
E0006B9

PROGRESS SUMMARIES

Table of Contents

Organization and Structure of Regional Medical Programs:

1. Regional Advisory Groups--Composition and Methods of Appointment
2. Regional Advisory Groups--Activities
3. Executive Committees--Composition and Activities
4. Boards of Directors--Composition and Activities
5. Categorical and other Planning Committees--Structure and Composition
6. Categorical and other Regional Committees--Activities and Accomplishments
7. Local and Area Advisory Group--Composition and Activities
8. Core Staff--Organization, Size, Composition
9. Core Staff--Consultant/Broker/Facilitator Role

Planning and Decision-Making Activities:

10. Planning and Feasibility Studies
11. Institutional/Organizational Participation
12. Regional Review and Approval Process

Operational Activities:

13. Project Sponsorship
14. Institutional/Organizational Participation
15. Patient Care
16. Training

17. Cost Sharing on Projects

18. Project Staffing

Relationships with Federal Programs:

19. Comprehensive Health Planning

20. Other Federal Programs

General Information:

21. Regional Size and Boundaries

22. Subregionalization

23. Program Information Activities

January 1970

REGIONAL ADVISORY GROUPS -- COMPOSITION AND METHOD OF APPOINTMENT

There are a total of 2,463 members on the 55 Regional Advisory Groups. The Regional Advisory Groups range in size from 12 to 229, the average size being 45.

From a professional (or occupational) standpoint, nearly half (46%) of the advisory group members are physicians. From an affiliation viewpoint, nearly two-thirds (65%) represent a health interest, institution, or provider group. A breakdown of Regional Advisory Group membership follows:

Table 1: By Profession

	Number	Percent
TOTAL	2463	100
Physicians	1139	46
Registered Nurses	142	6
Hospital & Nursing Home Administrators	225	9
Other Health	163	7
Business or Managerial	332	13
Other Non-Health Occupations	423	19

Table 2: By Affiliation

	Number	Percent
TOTAL	2463	100
Medical Schools	194	8
Affiliated Hospitals	120	5
Hospitals & Other Hospital Interests	286	12
Medical Societies	235	9
Public & Other Health Agencies	202	8
Voluntary Health Agencies	231	9
Health Practitioners	349	14
Public or Consumer Representation	436	18
Others	410	17

Highlights

Since their initial establishment some three to four years ago, the Regional Advisory Groups have been developing with a trend toward larger, more representative membership and a trend toward the Regional Advisory Groups determining that membershp itself. To demonstrate the first point, there were 1,147 persons on Regional Advisory Groups in 1966 for an average membership of 29. Today, there are 2,463 Regional Advisory Group members for an average of 45. The trend toward these advisory groups determining their own membership is illustrated by the fact that in 1966, 31 of them were appointed by the governor,

medical school dean or the participating health institutions of the region but now, only 13 of the advisory groups are appointed in this manner and 25 are appointed by their members or the chairman of the advisory group.

Other highlights of Regional Advisory Groups are as follows:

* They are indeed broadly representative of the health interests, institutions and groups of the region.

  . Virtually all of the country's medical schools are represented.
  . Most of the state medical societies are represented along with many local societies.
  . Most of the state chapters of the American Heart Association and the American Cancer Society have representation.
  . Virtually all state health departments are represented by either the state health officer or his designee.
  . A significant number of practicing doctors, nurses and other health professionals are members.

* Public or consumer representation has grown slowly but steadily until it now stands at 18% compared with 14% in 1966. It should be noted, moreover, that from a professional or occupational standpoint nearly one-third of advisory group members are not health professionals or employed in the health field. Some of these, however, are representative of a health interest such as lay trustees of hospitals or lay directors of voluntary health agencies.

* In 50 of the 55 regions, the Regional Advisory Group is governed by formal by-laws. In the remaining 5 regions, the group operates under less formal but mutually agreed upon operating procedures.

Explanation and Comments

Many of the persons on Regional Advisory Groups can be said to be representative of more than one sector of the health care community but each region has designated only the primary affiliation of each individual. For instance, almost all doctors are members of medical societies even though they may work for the American Heart Association and maintain a private practice. This kind of duplication is impossible to avoid but by specifying the primary affiliation, the duplication is reduced to a minimum.

In reference to the method of appointing Regional Advisory Groups, the process in some cases is very involved and only the final appointing authority has been considered.

Three of the categories in Table 2 deserve further explanation. The category Hospitals and other Hospital Interests includes hospitals not affiliated with a medical school, hospital associations and health insurance companies. Similarly,

the "Other" category includes representatives of: (1) nursing schools and schools of public health, (2) faculty members of community colleges and departments of a university not associated with the medical school, (3) health professional societies other than the medical societies and (4) government agencies (state and local) other than the departments of health. Also, the category "Health Practitioner" is made up of providers of health care who are not identified with any particular institution. The great majority of persons in this category are practicing physicians but nurses, dentists, nutritionists and other health workers are included.

Questionnaire Reference: II.B.4,5,&8.

Analyst: Stephen Bell

January 1970

REGIONAL ADVISORY GROUPS -- ACTIVITIES

Regional Advisory Groups are involved in a wide range of activities. The primary functions more or less common to all, however, are overall program guidance -- that is, determination of the overall scope, nature and direction of the program policies and overall objectives and priorities -- and the review of operational proposals. All project applications must be reviewed and favorably recommended by the advisory group before they can be considered by the National Advisory Council.

To fulfill the function of overall program direction, the advisory groups have established committees for program planning and administration and in most cases have established guidelines for program development. In addition to the formal review of projects, most Regional Advisory Groups have established their own guidelines for the type of projects which will be considered.

One gross index of the level of activity of Regional Advisory Groups is the number of meetings held. More than half of the groups meet quarterly and overall, the average frequency of meetings has been 4 times a year. Attendance at the 666 Regional Advisory Group meetings held over the last four years has averaged roughly 20 members per meeting.

Highlights

* Advisory groups, in addition to being a key planning body in the regions themselves, have been responsible for or stimulated the establishment of 831 categorical and other planning committees, task forces and subregional advisory groups.

* They have reviewed 1,553 projects recommending 1,021 for approval.

* In most regions the advisory group also established written guidelines for appropriate projects.

* In most regions, the Regional Advisory Group serves as a facilitator in bringing together the health interests of the region; and it has through the interlocking directorate phenomenon and by other means, been an important mechanism for bringing about cooperation between the RMP and the various CHP agencies within the region.

* There have been 666 RAG meetings over the past four years. An average of 20 persons attended each meeting for a percentage attendance of 57%.

Explanation and Comments

Virtually all of the regions indicated that even though the Regional Advisory Group met at prescribed intervals, there was provision for the group to convene on short notice if the needs of the region made it necessary.

The information in this analysis was derived on the one hand from a composite of two questions on the questionnaire dealing with the number of meetings and attendance as related to the number of RAG members and on the other hand from an anecdotal question concerning the "major accomplishments" of the Regional Advisory Group. Because of the type of data contained in these questions, the thrust of this analysis is commonality rather than diversity. To explain, the analysis deals with overall attendance and what most of the Regional Advisory Groups are doing instead of the range of attendance and the range of activities with which the Regional Advisory Groups concern themselves. As a result, the information may be misleading in that it does not reveal the individual "personalities" of the 55 Regional Advisory Groups.

Questionnaire Reference: II.B.4,6,7 & 10

Analyst: Stephen Bell

January 1970

EXECUTIVE COMMITTEES

Forty-one (41) of the regions have executive committees, mostly of their Regional Advisory Groups which because of their activity level and designated functions have substantial influence on program development.

Generally, these executive committees function in some or all of the following areas:

* Act in the RAG's stead except on final project or policy decisions or subject to full RAG approval.

* Develop the agenda for RAG meetings and do those things which will expedite RAG operations.

* Act as the day-to-day advisor to the program coordinator and core staff on behalf of the RAG.

* Aid in the management of personnel and fiscal details of the program.

* Serve as appointing/nominating body for RAG and/or other committee memberships.

* Make substantial input to policy and priority decisions.

Executive committee membership is <u>not</u> representative of the larger advisory group; it is very heavily weighted by physicians and representatives of medical schools.

<u>Highlights</u>

* Of the 41 executive committees, 27 (68%) are appointed by the RAG; the others by grantees, coordinators, boards of directors, medical school deans or other specified bodies.

* However, 35 of the 41 (85%) do report to the RAG. Four (4) report to boards of directors of new corporations,one (1) to the coordinator and one (1) to a committee serving in an advisory capacity to the coordinator.

* 317 (75%) of the members of executive committees are also RAG members.

* 284 (67%) of the committee members are physicians. In four regions (Alabama, Albany, Maryland and North Carolina) all members are physicians; and in four others (Oklahoma, Metropolitan D. C., Georgia and Illinois) there is only one non-physician on each.

* 102(24%) of the committee members represent medical schools. in three regions (Illinois, Maryland and North Carolina) there is only one non-medical school member.

* RMP core staff accounts for 20 members or 5% of total committee membership.

* While most of the committee action is subject to approval by the RAG or other parent body, there are several apparent exceptions:

  - In two regions (North Carolina and Rochester,) both the memberships of which are dominated by physicians and medical school representatives they appear to have authority to reject project proposals.

  - Five committees have the authority to hire and/or fire the Coordinator.

