended. The decision to employ indigenous workers with firsthand knowledge of their respective working areas indicated that action oriented planning and implementation of program activities can be initiated more quickly and be more concentrated on the real health needs in the respective geographical areas. The central office staff of the RMP of Texas was acknowledged to be highly qualified, enthusiastic and well directed by its Coordinator and Regional Advisory Group. Also noteworthy was the involvement and participation of practicing physicians at both the decisionmaking level and in the area of ongoing projects, especially those which have assisted the physician with upgrading patient care. It was noted that other key health groups, including CHP, the State Health Department, the nursing association, the hospital association and voluntary health agencies are supportive of the RMP of Texas. As recommended by the site visitors, the August 1971 Council approved the Region for two years support, including a developmental component.

MEMORANDUM

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

TO : THE RECORD

DATE: July 24, 1972

STAFF OBSERVATIONS

FROM : Operations Officer
Mid-Continent Operations Branch

SUBJECT: Comments agreed upon at RMPS Staff Meeting July 18, 1972, regarding the Triennial Application from the Regional Medical Program of Texas and the Site Visit scheduled August 1-2, 1972.

Participants:

- * Michael J. Posta, Chief, Mid-Continent Operations Branch
- * Luther J. Says, Jr., Mid-Continent Operations Branch
- * Joseph L. de la Puente, Office of Planning and Evaluation
- * Jimmy Roberts, M.D., Division of Professional and Technical Development
- Harold White, Grants Management Branch

* Denotes staff members of the proposed site visit team.

Summary:

The meeting began with a brief review of the references prepared for the site visitors with particular attention to the history of TRMP, previous site visit, advice letter, Management Information System printouts on previous funding, breakout of the proposed three year spending, and descriptor summary.

Staff noted the funding of current 04 year to be as follows:

<u>Date of Award</u>	<u>Period</u>	<u>Amount (d.c.)</u>	<u>Activities</u>
9/3/71	9/1/71-8/31/72	\$1,274,565	Program Staff \$523,081 15 Projects \$751,484
1/20/72 (Amended)	9/1/71-8/31/72	\$1,390,435	Program Staff \$551,617 Developmental \$ 87,334 15 Projects \$751,484
6/26/72 (Amended - 4 mo. ext.)	9/1/71-12/31/72	\$2,106,720	Program Staff \$953,818 Developmental \$120,000 31 Projects \$1,032,902

The proposed triennial funding (d.c.) plan is as follows:

	<u>05</u>	<u>06</u>	<u>07</u>
Program Staff Activities	\$ 754,129	\$ 862,762	\$ 877,970
Developmental Component	160,000	200,000	225,000
Projects (27)	1,264,341 (16)	796,960 (9)	537,538
Unspecified Growth Funding	<u>-0-</u>	<u>480,000</u>	<u>760,000</u>
Total	\$2,178,470	\$2,339,722	\$2,400,508

The renal disease and GRO components consists of five projects each.

It was interesting to note that support of 13 projects will be phased out during the current 04 period. Continuing support for two more years is requested for the five GRO projects which began at the beginning of the current 04 period. Continuing support for one more year is requested for the Electrical Hazards project now completing its first year. Continuing support is requested for eleven new projects which began during the last quarter of the current extended 04 period. Ten new activities are proposed, five of which represent the renal disease component. Of the 21 new activities (11 began in the current period), ten are currently budgeted for one year only, two for two years and nine for three years.

Staff was favorably impressed that most of the project sponsors are other than medical schools and most of the activities are subregional. The primary activities are continuing education, training new and existing health manpower, patient care and coordination of health services. Only two projects are categorical disease oriented. Mexican-Americans are the primary target population of five projects (four in the Rio Grande Valley and one in the San Antonio area). Blacks are the secondary target population of two projects. Other special target groups include: 1 for the inner city poor, 14 for rural areas, and 2 for other poor. Primary health care delivery methods represented by the projects: ambulatory care, extended care, home health care, in hospital care, and mobile units. Primary elements include access, area health education (4), medical consultation, health team approach, joint services, patient and public education, and safety. The health professional target groups include physicians, nurses and almost all categories of allied health personnel.

Issue Requiring Attention of the Site Visitors

The site visitors should specifically explore TRMP's progress relative to the six constructive criticisms enumerated in the RMPS advice letter of August 11, 1971.

Page 3 - THE RECORD

Other issues should include:

- 1) Utilization of consumer groups in establishing objectives and priorities.
- 2) Relationships with CHP "a" and "b" agencies in planning and project development; particularly since only 5 of 21 "b" agencies have been funded and TRMP local advisory groups have not been activated.
- 3) Why are no planning and/or feasibility studies included in the application?
- 4) What is the current status of emergency medical services and what is TRMP's role?
- 5) Of those projects where TRMP support is to be phased out in the 04 year, how many will continue?
- 6) Proposed budgets indicate only minimal support from other sources. If successful, what are the assurances of their continuation after cessation of TRMP support?
- 7) In the long range planning, what will the relationships be between GRO projects and Area Health Resource Information Centers?
- 8) With regard to GRO projects, what are the cost-sharing services other than education?
- 9) Explore rationale of funding of the many new projects for one year only, as well as unspecified growth funding in the 06 and 07 years.


Luther J. SAYS, Jr.

Region Virginia RM 00049
Review Cycle 10/72
Type of Application:
Triennium
Rating 287

Recommendations From

SARP Review Committee
 Site Visit Council

RECOMMENDATION: The Review Committee accepted the recommendation of the site visitors that the Virginia Regional Medical Program be approved for:

1. Triennial status at a \$1,800,000 direct cost level for each of three years.
2. A developmental component in the requested amount to be funded within the total \$1.8 million level.

Critique - The Chairman of the site visit team presented the findings of the team to the Review Committee. Progress of the Program since the last site visit was illustrated both by reference to the Region's change in attitude and the favorable response by the Regional Advisory Group, the Coordinator, and Program Staff in regard to past concerns and recommendations of review groups. The site visitors' evaluation of programmatic achievements, current concerns and recommendations emanating from the August 1972 visit were presented.

Committee discussion focused upon the recommended funding level for the Program. Clarification of the requested amount within the Program Staff budget for central staff services was provided.

The Program's capability to effectively allocate and utilize the recommended funds was discussed. The Chairman of the site visit team reported that the Program had attained a maturity of judgment and a demonstration of competency (in the way it had moved and in the way it anticipated it was going) that qualified it for triennial status at this point in time.

Dr. William G. Thurman was not present during the discussion.

EOB/DOD 10/2/72

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>03</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 501,225	\$1,016,407	\$1,054,027	\$1,159,429			
CONTRACTS *	(41,802)	(376,769)	-	-			
DEVELOPMENTAL COMPONENT	-0-	80,000	80,000	80,000			
OPERATIONAL PROJECTS	536,566	1,893,136	1,574,982	1,169,137			
Kidney **	X	(136,996)	(142,675)	-			
EMS **		(128,045)	(52,094)				
hs/ea **		(48,660)	-	-			
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$1,037,791	\$2,989,543	\$2,709,009	\$2,408,566	\$1,800,000	\$1,800,000	\$1,800,000
COUNCIL RECOMMENDED LEVEL	\$1,010,000						
* Included in Program Staff Total							
** Earmarked - Included in Operation Projects - Total							

SITE VISIT REPORT
VIRGINIA REGIONAL MEDICAL PROGRAM
August 3-4, 1972

I. SITE VISIT PARTICIPANTS

Consultants

Sister Ann Josephine, Chairman, Administrator Holy Cross Hospital,
Salt Lake City, Utah
Benjamin W. Watkins, D.P.M., 470 Lenox Avenue, New York, New York
Morton C. Creditor, M.D., Coordinator, Illinois Regional Medical
Program, 122 South Michigan Avenue, Suite 939, Chicago, Illinois
William Vaun, M.D., Director of Medical Education, Monmouth Medical
Center, 300 2nd Avenue, Long Branch, New Jersey

Staff, Regional Medical Programs Service

Mr. Frank Nash, Acting Chief, Eastern Operations Branch
Mr. Clyde Couchman, Program Director, RMPS - DHEW Region III
Ms. Joan Ensor, Program Analyst, Office of Planning & Evaluation
Ms. Marjorie L. Morrill, Health Consultant, Division of Professional
& Technical Development
Mr. George Hinkle, Public Health Advisor, Eastern Operations Branch

Staff, Virginia Regional Medical Program

Eugene R. Perez, M.D., Executive Director
Jack L. Mason, Ph.D., Asst. to Executive Director for Evaluation
Ms. Ann S. Cann, Communications & Community Affairs
Ms. Tandy Shields, Assistant to Communications & Community Affairs Officer
Mr. Freeman H. Vaughn, Program Development & Operations Officer
Mr. Sam Kalman, Planning & Technical Services Officer
Mrs. Barbara Peace, Records and Registries Administrator
Mr. Archie Nelson, Jr., Assistant Allied Health Officer
General W. C. Haneke, Business Administrator
Mr. Arthur L. Burton, Assistant Business Administrator
Mrs. Mildred Brown, Community Liaison Officer
Mr. Fred Beamer, Community Liaison Officer
Mr. Henry Kauffelt, Community Liaison Officer
Mrs. Wilma Schmidt, Community Liaison Officer
Mrs. Norma L. Doeppe, Executive and Administrative Secretary

Representatives of the Virginia Region

A. Regional Advisory Group - Members

Anthony J. Munoz, M.D., Medical Society of Virginia, Private Practice,
Farmville, Virginia, Chairman of the RAG and Executive Committee

Representatives of the Virginia RMP (continued)A. Regional Advisory Group - Members (continued)

- Mack I. Shanholtz, M.D., Commissioner, Virginia State Health Department, Richmond, Virginia, Executive Committee of RAG, Bylaws Committee
- Mr. Hunter A. Grumbles, Hospital Administrator, Memorial Hospital, Danville, Virginia, Executive Committee of RAG, Program Committee
- Mr. Bernard W. Woodahl, Executive Vice President, Virginia Division American Cancer Society, Richmond, Virginia, Cancer Committee, Executive Committee of RAG
- L. A. Woods, M.D., Vice President for Health Sciences, Virginia Commonwealth University, Richmond, Virginia, Executive Committee of RAG.
- Frank A. Wade, M.D., Chairman, Medical Society of Virginia, Private Practice, Roanoke, Virginia, Review & Evaluation Committee
- R. A. Mackintosh, M.D., Private Practice, President-Virginia Academy of General Practice, Review & Evaluation Committee
- Thomas C. Barker, Ph.D., Dean, School of Allied Health Professions, Virginia Commonwealth University, Review & Evaluation Committee
- Mr. James M. Stone, Executive Director, Virginia Heart Association, Richmond, Virginia, Heart Disease Committee
- Robert T. Manning, M.D., Dean, Eastern Virginia Medical School, Norfolk, Virginia
- Mr. D. Joseph Moore, Executive Director, Tidewater Regional Health Planning Council, Norfolk, Virginia
- Mrs. Jane B. Nida, Director, Department of Libraries, Arlington County, Arlington, Virginia

B. Board of Directors - Members

- Daniel Mohler, M.D., Associate Dean, University of Virginia, School of Medicine, Charlottesville, Virginia
- Charles Townes, M.D., Ph.D., Medical Director, Memorial Hospital, Virginia State College, Petersburg, Virginia
- Kinloch Nelson, M.D., Assistant Chief Staff for Education, Veterans Administration Hospital, Richmond, Virginia

C. Ad Hoc and Standing Committees

- John C. Hortenstine, M.D., Director of Medical Education, Winchester Memorial Hospital, Winchester, Virginia, Chairman, Heart Committee
- Walter Lawrence, Jr., Division of Oncology, Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia, Chairman, Cancer Committee
- James C. Pierce, M.D., Medical College of Virginia, Surgery Department, Richmond, Virginia, Committee on Kidney Disease

D. Organizations/Institutions

Daniel Mohler, M.D., University of Virginia*
Warren H. Pearse, Virginia Commonwealth University (VCU)
L. A. Woods, M.D., Vice President of Health Sciences, VCU *
Robert T. Manning, M.D., Eastern Virginia Medical School*
Raymond P. White, D.D.S., School of Dentistry, VCU
Mr. James Moore, Medical Society of Virginia
Frank A. Wade, M.D., Chairman, Medical School of Virginia *
Charles Townes, M.D., Ph.D., Old Dominion Medical Society*
R. A. Mackintosh, M.D., Virginia Academy of General Practice*
Mrs. Barbara Walker, Virginia Nurses Association
Mr. Earl Willis, Virginia Hospital Association
Mr. Herbert Seal, Virginia Nursing Home Association
F. B. Wiebusch, D.D.S., Virginia Dental Association
Mayer Levy, D.D.S., Virginia Dental Association
Mr. Keith Kellum, Virginia Pharmaceutical Association
Ms. Barbara Gibson, Virginia Pharmaceutical Association
Mr. James H. Stone, Virginia Heart Association*
Mr. Bernard Woodahl, American Cancer Society, Virginia Division*
Mr. Edgar J. Fisher, Jr., Va. Council on Health & Medical Care
Miss Ann McNeill, Tuberculosis & Respiratory Disease Association
Mr. Henry Harmon, Model Neighborhood
Mrs. Poe, Model Neighborhood
Mr. David Benson, RGAP (O.E.O.)
Mr. W. H. Brower, CHP (A)
Mr. D. Joseph Moore, CHP (B)*
Kinloch Nelson, M.D., Veteretrans Administration*
Mack I. Shanholtz, M.D., Virginia State Health Department*

E. Others

Mr. Beverly Orndorff, Science Writer, Richmond Times Dispatch
Ms. Alberts Clayborn, Richmond News Leader
Mr. Gene A. Pierce, MCV, Renal Disease
Mr. Robert Youngerman, Southeastern Inter-regional Exchange Program
Mr. John Taylor, Congressman Satterfield's Assistant

*Dual Listing

INTRODUCTION:

II. PURPOSES OF THE SITE VISIT The Virginia Regional Medical Program will have completed its first three years as an operational program on December 31, 1972. The purpose of the August 3-4, 1972 site visit was to assess the region's overall progress, the quality of the current program and its prospects for the next three years.

The site visitors reviewed the Virginia RMP's decisionmaking and review processes, administrative and evaluation capabilities, and the current planning, involvement and accomplishments with respect to program directions of the Regional Medical Programs Service.

The new review criteria and Mission Statement were used by the site visit team as a guide in evaluating the overall program and arriving at programmatic recommendation.

III. SITE VISIT OBSERVATIONS

Goals and Objectives

The Virginia RMP goals and objectives were developed after the newly established Program Committee had reviewed national, state, and local health priorities and received input from state and local health planning councils, the various health societies and associations, other RAG members, and the Virginia RMP staff. These goals and objectives reflect the latest mission statement of the RMPS and are explicitly stated even to the extent that activities to be directed toward implementation and accomplishment of the stated objectives are delineated. They are considered to reflect regional needs and problems to the extent that the activities identified with the goals and objectives evolved from need identifying conferences and feasibility and planning studies. It is considered that they have been accepted by the health providers and institutions of the region as signified by formal endorsement of the Program health provider groups, and membership of health providers and consumers on the RAG, the Board of Directors and various RAG committees. However, it does appear that community and consumer group participation in the development of the goals and objectives has been limited to their representation on VRMP review and decisionmaking groups.

The region has endeavored to prioritize the goals and objectives as well as proposed program activities. A very thorough numerical rating system has been devised for establishing relative priorities of individual projects/activities at the time they are reviewed by the RAG. Rating sheets are utilized that measure ten positive elements (need-intensity need-extent, potential benefit success probability, resource use and generation, scientific/technical characteristics,

evaluation, educational strength, budget analysis, and program balance) and one negative element (adverse reaction or effects). These elements are rated on a scale ranging from 0 to 5 and adjusted by assigned "weighing factors" that reflect the relative importance of each of the elements evaluated. Although the procedures followed, and the goals, objectives and priorities established appear to be adequate, evidence was found that there is no clear plan for utilizing the ranking system in establishing funding priorities. It is the consensus of the site visit team that confusion exists as to the purpose and potential benefit of priority ranking as a mechanism for funding determinations and decisionmaking. It is suggested that members of the Program need to more fully discuss and understand the intended purpose and method envisioned for utilization of the goals, objectives and project ranking system in future funding and policy determinations.

Accomplishments and Implementation

The VRMP is in its third year of operational activity, having been awarded operational status effective January 1970. There is evidence that provider groups are looking to VRMP for consultation and assistance and that the involvement of physicians, nurses, allied health professionals, hospitals, universities and other agencies in efforts to improve health care throughout the region is making a difference in the total health care system.

Evidence of significant program staff activities was manifested by involvement directed toward improved care for stroke patients in underserved areas, development of skills in utilizing medical audit as an educational instrument to improve quality of patient care, and activities related to rehabilitation consulting teams for nursing homes, programs in sickle cell anemia and many other areas. Program staff has assisted in the establishment of the Virginia Medical Information System as a Statewide Biomedical Library service which is currently planned for expansion to a subregional level. The coronary care evaluation project that originally began with five participating hospitals was expanded to eleven; now that RMP funding is to be discontinued, it is anticipated that the effort begun by the VRMP will continue at some hospitals and be discontinued at others where the original objectives have been accomplished. Current plans provide for continuation and/or expansion of successful efforts associated with consultations in discharge planning, community hospital based physician education, and improved care for stroke patients in underserved areas. Program staff activities have stimulated or directly resulted in greater involvement of dentists, pharmacists, and allied health personnel. Activities have resulted in better utilization of manpower through the continuing education efforts and dissemination of new knowledge and techniques through training programs for myocardial infarction, cardiopulmonary resuscitation,

emergency coronary care, and continuing education training for nursing personnel. There is a measure of accomplishment in the building of relationships in the five subregional districts staffed by the Community Liaison Officers. This process has been continuously evolving throughout the development of the VRMP.

Areas of planned development that should have a direct effect on the quality of care and better utilization of manpower include proposed project activities associated with family nurse practitioners, career opportunities for hospital personnel, obstetric training for nurse practitioners, automatic patient history development and translation. Progress toward cost moderation is anticipated by program staff's discharge planning effort and the proposed project for development of shared services, facilities and personnel for rural health care institution of Virginia.

Minority Interest

It is not clear to what extent the Region has identified and analyzed existing data that could permit the RMP to assess its role in meeting health care needs of the underserved areas. However, the response in supporting sickle cell anemia education and screening activities and the measurable model cities involvement by program staff would indicate positive action in meeting the needs of minority groups. The site visitors were apprised of other endeavors to stimulate a greater response for serving minority needs that were unsuccessful primarily due to this group's preoccupation with employment and housing deficiencies. It was suggested that the VRMP should seek a more positive input in this area from minority members of the RAG and Board of Directors. It is believed that this input could result in stimulation of ideas that could then be more fully developed by program staff with continued consultation provided by these members.

Minority groups are represented on the Board of Directors (2 of 12), the RAG (4 of 34) and professionally on the program staff (3 of 19). However, the representation on standing committees and on other committees of the VRMP was not viewed as favorable.

Increased minority group representation should be considered, not to arrive at an equitable percentage relationship, but to reflect the magnitude of the problem and to better serve the minority group population in the VRMP area.