Representative of the kinds of activities, and indicative of the amount of influence of executive committees, is the following quote describing activities of the Washington/Alaska executive committee:

"The Executive Committee has provided expert advice and counsel to the Director in internal staff and organization matters, including the review of candidates for staff position, termination procedures, and revision of the organization structure. The Committee has been helpful with regard to external matters such as the sensitive and important relations between WARMP and others in the health field. The Executive Committee has served as a valuable review and reactor group relative to important and complex matters to be presented to the RAC as a whole. This has allowed indepth consideration of problems and when appropriate, the submission of recommendations to the RAC.

Individually and as a group, the Executive Committee has been of great assistance to the Director; his contacts with them are frequent and valuable. On the other hand, there is good reason to believe that the more frequent meetings with the Executive Committee have increased their understanding of the Program and their commitment to it."

Questionnaire Reference: II.E.1-7.

Analyst: Patty Mullins

Regions: 55, of which 41 Regions reported having executive or steering committees.

Supporting Tables

Table 1: Membership Composition, by Profession

Professional Category	Number	Percent
Physicians	284	67%
Registered Nurses	16	4
Hospitals & Nursing Home Administrators	31	7
Other Health	25	6
Business or Managerial	34	8
Other	33	8
Total	423	100%

Table 2: Membership Composition, by Affiliation

Affiliation	Number	Percent
Medical School	102	24%
Affiliated Hospitals	21	5
Other Hospital and Related Agencies	38	8
Medical Society	48	11
Public and Other Health Agencies	31	8
Voluntary Health Agencies	28	7
Health Practicioners	67	16
Public or Consumer	40	10
Other	48	11
Total	423	100%

BOARD OF DIRECTORS

Boards of Directors administer new organizations or corporations which have been formed to manage the Regional Medical Programs in seventeen regions. The Regions report that the neutrality of these organizations benefits the regional programs by facilitating cooperation between different health interests, particularly medical schools. These Boards are active bodies, meeting an average of 18 times a year, and have responsibility for administration and fiscal management of the programs as well as varying degrees of policy-making authority. With a total of 264 members, the Boards are composed mainly (69%) of physicians, and there is considerable overlap in membership with the Regional Advisory Groups, (56% of board members are also on the RAG's).

Highlights

Boards of Directors are active administrative and policy shaping bodies of the Regional Medical Programs.

The kinds of influence that go into the boards is indicated in part by their composition.

* Most of the board members (69%) are physicians, and 19% are non-health professionals (mostly businessmen).

* Institutional representation, though spread fairly evenly, reflects a preponderance of medical school physicians (20%) and medical society representative (18%).

* Board members are also members of the Regional Advisory Groups in eleven regions. This represents 56% of the total Board membership. In six of these regions the entire Board is on the RAG.

* Boards range in size from 5 to 28 members with an average size of 16 members. They have met an average of 18 times a year: 6 Boards meet monthly or more often, 4 meet bimonthly, and the remaining 5 meet quarterly or less often.

Their activity and influence are reflected in the kinds of responsibilities they have.

* Almost all Boards are responsible for administration and financial management of the region or corporation. Some, such as Ohio Valley's Board, are concerned solely with administrative matters. Many Boards, such as Northeast Ohio and Western New York, also have major authority in developing policy and direction for the regional program.

* Boards of Directors also review and approve project proposals. In a few cases the Board's approval is necessary, along with approval of the RAG, for the project proposal to be submitted for national approval.

The major benefit reported by the regions from forming a new corporation or organization to administer the Regional Medical Program is its neutrality which facilitates or enables cooperation between different health interests. Incorporation or the formation of a new organization has resulted in the following other benefits:

* Effective mediation by the corporations between different medical schools in a region or between medical schools and other health interests.

* A broadened base of support gained for regional activities by bringing more new institutions into cooperation with the corporation or organization.

* Autonomy of operations, resulting in increased flexibility and increased convenience with fiscal and programmatic activities in the same place.

Explanation and Comments

Boards of Directors are generally defined as those bodies which have administrative authority over a corporation or organization formed to administer a Regional Medical Program. In one case (New Jersey) the Regional Advisory Group serves such a role and has been included as the Board since there is no other such body in that region. Another region (Northwestern Ohio) which has been included as having a Board, has no new corporation, but does have a Board which exercises functional authority over the entire program.

Questionnaire Reference: II.D.1,2,7

Analyst: Ann Stone

SUPPORTING TABLES

Table 1: Board of Director Composition by Profession

Kind	Number	Percent
Physicians	183	69
Registered Nurses	6	3
Hospital Administrators	23	8
Other Health	4	1
Business or Managerial	24	10
Other	24	9
TOTAL	264	100

Table 2: Board of Director Composition by Affiliation

Kind	Number	Percent
Medical School	55	20
Affiliated Hospitals	20	8
Other Hospital Interests	28	10
Medical Society	48	18
Public and Other Health Agencies	18	7
Voluntary Health Agencies	29	11
Health Practitioners	21	8
Public or Consumer	19	8
All Other	26	10
TOTAL	264	100

January 1970

CATEGORICAL DISEASE AND OTHER PLANNING COMMITTEES --
STRUCTURE AND MEMBERSHIP

There are, in addition to the Regional Advisory Groups and their executive committees, nearly 500 categorical disease and other planning committees within the 55 regions. These committees, which include over 5000 physicians, hospital administrators, medical center officials and others, have major responsibilities with respect to planning and program development, project review and in some instances, program administration. Their breakdown, along with membership composition follows:

Type of Committee	Number	Percent	No. of Regions
Categorical Disease (e.g. heart, stroke)	224	45.5%	50
Functional (e.g. continuing education, prevention)	170	34.5%	48
Programmatic (e.g. review, evaluation)	60	12%	31
Administrative (e.g. nominations) and Other	38	8%	21
	492	100%	

Committee Membership Composition by Profession

Professional Category	Number	Percent
Physicians	3,273	62%
Registered Nurses	486	9%
Hospital and Nursing Home Administrators	326	7%
Other Health	346	6%
Business or Managerial	312	6%
Other	577	10%
Total	5,320	100%

Committee Membership Composition by Affiliation

Affiliation	Number	Percent
Medical School	872	16%
Affiliated Hospitals	508	10%
Other Hospital Interests	879	17%
Medical Society	212	4%
Public and Other Health Agencies	290	5%
Voluntary Health Agencies	355	7%
Health Practicioners	1,180	22%
Public or Consumers	198	4%
Other	826	15%
Total	5,320	100%

Highlights

Committees, as vehicles for bringing diverse interests together, have succeeded in bringing together over 5,000 persons, mostly health professions and primarily physicians, to aid in the health planning process.

* All but two regions, Kansas and Mountain States, have committee or task force structure.

* Fifty of the fifty-three regions having a committee structure have categorical disease (e.g. heart, diabetes) committees. Only Missouri, Northlands and Northern New England have none.

* Forty-eight regions have "functional" committees dealing with such issues as manpower and rehabilitation which cross disease boundaries. There are none in Missouri, New Mexico, Rochester, Western New York or West Virginia.

* Four regions had committees on health costs, only one of which is still functioning. Four regions have committees concerned with disadvantaged/minority groups, and four with community health. There are two prevention committees.

* 5,320 individuals serve on the 492 committees, representing a vast amount of "volunteer" time and expertise being made available to RMP's.

* Committees are physician dominated; they account for 3,273 (62%) of the membership. Nurses represent 9% of membership, while hospital administrators, other health professions and non-health business and managerial persons each represent 6% of membership.

* There is a conspicuously low representation by Comprehensive Health Planning agency personnel, who account for only 21 (0.3%) of all committee members, and 64 members of the public, who account for less than 200 (4%) of membership.

* There have been over 2500 meetings of committees, representing an average of 4-5 meetings annually per committee.

* Approximately 400 studies have been conducted by committees and they have, additionally, reviewed over 1,700 project proposals and have actually developed over 300 operational projects for consideration for funding.

While physicians as a profession seem to dominate committee membership, it should be noted that the composition by affiliation is not dominated by any single category and, indeed the physicians appear to represent a broad spectrum of interests.

Nearly all of the regions have committees on heart, cancer and stroke; most have one or more concerned with the functional area of continuing education. As categorical restrictions are eased, there will probably be more functional committees springing up and there will probably be a corollary increase in the number of members representing professionals other than physicians and the public.

Explanation and Comments

For purposes of compilation, committees were classified into one of the following categories:

- Categorical/Disease Committees include committees concerned with specific conditions or body systems.

- Functional Committees include those concerned with issues which cross disease lines such as continuing education, prevention, computer and library.

- Programmatic committees include those concerned with RMP planning, data collection, project review, and evaluation.

- Administrative and other committees include those concerned with the RMP organization itself and its administration, and those other committees which were not otherwise classifiable.

Membership can be expressed in two manners. There are 5,320 individuals serving as committee members. These individuals, however, represent 5,624 memberships, since some serve on more than one committee.

Two regions, Kansas and Mountain States, have no such committees, reducing the universe to 53 regions.

Questionnaire Reference: II.F.1 & 2.

Analyst: Patty Mullins

Supporting Tables, Continued

Table 1. Number of Committees, by Type, and Number of Regions

Type of Committee	Number of Committees	Number of Regions
Categorical	**224**	
Heart	65	45
Cancer	60	48
Stroke	54	46
Pulmonary/Respiratory	10	10
Diabetes	6	6
Kidney/Renal	14	14
Unspecified Related	7	7
Pediatric Pulmonary	2	2
Dental	6	6
Programmatic	**60**	
Planning	10	10
Data/Demography/Statistics	11	11
Epidemiology	4	4
Coordinative	15	13
Evaluation	7	7
Project Review	13	13
Administrative	**27**	
Administrative	11	9
Executive	5	5
By Laws/ Nominations	11	9
ther	**11**	1

Type of Committee	Number of Committees	Number o Regions
Functional	**170**	
Continuing Education	45	37
Patient Services	4	3
Hospital Needs & Services	8	7
Radiation/Nuclear Medicine	5	5
Library	11	12
Communications/Information	16	16
Registeries	2	2
Computer	4	4
Health Costs	1	1
Manpower	11	11
Nursing	17	15
Allied Health	8	8
Extended Care	2	2
Prevention	2	2
Rehabilitation	5	5
Screening	7	7
Disadvantaged/Minority	4	4
Community Health	4	4
CCU	5	5
Other Functional Committees	9	9

January 1970

CATEGORICAL AND OTHER PLANNING COMMITTEES--ACTIVITIES AND ACCOMPLISHMENTS

Categorical and other planning committees report a variety of activities and reflect several major trends. In nearly all regions (48) these committees have a major responsibility for project development and review of projects. In almost all regions (49) these committees also do a great deal of the coordination and liaison work which is a necessary part of forming cooperative arrangements. By providing a forum, these committees have effectively brought together various interest groups, particularly for cooperative development of projects.

Committees generally help set objectives and priorities for RMP activities in 48 regions and also collect data about needs and resources of the regions. Many regions (34) have committees which provide technical assistance and consultation and some (13) which set specific standards and guidelines for facilities and projects. Committees in some regions (22) perform the evaluation of ongoing projects and programs in terms of goals and priorities. In addition, committees in at least 15 regions have conducted various studies to implement planning.

Highlights

Committee functions cover a broad spectrum of activities but there are several areas in which committees seem to have major responsibility. These areas are project development and review and the establishment of categorical and broader objectives. The following examples are illustrative of the range and kinds of committee activities.

* Committees have stimulated or developed over 400 projects and have reviewed over 1700 projects in 48 regions, with 690 (57%) of those reviewed being recommended for approval to their Regional Advisory Groups. Related activities, for example, have included:

  - The Bi-State RMP has developed a suggested protocol for project development which encourages the involvement as early as possible of the appropriate categorical committee in the form of an ad hoc planning group with the individuals or institutions which express initiative.

  - The Northlands RMP Education Committee has developed a comprehensive review form for projects which reflects their policy statement.

* In 44 regions committees collect data about the health needs and resources of the regions as a preliminary to establishing goals and priorities. For example:

  - The Greater Delaware Valley RMP Data Analysis and Monitoring Committee has compiled statistics on health manpower, facilities and vital statistics in the form of The Greater Delaware Valley RMP Fact Book.

  - The Indiana RMP Regional Characteristic Committee has compiled a health data bank for use in regional planning.

* Committees have established categorical and broader objectives and priorities in 48 regions. For example, the Illinois RMP Cancer Committee, in addition to establishing objectives, has translated these objectives into a system for evaluating projects by weighing the type of project and the type of cancer according to their established priorities.

* Thirteen regions have committees which are specifically designated to develop regional program objectives and priorities. The Nebraska-South Dakota RMP Planning Committee, for example, has developed overall program goals and priorities as well as determining a rating system for priority assessment of projects.

* Committees report performing coordination and liaison functions in 49 regions. Such work is often the first step in forming cooperative arrangements and has also produced a number of other significant results. For example:

  - The New Jersey RMP Urban Health Task Force, working with the Model Cities Program, has an elected citizens' health panel, and has provided that each model city will have a health planner and an elected citizens' health panel, and has instituted the requirement that consumers be represented in policy formation and review of ambulatory care services in three major urban ghetto hospitals.

  - In Susquehanna Valley three hospitals, as a result of their involvement with various committees of the RMP, went out on their own and planned and established a community Mental Health Facility, raising some funds on their own and receiving funds from sources other than RMP.

  - The Greater Delaware Valley RMP Kidney Committee, through close liaison with the local chapter of the Kidney Foundation, has succeeded in getting legislation for patient care either introduced or passed in the Pennsylvania, Delaware, and New Jersey state legislatures.

  - Many regions report that the largely "neutral" and "non-Federal" nature of RMP committees is appealing, and the access to, or voice in the disbursement of Federal dollars acts as an inducement to cooperation with a minimal compromise of interests.

* Technical review of projects and technical consultation is provided by committees in 32 regions. For example, the Ohio State RMP Stroke Task Force has a consultant committee which applies current technical knowledge to the review of projects.

* Committees in 13 regions have set specific standards and guidelines for facilities, projects, and institutions participating in their programs.

  . In the Central New York RMP the Cancer Committee and the Ad Hoc Committee on Radiotherapy established principles for the use of cobalt in different hospitals.

  . Categorical committees of the Greater Delaware Valley RMP have set specific standards and guidelines for model acute care demonstration unit of several kinds which are included in project proposals.

* Committees in 22 regions evaluate ongoing projects and programs after goals and priorities have been set and operational activities are underway. For example:

  . The Nebraska-South Dakota RMP has develped a formalized rating system to determine a project's accomplishments of goals.

  . The California RMP Coronary Care Unit Coordinating Committee, through contract with the Rand Corporation, has developed a uniform data collection system which serves as the basis for ongoing evaluation of CCU's. Their system is beginning to be used by CCU experts in other regions.

* Committees have conducted a variety of studies in at least 15 regions. Many of these studies are concerned with solutions to various health and planning problems. The Greater Delaware Valley RMP Cancer Committee, for example, prepared studies on the diagnosis and treatment of cancer of the cervix which have become the basis for a pilot program involving a low-income population.

Explanation and Comments

This analysis includes only those committee activities and accomplishments which the regions mention. It is quite possible that committees perform many functions that the regions have not mentioned in their answers. For this reason, and because it is based on narrative answers, the quantification of committee function tends to be somewhat arbitrary, and it is intended only to give an idea of the relative extent of various committee functions.

Questionnaire Reference: II.F. 3,4.

Analyst: Ann Stone

LOCAL AND AREA ADVISORY GROUPS

Local and area advisory groups act as local interpreters of program objectives to their communities in 27 regions with a total of 4843 members in the 335 advisory groups. These groups have the most local input into the planning process; they assist in project development and implementation and do much cooperative planning and coordination of activities with CHP 314 "b" agencies. These groups seem to be organized locally on the basis of hospitals, population or medical trade areas rather than medical schools. With 29% hospital-affiliated representatives and 15% public or consumer representation they are community-oriented and play a major role in determining local priorities for program activities according to the local needs.

Highlights

Local and area advisory groups handle a broad spectrum of RMP activities at the local level from setting priorities, program and project planning and development, coordination of community health activities to preliminary project review. The organization and membership of these advisory groups is indicative of their local orientation.

* There are 335 LAG's (or AAG's) in 27 regions with a total membership of 4843, and an average of 8 LAG's per region (excluding Georgia which has 129 LAG's). 21 regions have 10 or less LAG's. LAG's have an average of 21 members and have met approximately 5 times.

* LAG's are most frequently organized on the basis of population or medical trade areas. Some are organized according to hospital areas and to local medical societies. Very few LAG's are organized geographically with respect to medical schools.

* Institutional representation on LAG's indicates community orientation with 29% hospital representation, 19% health practitioners and 15% public or consumer representation. Physicians are the largest professional grouping represented on LAG's with 41% of the total membership.

The role of local advisory groups is reflected by their activities and accomplishments.

* The regions report that, by providing a common meeting ground, LAG's have been an effective means for implementing cooperation between institutions and professions for the improvement of health care at the local level.

* By assessing local needs and resources LAG's determine local priorities for program activities.
  - In the Georgia RMP the LAG's from five hospitals in the Augusta area have agreed upon establishing an independently-operated cancer facility to serve all hospitals in the area. The LAG's have decided upon this facility as the best means of meeting the needs for cancer care in the area.

* LAG's assist in planning and developing project proposals and with the preliminary review of locally-initiated proposals. They also assist in implementing projects or components of projects at the local level.
  - In the Colorado-Wyoming RMP the Pueblo Action Group has worked with the community to design a project proposal aimed at improving the delivery of health care services to disadvantaged Chicanos. This project has taken the form of a health care delivery system utilizing "home care" as the basic structural unit.

* LAG's do a great deal of cooperative planning and coordination with CHP 314 "b" agencies. In many cases the LAG and the CHP areawide health planning group are the same body, and the relationship with the 314 "b" agencies almost always includes overlapping membership and sharing of health information and data.
  - Three LAG's in the Western New York RMP have organized themselves in such a manner to allow them to serve as a planning and review committee for both the RMP and the CHP group in the region.
  - In the Oklahoma RMP the Ada LAG and the CHP group (in the Southern Oklahoma Development area) are jointly engaged in a Community Stroke Planning Program where the community involved includes six hospitals in five counties.