Continued Support

There is an established policy for withdrawing RMP financial support at the end of the initial three year support period. Although it was reported that it is actively seeking other sources of funding upon termination of RMP support, past efforts do not appear to have been very successful - a situation that is not uncommon to the VRMP. Currently, ten projects are ongoing: three are still in the initial year of support and without any positive indication of a future source of funding and two are being discontinued; one is being expanded on a subregional level with two of the three medical schools providing continued support for the ongoing portion, and two others are being continued either partially or completely by other funding sources; the two remaining ongoing activities are to be continued as central staff activities, only one of which has a positive commitment for continuation by other sources. The 15 proposed new projects in the triennial application relate more positively to this issue: The VRMP is currently seeking support from the National Center for Family Planning Services for two proposes sickle cell anemia activities and addresses the issue in a positive manner for ten of the remaining 13 project proposals. Of the remaining three, one is a short-term assistance type activity without any long-term qualities, one is reported as positively selected for continuation although the source of funding is not mentioned, and the issue is not addressed in the final one.

The Program is strongly advised to continue devoting this accelerated attention to all program elements (including program staff continuing activities) and to consider incrementally decreasing funding of activities over the approved support period to facilitate the use of RMP dollars for initiation of new activities directed toward accomplishment of goals and objectives.

Coordinator

Dr. Eugene Perez, the Program Coordinator, although he has a tendency to overreact must be described as a strong, competent leader that relates well with the RAG, the Board of Directors, members of his staff and other professional organizations. He has organized an effective and functioning staff that appears to be well qualified and highly motivated. Even though the administrative mechanisms are present for effective communication with the RAG, the presence of ideal communication was questioned by the site visitors and refinement of these processes is considered necessary.

It is strongly recommended that the Region be advised to accelerate its current ongoing effort to locate and hire an effective deputy director. Not only is a deputy coordinator considered essential to

insure continuity of the program, it would relieve Dr. Perez of many of the daily time consuming routines thus permitting an even greater involvement in overall program management and an intensification and improvement of daily communications both within and without the VRMP organizational structure.

Program Staff

The program staff is all full time, impressive, competent personnel with an adequate range of professional disciplines and management capabilities. Individual employees appear to be highly knowledgeable with respect to duties and responsibilities and very involved in activities to strengthen relationships and foster involvement of communities throughout the area. Site visitors, although not concerned with the flexibility and dedication of members of the staff, were apprehensive about the capability of the staff to adequately absorb the increased work load with respect to monitoring, evaluation and RAG liaison that is inherent in the proposed expanded program. (It is noted that the current application provides for seven secretarial positions and five other positions for a planner, assistant planner, statistician, health educator and a registrar.)

The site visitors were especially cognizant of substantive program activities placed under the management of program staff and encouraged the region to secure a firm commitment of the RAG for developing mechanisms for control and provision of necessary support for the management and program monitoring required of these activities.

The VRMP plans include the opening of subregional offices in each of the five areas of the State delineated by the Virginia Hospital Association. Each office is to be staffed by an area coordinator (currently employed and designated as a Community Liaison Officer) and a secretary. The responsibility of the area coordinator will be to work and plan with health care institutions, educational institutions, health professionals and subprofessionals and other interested personnel and programs for the improvement of the health delivery system through manpower development. It is also planned to establish Local Advisory Groups within each of the five areas to more adequately determine local health needs and methods for successful attainment.

Regional Advisory Group

The RAG is considered to be adequately representative of all key health interests, institutions and groups within the region and one that is actively participating in setting program policies, estab-

lishing objectives and priorities, and providing overall guidance and direction to the program activities although the site visitors sensed that a greater degree of guidance and direction may be needed with respect to program staff activities. The RAG meets at least quarterly and the meetings are considered to be well attended, especially when one views the wide geographical distribution of the membership.

An Executive Committee of the RAG has been established to act for the RAG between meetings, subject to subsequent approval of the entire group, but the visitors considered this six-member group small in comparison to the proposed expanded program and too provider dominated. It is recommended that the group be enlarged, preferably by the addition of consumer-non-provider type representation.

The Virginia RAG has made extremely significant progress in regard to orientation, indoctrination and active participation of its members since the last site visit. Members interviewed during the visit appear to be very capable and dedicated with the common goal of making the VRMP a viable and recognized health care source in Virginia. During the past year, the group's bylaws have been rewritten to (1) more effectively state its responsibilities and the responsibilities of the Executive Director to the group, (2) provide for more frequent meetings and (3) establish a new Program Committee, Bylaws Committee, an Ad Hoc Committee on Allied Health and an expanded role for the Review and Evaluation (R&E) Committee. The RAG membership in line with the expanded role of the R & E Committee, has participated in local site visits to ongoing projects and an increase in this type of effort is planned. However, as more fully discussed under the heading of "Management", it was the consensus of the team that the workload envisioned is too great for this five member R & E Committee. Improvement in this area, more effective channels for communication between the RAG and program staff as previously stated, and minor changes in the RAG composition and committees (such as lay consumer interests on the Executive Committee and more adequate (b) agency representation) are recommended to complement the already significantly improved RAG.

Grantee Organization

The Virginia RMP is an incorporated entity governed by a 12-member Board of Directors. The grantee organization was originally composed of 18 former RAG members who were very active and knowledgeable concerning the purposes and working mechanisms of a Regional Medical Program. Since incorporation, three of the original Directors have once again accepted membership on the RAG, thus assuring knowledge and understanding of the separate functions of each of the two groups.

The grantee organization provides adequate administrative support, the needed freedom and flexibility, and recognizes the RAG's policy-making role as set forth in the RAG bylaws. To further facilitate efforts to expand daily communications between the Board of Directors, the Executive Director, his staff, and the RAG, it is strongly recommended that ex-officio Board of Director membership on the RAG be provided, and vice-versa.

Participation

The Virginia RMP has established close interrelationships with major health oriented organizations within the State, it is in communication with Model Cities programs in Norfolk and Richmond, Virginia, and it has demonstrated effort toward developing relationships with CHP (b) agencies. Although the relationships with CHP (b) agencies have not been sufficiently accomplished, the Program appears to be cognizant of this need and has expressed its intent to continue efforts in this direction. In this connection, the need for adequate representation from all (b) agencies on the RAG was stressed by the site visitors.

Cooperative efforts and liaison with health oriented organizations are exemplified by interlocking memberships on the VRMP Board of Directors, the RAG's various standing and ad hoc review committees, and program staff. The State medical society has reviewed the new goals and objectives of the VRMP and has once again endorsed the program. The Region has established a working relationship with the newly emerged Eastern Virginia Medical School and has continued its involvement and mutual cooperative arrangement with the other two existing medical schools. It would appear that the political and economic power complex is actively involved with the participation of all three medical schools, CHP (a) and (b) agencies, the state and local health departments, both the Medical Society of Virginia and the Old Dominion Medical Society, Virginia Academy of General Practice, and others.

In view of the Program's interest in continuing education activities, it is encouraged to continue to improve relationships with the medical schools and the community colleges, but cautioned not to ignore hospitals in its continuing education efforts.

Local Planning

The VRMP has demonstrated achievement toward developing relationships with CHP (b) agencies. Although, the relationships have not been sufficiently developed, the Region appears to be cognizant of this

need and has expressed its intent to continue its efforts in this direction. In this connection, the degree of success varies in each of the five subregional areas of the VRMP. Active project participation by the Tidewater CHP (b) agency and membership of its Executive Director on the RAG tends to be indicative of opportunities of early planning input from this area, although the actual quality of the input could not be determined. Of the remaining five CHP (b) agencies in the region that are considered operational, positive relationships were reported by only one of the program staff Community Liaison Officers.

The Program has established a mechanism for obtaining CHP review and comment, but it would appear that the action is not completed with sufficient lead-time for the comments to be considered by the RAG. It was suggested to the site visitors that the "stepped-up" (one month) submission date for the current application did not provide sufficient time for receipt and consideration of comment during this submission cycle.

The VRMP's plans for Subarea Coordinator Officers and the establishment of Local Advisory Groups (LAG) are envisioned as providing a workable mechanism for greater local involvement in the development of program proposals and program direction. It is recommended that the Region be advised to consider representation from these LAG's (e.g. Chairman) as active members of the Regional Advisory Group to ensure local input into the decisionmaking and policy determining process.

Assessment of Needs and Resources

At the present time there is no systematic continuing method of identifying needs, problems and resources that has resulted in program decisions based on an analysis of data, but representatives of the Program have stated their intent to assess needs as identified by the emerging CHP process. Goals, objectives and priorities are largely designed to be consistent with national priorities and are in agreement with the RMPS mission statement for regional medical programs. The RMP has utilized group discussions, staff visits into the area, and the activities of the Community Liaison Officers in the five subareas of the VRMP to determine the immediate needs of the population.

The Virginia Council on higher education has been given the responsibility of compiling a complete inventory of all health care personnel and facilities within the region. The VRMP will cooperate with the Council in the survey activities and the publication of the results, and is actively collecting a data base (Central Tumor Registry) with the ultimate goal of providing better care for present and future cancer victims in Virginia.

An improved health data base is stated as one of the goals of the VRMP. Congruent with this goal is a planned survey to determine educational needs of health professionals and health care institutions to facilitate effective planning for continuing education of health care personnel.

Management

The management "blueprint" followed by the Virginia RMP appears to be conceptually adequate in that periodic progress and financial reports are required, provisions have been made for monitoring of projects and other activities by program staff and members of the RAG, and personnel are considered professionally qualified and competent. However, as stated elsewhere in this report and repeated here for both emphasis and quick reference, this is the area in which the site visitors believed a greater refinement and strengthening of procedures would most significantly improve the Program.

- a. The Review and Evaluation Committee (R & E) in its expanded role reviews and reports to the total RAG as to the efficiency of the various program activities, in addition to its primary responsibilities for (1) performing or causing to be performed all required technical reviews of new applications and (2) establishing a recommended priority for funding when reporting to the RAG. In this regard, especially with escalation of R & E Committee members' participation on site visits, it is the consensus of the team that the work load and responsibilities should be delegated to a larger base of technical and scientific expertise.
 - b. Communications should be improved both within the VRMP organizational structure and with other health interests throughout the region. Emphasis for improved communications within the organization is placed upon the need for more timely and complete involvement of the RAG in the day-to-day activities with possibly the program staff preparing briefs to facilitate absorption of the data by the RAG Chairman and other committees and members. In regard to other health agencies, improved communications and working relationships with the existing and emerging CHP (b) agencies are recognized for primary emphasis, especially with respect to determination of health needs in underserved rural and urban areas and for improved coordination with resultant minimization of duplication and dilution of health improvement efforts within the region.
 - c. The Executive Committee should be enlarged and be truly representative of the RAG composition. In this connection, non-provider representation should be included.
-

Evaluation

The VRMP is experiencing problems common to many RMP's in the development of an effective evaluation process. It has a full-time evaluation staff member, but the site visitors have concluded that it is too early to judge the evaluation program under way except to state that the techniques and evaluation data being obtained need to be improved. The evaluative system provides for progress reporting and review by project directors, site visits and routine monitoring by program staff and members of the RAG with provisions for feedback to appropriate groups. However, there is no indication that these evaluation efforts have resulted in program modifications or that ineffective activities have been discontinued or scaled down. Discussions with the Region in regard to its evaluative efforts and among members of the site visit team during executive sessions, highlighted the urgent need for all regional medical programs to improve evaluation methods and techniques. It was the consensus of the team that a greater effort needs to be directed toward facilitating exchange of ideas, methods and even "peer" review of evaluative techniques utilized by all regional medical programs in assessing both project and program effectiveness.

Action Plan

Since the last site visit, the VRMP has established a RAG Program Committee whose responsibility is to review and update goals, objectives, strategies and concepts for the VRMP along with the primary responsibility of providing guidance to the Executive Director for program activity and project development. The RAG has recently accepted new goals and objectives formulated by this Committee which enables them to move from a heretofore categorical emphasis. These are considered to be congruent with the national objectives and in agreement with the new RMP's mission statement.

Administrative procedures for reporting accomplishments, monitoring the progress and assessing and evaluating results have been established, but a greater refinement of these efforts is considered essential.

Dissemination of Knowledge

VRMP has been actively participating on the Coordinated Health Survey Committee with CHP and the Virginia Council on Health and Medical Care in surveying health manpower, facilities and services in the State and has assisted in the dissemination of the results. This survey will become an annual activity to establish a common data base

eventually to be transferred to a State Center for Health Statistics.

A Health Data Library, established in the VRMP office, provides services primarily utilized in program staff operations. However, these library resource materials are available to other agencies and other individuals upon request.

The Virginia Medical Information System project has provided ready access to medical information obtainable from regional and national sources. It is currently planned to establish two information sub-centers at community hospital libraries that will cooperate with the ongoing system that is to be continued by the two medical school participants. It is proposed that this endeavor will be supplemented by a Virginia Drug Information and Consultative Service project during the next triennium.

Provider groups and institutions that will benefit from the proposed activities have been determined to some extent, although, knowledge, skills and techniques to be disseminated, in most instances, are yet to be determined and are included as objectives of the activity. Many of the proposed activities are to be based in health education and research institutions of the region and are designed to provide better care to more people by improving the skills of physicians and dentists and by providing for the assumption of time consuming routine procedures by specially trained allied health personnel. These efforts, if successful, could result in improved availability and accessibility of health care accompanied by a moderation of health care costs.

Utilization of Manpower and Facilities

Improvement of the quality of health manpower and the efficiency and economy of health care services in Virginia are identified priority areas for the VRMP. Activities directed toward the development of shared services, facilities and personnel in rural areas, the provision for new types of allied health personnel such as the proposed obstetric and family nurse practitioner training programs, and efforts toward the expanded role for pharmacists and new career opportunities for hospital personnel will result in increased productivity of physicians and other allied health personnel. Although many of the activities are directed toward greater utilization of manpower and facilities in rural areas and will undoubtedly benefit the areas in which the activity is to be conducted, the immediate overall regional benefit is viewed as one that would be relatively insignificant.

Improvement of Care

By intensified utilization of local workshops, group discussions, activities of the Community Liaison Officers, staff visits throughout the area, and planning and feasibility studies the RMP has made progress in identifying problem areas and developed methods by which ambulatory care might be improved. Many of the program staff activities and project activities should measurably expand ambulatory and emergency medical service care. Health maintenance and disease prevention components realistically based on present knowledge are included in the application. However, in the opinion of the site visitors, the proposed objectives appear to be overly ambitious. It is anticipated that the activities could lead to improved access to primary care and health services in underserved rural areas, but that the improvement in underserved urban and ghetto areas will be minimal. As stated before, representatives of the VRMP were encouraged to increase staff efforts in the latter areas.

Short-term Payoff

Short-term payoff is inherently a part of the continuing educational and training proposals and will be realized if these activities are successful in accomplishing their stated objectives. In addition, program staff activities directed toward discharge planning,

the quality of medical care assurance based on chart audit and continuing education, rehabilitation consulting teams, and improved care for stroke patients all have the quality and potential for immediate benefit to recipients of the services. If one can assume that manpower savings realized by more efficient techniques, the use of less highly skilled personnel for routine services, and improved productivity of hospital and allied health personnel by providing greater career opportunities and incentives could lead to moderation of health costs, then the proposed activities will moderate health costs. However, short-term payoff does not appear to be the primary goal of the proposed program. The VRMP did not demonstrate to the site visit team that sufficient time had been devoted to the development of short-term goals, although the policy for withdrawing support after three years is well established and indications are that it can be done successfully.

Regionalization

The program plan should assist in creating new linkages among health providers and institutions, and it is aimed at assisting multiple provider groups and institutions. The Kidney Disease proposal, the Drug and Medical Information network projects, the Radiation Therapy Consultant Service activity, and the proposal for Development of Shared Services in Rural Health Care Institutions are specific examples of items included in the plan that have this underlying quality. Each of these is capable of insuring sharing of facilities and manpower and extending the capabilities to a larger area of the population. While a wide range of health providers are targeted and varied project activity is proposed, the site visit team was greatly concerned about the seeming absence of coordination between similar and related activities. It was suggested by members of the site visit team that consideration be given to combining some of the education and training activities proposed.

Other Funding

The Region has been reasonably successful in attracting funds for ongoing activities from local and State sources. The current application indicates other sources of funds totaling \$198,172 or 6.6% of the total requested direct cost amount. Furthermore, the VRMP has indicated that it is actively seeking other federal funds for support of the two sickle cell anemia activities included in

the current application. It is also noted that great strides have been made and more positive results are anticipated toward obtaining commitments assuring activity continuation from other funding sources once RMP funding is withdrawn. Please refer to the section Continued Support for a more detailed analysis of this area.

Conclusions

The site visit team was generally impressed with the progress of the VRMP since the last site visit. Indoctrination of the comparatively new RAG appears to have been successful in that the members are actively participating in the decision and policymaking processes. The development of this group has been further enhanced by the reappointment of three former RAG members who had resigned to accept appointment on the Board of Directors for the VRMP.

The VRMP has refined its organizational and managerial structure to provide for more frequent RAG meetings for execution of its responsibilities and greater involvement of RAG members in the evaluative and monitoring aspects of the program.

The concept of using Review and Evaluation Committee (R&E) members for monitoring of operational activities by reviewing progress reports and participating in site visits for evaluation (with the assistance of program staff and RAG members who live in the vicinity of the project) should be more workable if the R&E Committee is expanded to lessen the work load on individual members.

The VRMP bylaws have been rewritten to more positively state the functions of the RAG and the responsibilities of the Executive Director and his staff to the RAG. A new Program Committee has been established for regular review and modification of the goals, objectives, and priorities of the VRMP so that they may effectively reflect the needs of the region and still remain congruent with the mission of Regional Medical Programs as reflected by national needs and priorities.

The planned establishment of Subregional Area Coordinator offices in the five geographical subdivisions of the region and the formation of Local Advisory Groups (LAGs) to more positively determine local needs and priorities should provide an even firmer foundation for the program expansion envisioned in this application.

While focusing on the improvements and latent potential of the VRMP, one must also consider the need for further refinement (as noted

throughout this report) of the areas in which progress is so noteworthy with special consideration being given to the need for improved communications between the primary managerial components of the region: the RAG, Executive Director, members of the program staff (including the subarea coordinators) and the Board of Directors. The Region needs to develop improved coordination of fragmented efforts in similar and related type activities such as those directed toward pharmacists, dentists, and other allied health personnel. Isolated activities proposed in the area of emergency care systems need to be coordinated and developed on a regional basis with greater participation from interested groups. In this regard, since the August 3-4 site visit, word has been received from Dr. Perez, the Program Coordinator, that a meeting of representatives of health organizations and groups interested in emergency medical services was convened on August 9, preliminary to development of a Coordinated EMS System for the State of Virginia, (Progress was made and a follow-up meeting is planned.)

Recommendations

The proposal, as submitted, is viewed as an ambitious undertaking that might very well overburden the small though well qualified and administratively efficient program staff and place too great a monitoring and evaluative load on the maturing RAG and its Committee structure.

Accordingly, the site visit team recommends that the VRMP be approved for:

- (1) Triennial status at a \$1,800,000 direct cost level for each of three years;
- (2) A developmental component in the requested amount to be funded within the total \$1.8 million level.

In the opinion of the site visit team, while permitting expansion and growth to a viable region, funding support at the reduced level will make necessary greater program coordination among the various activities (program staff and projects) and closer monitoring of daily progress to obtain the most effective utilization of available funds.