* Local advisory groups are often the site for coordination of efforts between regions where they intersect locally.
  - An Intermountain RMP LAG planned a workshop held in Reno, Nevada which was directed toward improving coordination between the Intermountain, Mountain States and California RMP's in the Reno area.

Explanation and Comments

The distinction between local and area advisory groups is very hazy and the functions of the two groups seem very similar, if not identical. For this reason and because the reported incidence of the "area" groups is limited to a very few (6) regions, the two groups have been treated here as the same and for the most part can be considered to be local advisory groups.

There also seemed to be some confusion between local advisory groups and subregions. Although most (80%) of the regions consider LAG's to be the group concerned with the subregional geographic area, there seemed to be another distinction in that LAG's work through voluntary participation and the subregions have core staff field offices.

The most interesting thing about the LAG structural data is the vast range in the numbers and sizes of groups and their organizational bases. The question concerning the percentage of the population encompassed by the local groups was apparently misinterpreted by a number of regions and thus is probably inconclusive.

Questionnaire Reference: II.C.1-9 and II.G.1-9

Analyst: Ann Stone

Supporting Tables

Table 1: Local Advisory Group Composition by Profession

Kind	Number	Percent
Physicians	2000	41%
Registered Nurses	445	9%
Hospital Administrators	672	14%
Other Health	227	5%
Business or Managerial	522	11%
Other	996	20%
Total	4843	100%

Table 2: Local Advisory Group Composition by Affiliation

Kind	Number	Percent
Medical Schools	75	2%
Affiliated Hospitals	452	9%
Other Hospital Interests	954	20%
Medical Society	401	8%
Public and Other Health Agencies	500	10%
Voluntary Health Agencies	349	7%
Health Practitioners	904	19%
Public or Consumer	723	15%
All Other	485	10%
Total	4843	100%

Table 3: Organizational or Geographic Base of Local Advisory Groups

Organizational or Geographic Base	Number of Regions 1/
Population or Medical Trade Areas	18
Hospitals	8
Local Medical Societies	4
Medical Schools	3
Other	7

1/ Some regions have more than one basis for organizing LAG's; thus the number of regions does not add to 27.

Table 4: Distribution of Number of Local Advisory Groups per Region

Number of LAG's	Number of Regions
1 - 5	11
6 - 10	10
11 - 15	1
16 - 20	0
21 - 25	1
Over 25	2*

* Alabama has 45 LAG's and Georgia has 129 LAG's

January 1970

CORE STAFF ORGANIZATION, SIZE AND COMPOSITION

The diversified organizational structure, composition and size of the 55 Core staffs are reflective of the varying Regional approaches to dealing with local needs and problems. Some of the 1400 full-time equivalent Core staff members are organized primarily around the categorical diseases (e.g., Associate Directors for Heart, Cancer and Stroke), while others are organized along functional lines (e.g., Associate Directors for Community and/or Hospital Relations, Manpower Development, etc.). In addition to the central staff, several Regions have established subregional and/or institutional staffs (the latter usually located at medical schools) to facilitate and augment the efforts of local communities and RMP affiliated institutions in the planning and development of Regional Medical Programs. Core staffs range considerably in size from the smallest which are 2 and 12, to 135, the largest (California).

Profession	Nos. FTEs	Percent of Total
Physicians	218	16
Registered Nurses	66	5
Allied Health/Hospital Administration	50	3
Other Health Related	61	5
Education Specialists	42	3
Administrative/Fiscal	131	10
Other Professional/Technical	277	20
Secretarial/Clerical	518	38
TOTAL	1,363	100

Highlights

Core staffs have grown from about 100 staff members in December 1966 to over 1600 in June 1969. These 1600 people comprise the 1363 FTEs noted above. Of particular interest are the following:

* The average Core staff has 23 FTEs (27 people). About one-third of the Regions have less than 20 people for the Core, while another one-fifth have over 40 people. About 70% of the staff are full-time and 30% are part-time.

* All but one Region (Susquehanna Valley) has a physician on its Core staff. Most physicians serve on a part-time basis, while most of the other professionals -- nurses, hospital administrators, education specialists, etc. serve on a full-time basis.

* About 13 Regions have no RNs, 30 have no hospital administrators, 24 have no education specialists, and 34 have no allied health person.

* About 72% of the staff are located in the central core office, while 21% are institutionally based (e.g. in co-sponsoring medical schools, hospital councils etc.) and 7% serve as field or subregional staff.

Explanation and Comments

Two occupational categories used in the Questionnaire "Other Professional" and "Administrative/Fiscal" carry 30% of the staffing reflected here. The former group may include some of the "generalists" who are dealing with the broader problems of building relationships with other agencies and institutions. For indeed, there does seem to be a trend toward using "non-health" generalists for these types of activities, thus limiting the effectiveness of using the traditional health occupational categories to gain insights into core staffing arrangements. For example, several Regions are using such people as lawyers, former pharmaceutical detail men, and others with more general backgrounds to handle management problems and community and institutional relationships.

Questionnaire Reference: II.H.1&4.

Analyst: Rhoda Abrams

SUPPORTING TABLES

TABLE 1 - Locale of FTE Core Staff Members

Profession	Total	Central	Institutional	Field
TOTAL	1,363	993 (72%)	271 (21%)	99 (7%)
Physicians	218	131	64	23
Registered Nurses	66	45	14	7
Allied Health/Hospital Adm.	50	40	7	3
Other Health Related	61	50	7	4
Education Specialists	42	23	16	3
Administrative/Fiscal	131	113	14	4
Secretarial/Clerical	518	370	109	39
Other	277	221	40	16

TABLE 2 - Full-time/Part-time Breakdown

Profession	Total	%	Full-time	Part-time
TOTAL	1,625	100	1,122	503
Physicians	349	21	122	227
Registered Nurses	74	5	58	16
Allied Health/Hospital Adm.	60	4	46	14
Other Health Related	77	5	52	25
Education Specialists	42	2	30	12
Administrative/Fiscal	148	9	117	31
Secretarial/Clerical	569	35	467	102
Other	306	19	230	76

January 1970

CONSULTANT/BROKER/FACILITATOR ROLE OF CORE STAFF

Two of the more significant, and increasingly visible, functions of the Core staffs are those of (1) providing consultant or professional services to local institutions and (2) serving as a facilitator or convenor of multiple interest groups to solve local problems. Regions varied considerably in the emphasis given to these functions. Generally these were activities not requiring RMP operational project funds, and very often, the RMPs assisted organizations in obtaining funds from other sources.

Highlights

* 46 Regions provided anecdotes on the RMP core staff serving as a consultant and technical resource in the Region. One Region even described one of its major accomplishments as creating a "health identity."

* About 18 Regions reported anecdotes on technical assistance and brokerage functions related to hospitals and hospital associations. These ranged from assisting in the merger of hospitals to developing joint hospital services and specific clinical facilities.

* 22 Regions reported anecdotes on the core staff serving as broker/facilitator in getting other groups to come together to plan or implement activities -- generally not related to RMP funded operational project activities.

* 11 Regions reported on how the core staff facilitated the creation of new coordinating councils, most of which related to improving the planning and organization of regional health education programs.

* A few Regions reported accomplishments related to affecting the behavior of other organizations.

Discussion

A. Serving as a Technical Resource or Consultant

Forty-six Regions reported examples or anecdotes of core staff serving as a technical resource and as providing consultation services to health organizations such as hospitals, CHP, educational institutions, Model Cities, OEO and others. This appears to be one of the major areas of activity for the core staff, although some Regions appear to be more heavily involved in this area than in others. For example, North Carolina reports that "this type of activity has consumed an increasing percentage of the time of RMP core staff members, . . . about 15%."

1. Hospitals

Maine: The core staff is "heavily involved in assisting an area of this region in which two towns have decided to build one joint hospital. There exists in each locality a small inefficient, acute unit at the

present time. Regional Medical Programsis in effect managing their total planning program which includes the acute care of the patient with heart disease, cancer, and stroke, the concept of progressive patient care, methods of patient flow and referral, new methods of construction, new methods of payment, and all the elements that go into a future health care setup. This is being done in cooperation with the hospital planning boards, the 314b agency of the area with anticipated assistance from, in part, Regional Medical Program, and other assistance from the National Center of Health Services Research and Development."

2. Hospital Associations
Washington/Alaska, Intermountain, Iowa, Colorado-Wyoming and other Regions reported instances of providing assistance to state hospital associations.

3. Consultation to Comprehensive Health Planning
About eleven Regions reported examples of providing consultation services to CHP agencies -- both A&B. Consultation ranged from providing data collection designs and services to helping to develop (B) applications.

4. Educational Consultations
This is one of the most active areas of core staff consultation services. Activities ranged from serving as a resource on curricula development to the broader areas of planning for manpower development and cooperative regional educational programs.

Connecticut: "To insure cooperative planning at the state level for expanding allied health manpower requirements, the CRMP staff serves as official consultants to the Connecticut Commission on Higher Education which is responsible for coordinating all post-high school educational planning. This has placed CRMP staff in position to offer assistance in such areas as distribution of educational facilities, health occupation curricula, financing and affiliations between educational and clinical facilities and accreditation. At the Health Service Area level, CRMP staff serve as a technical resource to a multi-agency group exploring development of an educational consortium for health occupation education."

5. Model Cities and OEO
Cited by about 10 Regions were technical services to Model Cities, OEO and related agencies. The types of services and resources provided ranged from assisting in the development of a grant application to providing educational and other specialized resources.

New Jersey: "The Urban Health Coordinator for Newark developed an application, which was funded, for the establishment of a Health Services Research Unit for the City of Newark. This unit of three technical specialists in health planning will serve as a pilot demonstration for health component planning for Model Cities throughout the country. The Urban Health Coordinator assigned to Hoboken was instrumental in developing cooperative arrangements necessary to finance and conduct a household survey of Model Neighborhood residents' opinions on the health care they received. Involved were the Department of Community Affairs, the local Model Cities agency and Opinion Research Corporation of Princeton which carried out the survey. RMP staff contributed to questionnaire design and construction. Also, the Urban Health Coordinator arranged for the recruitment and training of Model Neighborhood residents and interviewers."

B. Facilitating Cooperative Planning and Other Activities Among Other Organizations and Groups

About 22 Regions reported anecdotes reflecting this type of activity. Activities included:

1. Facilitating creation of new community coordinating councils.
2. Bringing organizations together for cooperative planning or specific problem solving.
3. Influencing the decision and/or behavior patterns of particular groups and organizations.

These efforts were aimed at problems ranging from general health planning to regional manpower problems, institutional problems, regional laboratory services, and the like.

1. New, Coordinating Councils

Eleven Regions reported anecdotes on how they facilitated the creation of new councils. Often these were concerned with regional educatinal problems, but other areas cited included inner city problems and cardiovascular services.

Louisiana: "LRMP assumed the position that it should deal with institutions as a single entity on matters that related to the Medical Center as a whole. The Director, therefore, informed the three institutions of this approach. A committee was formed to act as the primary contact between the Medical Center and LRMP. Representatives began to discuss the problems confronting the Center in relationship to the RMP. It became quite evident that by working together, they could more effectively approach those non-RMP related issues as well and that it would be most desirable to have representatives from the top-most decision making bodies combine their efforts in devising a means to plan future activities together, while preserving their individual autonomy. In addition, representatives from the Board of Directors of Charity Hospital met with these groups to discuss this approach. They jointly agreed to petition the State to establish the "Health

Education Authority of Louisiana" to serve as a means for jointly planning the future growth of the Medical Center. The legislature responded enthusiastically and passed the enabling act. HEAL is now a budding reality. Although HEAL came about through the efforts of many, many health professionals, civic leaders, lawmakers, etc., we cannot help but feel a certain degree of paternal pride since the effort began as an attempt at cooperation among these institutions for the purpose of participating in the Regional Medical Program."

In North Carolina, a hospital commission has been developed on a seven county basis, and in Oregon, a Portland Cardiology Council was formed. Indiana helped organize an inner city council.

2. Affecting the Decision and/or Behavior of Other Institutions

In Northlands, the involvement of University Continuing Education faculty in the Education Committee of NRMP has resulted in their taking an entirely new look at their relationships with peripheral areas, and in planning cooperative educational efforts to involve other organized health interest groups. This relationship may also lead to use of some Core personnel within the University to participate in the revision of core curricula for medical students, which is felt to be fundamental to achieving success in continuation education.

Connecticut: The development of a radiation-therapy unit with a state institution in a peripheral area of the region provided CRMP staff an opportunity of cooperating with Connecticut Hospital Planning Commission, Hill-Burton Agency, State Health Department, Yale Medical School and two general hospitals to design the arrangements for patient care services so that it could function as a subregional center thus avoiding construction of similar facility in a neighboring community hospital.

Questionnaire Reference: II.H.7.

Analyst: Rhoda Abrams

January 1970

PLANNING AND FEASIBILITY STUDIES

A total of 922 planning and feasibility studies have been completed, are underway, or proposed by the 55 regions. These studies fall into the following areas or patterns of emphasis:

Types of Study	TOTAL	Completed	In Process	Proposed
	922	344	417	161
Manpower and Training:	252	112	104	36
Physician manpower	(53)	(28)	(19)	(6)
Nursing manpower	(56)	(27)	(24)	(5)
Other health manpower	(57)	(24)	(26)	(7)
Continuing education	(86)	(33)	(35)	(18)
Services and Facilities:	194	81	83	30
Coronary care services and facilities	(69)	(34)	(29)	(6)
Other clinical services and facilities	(77)	(27)	(35)	(15)
Medical library resources	(48)	(20)	(19)	(9)
Medical Demographic/Socio-economic:	373	123	175	75
Patient origin/referral	(47)	(17)	(24)	(6)
* Disease patterns	(185)	(67)	(87)	(31)
Transportation and emergency care patterns	(34)	(8)	(15)	(11)
Communication patterns	(31)	(7)	(15)	(9)
Demographic	(55)	(22)	(24)	(9)
Health care costs/financing	(21)	(2)	(10)	(9)
Other	103	28	55	20

* About evenly divided among heart disease, cancer and stroke.

Highlights

There has been a high concentration of studies in certain areas of interest; namely, disease patterns (185), continuing education (86), and other clinical services and facilities (77). This probably reflects the program's early emphasis on the categorical diseases and continuing education.

Other highlights of these planning and feasibility studies include:

* Health care costs and financing (21), communication patterns (31), and transportation and emergency care patterns (34) were among the least studied areas. It appears, however, that health care costs and financing may be an area of increased interest at this time. For while only two such studies have been completed, an additional 19 are either underway or proposed.

* Studies of smoking and health, health care of the poor, legal barriers to innovation in medicine, long-term care and home health care are among those in the "other" category.

As to the relationship of these planning and feasibility studies to operational projects, some 195 projects were identified as having been developed because of a planning study. These were concentrated in the areas of services and facilities (63) and manpower and continuing education (64). Examples of how planning and feasibility studies have led directly to operational projects include the following:

* In Bi-State, a radiation therapy planning study pointed up the need for radiotherapy consultation and a shortage of radiation therapy technicians. This led to the development of a funded project for Telecopier Communication Networks and Training Programs for Technicians.

* In Indiana, there was an initial feasibility study of a multiphasic screening program in which 1300 cases were processed. This allowed them to "shake down" the screening process and educate the screening technicians. This preliminary work led to the development of the Multiphasic Screening Program in Indianapolis, which plans to screen 30,000 within three years.

* In New Jersey, a statewide survey was conducted to determine the present facilities and manpower training programs existing and proposed for coronary care and intensive care units. The results of this survey were used in the development of three coronary care nurse training proposals which have been funded and are now operating.

* In Northwestern Ohio, the preliminary success of a campaign to discourage smoking in Toledo led to an operational project funding an expanded effort.

Many feasibility studies proved useful even though they did not lead to operational projects. In Louisiana, for example, a study on the availability and distribution of health personnel has been used in the delineation of health care regions within that State and should facilitate more effective health care planning at both the local and State levels. In New Jersey, a heart screening survey was undertaken as a feasibility study in Newark. Working with the Model Cities agency, screening procedures were conducted on over 850 persons at three mobile trailer locations during a period of seven working days. Participants from the model neighborhoods acted as interviewers and were trained as technicians for the survey.

Some of the projects which were developed out of planning studies are currently being funded by other agencies and institutions in the regions. For example:

* A study of stroke care in Tulsa, Oklahoma, led to the formation of the Hillcrest Hospital "Stroke Team," non-RMP funded.

* In Albany, an operational proposal resulting from a planning study is being funded by the National Library of Medicine.

* In Arizona, two projects were funded from other sources -

  (1) One-day workshop in Phoenix to demonstrate uses of TV in continuing education.

  (2) Three-day workshop at Cochise College for the training of Inhalation Therapy personnel.

* A regional rehabilitation center in Nashville, Tennessee, received planning support from the Tennessee Mid-South RMP.

Explanation and Comments

Planning studies are generally viewed as aiming at a broad program area, such as the manpower and facilities resources in a region, the adequacy of and need for specialized clinical facilities, disease and patient referral patterns, and unmet educational needs. Feasibility studies, on the other hand, are usually aimed at assessing the workability and utility of particular program elements. This might include assessing the effectiveness of telephone, radio and television networks in linking community hospitals to university medical centers, or exploring various methods of patient care demonstrations.

Questionnaire Reference: III A.1. and 2.

Analyst: Lyman Van Nostrand

January 1970

PARTICIPATION IN RMP PLANNING AND DECISION-MAKING

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

Kind of Participant Institution or Organization	Number Represented	Per Cent of Total
Educational Institutions, including Medical Schools	638	10
Medical Societies, State and Local	761	11
Nursing, Dental, and Other Health Professions Groups	546	8
Voluntary Health Agencies	721	11
Health Planning and Related Agencies	790	12
Hospitals and Other Care Institutions	2,621	39
Others, Largely Non-health	642	9
TOTAL	6,719	100%

Highlights

Regional planning and decision-making have involved a large number and broad spectrum of health institutions and organizations, particularly from the private and voluntary sectors. Specifically, representatives of:

* Every state medical society, hospital association, heart association, and cancer society, as well as many local chapters of the state organizations.

* Almost one-third of the nation's hospitals (2056) and about 60% (565) of its extended care facilities.

* All state health departments and over 200 city and county health departments.

* Almost all state Comprehensive Health Planning agencies and 126 areawide ones.