RMPS STAFF BRIEFING DOCUMENT

#1.8 MW/D Long

REGION: VirginiaOPERATIONS BRANCH: EasternNUMBER: RM 00049Chief: Mr. Frank NashCOORDINATOR: Eugene R. Perez, M.D.Staff for RMP: George F. HinkleMarjorie MorrillLAST RATING: 246Joan EnsorCharles Barnes

TYPE OF APPLICATION:

 Triennial 3rd Year
 Triennial

Regional Office Representative:

Mr. Clyde Couchman 2nd Year
 Triennial Other

Management Survey (Date):

Conducted: July 1971

or

Scheduled: _____

Last Site Visit: September 14-15, 1971

Sister Ann Josephine, Review Committee, Chairman

Bruce W. Everist, Council Member

Louis K. Collins, M.D., Consultant, Private Physician

William C. Fowkes, Jr., M.D., Consultant, California RMP, Region III

Fred Shapiro, M.D., Consultant, Renal Disease

Staff Visits in Last 12 Months:

April 6, 1972 - Attend RAG meeting and discuss recent developments at the National VRMP level.

April 17, 1972 - Provide staff assistance in resolution of a proposed (subsequently approved/funded) Emergency Medical Services Project.

June 7, 1972 - Attend RAG meeting for review and approval of Triennial Application.

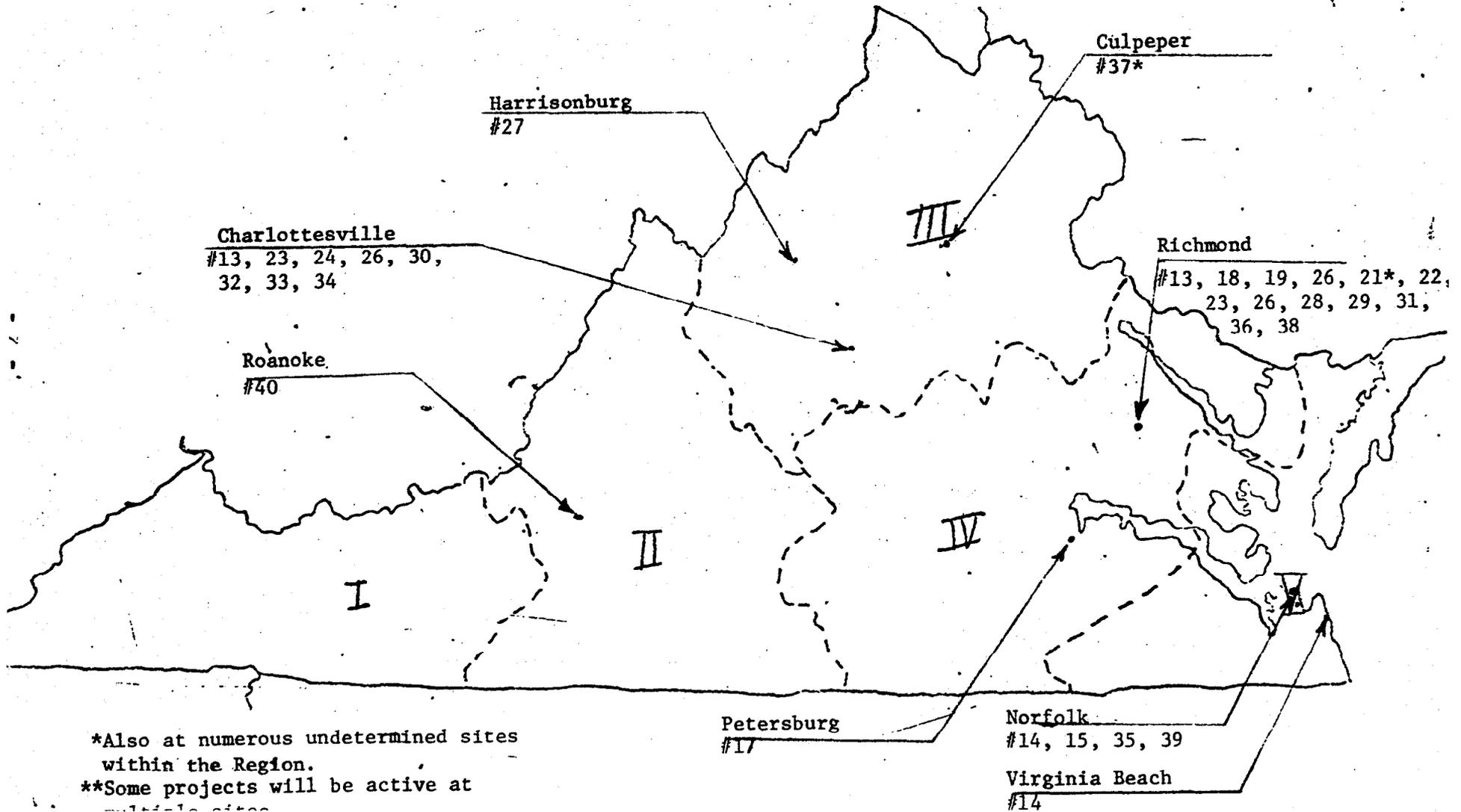
Recent events occurring in geographic area of Region that are affecting RMP program:

(a) In 1972 the General Assembly of Virginia amended and re-enacted legislation relating to exemption from tort liability of persons rendering emergency medical services in Virginia. After July 1, 1972, paramedics who are properly trained may perform more advanced emergency procedures such as initiating intravenous fluid therapy, administering medications to relieve pain and prevent cardiac arrest, and perform cardiac defibrillation.

(b) Legislation has been passed that permits dental students entering their senior year to accept summer employment in state supported and government institutions in the community when supervision is provided by a Medical College of Virginia (School of Dentistry) faculty appointee.

VIRGINIA REGIONAL MEL PROGRAM

SUB REGIONS (FIVE) + PERFORMANCE SITE DATA **
TRIENNIAL APPLICATION.



*Also at numerous undetermined sites within the Region.

**Some projects will be active at

DEMOGRAPHIC INFORMATION

Population (1970 Census): 4,648,500; Approx. 63% urban, 19% non-white and a median age of 25.9.

	<u>State</u>	<u>U.S.</u>
Under 18 years	35%	35%
18-65 years	57%	55%
65-over	8%	10%

Land area: 39,838 square miles Population Density: 117/square miles

<u>Major SMS Areas:</u>	<u>Population (000)</u>	<u>RMP Sub-Region</u>
Lynchburg	121.8	II
Newport News-Hampton	289.3	V
Norfolk-Portsmouth	633.1	V
Richmond	515.6	IV
Roanoke	179.4	II
(Metro DC Area)	(350.0)	(III)

Health Statistics: Mortality rate per 100,000 population for Heart Disease is 312, 128 for cancer and 85 for CNS Vascular Lesions all of which are from 15-19% below the National average. Deaths per 100,000 for all causes is 820.9 whereas the U.S. average for all causes is 935.7.

Facilities:

The State has two major medical facilities, the Virginia Commonwealth University (Medical College of Virginia) and the University of Virginia School of Medicine. Within the State are 34 nursing schools that offer Registered Nurse programs and 44 nursing schools which offer L.P.N. programs. There are eleven schools of medical technology, four cytotechnology facilities and 23 Radiologic technology facilities within the State. One school each in the disciplines of Dentistry, Pharmacy, and Allied Health and Physical Therapy are located within the State at the Virginia Commonwealth University, Richmond.

The American Hospital Association (1970 Guide Issue) reports 102 short term hospitals and two long term general hospitals with 16,385 and 434 beds, respectively plus two V.A. General hospitals with total bed capacity of 1,493. There are 82 skilled nursing homes, 59 personal care homes with nursing care and 20 long term care units with respective bed capacities of 6,862, 2,873 and 925.

The State of Virginia has 4,900 physicians (106/100,000) and 28 osteopaths. There are 16,487 professional nurses of which 4,975 are inactive and 5,843 licensed practical nurses of which 959 are inactive. The Virginia region has approximately 949 radiologic technologists, 2,611 pharmacists, 2,552 dentists, and 433 dieticians.

Feasibility + Policy Studies
to be conducted by Care
COMPONENT AND FINANCIAL SUMMARY
TRIENNIAL APPLICATION

Component	Current Annualized Level <u>03</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 501,225	\$1,016,407	\$1,054,027	\$1,150,429			
CONTRACTS *	(41,802)	(376,769)	--	--			
DEVELOPMENTAL COMPONENT	- 0 -	80,000	80,000	80,000			
OPERATIONAL PROJECTS	536,566	1,893,136	1,574,982	1,169,137			
Kidney **	X	(136,996)	(142,675)	--			
EMS **		(128,045)	(52,094)	--			
hs/ea		(48,660)	--	--			
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$1,037,791	\$2,989,543	\$2,709,000	\$2,408,566			
COUNCIL RECOMMENDED LEVEL	\$1,010,000						

* Included in Program Staff total

** Earmarked - Included in Operational Projects - total

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE
FUNDING HISTORY LIST

RFP5-C57-JTCFHL-20

REGION 49 VIRGINIA		RMF SUPP YR C3		OPERATIONAL GRANT (EXCEPT COSTS ONLY)		ALL REQUEST AND AWARDS AS OF JUNE 30, 1972			
COMPONENT NC	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1	02 03/71-12/71	03 01/72-12/72	TOTAL	04 01/73-12/73	05 01/74-12/74	06 01/75-12/75	TOTAL
CC00	PROGRAM STAFF	375400	364979	501225	1241604	1014407	1054027	1155425	3229863
D000	DEVELOPMENTAL C					80000	80000	80000	240000
CC1	MYOCARDIAL INFAR	116300	80000	78570	274870				
002	CORONARY CARE E	48400	34100	40200	122700				
003	CARDIOPULMONARY	47500	27100	31000	105600				
004	STROKE IN A SMA	62500	32600	39166	134666				
007	VIRGINIA MEDICAL	62500	44100	52872	159472				
CC8	STATEWIDE TPCPR		14303	20850	35153				
009	CONT ED FOR NUR	72100	75800	100320	249220				
013	CONTACT CF EAC			120000	120000	136556	142675		279671
014	EMERGENCY CORON			53588	53588	61311	59367		120678
015	EMERGENCY MEDIC			30250	30250	128045	57054		180139
016	CLINIC DEV FOR					40566	52567	65324	158877
017	POPULATION STD					134335	116610	114610	365555
018	VIRGINIA DRUG I					139719	125264	120564	385547
019	CHRONIC DISEASE					45900			45900
020	MODEL NEIGHBORH					95770	75722	78247	245739
021	EMERG MED TECH					15000	12000	9000	36000
022	CONTINUING EDUC					36623	38254	40972	115849
023	SUB FECTUAL PE					38036	33555		71591
024	TRAINING PROGRA					59819	59803	103585	303611
026	FACTATION THERA					104113	46625	61475	212211
027	NUTRITION EDUCA					12145	13350		25535
028	CAREER OPPORTUN					97416	76840		174256
029	EXPANDED ROLE F					136413	130863	110848	378124
030	CCAT EDL PRCG P					37578	37841	39153	114612
031	PILOT PRCG CONT					11015			11015
032	PREHOSP EMERG P					85434	78674	78674	245782
033	C O P D REHAB P					21400	16500	16500	55200
034	ING CENTAL AUX					77060	15124	16075	108259
035	ALTO PATIENT MI					45164	128052	156111	333327
036	OBSTETRIX TRAIN					67587	60172	61052	188811
037	SHARED SERV PUR					93261	72890	38870	205021
038	SYSTEM FOR MCNT					41532	58656	24029	124217
039	FAMILY EDUCATIO					29818	31000	33200	94018
040	COMMUNITY HEALT					46660			46660
- TOTAL -		786100	672982	1068041	2527123	2585543	2709009	2408566	8107118

JULY 18, 1972

BREAKDOWN BY REGION
OF PROGRAM PERIOD

REGION - VIRGINIA
DH 00048 10/72

PAGE 1
DHHS USE ONLY

IDENTIFICATION OF COMPONENT	(5) CENT. WITHIN APPR. PERIOD OF SUPPORT	(2) CENT. REYCAD APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRECT CCSTS	1ST YEAR INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF		\$1,016,407			\$1,016,407		\$1,016,407
0000 DEVELOPMENTAL COMPONENT				\$80,000	\$80,000		\$80,000
013 COMP PROG CNTR END STAGE E KIDNEY DISEASE	\$136,556				\$136,996	\$34,605	\$171,601
014 EMERGENCY CORONARY CARE PROGRAM VA BEACH		\$61,311			\$61,311		\$61,311
015 EMERG MED SERV SYSTEM		\$128,045			\$128,045		\$128,045
016 CURRIC DEV FOR TRNG DIRS AND ALLIED HLTH PERS				\$40,986	\$40,986	\$12,063	\$53,049
017 POPULATION STC SCREENING COUNSELING SICKLE CELL				\$134,335	\$134,335	\$25,661	\$159,996
018 VIRGINIA DRUG THERAPY N AND CONSULTATIVE SYSTEM				\$139,719	\$139,719	\$27,882	\$167,601
019 CHRONIC DISEASE PREVENTI ON PROJ SICKLE CELL ANEM				\$49,900	\$49,900		\$49,900
020 MODEL NEIGHBORHOOD HEALTH PLAN				\$95,770	\$95,770	\$7,661	\$103,431
021 EMERG MED TECH TRNG PROJ				\$15,000	\$15,000		\$15,000
022 CONTINUING EDUCATION IN CLINICAL PHARMACY				\$36,623	\$36,623	\$11,123	\$47,746
023 SUB REGIONAL MEDICAL INF ORMATION NETWORK				\$38,036	\$38,036	\$5,711	\$43,747
024 TRAINING PROGRAM FOR FAM ILY NURSE PRACTITIONER				\$99,819	\$99,819	\$22,575	\$122,394
026 RADIATION THERAPY CONSLT SERV VA				\$104,113	\$104,113	\$35,779	\$139,892
027 NUTRITION EDUCATION FOR OPTIMUM HEALTH				\$12,145	\$12,145	\$2,708	\$14,853
028 CAREER OPPORTUNITIES DEV FOR HCSP PERSONNEL				\$97,416	\$97,416	\$7,793	\$105,209
029 EXPANDED ROLE FOR PHARMA CIST				\$136,413	\$136,413		\$136,413
030 CONT EDU PROG PERINATAL MED COM HOSP				\$37,578	\$37,578	\$13,500	\$51,078
031 PILOT PROG CONT EDU DENT AL PRACTITIONERS LCC				\$11,015	\$11,015	\$235	\$11,250
032 PREHCSP EMERG MED ADV TR NG				\$89,434	\$89,434	\$36,966	\$126,400
033 C O P D REHAB PROGRAM				\$21,400	\$21,400		\$21,400
034 TRNG DENTAL ALX IN PREVEN TIVE DEN AND RAD				\$77,060	\$77,060	\$20,702	\$97,762
035 AUTC PATIENT HIST DEV AN D TRANS PROJ				\$49,164	\$49,164		\$49,164

JULY 16, 1972

BREAKDOWN OF REQUEST
ON PROGRAM FUNDING

REGION - VIRGINIA
PM 00049 10/72

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MAY 1972

IDENTIFICATION OF COMPONENT	(1) CONT. WITHIN APPR. PERIOD CF SUPPORT	(2) CENT. BEYOND APPR. PERIOD CF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	1ST YEAR DIRCT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
036 OBSTETRIX TRAINING PROGR AM				\$67,587	\$67,587	\$7,528	\$75,115
037 SHARED SERV RURAL HEALTH CARE INST				\$23,261	\$23,261		\$23,261
038 SYSTEM FOR PLANNING QU ALITY OF CARE IN HMOs				\$41,532	\$41,532		\$41,532
039 FAMILY EDUCATION PROGRAM				\$29,818	\$29,818		\$29,818
040 COMMUNITY HEALTH EDU CON SORTIUM				\$48,660	\$48,660		\$48,660
TOTAL	\$136,996	\$1,205,763		\$1,646,784	\$2,985,543	\$272,496	\$3,262,039

JULY 18, 1972

BREAKOUT OF REQUEST
BY PROGRAM NUMBER

REGION - VIRGINIA
RM 00045 10/72

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MMS (3M) JUNE 72

IDENTIFICATION OF COMPONENT	(1) CONT. WITHIN APPR. PERIOD OF SUPPLRT	(2) CONT. BEYOND APPR. PERIOD OF SUPPLRT	(3) APPR. NOT PREVIOUSLY FUNDED	(4) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
COGO PROGRAM STAFF		\$1,054,027			\$1,054,027
0000 DEVELOPMENTAL COMPONENT				\$00,000	\$00,000
013 CCMP PROG CONTR END STAG E KIDNEY DISEASE	\$142,675				\$142,675
014 EMERGENCY CORONARY CARE PROGRAM VA BEACH		\$59,367			\$59,367
015 EMERG MED SERV SYSTEM		\$52,094			\$52,094
016 CURRIC DEV FOR TANG EIRS AND ALLIED HLTH PERS				\$52,567	\$52,567
017 POPULATION STD SCREENING COUNSELING SICKLE CELL				\$116,610	\$116,610
018 VIRGINIA CRG INFCAMATIC N AND CONSULTATIVE SYSTEM				\$125,264	\$125,264
019 CHRONIC DISEASE PREVENTI ON PROJ SICKLE CELL ANEP				\$75,722	\$75,722
020 MODEL NEIGHBORHOOD HEALT H PLAN				\$12,000	\$12,000
021 EMERG MED TECH TRNG PRCG				\$38,294	\$38,294
022 CONTINUING EDUCATION IN CLINICAL PHARMACY				\$33,555	\$33,555
023 SUB REGIONAL MEDICAL INF ORMATION NETWORK				\$99,803	\$99,803
024 TRAINING PROGRAM FOR FAM ILY NURSE PRACTITIONER				\$46,625	\$46,625
026 RADIATION THERAPY CONSUL SERV VA				\$13,390	\$13,390
027 NUTRITION EDUCATION FOR OPTIMUM HEALTH				\$76,840	\$76,840
028 CAREER OPPORTUNITIES DEV FOR HCSP PERSONNEL				\$130,863	\$130,863
029 EXPANDED ROLE FOR PHARMA CIST				\$37,841	\$37,841
030 CONT EDU PRCG PERINATAL MED COM HOSP				\$78,674	\$78,674
031 PILOT PRCG CONT EDU DENT AL PRACTITIONERS LLC				\$16,900	\$16,900
032 PREHCSP EMERG MED ADV TR NG				\$15,124	\$15,124
033 C O P D WEHAE PROGRAM				\$128,052	\$128,052
034 TNG DENTAL AUX IN PREVEN TIVE DENT AND RAD					
035 AUTO PATIENT HIST DEV ANI D TRANS PROJ					

JULY 18, 1972

BREAKOUT OF REQUEST
05 PROGRAM PERIOD

REGION - VIRGINIA
RM 00049 10/72

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IDENTIFICATION OF COMPONENT	(5) CNT. WITHIN APPR. PERIOD OF SUPPORT	(2) CNT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
036 OBSTETRIX TRAINING PROGRAM				\$60,172	\$60,172
037 SHARED SERV RURAL HEALTH CARE INST				\$72,890	\$72,890
038 SYSTEM FOR MONITORING QUALITY OF CARE IN HMOS				\$58,656	\$58,656
039 FAMILY EDUCATION PROGRAM				\$31,000	\$31,000
040 COMMUNITY HEALTH EDUCATION CENTER					
TOTAL	\$142,675	\$1,165,488		\$1,400,846	\$2,709,009