* 42 local OEO and 48 Model Cities programs.

* All (104) medical schools, all schools of public health and 44 of the 56 dental schools in the U.S.

Explanation and Comments

Active involvement in regional planning and decision-making is defined to include (1) having representation on the regional advisory group, categorical or planning committee; (2) conducting or administering planning studies or

sharing in the funding of such studies; (3) providing consultative services; (4) acting as advisory or clearance body for the region; and/or (5) otherwise making a substantial contribution to planning or decision-making.

In the analysis of this question every effort has been made to eliminate duplications of institution/organization listings between the various regions. In areas where there are overlapping regional boundaries, often representatives of the same institution will serve on planning bodies in more than one region. Likewise, some institutions administer studies, provide consultant services and perform various other functions in 2 or more regions. In every instance where feasible, duplication was noted and the figures adjusted accordingly.

In some cases, however, it was impossible to pinpoint duplications between the regions, so some of the figures appearing here may be slightly overstated.

Questionnaire Reference: III. A. 9.

Analyst: Joan Ensor

SUPPORTING TABLES

Table 1: Educational Institutions Participating

Kind	Number	Percent
Medical Schools	104	17
Nursing Schools	183	29
Dental Schools	44	7
Schools of Public Health	16	2
Schools of Education	101	16
Community and Junior Colleges	97	15
All other	93	14
TOTAL	638	100

Table 2: Medical Societies and Physicians' Groups Participating

Kind	Number	Percent
State Medical Societies	52	7
State Osteopathic Societies	45	6
County/local Medical Societies	530	70
American Academy of General Practice	45	6
All other	89	11
TOTAL	761	100

Table 3: Nursing, Dental, and other Health Professional Groups Participating

Kind	Number	Percent
State and Local Nursing Associations	151	28
State and Local Dental Associations	83	15
State Hospital Associations	52	9
Local Hospital Associations	71	13
All others	189	35
TOTAL	546	100

Table 4: Voluntary Health Agencies Participating

Kind	Number	Percent
State Heart Associations	52	7
State Cancer Societies	52	7
Local Heart Associations	190	26
Local Cancer Societies	184	26
All others	243	34
TOTAL	721	100

SUPPORTING TABLES (continued)

Table 5: Health Planning and Related Agencies Participating

Kind	Number	Percent
State Health Departments	52	7
City/County Health Departments	223	28
State 314(a) Health Planning Agencies	51	7
Areawide 314(b) Health Planning Agencies	126	16
Regional Health and Hospital Councils	86	11
OEO Programs	42	5
Model Cities Programs	48	6
All Others	162	20
TOTAL	790	100

Table 6: Hospitals and other Care Institutions Participating

Kind	Number	Percent
Short-term, Non-Federal Hospitals	1923	73
VA and Other Short-term Federal Hospitals	133	5
Nursing Homes and Extended Care Facilities	565	22
TOTAL	2621	100

Table 7: Other Institutions and Organizations Participating

Kind	Number	Percent
Insurance Companies	77	12
Labor Unions	73	11
Private Profit-making Companies	115	18
Non-profit Institutions	79	12
All Other	298	47
TOTAL	642	100

January 1970

REGIONAL REVIEW AND APPROVAL PROCESS

Regional Advisory Groups must review and act upon all operational proposals. Only those favorably recommended or approved may be included in the regions' grant requests.

The fact that slightly less than two-thirds of the proposed operational projects or activities presented to advisory groups have been approved by them -- 1021 out of a total of 1553 -- is evidence that this regional authority and responsibility is being exercised in a critical, rather than mere rubber-stamp fashion.

		Disposition							
		Approved		Disapproved		Ret'd for	Defer-	Ref'rd Other Sources	Pend-
	Total	No.	%	No.	%	Revis.	red	Support	ing
RAG	1553	1021	66%	251	16%	110	84	25	62
Categorical & Other Plg. & Review Grps.	1508	858	54%	273	18%	189	147	11	133
Others:									
Executive Cmtes.	777	477	61%	140	18%	71	31	2	56
Bds. Directors	229	153	67%	26	11%	26	11	2	11
Local & Area Adv. Groups	268	197	74%	28	10%	15	4	3	21
All Others	696	419	60%	80	11%	64	70	18	45

Highlights

Most regions (45) have, in addition to their Regional Advisory Groups, a series of categorical and other planning and review committees to assist with the review of operational proposals. These committees generally review and evaluate proposed operational projects and activities for their technical or substantive merit prior to final action by the advisory groups. Far less frequently, other organizational components of the regions, such as executive committees (28), boards of directors of new corporations (10), and local or area advisory groups (21) also may be involved.

Other highlights of the regional review and approval process are as follows:

* A total of 468 of the 1021 operational projects approved at the regional level, or almost one-half, are now being carried out by regions.

* Another 286, or roughly one-fourth, were pending review and action at the Federal level.

* Twenty (20) regions had referred projects to other sources for funding. In general, these referrals were to universities, state health departments, local heart associations, and the Division of Manpower Training and Development. For the most part, such referrals were made because the projects did not fall within the RMP Guidelines.

* In addition to recommending approval, proposals have been deferred, returned for revision, or were pending, as well as having been disapproved or referred to other sources of support.

Explanation and Comments

Fifty-three (53) of the 55 regions had had operational proposals presented to, and acted upon by, their Regional Advisory Groups as of June 30, 1969, even though only 41 had operational awards as of that date. Nassau-Suffolk and Northeast Ohio were the two exceptions.

The "Total" column in the above table reflects the total number of proposals reviewed. These totals reflect considerable overlap, since several groups may review the same proposals.

The figures in this review, such as the number of ongoing projects, the number of regions having a board of directors, etc., are those which were submitted by the region. However, these figures differ slightly from those used and compiled by RMPS.

Questionnaire Reference: III. D. 1.

Analyst: Lawrence M. Witte

January 1970

SPONSORSHIP OF OPERATIONAL PROJECTS

Sponsorship of operational projects is an important aspect of institutional participation in RMP-funded operational activities, since it entails overall administrative responsibility for the conduct and operation of a project often including the disbursing of project funds. The breakdown of institutional sponsorship of the 386 projects in the 39 operational regions is as follows:

Type of Sponsoring Institution	Number	Percent
Medical and Other Health Professional Schools	62	21
Hospitals	163	54
Voluntary Health Agencies	21	7
Others	54	18
TOTAL	300	100

Highlights

The sponsorship of operational projects takes various forms. One type of sponsorship is that of a single institution being responsible for the administration of the project and also serving as the actual site or location of the project. Another type of sponsorship is the case of one institution having administrative responsibility but with the project actually being carried out by another institution. The great majority of projects, 331 (or 88%), have single institution sponsorship. In the remainder, 55 (or 12%), several institutions jointly administer a project. Some concrete examples of these various forms of project sponsorship are:

* An example of a single institution sponsoring a project and also being the location of the project is the Training Program in Reality Orientation Technique project in the Alabama RMP. This project is sponsored by the Veterans Administration Hospital in Tuscaloosa, Alabama and all of the project activities are carried out at the Veterans Administration Hospital.

* An example of one institution sponsoring a project but the activity taking place at other institutions is the Statewide Program in External Cardiopulmonary Resuscitation project in the New Jersey RMP. This project is sponsored by the New Jersey Heart Association but the project is actually located in four major hospitals in New Jersey.

* 55 projects (12%) are sponsored by more than one institution. An example of several institutions having administrative responsibility for one project is the Training Unit for Intensive Care of The Cardiac Patient project in the Missouri RMP. This project is sponsored by the University of Missouri Medical Center, the University of Missouri School of Nursing and the Extension Division of the University of Missouri. Moreover, the

project is being carried out in close cooperation with the Missouri Hospital Association, Missouri State Medical Association, Missouri Heart Association and the Missouri Osteopathic Association.

Explanation and Comments

As already mentioned, project sponsorship should be considered as an important type of institutional participation. The distinguishing factor between a sponsor and a participant is that the sponsor is responsible to the Regional Medical Program for administration of the project and the participant does not have this responsibility. Unfortunately, there is no universally accepted definition of project sponsorship with the result that what is a sponsor in one region may be only a participant in another region. Therefore, the number of sponsors may be greater than what is reported in this analysis.

The category "others" includes a wide variety of institutions with state and local health departments, medical societies and hospital associations making up the largest segment.

Questionnaire Reference: IV, B. 5.

Analyst: Stephen Bell

January 1970

PARTICIPATION IN RMP OPERATIONAL PROJECTS

Approximately 2400 hospitals, medical schools, and other health institutions and organizations are participating in RMP-funded operational activities and projects in 39 regions. Such participation is one gross index of cooperation among the diverse health elements in the region and the community. The breakdown by type of organization and type of participation is as follows:

Kind of Participant Institution/Organization	Number	Percent	Type Participation (#) Primary	Secondary
Medical Schools & Other Educational Institutions	181	7	114	98
Medical Societies and Health Professional Groups	70	3	38	58
Voluntary Health Agencies	45	2	26	27
Health Departments, State and Local	67	3	40	54
Hospitals and Other Care Institutions	1855	78	1040	1478
Other	173	7	81	115
TOTAL	2391	100	1339	1830

Highlights

Not surprisingly, hospitals and other care institutions (including nursing homes and extended care facilities) constitute the largest single category of participating institutions and organizations, nearly four-fifths of the total. It is interesting to note in the way of comparison that hospitals account for only 39% of the total participation in RMP planning and decision-making. Other highlights include:

* In comparing types of participation, one finding worthy of note is that only in the category of medical schools and other educational institutions is there more primary than secondary participation. (See following "Explanations and Comments" for definition of these two categories). This indicates that medical schools are in most regions still a primary center of RMP activity.