JULY 18, 1972

BREAKOUT OF REQUEST
BY PROGRAM PERIOD

REGION - VIRGINIA
RM 00049 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF		\$1,159,525			\$1,159,525	\$2,229,863
0000 DEVELOPMENTAL COMPONENTS				\$200,000	\$200,000	\$240,000
013 COMP PROG CONTR END STAG F KIDNEY DISEASE						\$279,671
014 EMERGENCY COPCARY CARE PROGRAM VA BEACH						\$120,678
015 EMERG MED SERV SYSTEM						\$180,139
016 CURRIC DEV FOR TRNG DIRS AND ALLIED HLTH PERS				\$65,324	\$65,324	\$158,877
017 POPULATION SYC SCREENING COUNSELING SICKLE CELL				\$114,610	\$114,610	\$365,555
018 VIRGINIA DRUG INFORMATIC A AND CONSULTATIVE SYSTEM				\$120,564	\$120,564	\$285,547
019 CHRONIC DISEASE PREVENTI ON PROJ SICKLE CELL ANEM						\$45,900
020 MODEL NEIGHBORHOOD HEALT H PLAN				\$78,247	\$78,247	\$249,739
021 EMERG MED TECH TRNG PRCG				\$9,000	\$9,000	\$36,000
022 CONTINUING EDUCATION IN CLINICAL PHARMACY				\$40,972	\$40,972	\$115,889
023 SUB REGIONAL MEDICAL INF ORMATION NETWORK						\$71,591
024 TRAINING PROGRAM FOR FAM ILY NURSE PRACTITIONER				\$103,989	\$103,989	\$302,611
026 RADIATION THERAPY CONSL SERV VA				\$61,475	\$61,475	\$212,221
027 NUTRITION EDUCATION FOR OPTIMUM HEALTH						\$25,535
028 CAREER OPPORTUNITIES DEV FOR HCSP PERSONNEL						\$174,256
029 EXPANDED ROLE FOR PHARMA CIST				\$110,848	\$110,848	\$378,124
030 CONT EDU PROG PERINATAL MED GEN HDSP				\$39,193	\$39,193	\$114,612
031 PILOT PRCG CONT EDU DENT AL PRACTITIONERS ICC						\$11,015
032 PREHCSP EMERG MED ADV TR NG				\$78,674	\$78,674	\$246,782
033 C O P D REHAB PROGRAM				\$16,900	\$16,900	\$55,200
034 TRNG DENTAL ALX IN PREVEN TIVE DEN AND RAC				\$16,075	\$16,075	\$108,259
035 AUTC PATIENT HIST DEV AN D TRANS PRCG				\$156,111	\$156,111	\$333,327

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JULY 18, 1972

BREAKOUT OF REQUEST
06 PROGRAM PERIOD

REGION - VIRGINIA
RM 00049 10/72

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IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
036 OBSTETRIX TRAINING PROGRAM				\$61,052	\$61,052	\$189,811
037 SHARED SERV RURAL HEALTH CARE INST				\$38,870	\$38,870	\$205,021
038 SYSTEM FOR MONITORING QUALITY OF CARE IN MHOS				\$24,029	\$24,029	\$124,217
039 FAMILY EDUCATION PROGRAM				\$33,200	\$33,200	\$94,018
040 COMMUNITY HEALTH EDUCATION CENTER						\$48,660
TOTAL		\$1,159,429		\$1,249,137	\$2,408,566	\$8,107,118

HISTORICAL PROGRAM PROFILE OF REGION

The Virginia Regional Medical Program received its initial planning grant award in January 1967 with the University of Virginia School of Medicine in Charlottesville, Virginia as the Grantee. Congruent with awarding the 02 year continuation grant for planning activities in March 1968, the grantee was changed to the Medical College of Virginia in Richmond, Virginia (now the Virginia Commonwealth University).

The first two years of planning activity were marked with concerns relative to the absence of representation of paramedical personnel and minority groups on the Regional Advisory Group and inadequate Program Staff. In addition, evidence of a cooperative medical school commitment to the Program was not present, planning efforts continued to remain at a minimum level, and sub-regionalization was considered to be at an elementary stage.

In July 1968, the Region's operational grant application was disapproved with the awarding of continuation support for an 03 year of planning activities. The Region was advised that core activities be strengthened, that a regional approach be used in project development, and that the Advisory Group be increased in number and that it include representation from paramedical professions and minority groups.

The Region resubmitted its operational grant application to the December 1969 Council and a site visit was made to the Region on October 1-2, 1969. The December 1969 Council concurred with the recommendations of the site visitors and the Review Committee that the Region be awarded operational status. Of the seven projects in the application, Council approved five projects for the initial operational status award and then subsequently (March NAC) approved two new projects, one of which was funded during the 01 operational year with additional funds and the other through the rebudgeting mechanism. The Medical College of Virginia remained the grantee organization for the Virginia RMP. Nine additional members had been appointed to the Regional Advisory Group, which brought the total membership to twenty (20) members (current membership is 36). Four outstanding committees on heart disease, cancer, stroke and related diseases were created to replace Task Force members and these were broadened to include dentists, nurses, hospital administrators and minority representation. Regional representation was also taken into consideration in the formation of these committees. An Executive Committee, consisting of six members and exercising all of the authority of the Advisory Group relevant to its functions at interim between meetings of the RAG, was activated. At this time, each medical school established an RMP Committee for heart disease, cancer, stroke and related diseases. Each medical school Committee chairman acted in liaison capacity between the schools and the RMP Central Office and also as an official member of the Coordinating Planning and Evaluation Committee (Medical School Liaison officers have been eliminated in new VRMP, Inc. organization).

During the February 1971 review cycle the Region's request for a developmental component was denied because the plan of action was thought to be too general and a sufficient degree of maturity had not been attained. Concern was also expressed over the reduction of medical representation on program staff by the deletion of three consultant positions although there was indication that active recruitment for a physician to fill the deputy coordinator position was underway (recruitment for this position is not included in the current application). The inability to detect a satisfactory plan of action remained a growing concern although it was encouraging to note that steps had been taken to strengthen the program evaluation and administrative sections.

Effective March 1, 1971, the Grantee was changed from the Virginia Commonwealth University to a corporate body, the Virginia Regional Medical Program, Inc. The motivating reason for this change in grantee evolved from what was considered to be inadequate fringe benefits. The Virginia Commonwealth University is a state supported institution, its employees are regulated by the State Merit System and given State retirement benefits. However, since the VRMP employees are paid by a Federal grant they were not considered to be State employees and were not eligible for State employee fringe benefits.

A Regional Medical Programs Service Management Survey was conducted on July 26-28, 1971 during which the administrative systems, policies and practices were reviewed. Although some areas were considered to need greater administrative and fiscal controls, major deficiencies were not uncovered. The supervisory position for the Division of Administration and Grants Management (Business Administrator) was considered to be the key to providing the necessary controls. In a relatively short time four different individuals had occupied this position. The incumbent during the Management Survey still serves in this capacity.

The last review cycle (October/November 1971) included a September 13-14 site visit initiated at the request of the Coordinator. The paramount issues of discussion focused upon the newly established Regional Advisory Group the difficulties encountered by the Region in changing its program direction from one of a strictly categorical nature, and the request for a developmental component.

Concomitant with the March 1, incorporation all but two of the existing members of the Regional Advisory Group were organized into an eighteen (18) member Board of Directors. The RAG membership was increased to thirty-six that included two former RAG members and ten members who had functioned in various committee capacities. Reviewers were concerned about the relative newness of the RAG and recommended that extensive orientation measures be taken, the RAG meet at least on a quarterly basis, and a mechanism be developed to enable the RAG to participate in a more meaningful project/program review and evaluation. Furthermore, the Region's goals were considered to be quite diffused, the categorical emphasis of the projects was not favorably reviewed and the developmental

request was disapproved. It was suggested that another year was needed for the Region to indoctrinate and develop the RAG into an effective decisionmaking group and present a program application along the guidelines of the new Regional Medical Program mission.

The newly established RAG had met only once prior to the last review cycle, but has had four meetings since December, including a two-day retreat for orientation of new members. RMPS staff has attended two of the recent RAG meetings during which project activities, program goals and objectives were review. The discussions were lively with almost 100% participation from the members. RAG members have reportedly site visited projects for evaluative purposes and indoctrination.

The RAG bylaws and VRMP Guidelines for Project Applications have been re-written since the last review cycle and the goals and objectives have been revised from a strict categorical emphasis (heart, cancer, etc.) in an effort to implement the new mission of Regional Medical Programs in a manner designed to be harmonious with national needs and priorities and the needs of the people of the State of Virginia.

STAFF OBSERVATIONS

Principal Problems:

The absence of a deputy coordinator and the diminishing physician input to Program Staff.

Program Staff turn-over since last review.

Apparent fragmentation of project and continuing education efforts.

Over-reaction of the VRMP to areas of concern and funding decisions made at the National level.

Degree and actual extent of cooperative relationships with other organizations. (CHP Agencies and Medical Schools)

Principal problems during last review:

1. Little accomplishment toward establishment of new goals and objectives.
2. Medical school involvement other than through project activity.
3. Need for indoctrination of new Regional Advisory Group - more frequent meetings.
4. Inadequacy of meaningful mechanism for RAG to participate in project/program review and evaluation.
5. Need for refinement of role definition and role distinction of the Board of Directors and the Regional Advisory Group.
6. Greater emphasis needed for coordination of the Region's efforts in responding to consumer needs and in programming these activities into the overall goals and plans.
7. Categorical emphasis of projects.

Principal Accomplishments

Location of nursing coordinators in five educational institutions throughout the State. (Project #9).

Establishment of Virginia medical information system as a statewide biomedical library service. (Project #7)

Efforts to improve management of stroke patients in rural areas by involvement of medical center with the physicians and other health professionals in the community. (Project #4)

Emergency medical service training activities associated with CPR and emergency coronary care procedures for volunteer rescue squads, (Projects #3 & 14)

Reported success of a discharge planning feasibility study and its plan for expansion to VRMP subregions.

Initiation of Sickle Cell Anemia (SCA) education program in public schools and provision of assistance in coordinating SCA efforts throughout Virginia.

Involvement of closer working relationships between the three medical schools, the State Health Department and the Virginia Medical Society.

The VRMP and the School of Allied Health of Medical College of Virginia conducted the first State conference of allied health in the State of Virginia.

Efforts of Program Staff associated with development of skills in utilizing medical audit as an educational instrument to improve quality of patient care.

Impressive program of continuing education for nurses and the movement toward expansion to other allied health professions.

The establishment of new goals and objectives and its movement in a new direction to improve health care delivery professions.

Important steps toward improving the basic organization: incorporation, accelerated efforts to indoctrinate the new Regional Advisory Group, assignment of Review and Evaluation Committee members to projects for review of progress reports, site visits and evaluation, and updating of the RAG By-Laws and Virginia RMP Guidelines for Project Application.

Issues requiring attention of reviewers

1. Evaluation of progress toward resolving principal problems as determined by last review.
2. Capability (qualifications and potential) of new Program staff.
3. Policy issues with respect to:
 - (a) Tumor Registry Activity.
 - (b) Sickle Cell Anemia activities (Projects and Central Regional Services Activities).
 - (c) Nature of some activities classified as Central Regional Services Activities.

SITE VISIT REPORT

WEST VIRGINIA REGIONAL MEDICAL PROGRAM

AUGUST 7 & 8, 1972

SITE VISIT PARTICIPANTS

Consultants

Henry Lemon, M.D., Professor of Medicine, University of Nebraska, Omaha, Nebraska, Chairman
Gladys Ancrum, Ph.D., Community Health Board of Seattle, Seattle, Washington, Review Committee member
Bland Cannon, M.D., Memphis, Tennessee, National Advisory Council member
Winston R. Miller, M.D., Director, Northlands Regional Medical Program, Inc., St. Paul, Minnesota
Richard Haglund, Acting Director, Intermountain Regional Medical Program Salt Lake City, Utah

RMPS Staff

Clyde Couchman, Program Director, RMP, Office of the Regional Health Director, DHEW Region II
Joan Ensor, Program Analyst, Office of Planning & Evaluation, Division of Operations & Development, RMPS
Martin Greenfield, M.D., Health Consultant, Division of Professional & Technical Development, RMPS
Frank S. Nash, Acting Chief, Eastern Operations Branch, Division of Operations & Development, RMPS
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West Virginia RMP

Charles D. Holland, Director
William A. Ternent, Associate Director
Norene M. Thieme, Program Analyst
Sheila D. Baquet, Office Assistant I
David S. Hall, Ph.D., Director, Office of Research & Evaluation
Edward M. Bosanac, Data Analyst
Peter P. Gallina, Coordinator Field Operations
William G. Cooper, Area Liaison Officer
Gerard R. Hummel, Area Liaison Officer
Larry E. Yost, Ph.D., Program Specialist, Health Manpower
William D. Wyant, Program Specialist, Emergency Medical Service
Robert B. Williams, Program Specialist, Health Care Delivery Demonstration

SITE VISIT PARTICIPANTS (continued)

RAG Members

Jimmie L. Mangus, M.D., Chairman
Frank W. McKee, M.D., Dean West Virginia University of Medicine
Charles E. Andrews, M.D., Provost for Health Science, West Virginia School of Medicine
Harry S. Week, M.D., President, State Medical Association, Planning and Evaluation Committee member
Maynard Pride, M.D., Private Physician, Health Manpower Committee member
A. Thomas McCoy, M.D., West Virginia State Medical Association, Health Manpower Committee member
Fay P. Greene, M.D., West Virginia State Medical Association, Health Care Delivery Demonstrations Committee member
Patricia Brown, Consumer Member, Planning and Evaluation Committee, Consultant Representative, State Comprehensive Health Planning Council

Committee Members

Dr. Ralph Nelson, Planning and Evaluation Committee member, Provost-off-Campus Education, West Virginia University
Dr. Harry Stansbury, Planning and Evaluation Committee member, Director, Comprehensive Health Planning
Charles Lewis, Member, Health Manpower Committee, Staff member, State Medical Association
Daniel Hamaty, M.D., Chairman, Health Manpower Committee
Mrs. Gearlean Slack, Member, Health Manpower Committee, Associate Professor, West Virginia University School of Nursing, Director, Continuing Education
Robert Eakin, Member, Health Care Delivery Demonstration Committee, Administrator, Memorial General Hospital Association
Mrs. Carol Cutlip, R.N., Member, Health Care Delivery Demonstration Comm., Assistant Administrator, Fairmont Clinic
Leon H. Kingsolver, Member, Health Care Delivery Demonstration Committee, Director, Comprehensive Council of Region VII
Fred Parker, Member, Emergency Medical Services Committee, Southern West Virginia Regional Health Council
Samuel W. Channell, Member, Emergency Medical Services Committee, Executive Director, West Virginia Pharmaceutical Association, Osteopathic Association

Other Resource Persons and Visitors

Edward Perrine, Immediate Past Director, Health Planning Association of North Central West Virginia, Region V
Walter H. Moran, M.D., Professor, Department of Surgery West Virginia University School of Medicine

Other Resource Persons and Visitors (continued)

Patrick Hamilton, Attorney for the HYGEIA Foundation

James Hart, Consultant for the HYGEIA Foundation, Representative of the
Charleston Area Medical Office United Mine Workers Welfare and Retirement
Fund

Mrs. Joanne Ross, Director, Southwest Community Action Council

Joseph T. Skaggs, M.D., Former RAG member, Leader of a developing group
practice in Charleston, West Virginia

Barbara Jones, M.D., Professor and Assistant Chairman, Department of
Pediatrics, West Virginia University

Allen Strum, Project Director, Upshur County School Health Program

Larry Thompson, Director, Health Incorporated, Parkersburg, West Virginia

Robert Youngerman, Inter-Regional Informational Exchange Program Representative

Allen Graham, M.D., National Health Service Corps Assignee to the Crum-
Kermit Medical Center

INTRODUCTION:

The primary objectives of this site visit were to review progress made by the West Virginia RMP since the last visit and to determine their overall readiness for implementation of a three year program plan.

Based upon the evidence and information gained through this site visit, it is concluded that progress has been made and that the West Virginia RMP is truly developing a regionalized program. The strong points of this program are well chosen and clearly recognized objectives around which planning revolves. They are: Health Care Delivery; Emergency Medical Service; and Health Manpower. The site visit agenda was organized primarily around the program objectives.

The West Virginia RMP has been guided by an effective combination of the West Virginia Medical Center and the State Medical Association who provide medical direction to the Coordinator. The site visit team rated the Coordinator very high for his administrative abilities, energy, and understanding of the needs and practicalities of program achievement in this area. The program staff functions very well with the Regional Advisory Group, reacting appropriately to the health needs of the region. Staff has been very effective in working with other organizations in the State to get matching funds and in particular, to develop structures for comprehensive health care planning ("b" agencies), although these agencies have experienced delay in getting under way. The West Virginia RMP has approached the improvement in health care delivery by multiple routes and has developed six subregional offices staffed by regional liaison officers. The regional liaison officers closely coordinate their activities with the "b" agencies and the University's county extension programs and this approach has proven effective in gaining entree to interested consumers and providers in the area.

The site visitors reviewed the West Virginia RMP's decisionmaking and review processes, administrative and evaluation capabilities and current planning, involvement and accomplishment with respect to the program directions of the Regional Medical Programs Service. The review criteria and Mission Statement were used by the site visit team as a guide in the evaluation of the overall program.

1. GOALS, OBJECTIVES, AND PRIORITIES (8)

For the most part the program has been characterized by exceptional performance in this area. In fact, one of WVRMP's major strengths lies in a well conceived and developed planning process built around clearly defined program goals and objectives. The program has continued to refine and redefine these objectives, and has arrived at three primary goals toward which it will direct its efforts; these address the State's most critical health needs: health care delivery, emergency medical services, and health manpower. The priority concern for all of these goals is creating and improving access to care in the unserved and underserved portions of the region.

The question of the degree of provider acceptance of the program's goals and priorities is one that is difficult to answer. It is clear that key provider institutions (e.g., medical school and state medical society) accept and understand the basic tenets of the RMP, but it appears doubtful that the word has been adequately spread to some of the more rural areas, particularly to community physicians and foreign medical graduates practicing in remote locations. There is little question that the stated objectives respond to community needs and that their formulation was based on perceptive recognition of consumer needs; this program can certainly be described as one whose prime focus is to meet the desparate health needs of the medically indigent.

Recommended Action:

2. ACCOMPLISHMENTS AND IMPLEMENTATION (15)

Program staff activities have resulted in substantial achievements, including in particular the development of a number of programs directed toward improving the distribution of medical services in the region. These programs, primarily dealing with the establishment of outpatient clinics and group practices in underserved areas of the State, are based upon a thirty-year background of community efforts to increase and maintain physician coverage of the State's population. Although the clinics will probably neither lead to wider application of knowledge and techniques nor to any reduction of medical care costs, there is no question that they are the sorts of program which will meet a critical need in West Virginia, that of providing access for those who now enjoy only limited or no entry into West Virginia's health care system.

2. ACCOMPLISHMENTS AND IMPLEMENTATION (15) Continued

Particularly encouraging is the development of group practice affiliations in two major medical centers remote from the University. It is anticipated that these will be sites for expanded residency training programs at some point in the future, and that they will become subcenters of excellence for the care of categorical diseases. Their establishment should be recognized as one of the outstanding achievements made through the coordinated efforts of the medical school and the RMP, both by virtue of their intrinsic value and because they have resulted in a broader base for physician and other provider acceptance of the Regional Medical Program.

Recommended Action:

3. CONTINUED SUPPORT (10)

The policy of actively searching out other sources of funding for activities begun under RMP auspices has been one of the program's major strengths. One must note, however, that West Virginia RMP may encounter difficulty in pursuing this policy in the future because of the State's limited resources.

Recommended Action:

4. MINORITY INTERESTS (7)

West Virginia's black minority makes up approximately four per cent of the State's population. Ethnic pockets exist only in the larger cities, notably Charleston (5.6% black) and southern McDowell county (25%). Questioning of the program staff and RAG members brought out the fact that the major focal point of the program has been the poverty level and medically indigent population in general, without attention to specific minority groups. The program has a good working relationship with the Appalachia Regional Commission and has been successful in obtaining funds to support projects directed to the poverty level and medically indigent population. Although the program has apparently given some thought to the development of activities in the McDowell area, there have been some problems with the project director of the five million dollar health care program, supported by the Appalachian Regional Commission, in the entire nine-county southern portion of the State, including McDowell. Due to these conflicts, this has been the last area to be considered in the RMP's subregionalization plan.

While the Coordinator was emphatic about his efforts to recruit minority employees for the program staff, it was the feeling of the visitors that minority groups were under-represented (currently minority employment consists of only one black secretary) and that efforts should be continued to recruit both blacks and women to the staff. Another matter of concern mentioned was that of the University's policy in recruiting students for medical training; it is one of accepting only "high achievers," that is, those students with records of outstanding accomplishment in their undergraduate studies. It was brought out in the discussion that the level of educational services in many of the poverty districts was such that little achievement could be demonstrated, thus creating somewhat of an artificial barrier for minority students wishing to further their education. It is hoped that the University's admission policy might be modified; until that time, however, the RMP should continue efforts to recruit qualified minority staff members from outside the State.

Recommended Action:

5. COORDINATOR (10)

The Coordinator has obviously provided strong leadership in the development of the West Virginia RMP. He has adequate administrative and managerial abilities to deal with the problems with which he is faced. He relates and works well with the RAG and in the last four months has recruited an individual as associate coordinator who appears likely to provide the necessary planning and administrative assistance needed in a larger program. (In addition to the associate coordinator the RMP has hired three program specialists, a data analyst and a field representative.) The site visitors feel that it is advantageous to have a non-medical man in this particular position since he has to relate equally diplomatically to the University and to the leadership of the State Medical Association in a manner which will generate a minimal amount of friction and a maximal amount of cooperation. This has obviously been achieved.

Recommended Action:

6. PROGRAM STAFF (3)

The program staff are all full-time and represent a broad range of competence with the exception of the key disciplines of medicine and nursing. A physician and nurse staff position should be established in the program staff at least as half-time positions with authority and responsibility in the areas of planning and evaluation.

Recommended Action:

7. REGIONAL ADVISORY GROUP (5)

The RAG and its subcommittees have more than adequate representation from providers and other health interests throughout the State. The RAG itself is heavily provider oriented: including alternates, its total membership of 38 (+12 alternates) consists of 24 physicians, four hospital administrators, and five other health professionals, all together accounting for over 90% of the membership. Of the four non-provider members, only one might be considered a "real" consumer, in the sense that she represents the poor and medically underserved population of the region. It was the consensus of the site visit team that the Regional Advisory Group composition should be modified to be more representative of consumer groups (including racial minorities which currently have only minimal representation), the nursing and allied health professions, and community colleges.

This modification may well necessitate amending the RAG bylaws, which now call for representation from a specific list of health organizations and interests in the State. The team was especially impressed by the testimony of one of the RAG members, Ms. Brown describing her "living room" approach for stimulating consumer interest both in the West Virginia RMP and in health care in general. It is hoped that this approach will do much to foster consumer participation in the program.

It was felt that the RAG has an excellent attendance and participation record. Meeting of RAG subcommittees, likewise, seem to be well attended and to have garnered enthusiastic support.

While the RAG does play a role in determination of policy and overall program direction, it was the site team's impression that this role is one more of reaction than action. It seems that program staff are responsible for most of the actual planning and program implementation, although the RAG is kept informed of developments. From information presented, it appears also that RAG does not monitor or evaluate program staff activities.

The RAG's Executive Committee, like the larger body, is not broadly representative of the health and consumer interests in the State. This particular group, in fact, numbers no racial minorities or women among its members. It was the visitors' feeling that this group also needs to be expanded to provide for more input from nurses, allied health personnel, and consumer groups.

7. REGIONAL ADVISORY GROUP (5) Continued

Since staff is non-medical and under great influence from the University it seems appropriate that specific mechanisms be developed to insure that RAG expertise and perspective are utilized in monitoring and evaluating program development. This will help provide a broad conceptual framework for revising or discontinuing specific activities.

Recommended Action:

8. GRANTEE ORGANIZATION (2)

The Dean of the Medical Center stated that he is the budget officer for West Virginia RMP and that he periodically meets with Mr. Holland (although there is no regular schedule for such consultation). The Dean attends most of the Executive Committee meetings. He further stated that it is Mr. Holland's responsibility to keep him informed of West Virginia RMP's activities. Open lines of communications are maintained between the University and the RMP. There is a Medical Advisory Committee to the Coordinator, composed of the Dean, the Provost for Health Sciences and a Professor of Surgery. Again, no meetings of this group are scheduled. In terms of contractual procedures the RMP must use the University system, and as a state institution, the University must use state procedures and meet state requirements. All contracts are processed and approved through the President's office of the University. This system is complex but the University is wholly committed to the RMP and its success and has made several significant efforts to eliminate procedural delays that the RMP has encountered.

Responding to site visit team questions about the informality of staff, RAG and grantee relationships, the Dean stated that "it seems to bother you people that we get along so well together." He said "we have a compatible marriage and that if the RMP did not have the support of the University it would be a disaster because they could not stand alone." This further substantiates other reports such as the Management Assessment Report that the West Virginia RMP is strongly supported by the University. The site visit team was convinced that the grantee organization does provide adequate administrative support within the constraints of the state government system and permits sufficient freedom for

8. GRANTEE ORGANIZATION (2) Continued

program development. The University does not seem to be interfering with RAG's policy making role. There is obviously very good communication and liaison between the RAG, the program staff and the University through the crucial presence of Dr. Andrews who has exerted a very strong directional influence in the past. He claims currently not to be directly involved in programs, although his influence is probably still significant in less direct ways.

However, West Virginia RMP may need special consideration by the University in terms of personnel policy and the establishment of salary levels for program staff in order to be competitive with other RMP's to recruit and retain competent program staff.

Recommended Action

9. PARTICIPATION (3)

Almost all key health interests are actively participating in the West Virginia RMP and it does not seem to have been captured or co-opted by any major interest. The region's political and economic power complexes are involved but the HYGEIA Foundation which provides a significant portion of health care in the State has not yet been brought into active RAG participation. As an example of participation Mrs. Joanne Ross, Director, Southwest Community Action Council stated that the RMP regional liaison officer has provided a great deal of assistance and that "RMP is a mover and a doer."

Recommended Action

10. LOCAL PLANNING (3)

The State Comprehensive Health Planning Agency is in the Governor's office staffed with a full-time director and a secretary. There are six established (b) agencies and West Virginia RMP has been instrumental in getting each of them operational. As a result of a recent CHP study a total of eleven (11) regions have been certified for planning. This means five (5) more (b) agencies are to be developed. West Virginia RMP will provide assistance in the development of these (b) agencies. The State Agency Director says he has no problems with matching funds, but the (b) agencies have a lot of problems with matching funds. The State agency provides assistance to RMP staff in developing data. The comprehensive health care agencies have been slow in developing, but we might anticipate a faster growth in the future.

West Virginia RMP has recently developed and published a report entitled, Guidelines for Proposal, Review and Operations of Activities which adequately describes the review process of the region. The Guidelines specify that the proposal is sent to the appropriate comprehensive health planning agency for its review and comment at the same time the proposal is submitted to the West Virginia RMP Technical Review Committee for its assessment. From all indications very good working relationships exist between West Virginia RMP and CHP. The Guidelines as written more than meet the stated review requirements of applications by CHP.

Recommended Action:

11. ASSESSMENT OF NEEDS AND RESOURCES (3)

The West Virginia RMP has participated with the University and CHP in data collection to identify health needs, health manpower and health resources in the State. Health needs in the State are many and are characterized by the State being the third most rural in the nation, by having the second highest ratio of proprietary hospitals, and by having a very high percentage of physicians who were trained in other countries. The State has approximately 400 unlicensed foreign named physicians working in the State. A method should be developed to provide full accreditation for those physicians and equal participation in the affairs of the medical community. The need to establish residency training programs in

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PREPARED BY: Norman Anderson

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the State is well documented. Over the past few years West Virginia has increased nursing manpower by approximately 30 percent and a corresponding decrease in physician manpower by approximately 30 percent. Many of the remaining physicians will be of retirement age in the next few years. The current triennial application was developed concurrently with the goals and objectives and the restructuring of the technical committee and program staff. In the past the area liaison officers have functioned somewhat independently in assessing the health needs in their area.

Recommended Action:

12. MANAGEMENT (3)

The central office program staff was reorganized and expanded to support the work of the field staff. The area liaison officers together with the field operations coordinator make up an organizational unit which is one of only two activities that report directly to the program coordinator. The other organizational unit is the Office of Program and Grants Management which is a standard administrative service organization. In view of the projected program growth this office may need to develop additional strength to provide the coordinator with adequate financial monitoring and control.

All three of the other program staff organizational units report to the Coordinator through the recently established position of associate coordinator. These three organizational components are: Office of Program Research and Evaluation, Office of Program Planning and Development, and Office of Information and Communications. The Office of Program Planning and Development is a new activity that was initiated to assist the field staff. This office is comprised of four staff specialists in the area of Health Care Delivery Systems, Emergency Health Services, and Health Manpower and Medicine.

12. MANAGEMENT (3) Continued

Changes made following the Management Assessment visit in June, are apparently seen as satisfying personnel and organization structure needs for the future. This may need further review, if the projected program expansion is approved. Position descriptions are not yet available and fiscal procedures have not been written out. With the Management Assessment and site visit accomplished, staff plans to take up these tasks.

Recommended Action

13. EVALUATION (3)

The Office of Program Research and Evaluation is staffed by a program evaluator, a data analyst and a research assistant. Evaluation is in the process of transition and change and upgrading cannot be adequately evaluated in all phases as yet. West Virginia RMP does require quarterly progress and financial reporting on all operational activities. Field staff members periodically meet with project directors in their areas to discuss progress of a given activity as it relates to the objectives.

Recommended Action

Program Proposal

The priorities of the proposed program by the region are well established and understood in terms of objectives, but their use in the selection of proposals to be funded, and in preparation of the developmental component are not spelled out in detail. The activities are highly congruent with national objectives and needs. The proposals appear soundly based and realistic in view of resources. The results can be quantitatively evaluated, although we are not sure that enough sophistication has developed in the review and evaluation process to insure this. The reporting methods proposed for three month monitoring of projects seem fairly subjective at present. The region has been quick to modify its objectives when necessary.

A decision was made early, in view of their major objectives, to improve health care delivery but to leave to the University the major responsibility for continuing education. Some limited self-evaluation demonstration projects have been developed for physicians, and a visiting physician program was instituted which was not very successful and is no longer operational. Linkages are being developed for closer cooperation in postgraduate medical education at the residency level. The emphasis is upon delivery of the common rather than rarely required facets of health care, such as emergency medical services.

The program generally should have an impact on improvement of facilities for delivery of health care and utilization of present personnel (midwife and pediatric nurse physicians assistants). The planning for this began early in the program.

Improvement of clinic care is a major prospect for several portions of West Virginia through the development of new clinics. The total program emphasis deals with the development of improved access to patient care under difficult local conditions. These activities are strongly sub-regionalized and can be expected to have immediate payoffs in better patient care, with increased availability of and access to services, and improved quality of care. However, total medical care costs will probably increase rather than decrease as services are made available to areas where medical care has previously been nonexistent or in very short supply.

Important developments to improve categorical types of health care in the long run appear through:

1. Supporting care linkages between the general group practices in outlying communities (such as Hygeia supported clinics) and multi-specialty groups in urban areas, as in Charleston and Huntington.
2. Development of residency programs in the latter areas, which can increase physician retention in the state from a 40% level at the

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end of medical school, to a 70% level at the end of residency training. There are no residency training programs now, although one is being started.

These two factors will strengthen relations between general and specialty care and should lead to improvement in the quality of care.

The region has been outstanding in obtaining outside funding for its programs. This fact alone serves as the most concrete demonstration of the value and viability of the program plans. The site visitors, however, believe that an official letter from the State Medical Society, endorsing the program as stated in the triennial application, would be helpful.

It is the site visitors' opinion that an action pattern has been established which, barring unforeseen complications, can improve the quantity 200-300% within the next decade. This impression was substantiated by a visit to the Fairmont Clinic to determine what has been accomplished through strictly local means.

Site Visit to Fairmont Clinic, Fairmont, W. Va.; August 8, 1972

The site visitors terminated their work with a visit to a nonprofit clinic organized 15-20 years ago by the Monongehela Valley Health Association (a lay group) which now offers a full range of health services, including home care, clinic care, and hospital care. The clinic averages 500 patient visits daily from 8 a.m. to 10 p.m., with a staff of 13-14 full-time physicians, and with its own integral pharmacy, X-ray, lab, emergency room, record room, and podiatry service. It accepts all patients, including 50% not covered by third party or personal finances, and operates two satellite clinics in the hills six and 31 miles distant. The average patient visit cost runs from \$20-25. Records are all typed and of high standard, with a unit system embracing hospital, clinic, and home care. There is a separate five-story building downtown housing their home health service. This is split into care groups by age (over 56 and under 65), with two separate nursing staffs, and covers the surrounding rural area as well. The Fairmont clinic has one of the new Family Health Center Grants thus far awarded by HSMHA.

This clinic, and an even more extensively developed clinic at Elkins, which includes transportation facilities for patients, should at some time receive careful evaluation with respect to actual costs and benefits of operating an areawide health system embracing the home and clinic (but not hospital costs, these being handled by an independent agency).

At present there is little linkage between this clinic and WVU Medical Center, since third and fourth year clinical clerks have been withdrawn in favor of hospital assignments. RMP assisted materially in

obtaining the Family Health Center Grant, and has established an excellent working arrangement with this clinic. The clinic represents a tremendous demonstration project and local resource

SUMMARY

The site visit team was very impressed with the energetic program staff, the cooperation and assistance provided to other agencies, the coordinated team approach to health care, the excellent subregionalization and their resourcefulness in garnering funds from other sources. The WVRMP was described as a well oiled machine that is responsive to the health needs of the region. The site visitors were pleased with the recently developed and published report entitled: Guidelines for Proposal, Review and Operations of Activities which adequately describes the review process of the region. Everyone agreed that this is a well prepared report and a definite asset to program development.

The grantee organization has been responsive to the needs of the WVRMP as was described in the Management Assessment Report in April when the grantee obtained authorization from the West Virginia State Auditor to make operating capital advances to institutions that collaborate with the Regional Medical Program and do not have the capital to implement the agreed upon program activity. During the course of this site visit this continued commitment was restated.

It was felt that there has been adequate flexibility established with RMP under the university structure, however, some problems still exist concerning the fiscal system, salaries, personnel qualification, and acceptance by the university personnel system which are slowly being aired.

The team was a little concerned with the informality of the administrative procedure, but observed that excellent rapport has been established with the key health industry in the state. We did suggest that the administrative procedures be adequately described in writing.

It is the opinion of the site visitors that the West Virginia Regional Medical Program has made an impact on the Health Care System. This is a mature region that has performed well and has acquired the necessary skills and organization to continue to improve and influence the health care system in the wild and wonderful State of West Virginia.

RECOMMENDATIONS

1. That the West Virginia Regional Medical Program be approved for triennial status with the following funding levels:

04 operational year	\$1,500,000
05 operational year	\$1,600,000
06 operational year	\$1,700,000

The recommended funding levels include the developmental component request. The site team made these recommendations based upon the following: (a) that the program is not requesting any major increment in program staff support, even though the visitors felt that the program is slightly understaffed; (b) the visitors in particular voiced concern with regard to two of the proposed operational activities: the first, Voluntary Office Self-Audit Services, because it reaches only a limited number of physicians in the state and its cost benefit relationship seem very high; and the second, the Camden-on-Gauley Medical Center, because the team felt that the RMP should make efforts to obtain matching funds from the Hygeia Foundation, which is sponsoring the program.

2. That nursing, medicine, and social service disciplines be added to program staff as at least half-time positions with major responsibility and authority in the areas of planning and evaluation.
3. That written policies and procedures delineating the respective administrative responsibilities of the WVRMP and the grantee institution be developed.
4. That the bylaws of the Regional Advisory Group be revised to allow broader representation and specific responsibilities of the grantee, the RAG and the program staff. Rural health care provider institutions, allied health, nursing professions, and consumer interests should be represented on the RAG. Flexibility should be increased by specifying types of representation desired, rather than specific organizations. Currently, any change requires revision of the bylaws. It was felt that addition of representatives from the rural provider institutions (especially the UMW-affiliated Hygeia and Ephraim McDowell Foundations) was especially important, since these organizations have contributed heavily in carrying out the RMP goals for broader health care coverage. The RAG could easily reduce its representation among the categorical voluntary health agencies to a single representative member for all of the agencies currently represented. Further, RAG should increase membership from community colleges, nursing, social service, allied health, and consumer groups.
5. That RAG develop a procedure for applying established program priorities and criteria in project funding determinations. This should be part of a comprehensive review and funding process.
6. That efforts to recruit additional female and minority personnel on program staff be continued, and that activities be initiated which will impact on specific minority pockets.
7. That a portion of the developmental component be used to carry out the additional planning and research necessary to develop a residency training program for primary and secondary physician training

RMP: WEST VIRGINIA

PREPARED BY: Norman Anderson

DATE: 10/72

in several of the major hospitals in the State. It is to be noted that the State Medical Society has obtained \$300,000 from the State legislature to assist in the improvement of the residency training program. The site visitors did not perceive that the developmental component was to be used for anything other than the general objectives and patterns of activities that were described. The site visit team felt it would be appropriate for the West Virginia RMP to utilize portions of this developmental component to obtain maximal physician retention estimated at 70% through assisting in the establishment of the residency training programs outside of the medical center, particularly in Charleston, Wheeling, and other major communities in the region.