* Six separate instituions or organizations were, on the average, participating in each of the 378 operational projects in the 39 regions. Some instances of institutional cooperation and coordination are illustrated by the projects cited below:

  . A project of the North Carolina RMP deals with the development of the coronary care unit and training of nurses in its operation. It is a good example of cooperation among different types of institutions and organizations; sponsored by the state heart association, the

project is carried out by a university-affiliated medical center, two medical schools, six short-term, non-Federal hospitals, and one Veterans' Administration hospital.

- A project to combat smoking in the Oklahoma region is sponsored by the state chapter of the American Cancer Society and involves eleven other organizations including the state heart association, the state tuberculosis and respiratory disease association, the state medical society, the state departments of health, welfare and Indian health, the Oklahoma School of Public Health, the state nurses' association, the state division of the American Association for Health, Physical Education and Recreation, and two state teachers' associations.

- The Albany RMP has initiated a project concerned with linkage of area hospitals by a two-way radio system and the education and training conducted through the system. This project, sponsored by the Albany Medical College, has so far involved 49 short-term and two VA hospitals in five states.

- Another North Carolina project, entitled "Diabetic Consultation and Education Services," has involved participation by 9 organizations -- 3 medical schools, 4 hospitals, the state diabetes association, and the Carolinas Camp for Diabetic Children. All of these are coordinating their efforts for education and medical service for the diabetic patient.

Explanation and Comments

This analysis is based on 378 projects reported by 39 regions. Although 41 regions are now operational, two of these (Maryland and Mississippi) have become operational too recently to supply any valid data on participation.

Primary participation is defined as either 1) serving as the location of all or part of a project; 2) sponsoring a project, i.e., having overall administrative responsibility for the project; or 3) receiving RMP funds. Secondary participation includes all other capacities in which an institution might serve - most notably, having its personnel trained, providing consultation or teaching staffs, or supplying various services and/or facilities. There are necessarily duplications between primary and secondary participation as listed in the preceding table since many institutions and organizations are involved in both types of participation.

Questionnaire Reference: IV.B.12

Analyst: Joan Ensor

Regions: 39

Supporting Tables

Table 1. Educational Institutions Participating

Type of Institution	Number Participating	Percent Total	Type of Participation Primary	Secondary
Medical Schools	54	30	42	32
Nursing Schools (RN & LPN)	30	16	7	12
Schools of Dentistry	3	2	2	1
Junior Colleges	17	9	14	10
Vocational/Technical Schools	12	7	2	9
Other Universities and Colleges	65	36	47	36
TOTALS	181	100	114	98

Table 2. Medical Societies and Health Professional Groups Participating

Type of Group	Number Participating	Percent Total	Type of Participation Primary	Secondary
State Medical Society	9	13	3	8
Local Medical Society	19	26	12	18
Osteopathic Society	2	3	1	1
Other Medical Society	4	6	1	4
Hospital Associations	8	12	5	6
Other Health Professional Associations	28	40	16	21
TOTALS	70	100	38	58

Table 3. Voluntary Health Agencies Participating

Type of Agency	Number Participating	Percent Total	Type of Participation Primary	Secondary
State Heart Association	18	40	14	8
County Heart Association	4	9	4	0
State Cancer Society	11	24	3	9
County Cancer Society	1	3	1	0
Other	11	24	4	10
TOTALS	45	100	26	27

Table 4. Health Departments Participating

Type	Number Participating	Percent Total	Type of Participation Primary	Secondary
State	18	27	11	10
Local	49	73	29	44
TOTALS	67	100	40	54

Table 5. Hospitals and Other Care Institutions Participating

Type of Institution	Number Participating	Percent Total	Type of Participation Primary	Secondary
Short-term, non-Federal	1638	88	990	1276
VA	39	2	19	37
USPHS	14	1	10	12
Military	15	1	5	11
Other Federal	3		1	2
Nursing Home and Extended Care Facilities	146	8	15	140
TOTALS	1855	100	1040	1478

Table 6. Others Participating

Type	Number Participating	Percent Total	Type of Participation Primary	Secondary
Local/State Government Department/Agencies	78	45	9	73
Health Planning Agencies	12	7	8	5
Libraries	15	9	12	2
Federal Government	6	3	2	5
Non-Profit Foundations	14	8	13	6
Other	48	28	37	24
TOTALS	173	100	81	115

January 1970

OPERATIONAL ACTIVITIES -- IMPACT ON PATIENT CARE

RMP-funded operational projects and activities have directly affected about 142,000 persons through patient care services. The primary type of service provided has been screening, affecting 113,000 persons. A breakdown by disease category follows:

	Total No. Affected	% Total	Number Screened	% Screened
Heart Disease	26,512	19	11,066	42
Cancer	51,875	36	45,939	89
Stroke	1,646	1	1,032	63
Pulmonary Disease	22,553	16	21,656	96
Related Disease	2,978	2	2,855	96
Multicategorical/ non-specific	36,803	26	30,652*	83
TOTAL	142,367	100	113,200	80

* Multiphasic Screening

Highlights

* About 12,000 patients have been treated in coronary care units sponsored by the various regional medical programs. This represents the largest single group of persons treated for a particular disease.

* 69 percent of the persons affected by patient services are at or below the poverty level. This is due to large-scale screening programs which are primarily directed at serving the low-income population. (See Table 2 attached.)

* Screening accounts for about 80 percent of the people affected -- cancer screening affected the greatest number of persons (46,000), with multiphasic screening the next highest (31,000).

* Information available pertaining to screening and detection indicates that about 90 abnormalities are found for every 1,000 persons screened. (See Table 1 attached.) The rate is considerably higher in projects such as the Flanner House screening program cited below which are aimed at high risk groups.

* Following are some examples of the patient care services which are being carried out in the regions:

  . The Flanner House multiphasic screening project in the Indiana region is conducted solely for disadvantaged residents of Indianapolis. The project has screened 2,600 persons, of whom 1,600 were found to have abnormalities. Positive detections are referred to community hospitals and private physicians for follow-up care.

- A project aimed at the eradication of cervical cancer is being undertaken in the Texas region. With its center at the Southwestern Medical School at San Antonio, the project involves 109 satellite clinics which have screened 39,000 indigent women since July 1968.

- The Vanderbilt University coronary care unit program of the Tennessee Mid-South Regional Medical Program has as its aim the establishment of coronary care unit systems in small community hospitals remote from metropolitan areas. Vanderbilt serves as an information source and the coordinating headquarters for a network which is presently comprised of eleven hospitals which have treated 350 persons in their coronary care units since the project's inception.

- The New Mexico RMP is involved in a stroke rehabilitation project which utilizes an innovative visiting team approach. The major efforts here are concentrated on encouraging community hospitals to develop rehabilitation programs with guidance and supervision from the Stroke Team. To date 200 stroke patients in hospitals, nursing homes and outpatient clinics have directly benefitted from the team's efforts.

* One very important facet of many RMP operational activities is the indirect results and benefits flowing from them. An excellent example of this spin-off phenomenon is the coronary care network established with the financial and other assistance of the North Carolina RMP.

The direct and immediate beneficiaries to date have been the 300 patients who received coronary care services in the isolated Appalachian Region of Western North Carolina known as the State of Franklin because they had available to them a newly established network of coronary care units, including 13 monitored beds, located in 8 hospitals. These small hospitals -- all are under 50 beds -- are linked to each other and to the Bowman Gray School of Medicine by a new telephone line for transmission and analysis of EKGs, as well as for other types of immediate consultations. Supported by physicians and nurses recently trained in modern coronary care techniques, as well as two mobile intensive coronary care ambulances with drivers trained in cardiac resuscitation techniques, this experimental program is beginning to show results; preliminary data reported by the Region indicates a 67% reduction in mortality from acute myocardial infarction, as well as overall improvements in the handling of shock patients from ambulance to emergency room. In addition, the feelings of professional isolation have been diminished because of the communications hookup with Bowman Gray.

This coronary care network and activity, moreover, appears to have had considerable indirect effect and impact. Many of the physicians in the area are increasing, where indicated, referrals of patients to the one cardiologist in the area. Similarly the eight small hospitals are beginning to think in terms of and more towards some degree of differentiation and division of labor in fields other than coronary care, since clearly no one of them can be truly self-sufficient. Thus, the hospital which has the services of area's only physical therapist is becoming the locus for physical therapy and rehabilitation services. Several years ago all of the hospitals were threatened by the possibility of non-accreditation. Now there is the definite prospect that they will receive a joint accreditation by the AHA as a "single" hospital. There is little question

in the minds of the physicians and hospital administrators in the area that these developments will help raise the level of care and make that care generally available to all the people throughout the State of Franklin; and that this has been aided and abetted in some measure by the efforts of the North Carolina RMP and the coronary care network which it helped to establish in that area.