Review Cycle: 10/72

RMPS STAFF BRIEFING DOCUMENT

1.5 } SV Rec
1.6 }
1.7 } Approval

REGION: West Virginia

OPERATIONS BRANCH: Eastern

NUMBER: RM 00045

Chief: Frank Nash

COORDINATOR: Mr. Charles Holland

Staff for RMP: Norman Anderson
Eileen Faatz

LAST RATING: 358

TYPE OF APPLICATION:

- Triennial 3rd Year Triennial
- 2nd Year Triennial Other

Regional Office Representative:
Clyde Couchman

Management Survey (Date):

Conducted: April 24-27, 1972
or
Scheduled: _____

Last Site Visit:

(List Dates, Chairman, Other Committee/Council Members, Consultants)
July 8, 1969 - Anne Pascasio, Ph.D. - RMP Review Committee
Bruce Everist, M.D. - RMP National Advisory Council
Desmond O'Doherty, M.D. - Consultant

Staff Visits in Last 12 Months:

(List Date and Purpose)
September 28, 1971 - Alan S. Kaplan, M.D. (Staff Assistance)
April 24-27, 1972 - Management Assessment (Tom Simonds, Rod Merzker, N. Anderson)
April 26, 1972 - Verification of Review Process (N. Anderson, Clyde Couchman)
June 23, 1972 - Staff Visit (N. Anderson)

Recent events in geographic area of Region that are affecting RMP program:

1. WVRMP has recently redefined and restated their objectives to be more responsive to the needs of the Region.
2. The Technical Review Committee structure has been reorganized. A Technical Review Committee has been established for each of the three objectives.
3. WVRMP has developed and published a report entitled, Guidelines for Proposal, Review and Operations of Activities which describes the review process of the Region.
4. Management Survey team report and verification of the review process report.

DEMOGRAPHIC INFORMATION

1. Geography

The region conforms to the political boundaries of West Virginia. For planning purposes the region has been divided into nine sub-regional areas. The boundaries of these sub-regional areas are the same as those of CHP "B" and the State Economic Development Department. Land area: 24,079 square miles.

2. Population: 1970 Census

- a. Total: 1,744,200
- b. Urban: 39%
- c. Rural: 61%
- d. Minority: 4%

3. Income: Average income per individual - 1969-1970

State of West Virginia - 1969 (\$2,610) - 1970 (\$2,929)
 United States - 1969 (\$3,680) - 1970 (\$3,910)
 West Virginia ranks 46th in the U.S. per capita income

4. Age distribution:

<u>Age group</u>	<u>West Virginia</u>	<u>U.S.</u>
under 18 years	33	35
18-65 years	56	55
65 years and over	11	10

5. Facilities and Resources:

- a. West Virginia University School of Medicine
- b. Sixteen Schools of Professional Nursing, seven of them college or university based.
- c. Sixteen School of Practical Nursing

Allied Health Schools

- a. Two schools of cytotechnology
- b. Seven schools of Medical technology
- c. Twenty-four schools of radiologic technology

Hospitals

- a. Short term - 74 - 9,286 beds
- b. Long term - 2 - 460 beds
- c. V.A.General Hosp. -4-1,257 beds

6. Manpower: Active

- * a. Physicians - 1,596
- b. Osteopath - 100
- Total - 1,696 (94 per 100,000)
- c. Professional Nurses - 4,704 (260 per 100,000)
- d. Lic. Pract. Nurses - 2,317 (136 per 100,000)

* From a study conducted last year, utilizing the West Virginia Medical Association Journal of new members of the West Virginia State Medical Association from 1961-1971, the following data was collected. A preliminary analysis of the data shows that, of all new members of the State Medical Association, a significantly high and growing proportion are foreign medical graduates (9% of these joining in 1961 vs. 65% in 1971).

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level <u>04</u> Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 577,086	\$ 584,725	619,197	656,279			
CONTRACTS	148,466	95,222	--	--			
DEVELOPMENTAL COMPONENT	--	80,000	80,000	80,000			
OPERATIONAL PROJECTS	222,914	1,135,153	1,163,721***	1,263,721***			
Kidney	X	(25,000)					
EMS *		(41,506)	(27,556)	(24,105)			
hs/ea		(49,830)					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS**	800,000	\$1,799,878	\$1,900,000	\$2,000,000			
COUNCIL RECOMMENDED LEVEL	\$ 929,810						

* \$63,375

**\$863,375

*** Includes Unspecified Growth Funds

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

HYPS-CSP-JTCFHL

REGIOA 45 W VIRGINIA

PMP SLPP YR 03

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	**	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1	C2	C3	TOTAL	**	C4	C5	C6	TOTAL
			01/71-12/71	01/72-12/72		**	01/73-12/73	01/74-12/74	01/75-12/75	
000	PROGAM STAFF	283700	472485	577000	1333275	**	584725	619157	656275	1660201
000	DEVELOPMENTAL C					**	80000	20000	80000	240000
001	ED PRG STAFFIA	31000			31000	**				
004	ACFTING CARE ST	26700	541		27241	**				
005	NAT LIFE HIST S	31400			31400	**				
006	PELICCTER FEAS	22300	4550		31850	**				
008	PHYSICIAN SELF		52922	100000	152922	**	104845			104845
010	MULTI UNIT CLIP		17377	15875	37252	**	35000	20000		55000
011	SCHOOL HEALTH P		64720	71400	136120	**	84033			84033
013	SEGMENTATION OF			24001	24001	**				
014	PEDIATRIC NURSE			7500	7500	**	54900			54900
015	LEGAL PROJCT					**	56637	39460		96097
016	VISITING PHYSIC					**	21524	22000		43583
018	A FURAL MULTI C			35,000	35,000	**	41200			41200
021	SATELLITE HEALTH					**	91239	100000	50000	241239
022	PARKERSBURG ARE					**	11000	11000		22000
023	COMPREHENSIVE I					**	50000	41130	42630	133760
024	COMPREHENSIVE V					**	24700	36675	30000	91375
025	FURAL MULTI COL					**	31000			31000
026	FURAL MULTI COL					**	34741			34741
027	PROJECT MATCHUP					**	44847			44847
028	PARKERSBURG PAR					**	45000			45000
029	HYGETA HOME HEA					**	37000	87930		124930
030	CAMDEN DA GALLE					**	256860			256860
031	DISCHARGE PLANN					**	28500			28500
032	BIOCHEMICAL CLIP					**	30000	24000	24000	78000
033	JACKSON REGIONA					**	41500	27550	24100	93150
033	UNSPECIFIED GFC					**		87000	116490	203490
020	INSTR & CERT OF EMT INSTRUCTORS			28,375	28,375	**				56750
- TOTAL -		357100	617015	863,375	1,876,090	**	1759878	1980000	2080000	5859878

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JULY 17, 1972

DEPARTMENT OF HEALTH
US PROGRAM PERIOD

REGION - W VIRGINIA
OM 00045 10/72

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IDENTIFICATION OF COMPONENT	(1)	(2)	(3)	(4)	1ST YEAR DIRECT COSTS	1ST YEAR INDIRECT COSTS	TOTAL
	CONT. WITHIN APPR. PERIOD OF SUPPORT	CONT. BEYOND APPR. PERIOD OF SUPPORT	APPR. NOT PREVIOUSLY FUNDED	NEW, NOT PREVIOUSLY APPROVED			
0000 PROGRAM STAFF		\$584,725			\$584,725	\$167,629	\$752,354
0000 DEVELOPMENTAL COMPONENT				\$80,000	\$80,000		\$80,000
008 VOLUNTARY OFFICE SELF AU DIT SERVICE	\$104,845				\$104,845	\$10,540	\$115,385
010 MULTI UNIT COMMUNICATION S FACILITY	\$39,685				\$39,685	\$12,842	\$52,527
011 SCHOOL HEALTH PROGRAM RU RAL COMMUNITIES	\$84,033				\$84,033		\$84,033
014 PEDIATRIC NURSE PRACTITI UNER		\$54,900			\$54,900	\$17,025	\$71,925
015 LEGAL PROJECT			\$56,637		\$56,637	\$22,325	\$78,962
016 VISITING PHYSICIANS IN RI ESIDENCE PROGRAM			\$21,524		\$21,524	\$5,554	\$27,078
018 A RURAL MULTI COUNTY EMS SYSTEM		\$41,200			\$41,200		\$41,200
021 SATELLITE HEALTH CENTERS RANDOLPH COUNTY				\$91,239	\$91,239		\$91,239
022 PARKERSBURG AREA HOME HE ALTH SERVICES				\$11,096	\$11,096		\$11,096
023 COMPREHENSIVE HEALTH SER VICES PLANNING GRANT				\$50,900	\$50,900		\$50,900
024 COMPREHENSIVE MATERNITY CARE DEMONSTRATION				\$24,700	\$24,700		\$24,700
025 RURAL MULTI COUNTY HOME HEALTH SERVICES GRANT				\$31,000	\$31,000		\$31,000
026 RURAL MULTI COUNTY HOME HEALTH SERVICES SUMMERS				\$34,741	\$34,741		\$34,741
027 PROJECT MATCHUP				\$44,847	\$44,847		\$44,847
028 PARKERSBURG MARIETTA COM MUNITY HEALTH MANPOWER				\$49,830	\$49,830		\$49,830
029 HYGEIA HOME HEALTH SERVI CES				\$37,010	\$37,010		\$37,010
030 CAMDEN DR GAULEY MEDICAL CENTER				\$256,860	\$256,860		\$256,860
031 DISCHARGE PLANNING PROGR AM IN A COMMUNITY HOSP				\$28,500	\$28,500		\$28,500
032 BIOMEDICAL COMPUTER INFO MATION SERVICE PROJECT				\$30,100	\$30,100	\$6,810	\$36,910
033 JACKSON REGIONAL EMERGEN CY MEDICAL SERVICES SYS UNSPECIFIED GROWTH FUNDS				\$41,506	\$41,506		\$41,506
TOTAL	\$228,563	\$680,825	\$78,161	\$812,329	\$1,799,878	\$242,725	\$2,042,603

JULY 17, 1972

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

REGION - W VIRGINIA
ON 00145 1072

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IDENTIFICATION OF COMPONENT	(3) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	2ND YEAR DIRECT COSTS
000 PROGRAM STAFF		\$619,197			\$619,197
000 DEVELOPMENTAL COMPONENT		\$80,000			\$80,000
008 VOLUNTARY OFFICE SELF AID SERVICE					
010 MULTI UNIT COMMUNICATIONS FACILITY		\$20,000			\$20,000
011 SCHOOL HEALTH PROGRAM RURAL COMMUNITIES					
014 PEDIATRIC NURSE PRACTITIONER					
015 LEGAL PROJECT			\$39,460		\$39,460
016 VISITING PHYSICIANS IN RESIDENCE PROGRAM			\$22,059		\$22,059
018 A RURAL MULTI COUNTY EMS SYSTEM					
021 SATELLITE HEALTH CENTERS RANDOLPH COUNTY				\$100,000	\$100,000
022 PARKERSBURG AREA HOME HEALTH SERVICES				\$11,096	\$11,096
023 COMPREHENSIVE HEALTH SERVICES PLANNING GRANT				\$41,130	\$41,130
024 COMPREHENSIVE MATERNITY CARE DEMONSTRATION				\$36,615	\$36,615
025 RURAL MULTI COUNTY HOME HEALTH SERVICES GRANT					
026 RURAL MULTI COUNTY HOME HEALTH SERVICES SUMMERS					
027 PROJECT MATCHUP					
028 PARKERSBURG MARITTA COMMUNITY HEALTH CENTER					
029 HYGEIA HOME HEALTH SERVICES				\$87,930	\$87,930
030 CAMDEN ON GAULEY MEDICAL CENTER					
031 DISCHARGE PLANNING PROGRAM IN A COMMUNITY HOSPITAL					
032 BIOMEDICAL COMPUTER INFORMATION SERVICE MEDLINE				\$24,000	\$24,000
033 JACKSON REGIONAL EMERGENCY MEDICAL SERVICES SYSTEM				\$27,556	\$27,556
UNSPECIFIED GROWTH FUNDS				\$870,957	\$870,957
TOTAL		\$719,197	\$61,519	\$1,199,284	\$1,980,000

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	3RD YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
000 PROGRAM STAFF		\$450,279			\$450,279	\$1,060,201
000 DEVELOPMENTAL COMPONENT		\$80,000			\$80,000	\$250,000
008 VOLUNTARY OFFICE SELF AU DIT SERVICE						\$104,845
010 MULTI UNIT COMMUNICATION S FACILITY						\$59,685
011 SCHOOL HEALTH PROGRAM RU RAL COMMUNITIES						\$85,033
014 PEDIATRIC NURSE PRACTITI ONER						\$55,900
015 LEGAL PROJECT						\$96,097
016 VISITING PHYSICIANS IN F ACILITY PROGRAM						\$53,583
018 A RURAL MULTI COUNTY EMS SYSTEM						\$41,200
021 SATELLITE HEALTH CENTERS RANDOLPH COUNTY				\$50,000	\$50,000	\$241,239
022 PARKERSBURG AREA HOME HE ALTH SERVICES						\$22,192
023 COMPREHENSIVE HEALTH SER VICES PLANNING GRANT				\$42,630	\$42,630	\$134,560
024 COMPREHENSIVE MATERNITY CARE DEMONSTRATION				\$38,025	\$38,025	\$99,340
025 RURAL MULTI COUNTY HOME HEALTH SERVICES SEAM						\$31,000
026 RURAL MULTI COUNTY HOME HEALTH SERVICES SUMMERS						\$35,741
027 PROJECT MATCHUP						\$45,857
028 PARKERSBURG MARIETTA COM MUNITY HEALTH PARTNER						\$49,830
029 HYGEIA HOME HEALTH SERVI CES						\$124,940
030 CAMDEN ON GALLEY MEDICAL CENTER						\$256,850
031 DISCHARGE PLANNING PROGR AM IN A COMMUNITY HOSP						\$28,500
032 BIOMEDICAL COMPUTER INFO MATION SERVICE MODEL				\$24,000	\$24,000	\$78,100
033 JACKSON REGIONAL EMERGEN CY MEDICAL SERVICES SYS UNSPECIFIED GROWTH FUNDS				\$24,105	\$24,105	\$93,167
				\$1,164,961	\$1,164,961	\$2,035,918
TOTAL		\$736,279		\$1,343,721	\$2,080,000	\$5,859,878

9

History - In December 1965, Dr. Clark K. Sleeth, then Dean of the West Virginia University School of Medicine, convened a meeting to discuss the State's participation in RMP. The meeting was attended by representatives of the State Departments of Health and Welfare, the West Virginia Heart Association, the West Virginia Division of the American Cancer Society, the West Virginia Hospital Association, the West Virginia University Medical Center and the general public. Upon unanimous agreement to participate, the Medical Center was selected to initiate and coordinate planning to establish the WVRMP. A 28-member RAG was appointed and Dr. Sleeth was elected chairman. The RAG appointed a 12-member staff committee to prepare the planning grant application.

This region received a planning grant for three years beginning January 1, 1967. The amount awarded the second year included a supplement of \$141,807 for four feasibility studies; (1) Survey of a Rural Area (Blacksville); (2) Mechanical Morbidity Reporting by Physicians; (3) Coronary Care Unit; and (4) Physicians Self-Audit. The latter three also were supported in the third year. The third year was extended seven months to August 31, 1970, and the Self-Audit to September 30, 1970, with no additional funds.

A site visit was made in July 1969 to assess the region's capability to become operational. It was noted that when the WVRMP began, it had many obstacles to overcome. The State suffered from critical economic crises, leaving most areas without adequate health care. Small towns, rural and mountain areas, so predominant in West Virginia, lacked health personnel. The medical school was only 11 years old and there was little evidence of effective continuing education into the hospitals and medical profession. Adding to these problems, Dr. Wilbar, the Regional Coordinator, died in January 1969. Mr. James G. Holland, Associate Coordinator, was serving as Acting Program Coordinator. Despite the dearth of resources and the unfilled coordinator position, the site visitors believed the region was ready for operational status. The West Virginia University Medical School has taken an active role in the WVRMP and good physician and nurse participation was evident. The region also has established appropriate cooperative arrangements. As pointed out to the region, there was a need for better minority representation on the RAG. The 35-member RAG only recently had organized its committee structure, and it was too early to determine how well it was working. Subarea offices based on joint planning with Comprehensive Health Planning were projected for the near future. Council recommended approval for operational status for three years for core and four projects. Mr. Charles D. Holland was appointed Regional Coordinator and to provide appropriate supervision of the medical aspects, a special Medical Advisory Committee was constituted to assist the Coordinator.

History (continued)

When Committee and Council took a brief look at the region early in 1971 when supplemental support for new projects was requested, it was observed that although the region had been operational for only one year, the program seemed to be moving forward under effective leadership. Subsequently, however, the across-the-board twelve percent reduction for all RMPs reduced West Virginia's 02 year grant from \$516,567 to \$454,579. But later on in the year the region received an additional \$126,299 from unexpended 1971 appropriations to provide supplemental support for core and an ongoing project and to initiate an approved/unfunded project. This was a one-year supplement only, and the commitment for the 03 year remained at the reduced level of \$454,579.

HISTORY OF REGION

Principal Problems since Region received first planning grant in
January 1, 1967.

Review and Council Concerns

- a) The degree to which the regional activity would be expanded into peripheral areas.
- b) Lack of information on resources of the Medical Center.
- c) Relationships with other existing programs. (Appalachian Health Studies and Development)

Site Visit:

July 1969 (Preoperational) - Recommended operational status 1/1/69 - 12/31/70.

Concerns of Site Visitors

- a) The need for increased representation from the poor on the RAG.
- b) Recruit an educator to program staff for bringing in consultants with expertise in education. Review and Council recommended operational status.

October 1971 Review Committee and Council

- a) WVRMP was penalized because they had not had a site visit since 1968 and very few staff visits.
- b) Questions concerning the reorganization of the committee structure.
- c) Questions concerning the review process of the Region. Recommended staff assistance be provided to the Region to clear any problems in advance of submittal of the Triennial Application.

Principal Accomplishments:

1. Reorganization of the committee structure.
2. The recruitment of an Associate Director, three Program Specialists, a data analyst and a field representative.
3. Revision and simplification of the review process as spelled out in the WVRMP Guidelines which also outlines program objectives and priorities.

Principal Problems (Based on application, since last review)

1. Relationship between WVRMP and the grantee (University of West Virginia Medical School) which was dealt with through the management assessment visit.
2. The lack of poor white representation on the RAG, Committees, and few allied health representatives.

Principal Accomplishments (Based on applications, since last review)

1. Reorganization of the technical review committee's structure which has been conformed to the programs new objectives.
2. The development of "Guidelines for Proposal, Review, and Operation of Activities" which describes the review process.
3. Redefined and restated their objectives. The objectives are Health Care Delivery, Health Manpower and Emergency Medical Care and each objective has a number of sub-objectives.
4. WVRMP has filled the following positions: an associate coordinator, three program specialists, a data analyst and a field representative.
5. Through cooperative efforts and joint funding with a variety of public and private nonprofit organizations, five rural health care centers are being established. WVRMP staff play a crucial role in obtaining other funding, i.e., \$120,000 was "matched" by other one million dollars from other sources.

Issues requiring attention of reviewers

Same as principal problem. (WVRMP bylaws are very restrictive governing RAG composition. Site visit team may want to consider suggesting that the bylaws be rewritten.)

Region West Virginia RM 00045
Review Cycle October 10/72
Type of Application: Triennium

Rating 336

Recommendations From

SARP

Review Committee

Site Visit

Council

The Review Committee accepted the recommendations of the site visitors that the West Virginia Regional Medical Program be approved for triennial status with the following funding levels:

04	Operational Year	\$1,500,000
05	Operational Year	1,600,000
06	Operational Year	1,700,000

The recommended funding levels include the developmental component request.

Committee viewed West Virginia RMP as a viable program with a well conceived and developed planning process built around clearly defined program goals and objectives. Each proposal is directed to one of the three objectives-- health care delivery, emergency medical services, and health manpower. The goals and priorities are directed to improving access to care in the unserved and underserved portion of the region.

The concerns expressed by Committee have been adequately described in the Site Visit Report listed under recommendations. Committee recommended that the concerns be strongly emphasized in the advice letter. One major concern expressed by Committee is that "poor" people should have adequate representation on the RAG.

COMPONENT AND FINANCIAL SUMMARY
 TRIENNIAL APPLICATION

Component	Current Annualized Level _____ Year	Request for Triennial			Committee Recommendation for Council-Approved Level		
		1st year	2nd year	3rd year	1st year	2nd year	3rd year
PROGRAM STAFF	\$ 557,086	\$ 584,725	\$ 619,197	\$ 656,279			
CONTRACTS	148,466	95,222	--	--			
DEVELOPMENTAL COMPONENT	--	80,000	80,000	80,000			
OPERATIONAL PROJECTS	222,914	1,135,153	1,280,803	1,343,721			
Kidney	X	(25,000)					
EMS		(41,506)	(27,556)	(24,105)			
hs/ea		(49,830)					
Pediatric Pulmonary		()					
Other		()					
TOTAL DIRECT COSTS	\$ 800,000	\$1,799,878	\$1,980,000	\$2,080,000	\$1,500,000	\$1,600,000	\$1,700,000
COUNCIL RECOMMENDED LEVEL	\$ 929,810		\$1,980,000	\$2,080,000			

RMP'S STAFF BRIEFING DOCUMENT

REGION: Wisconsin

OPERATIONS BRANCH: SCOB

NUMBER: 37

Chief: Lee E. Van Winkle

COORDINATOR: John S. Hirschboeck, M.D.

Staff for RMP: Jeanne L. Parks, SCOB

LAST RATING: 350

William ("Bill") Reist, SCOB

Charles Barnes, GMB

Eugene Piatek, P & E

TYPE OF APPLICATION:

Triennial 3rd Year Triennial

2nd Year Triennial Other

Regional Office Representative:

Maurice Ryan

Management Survey (Date):

Conducted: _____

or

Scheduled: not scheduled

Last Site Visit: December 1970; Chairman Dr. Russel B. Roth, Council
Dr. Edmund Lewis, Review Committee

Staff Visits in Last 12 Months:

June 8-9, 1972: To attend RAG meeting to get overview of review process;
to see RAG in action in preparation for verification of
review process visit.

June 13, 1972: Verification of review process visit

Recent Events Occurring in Geographic Area of Region that are Affecting RMP Program:

In May 1971, the Governor of Wisconsin created a Health Planning and Policy Task Force to (1) study the state's health needs; (2) design a comprehensive system which would provide the health services consumers require; (3) compile a health plan and designate health priorities; (4) recommend a legislative program; (5) suggest any necessary administrative reorganization; (6) identify the responsibility for government, the providers, the educational system and the consumer; and (7) make recommendations on the financing of system and the consumer; and (8) make recommendations on the financing of health care, utilizing both public and private capital, with a request for early identification of those areas demanding priority attention.

To accomplish this far-reaching and significant undertaking, the following Task Force work groups were established:

- (1) Health Service Research & Development
- (2) Health Financing
- (3) Education of Health Workers
- (4) Transportation (EMS)

- (5) Health Planning
- (6) Environmental Health
- (7) Health Education of the Public
- (8) Personal Health Services
- (9) Evaluation of Health Services

Each of the work groups have projects or studies underway which will be finalized within the next six months and will provide the basis for final recommendations to the Governor.

The Governor also appointed a Health Policy and Program Council which carries, along with other duties, the responsibility for Comprehensive Health Planning under the Bureau of Comprehensive Health Planning, the state (a) agency. This Council will continue its work after the Task Force has completed its assignment and will be in a position to take action on program areas identified by the Task Force. WRMP has both staff and committee representatives on both groups. As policy develops for the State of Wisconsin, WRMP may have a significant role in the implementation of new programs which might arise out of the two bodies.

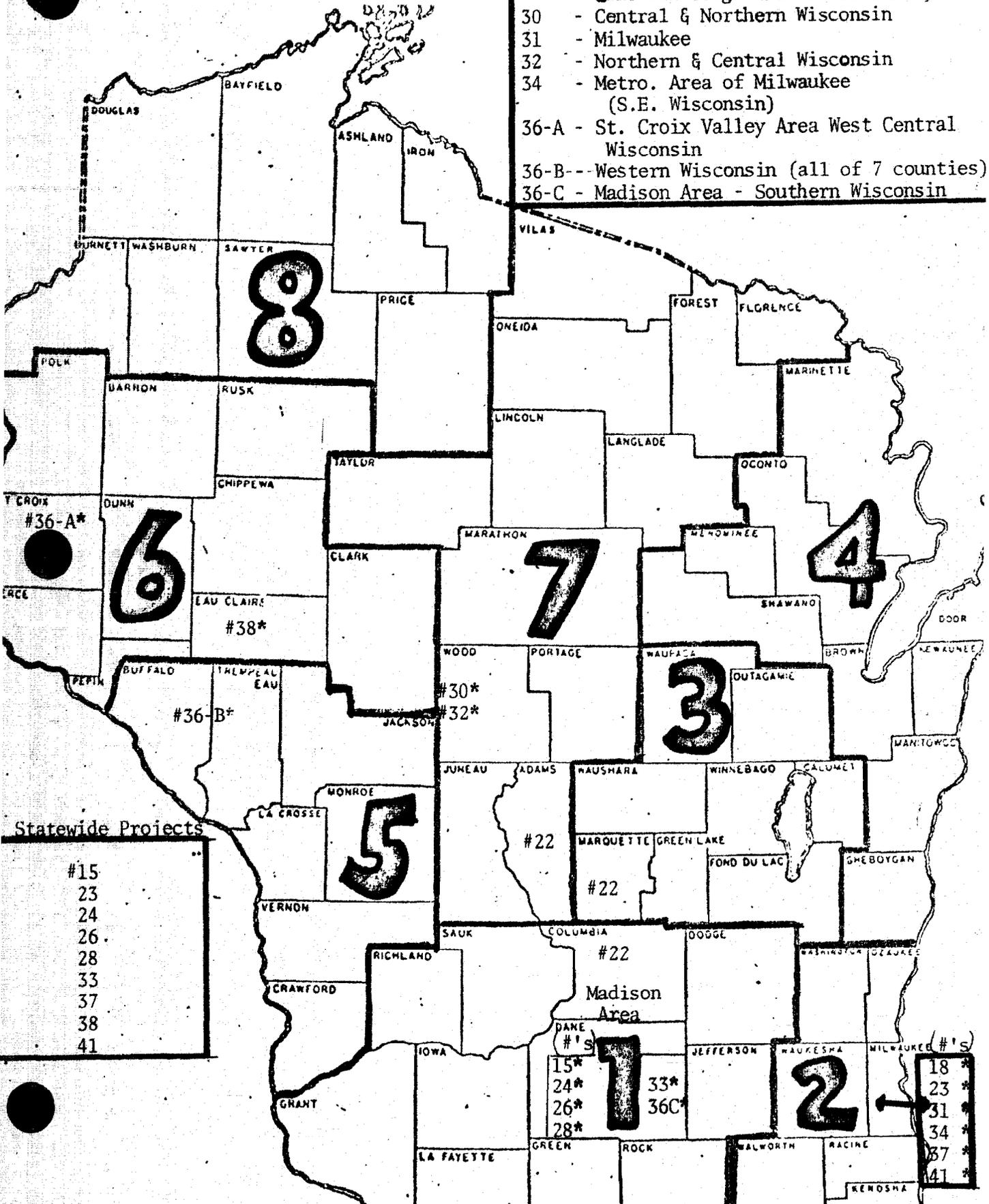
Three new CHP (b) agencies have become operational; one in North Central Wisconsin, one in North Western Wisconsin and one in the Lake Winnebago District. There are now 8 operational CHP (b) agencies in the State of Wisconsin.

Location of New and Operational Projects
 * (denotes project headquarters)

-3-

Regionalized Projects

- 18-A - SE Wisconsin
- 22 - three counties (1 each in Southern, Lake Winnebago and NC Wisconsin)
- 30 - Central & Northern Wisconsin
- 31 - Milwaukee
- 32 - Northern & Central Wisconsin
- 34 - Metro. Area of Milwaukee (S.E. Wisconsin)
- 36-A - St. Croix Valley Area West Central Wisconsin
- 36-B - Western Wisconsin (all of 7 counties)
- 36-C - Madison Area - Southern Wisconsin

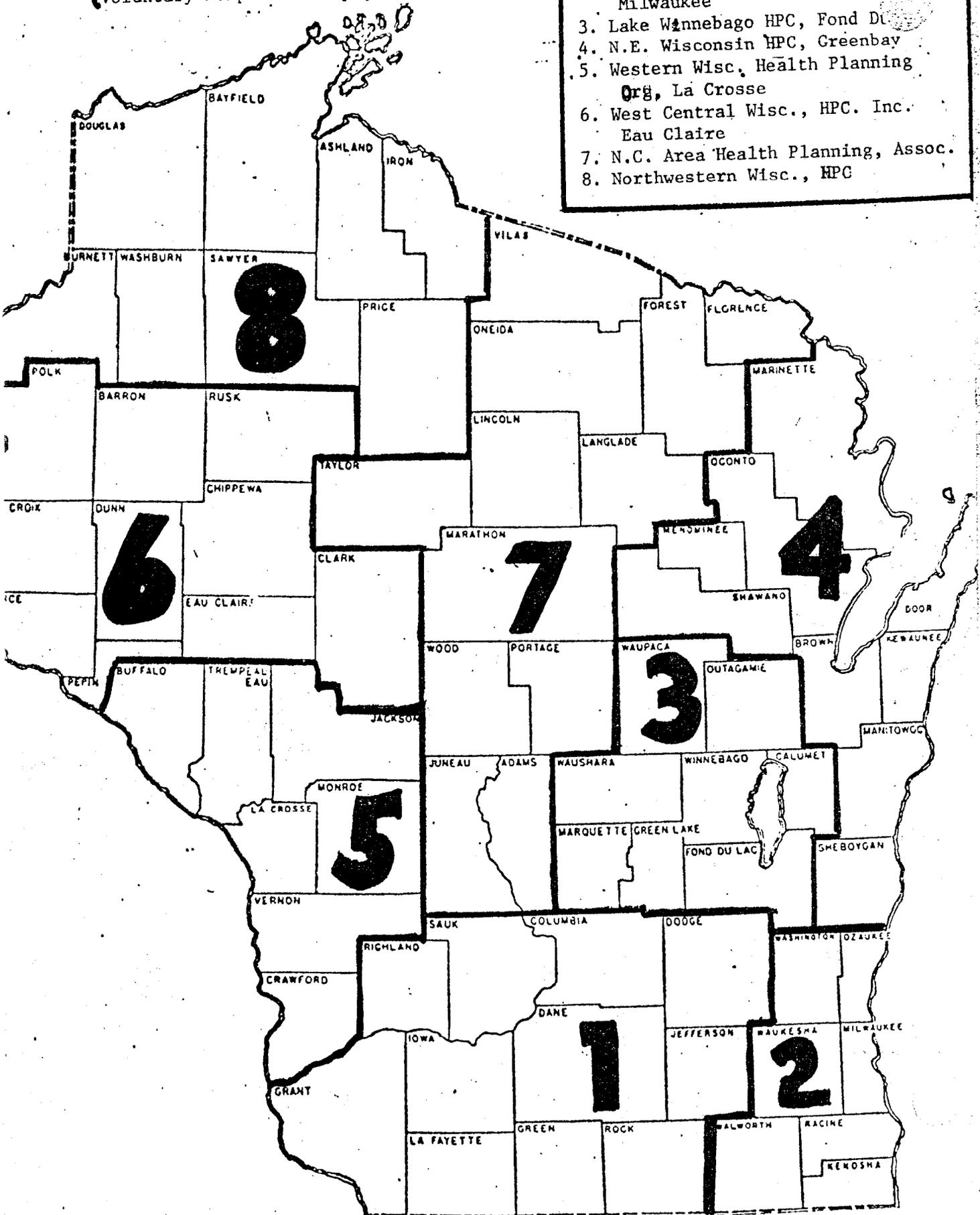


Statewide Projects

- #15
- 23
- 24
- 26
- 28
- 33
- 37
- 38
- 41

AREAWIDE HEALTH PLANNING AGENCIES
 (Voluntary Nonprofit Corp.)

1. Health Planning Council, Madison
2. CHP Agency of S.E., Wisconsin, Milwaukee
3. Lake Winnebago HPC, Fond Du Lac
4. N.E. Wisconsin HPC, Green Bay
5. Western Wisc. Health Planning Org., La Crosse
6. West Central Wisc., HPC. Inc. Eau Claire
7. N.C. Area Health Planning, Assoc.
8. Northwestern Wisc., HPC



DEMOGRAPHIC, FACILITIES AND RESOURCES STATISTICAL SUMMARY

37

REGION: WISCONSIN

Geography and Demography: The region encompasses the entire State.

Counties: 71

Congressional Districts: 10

Population: (1970 Census) 4,417,900

Urban: 66%

Density: 81 per square mile

Rural: 34%

Age Distribution:

Wisc.

U.S.

Under 18 years

36%

35%

18-64 years

53%

55%

65 years and over

11%

10%

Metropolitan areas: 6--total population: 2,388,000 (over 50% of State total)

Duluth-Superior (Minn-Wisc)--262.0

Madison--287.5

Green Bay--157.3

Milwaukee--1393.3

Kenosha--116.7

Racine--171.2

Race: Non-White--4% (large proportion Indians); White--96%

Resources and Facilities

Enrollment
1969/70

Graduates

Medical Schools--Med. College of Wisc., Milwaukee

416

88

University of Wisc. Med. Sch., Madison

409

92

Pharmacy--1 at University of Wisc. Hospitals, Madison

Dental School--Marquette University, Milwaukee

Professional Nursing Schools

Practical Nurse Training

25 (10 are based at colleges and Universities)

12--all at Technical Institutes

Accredited Schools

Cytotechnology--3

Medical Technology--35 incl. 1 at V.A. Hosp. (Wood)

Radiologic Technology--30 incl. 1 at V.A. Hosp. (Wood)

Physical Therapy--2 (Univ. of Wisc. Med. Sch. and Marquette U.)

Medical Record Librarian--1

Hospitals--Community General and V.A. General

	<u>#</u>	<u>Beds</u>
Short term	158	21,866
Long term (special)	8	1,198
V.A. (general)	2	1,342
Skilled Nursing Homes	353	27,205
Long term care units	65	3,667

Hospitals with selected special facilities

- Intensive Cardiac Care--52
- Cobalt therapy--24
- Radium therapy--41
- Isotope--42
- Renal dial (inpt)--18
- Rehab (inpt)--27

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>1st</u> (05 year)	Council-Approved Level For TR Year <u>2nd</u> (06 year)	Region's Request For TR Year <u>2nd</u> (06 year)	Recommended Funding For TR Year <u>2nd</u> <input type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium		
PROGRAM STAFF	529,955	X	625,607		X		
CONTRACTS	64,792						
DEVELOPMENTAL COMP.	117,822			200,898		<input type="checkbox"/> Yes <input type="checkbox"/> No	
OPERATIONAL PROJECTS	1,066,503			1,350,110			
Kidney	X			(312,881)		()	
EMS				(1,265,816)		()	
hs/ea				()		()	
Pediatric Pulmonary				()		()	
Other			()	()			
TOTAL DIRECT COSTS	1,779,072		2,176,615				
COUNCIL-APPROVED LEVEL	1,779,072	1,779,072	1,779,072				

JULY 12, 1972

DEPARTMENT OF HEALTH
OF WISCONSIN

REGION - WISCONSIN
ON 00077 10/72

PAGE 1
UNPUBLISHED

IDENTIFICATION OF COMPONENT	(5) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(1) NEW, NOT PREVIOUSLY APPROVED	CURRENT DIRECT COSTS	CURRENT INDIRECT COSTS	TOTAL
0000 PROGRAM STAFF	\$625,607				\$625,607	\$62,155	\$687,762
0000 DEVELOPMENTAL COMPONENT	\$200,890				\$200,890		\$200,890
015 COMPREHENSIVE RENAL PRCG RAM	\$312,881				\$312,881	\$57,177	\$370,058
018A DEPT OF HLTH MANPOWER AN D CON EDUCATION	\$57,965				\$57,965	\$8,835	\$66,800
022 CONTINUING ED IN REHABIL ITATION MEDICINE			\$54,341		\$54,341		\$54,341
023 CARDIAC AND INTENSIVE CA RE NURSING			\$54,521		\$54,521	\$21,410	\$75,931
024 CANCER REVIEW AND EMENDA TION CARE PROGRAM	\$37,729				\$37,729	\$11,964	\$49,693
026 PRIMARY CARE THE EXTENDE D ROLE OF THE NP/SC	\$131,616				\$131,616	\$54,806	\$186,422
028 DIAGNOSTIC AND THERAPEUT IC CRITERIA REVIEW			\$23,000		\$23,000	\$9,800	\$32,800
030 NORTH CENTRAL WISCONSIN OUTREACH		\$18,492			\$18,492	\$6,868	\$25,360
031 16TH ST COMMUNITY HEALTH CENTER HOPE INC		\$109,151			\$109,151		\$109,151
037 RESEARCH AND PLANNING OF HEALTH CARE				\$90,180	\$90,180	\$29,779	\$119,959
033 MED INSTRUMENTATION AND CONSULTATION SERVICE				\$159,312	\$159,312	\$56,336	\$215,648
034 VOLUNTEERS FOR STROKE RE HABILITATION				\$38,800	\$38,800		\$38,800
036A SHARED SERVICES PROGRAM ST GROIX PROJECT				\$25,950	\$25,950		\$25,950
036B SHARED SERVICES AREA 5 W EST WISCONSIN PROJECT				\$32,600	\$32,600		\$32,600
036C SHARED SERV PROGRAM MAD ISON HOSP GROUP				\$15,000	\$15,000	\$5,400	\$20,400
036 COMPONENT TOTAL				\$73,550	\$73,550	\$5,400	\$78,950
037 PRE ADMISSION TESTING PA RT				\$30,822	\$30,822		\$30,822
038 WISCONSIN HEALTH CARE RE VIEW				\$92,170	\$92,170		\$92,170
041 QUALITY NURSING CARE				\$65,580	\$65,580		\$65,580
TOTAL	\$1,366,696	\$127,643	\$131,862	\$550,414	\$2,176,615	\$324,530	\$2,501,145

JULY 14, 1972

DEPARTMENT OF HEALTH
OF WISCONSIN

REGION - WISCONSIN
BY 00017 10/72

PAGE 2

WPS (58) 21002 1

IDENTIFICATION OF COMPONENT	(1) CONT. WITHIN APPR. PERIOD OF SUPPORT	(2) CONT. BEYOND APPR. PERIOD OF SUPPORT	(4) APPR. NOT PREVIOUSLY FUNDED	(11) NEW, NOT PREVIOUSLY APPROVED	ADD'L YEAR DIRECT COSTS	TOTAL ALL YEARS DIRECT COSTS
0000 PROGRAM STAFF	\$671,276				\$671,276	\$1,296,823
0000 DEVELOPMENTAL COMPONENT	\$158,454				\$158,454	\$359,352
015 COMPREHENSIVE RENAL PROG RAM						\$312,881
013A DEPT OF HLTH MANPOWER AN D CON EDUCATION	\$38,644				\$38,644	\$96,609
027 CONTINUING ED IN REHABIL ITATION MEDICINE			\$57,428		\$57,428	\$173,785
023 CARDIAC AND INTENSIVE CA RE NURSING			\$54,521		\$54,521	\$109,052
024 CANCER REVIEW AND EMERGA TION CASE PROGRAM						\$37,729
025 PRIMARY CARE THE EXTENDE D ROLE OF THE NURSE	\$131,616				\$131,616	\$263,232
028 DIAGNOSTIC AND THERAPEUT IC CRITERIA REVIEW			\$23,000		\$23,000	\$46,000
030 NORTH CENTRAL WISCONSIN OUTREACH		\$18,492			\$18,492	\$36,984
031 16TH ST COMMUNITY HEALTH CENTER MORE INC		\$109,151			\$109,151	\$218,302
032 RESEARCH AND PLANNING OF HEALTH CARE				\$90,180	\$90,180	\$180,360
033 MED INSTRUMENTATION AND CONSULTATION SERVICE				\$159,312	\$159,312	\$318,624
034 VOLUNTEERS FOR STROKE RE HABILITATION				\$38,800	\$38,800	\$77,600
034A SHARED SERVICES PROGRAM ST CROIX PROJECT				\$24,625	\$24,625	\$50,575
036B SHARED SERVICES AREA 5 W EST WISCONSIN PROJECT				\$25,000	\$25,000	\$57,600
036C SHARED SFPV PROGRAM MADI SON HCSP GROUP						\$15,000
036 COMPONENT TOTAL				\$49,625	\$49,625	\$123,175
037 PRE ADMISSION TESTING PA T				\$28,652	\$28,652	\$59,474
038 WISCONSIN HEALTH CARE RE VIEW						\$92,170
041 QUALITY NURSING CARE				\$65,580	\$65,580	\$131,160
TOTAL	\$999,990	\$127,643	\$134,949	\$432,149	\$1,694,731	\$3,933,362

#61

AUGUST 2, 1972

REGIONAL MEDICAL PROGRAMS SERVICE

FINANCIAL HISTORY LIST

RPPS-CSP-JTCFFL

REGION 37 WISCONSIN

RMP SLPP YR CS

OPERATIONAL GRANT (DIRECT COSTS ONLY)

ALL REQUEST AND AWARDS AS OF JUNE 30, 1972

COMPONENT NO	TITLE	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	AWARDED	REQUESTED	REQUESTED	REQUESTED	REQUESTED
		C1	C2	C3	C4	05 09/71 - 12/72	TOTAL	C6 01/73 - 12/73	C7 01/74 - 12/74	C8 01/75 - 12/75	TOTAL
000	PROGRAM STAFF	415100	430800	435000	411700	660033	2357432	625607	671276		1256883
000	DEVELOPMENTAL A					130920	130920	200898	156454		355352
002	STCY PRG UTERIN	40100	153200	105000			330300				
003	FILCT DEM PULL	84600	61900	55400			201500				
004	CA CHEM T ALLTS	9100	65400	30500	33000		138030				
005	PC ED HLTH PRGF		71000	58500			125500				
005A	PC ED LTR SERV				16500		16500				
005B	DIAL ACCESS LTR				15000	24001	43001				
005C	SINGLE CONCEPT				15500		15500				
006	FACILITY = 6			123200	123500	126940	374046				
007B	CLA CCR ANGIOG		95700	5800	4000		106300				
007C	CVA PED CARD CI		204300	65400	44000		313700				
008	CA CHEM PETFL		10200	66700	28000		111784				
011	TISSLE TYPING M		8000	51400	43000		102400				
012	UTERINE CYTCCG		2500	40700	43500		95100				
013	REACT A TRAG SH		13100				13100				
013A	INACTIVE NURSE			60000			60000				
013B	CCNEC A TRAG SH			12400			12400				
015	COMPREHENSIVE R			450000		621816	1071816	312801			312801
016	MEDICAL LIBRARY			17000	10500		33500				
017	NURSE UTILIZATI			100600	114000	154550	370150				
018A	MEDICAL COLLEGE					77290	77290	57965	30044		50005
020	ACTN PRG DET PG				100525		100525				
022	CONTINUING EC I							54341	57420	62016	173785
023	CANCER AND INT							54521	54521		109042
024	CANCER REVIEW A					23272	23272	37725			37725
026	NURSE ASSOCIATE					82850	82850	131616	131616		263232
028	DIAGNOSTIC AND							23000	23000		46000
030	NORTH CENTRAL C					17150	17150	10452	10452		36904
031	SOUTH SIDE HEAL					55925	55925	109151	109151		218302
032	RESEARCH AND FL							90180	90180		180360
033	MED INSTRUMENTA							155312	155312		310624
034	WILLIAMS FOR							38800	38800		77600
036A	SHARED SERVICES							25550	24625		50175
036B	SHARED SERVICES							32600	25000		57600
036C	SHARED SERV FFC							15000			15000
037	PRE ADMISSIO Y							30022	20052		50074
038	WISCONSIN HEAL							92170			92170
040	ENS FOR WISCONS					1205010	1205010				
041	QUALITY NURSING							65500	65500		131000
- TOTAL -		548900	1162500	1685600	1023815	3242562	7667370	2176615	1694731	62016	3933262

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Historical Profile

The Wisconsin RMP's initial planning year began September 1, 1966, was designated as an operational program on September 1, 1967, and received Triennial States on September 1, 1971.

The Wisconsin RMP Inc. was formed as a collaborative venture by the Marquette School of Medicine and the University of Wisconsin. It encompasses the entire state of Wisconsin, with the largest concentration of its population in the seven Southeastern counties of Wisconsin, which serve as one of the area-wide health planning agencies--the CHPA for Southeastern Wisconsin (CHPASEW). The Region ranks high nationally in the amount of money spent for higher education. The Health Sciences Unit of the University Extension, University of Wisconsin in Madison has been a pioneer in the development of continuing education for resources for physicians, registered nurses, and allied health professionals, and has achieved national reputation for the excellence of its work. The WRMP has over the years collaborated with these resources which have resulted in the development of a number of operational programs designed for nurses and physicians and other health professions in the region.

During its early years of operation the WRMP has concentrated basically on quality of care in categorical disease areas and post-graduate education programs for physicians and nurses, with principal operational foci in the Marshfield, Milwaukee, La Crosse and Madison areas, and to a much lesser extent in the Central Northeast and Northwestern portions of the state. The northern portion of Wisconsin is characterized mostly by large rural areas sparsely populated with small rural hospitals and for the most part inadequate facilities. Operational programs have recently been developed which do provide some outreach to some of these rural areas. The region through its newly appointed field representative for Northern Wisconsin has been working with hospital administrations in this area and has assisted these hospitals in the development of collaboration and service sharing arrangements. The current application requests funds (Project #36A) for support of such an activity. Project #30, North Central Wisconsin, illustrates another example of an outreach program in the Northern and Central area for the small rural hospitals. These projects among others in the current application illustrate the region's emphasis on finding ways to extend services to areas outside the Metropolitan and University centers and the large group clinic settings, and on developing methods for monitoring the quality of care and moderating the costs of quality health care. The awarding of \$1,265,816 for a statewide EMS project for the State of Wisconsin also represents a program which would aid people in the Northern areas and will tie together a number of extremely scattered, smaller services. WRMP is working in close collaboration with a broad spectrum of the health groups in the region and has developed a network of communication and functional activity among medical centers, hospitals, and health agencies in the region.

The region has successfully terminated a number of its original three year projects by either receiving support from other sources, or because of unsatisfactory results. Appendix D of the current application describes the accomplishments and sources of funding of these terminated projects. Project #16, Medical Library, and Project #20, Action Program in Detection and Management of Gynecologic Malignancy, are projects

WRMP has improved the extent and quality of its evaluation procedures by the establishment of a Review and Evaluation Committee which has the responsibility for and has been actively involved in conducting project site visits and developing methods to produce "outcome" data rather than theoretical information. Evaluation is now built into projects during the initial stages of their development. The region's review process was the subject of a June 13, 1972 visit. It was found that the mechanics of the WRMP review process generally meet the minimum standards; however, it was recommended that provisional certification be given pending implementation of staff's recommendations and suggestions which relate to: (1) conflict of interest; (2) feedback letters; (3) provision of review criteria to potential applicants; (4) re-examination of the region's by-laws; and (5) provision of written review criteria to technical reviewers.

The region has expanded the membership of the Corporation from its original three to a total of nine members.

WRMP reassessed its utilization of developmental component funds in light of its present objectives, and have defined in greater detail its intent and purpose in developing program areas for developmental component funding. During the past year, seven activities were funded; five of these have been approved by the RAG for extended support and appear in the project section of the current application. Areas of activity include delivery of primary health care, and monitoring the quality of health care.

During the past year, increased efforts have been made in furthering effective communications and collaborative efforts in program planning and development with the state areawide CHP agencies. WRMP provided assistance to the Northeastern HPC in preparation of an application for a project with the Menominee Indians and has consulted with this HPC about cardiovascular surgery needs and neighborhood clinics. Consultation and assistance has also been provided at the request of the CHP agency of Southeastern Wisconsin, on matters relating to requirements of Cardiovascular Surgery. In collaboration with the Johnson Foundation of Wisconsin, the WRMP convened a conference to identify the components of an effective community action program to deal with the problems of sickle cell disease, established guidelines for such a program, and have since provided consultation to the Medical Society of Milwaukee County and the United Community Services of greater Milwaukee about sickle cell community action programs.

Issues Requiring Attention of Reviewers:

The basic issue is whether the WRMP should be approved and funded at the level requested in the current application. The request is for \$2,176,615 including \$200,898 for developmental component funds. The region is currently funded at its NAC approved level of \$1,779,072. Recommended funding for the development component should be based on this level.

If the region is approved and funded in the amount requested, it will be able to continue its basic program, as outlined in the current application, provide salary increases for program staff and initiate eight new activities which for the most part will provide services and health care needs to areas of the state which have in the past been neglected.

A staff review will be scheduled and if additional issues are raised the subject of a separate document.

Staff Observations

Principal Problems:

Prior to the submission of the WRMP's Triennial application, a site visit was conducted which revealed problems related to:

- (1) the lack of objective methods of evaluation
- (2) the inadequate representation of racial minorities on the RAG and a lack of minority representation on program staff.
(This still remains to be a problem, as there are still no racial minority program members, and only one minority (black) representative on the RAG.)
- (3) lack of sufficient depth of the program staff
- (4) the extent of subregionalization efforts, especially in the rural northern part of the State
- (5) developmental component request too broad and all encompassing, lacking specificity as to how the funds would relate to priority needs
- (6) The three-member corporation is not large or broad enough to govern such a large program as the WRMP, Inc.

Principal Accomplishments:

WRMP's Triennial Application reflected a definite response to the specific problems, concerns and recommendations of the reviewers.

The region has added depth and strength to the program staff by the addition of a Physician Associate Coordinator for Program Development and Evaluation (Madison WRMP office), a Deputy Coordinator for Regional Liaison (Milwaukee WRMP office), and a field representative who serves WRMP as liaison in the North Central area of Wisconsin. His efforts have been directed towards promoting and providing assistance in the development of collaboration and service sharing among the rural hospitals, particularly in the rural areas of Northern Wisconsin. He has worked successfully with the hospital administrations in the area and has identified opportunities for improved cooperation among these hospitals. As a result of these efforts, seven participating hospitals, working through a non-profit corporation are in the process of merging to share services and to combine health care services in an effort to provide more comprehensive services and to improve the quality of services that is so urgently needed in this target area.

WRMP has improved its subregional efforts by establishing cooperative relationships with some of the large proprietary clinics, namely, Marshfield and Gunderson. As an example, WRMP and staff members of the Marshfield Clinic have designed a proposal to establish the concept of regionalization by providing a variety of medical and laboratory services to the small rural hospitals in the North-Central area of Wisconsin. It is anticipated that other health care delivery systems within the central Wisconsin region will also participate in the provision of outreach services to these rural areas.

MEMORANDUM

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

TO : Director *PC 9/7/72*
Division of Operations & Development

DATE: September 7, 1972

FROM : Director
Regional Medical Programs Service

SUBJECT: Action on September 5 Staff Anniversary Review Panel recommendation concerning the Wisconsin Regional Medical Program application.

Accepted _____

Am

9/10/72

(Date)

Rejected _____

(Date)

Modifications

Region Wisconsin RFP
Review Cycle October 1972
Type of Application:
Anniversary within Triennial

Recommendations From

Rating - 336

State

Review Committee

Site Visit

Council

Recommendations:

1. That the region be funded for its 06 operational year at \$2,153,624 (d.c.) which includes \$312,881 for Renal activities. The amount recommended represents an increase of \$374,552 over the current NAC approved level of \$1,779,072.
2. That the developmental component be funded at 10% of the current annualized level (\$1,779,072) for a total of \$177,907 (which is included in the above recommended funding level) rather than the \$200,898 requested.

Critique:

In recommending a funding level, the panel noted that the region continues to be a strong viable program and has positively responded to and taken initiatives in resolving the concerns of the previous reviewers.

Panel was impressed with the leadership and management that exists in WRMP and noted that the program staff has been strengthened by the addition of an Associate Coordinator for Program Planning and Development and a Deputy Coordinator to assist in the overall operation and administration of the program.

The region has taken significant steps toward strengthening its evaluation procedures. A Review and Evaluation Committee has been established and has given evaluation a great deal of visibility. The R & E Committee has implemented an effective mechanism for project review and monitoring. The WRMP Director of Evaluation provides the needed assistance to the Committee in carrying out its task. Evaluation is used as a management tool to provide quantitative information for consideration in decisions leading to the better conduct of projects and to provide information for consideration in dealing with future support of project activities. The procedural steps in carrying out this process includes initial reviews of projects to determine the existence of some realistic evaluation procedural measures and the resources to carry them out, operational reviews as a monitoring function to insure that projects are meeting stated objectives, and terminal reviews to assess overall project performance and value to determine the future direction of projects. The region utilizes resources outside the WRMP in its evaluation process.

Additionally, in the area of program evaluation, the Wisconsin RMP participated in the Information Support System contract which is being supported by the Office of Planning & Evaluation under the direction of Dr. Harold Keairnes. The findings of that study were very favorable to the Wisconsin RMP and indicated that the WRMP is addressing the major health problems in the State, as defined by the health leaders in the region.

The region has been able to capture the interests and have good working relationships with virtually all of the key health agencies and institutions in the State. By working with a broad spectrum of health groups, WRMP has been able to develop a network of communications and functional activity among the Medical Centers, hospitals, and health agencies in the region. WRMP has worked in close collaboration with the Bureau of Comprehensive Health Planning since its inception. In addition, WRMP works closely with the eight established and operational areawide health planning agencies in the State. The Regional Advisory Group adopted a policy in 1969 regarding collaboration with the areawide health planning agencies. The stress is on developing projects in a subregional or areawide context with an appropriate awareness of the areawide goals and priorities, to share expertise and resources in solving problems of common concern, to provide professional and technological consultation to these agencies, and to interrelate committee and staff appointments with these agencies when desirable. WRMP is successfully carrying out this mission. WRMP has been very actively involved in providing consultation and assistance to these agencies in a number of areas.

WRMP has also been an important factor in bringing about closer cooperation between the two Medical Schools in Wisconsin.

The panel praised the region's "contract offerings approach" which was recently approved by the Regional Advisory Group as an experiment in contract offerings in certain program areas. \$100,000 has been earmarked to fund activities which the RAG has defined as high priority areas. This method has provided WRMP with an additional source of projects and contact with 63 different groups from 35 communities in the state. This has proven to change the focus of attention from the larger cities, large clinic groups and the University centers to the small town hospitals and grass roots health care personnel of many varied types. Three contracts, all in the area of shared services among small hospitals, have been developed as high priorities by the RAG for implementation. One such activity will provide outreach to the northern rural areas of the state and was developed largely through the effort of the WRMP liaison representative for northern Wisconsin. He has successfully promoted and assisted in the development of collaboration and service sharing among hospitals, particularly in the rural and northern areas of Wisconsin. If the program is successful as proposed it is, a quantum leap in fostering cooperation among hospitals which can only result in more efficient and better patient care.

The members of SAMP were impressed with the region's involvement in assisting the Governor's Health Policy and Planning Task Force which was appointed in June 1971, to study the state's health needs and develop a comprehensive health plan and policy for the State of Wisconsin. Its members include 9 people who are on Wisconsin RMP boards and committees. Dr. Hirschboeck is vice chairman of the Personal Health Services work group of the task force, which has been involved with problems of quality of health care, and have recently developed a discussion paper, "Maintaining the Quality of Health Care in Wisconsin." The WRMP has been involved in several activities relating to monitoring the quality of health care. For example, \$25,000 in developmental award funds have been made available to the Wisconsin Health Care Review, Inc., which is a corporation formed by the State Medical Society, Wisconsin Hospital Association and the Wisconsin State Dental Society.

The region is now requesting three years support for this activity. In addition, several other quality of care review programs are in existence in Wisconsin. The Marshfield clinic has a health service delivery research and evaluation program. Funds have been provided by the WRMP for this activity. Three year funding is also being requested by WRMP to continue this activity.

The panel in their review of the WRMP kidney proposal, were generally impressed with the development of the program so far, but were concerned with some trends which if not given early attention, could restrain the achievement of full program potential. Some dispersion of transplantation and related services was evident. There appears to be insufficient attention to the development of third-party sources of patient care support. There also appears to be an inadequate level of effort being focused on increased procurement of organs to support increased kidney transplantation.

It might be of interest to note that the WRMP has just won a National award for the 1972 Gerard B. Lambert awards, established to encourage innovations designed to improve patient care or reduce health casts. It is the first time a RMP has ever received the award. The award is for a WRMP funded activity "Nurse Utilization: A Patient Care Systems Project," a system of patient care based on patient needs on the theory that if a patient needs are designed for, the nurse will be utilized correctly. The system is currently in use at St. Mary's Hospital in Milwaukee and is in various stages of implementation in other hospitals throughout the nation.

COMPONENT AND FINANCIAL SUMMARY
ANNIVERSARY APPLICATION DURING TRIENNIUM

Component	Current Annualized Funding TR Year <u>1st</u> (05 year)	Council-Approved Level For TR Year <u>2nd</u> (06 year)	Region's Request For TR Year <u>2nd</u> (06 year)	Recommended Funding For TR Year <u>2nd</u> (06 year) <input checked="" type="checkbox"/> SARP <input type="checkbox"/> Review Committee	Recommended Level For Remainder of Triennium
PROGRAM STAFF	529,955	X	625,607	625,607	X
CONTRACTS	64,792		--	--	
DEVELOPMENTAL COMP.	117,822		200,898	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (177,907)	
OPERATIONAL PROJECTS	1,066,503		1,350,110	1,350,110	
Kidney	X		(312,881)	(312,881)	
EMS			(1,265,816)	()	
ns/ea			()	()	
Pediatric Pulmonary			()	()	
Other		()	()		
TOTAL DIRECT COSTS	1,779,072		2,176,615	2,153,624	
COUNCIL-APPROVED LEVEL	1,779,072	1,779,072	1,779,072		