Explanation and Comments

Of the 39 regions reporting data on operational projects, 29 are conducting projects with a component of patient care -- within the 29 regions, 122 projects reported usable data; and additional 23 had elements of patient care but no information available at this time.

Most of the persons screened also received other services such as patient education and home health services but it was impossible to make a count of these because of various services to the same patient group in a single project.

Questionnaire Reference: IV.B.19.

Analyst: Joan Ensor

SUPPORTING TABLES

Table 1: Screening and Positive Detections

Type of Screening	No. Screened for which Detection Info. Available	No. Positive Detections	Detection Rate
Heart Disease	7,978	1,268	16%
Cancer	45,939	395	1%
Stroke	84	58	69%
Pulmonary	21,340	2,409	11%
Related	2,855	127	4%
Multiphasic	29,896	5,615	19%
TOTAL	108,092	9,872	9%

Table 2: Number of Poverty-level Persons Affected

Disease Category	No. Persons Affected for Whom Data Are Available	Est. Percentage Poverty Level Persons
Heart	18,077	26
Cancer	48,877	93
Stroke	671	49
Pulmonary	13,553	54
Related	2,961	49
Multicategorical	36,490	66
TOTAL	120,629	69

January 1970

OPERATIONAL PROJECTS -- HEALTH PROFESSIONALS BENEFITTING FROM CONTINUING EDUCATION AND TRAINING PROGRAMS

Over 54,000 health professionals have benefitted from continuing education and training courses or seminars conducted through Regional Medical Programs. An additional 152,000 were reached via two-way and other communications media. A summary breakdown by professions and disease classification follows:

Persons Trained, By Disease			Persons Trained, By Profession		
Total	54,674	(100%)	Total	54,674	(100%)
Heart	24,326	(44)	Physicians	16,114	(30)
Cancer	2,554	(8)	Registered Nurses	25,291	(46)
Stroke	4,509	(5)	Allied and other Health	6,537	(12)
Pulmonary	3,234	(6)	Multiprofessional	6,732	(12)
Related	857	(2)			
Multicategorical	19,194	(35)			

In addition, a large number of patients, their families, members of the public and emergency personnel have benefitted from Regional Medical Program training.

Highlights

Continuing Education programs have been directed primarily at physicians and registered nurses and have generally encompassed more than one categorical disease. Where programs did focus on a categorical disease it was usually heart. Continuing education and training activities are conducted both through 1) traditional vehicles of formal courses and seminars, here called courses; and 2) through television, radio, and in some instances, programmed self instruction and phone consultation instruction.

* 152,599 (74%) of the total professionals reached were through courses offered on radio or television. The remaining 54,674 (26%) were course registrants, of which about half took part in courses of one day or less or of an intermittent nature.

* 76% of the professionals trained in courses were either physicians (30%) or registered nurses (46%). The allied health professionals (hospital administrators, dentists, therapists, dieticians and nutritionists, social workers, and medical records personnel) and health technicians combined account for only 12% of the course registrants.

* Most of the course trainees (44%) received instruction in heart programs, 8% in stroke, 5% in cancer courses, 6% in pulmonary, 2% in courses dealing with kidney disease and diabetes, and 35% in courses dealing with more than one disease.

REVISED

The majority of physicians enrolled in RMP-sponsored continuing education courses took part in relatively short-term training lasting from one to three days. Most attended courses which emphasized heart disease or were multi-categorical in nature. Exemplary of this kind of project, and illustrative also of educational outreach to professionals, is Wisconsin's cancer chemotherapy project. During the first phase of the project seven experienced cancer chemotherapists throughout the region collaborated in conducting a coordinated program of cancer chemotherapy, following an agreed-upon protocol. The second phase, during which the educational outreach took place, concentrated on these primary collaborating physicians training physicians in other areas throughout the state in modern methods of cancer chemotherapy. These secondary collaborators are now serving as chemotherapy consultants in their areas, thus achieving the objective of expert consultative resources in cancer chemotherapy in all areas of the region. The third phase of the program is concerned with its evaluation and development of the program into an inter-regional resource.

Half of all registered nurses benefitting from formal courses (as distinct from radio-TV training) were in courses concerning heart disease. Similarly, registered nurses accounted for the largest professional group in heart courses. Illustrative of the kind of Coronary Care Unit training for nurses which accounts for most of the nurses trained in heart programs is that conducted at Newark Beth Israel Medical Center in New Jersey, which provides 4-week training courses for nurses from hospitals in the most populated regions of the state. After their training, and their return to the employing hospital, each nurse-trainee is visited by a traveling team of physicians and nurses. They assist in adapting her knowledge and skills to her own situation and provide consultative services to the coronary care team as a whole. Those nurses who finish the original course are also given a one-day follow-up refresher course later.

Physicians and registered nurses account for over 90% of those trained via communications media. One of the largest projects utilizing electronic media is the California-based Medical Television Network, closed circuit TV supported by the California Regional Medical Program. Based at UCLA and ETV station KCET, the project currently produces and distributes videotapes to over thirty subscribing hospitals nationwide in addition to the 57 southern California institutions receiving the broadcast, and has plans for expansion.

Explanation and Comments

Of 41 operational regions in 55 surveyed, 38 had approximately 200 projects in which they reported a continuing education and/or training component.

Most of the training via communications media was through radio and television; California's Medical Television Network alone reached some 100,000 registrants. Included in numbers reflecting persons trained via communications media are those persons who benefitted from Dial Access, phone consultation, programmed self-instruction and the medical juke box.

Figures used throughout this analysis reflect the number of registrants, rather than the number of individuals, since raw data did not allow identification of multiple registrations by an individual.

The disease emphasis of courses was made according to the disease classification assigned each project by the Office of Health, Data, RMPS.

Questionnaire Reference: IV.B.20b.

Analyst: Patty Mullins

Supporting Tables

Table 1: Professionals Benefitting From Continuing Education and Training, By Disease Category

	Total		Registrations		TV - Radio	
	207,273	(100%)	54,674	(100%)	152,599	(100%)
Heart	24,628	(12%)	24,326	(44%)	302	(< 1%)
Cancer	2,554	(1)	2,554	(5)	-	
Stroke	4,509	(2)	4,509	(8)	-	
Pulmonary	5,734	(3)	3,234	(6)	2,500	(2)
Related	857	(< 1)	857	(2)	-	
Multi Categorical	168,991	(82)	19,194	(35)	149,797	(98)

Table 2: Professionals Benefitting From Continuing Education and Training, By Profession

	Total		Course Registrations		Through TV - Radio	
	207,273	(100%)	54,674	(100%)	152,599	(100%)
Physicians	91,531	(44%)	16,114	(30%)	75,417	(50%)
Registered Nurses	96,249	(46)	25,291	(46)	70,958	(46)
Allied Health 1/	10,228	(5)	5,676	(10)	4,552	(3)
Technicians 2/	1,451	(1)	861	(2)	590	(< 1)
Multiprofessional	7,814	(4)	6,732	(12)	1,082	(1)

Note: In addition to health personnel trained, 44,336 members of the public, patients, their families and emergency personnel (e.g. firemen, ambulance drivers) received instruction through RMP projects. Most attended courses of less than a full day, and most received instruction which was not restricted to a single disease category.

1/ Includes hospital administrators, dentists, therapists (PT, OT speech), dieticians and nutritionists, social workers, LPN's and medical record personnel.

2/ Includes medical and laboratory, X-ray, cardio-pulmonary, EKG, electronic, cyto- and other technicians and inhalation therapists.

January 1970

COST-SHARING IN OPERATIONAL ACTIVITIES

Nearly $15 million in funds and kind has been contributed towards the support of operational activities and projects in the 39 Regions which had achieved operational status as of June 30, 1969. This averages out to roughly $.27 contributed for each $1.00 awarded, since operational awards to these same Regions totaled $54.4 million. The breakdown by (1) type of contribution (or cost-sharing) and (2) the kinds of contributing institutions or agencies follows:

By Type or Category

	Amount	Percent
Funds	$ 3,451,013	24%
In Kind		
Personnel	2,764,890	20%
Equipment	2,087,348	15%
Facilities	4,679,282	32%
Non-Specified	1,212,593	9%
Totals	$14,900,127	100%

By Institution or Agency

	Amount	Percent
Medical Schools	$ 4,467,312	30%
Hospitals	5,200,504	35%
Official Agencies	2,851,955	20%
Voluntary Agencies	531,048	5%
Medical Societies	286,292	3%
Others	879,016	7%
Totals	$14,900,127	100%

Highlights

There are of course no formal RMP matching or cost-sharing requirements except for "construction," that is, alterations and renovations. Yet contributions to the support of RMP-sponsored operational activities have been significant.

* While largely in kind, contributions of funds constituted 24% of the $14.9 million total; and 24 or almost two-thirds of the 39 Regions reported some cash contributions.

* Contributions were widespread in the sense that there was some contribution of one type or another, towards each of the 244 operational projects in these Regions.

* Hospitals accounted for 35% of the total amount contributed. This was largely in the form of facilities and space made available, including the costs of remodelling and refurbishing such space; which also includes contributions of staff time, equipment, and the like, however.

* Medical schools were the second largest contributor, accounting for 30% of the total.

Examples of cash contributions included:

* $70,000 raised by a local radio station in Boise (Idaho) to assist with the establishment of a Diagnostic, Treatment and Education Program to Improve the Care of Cancer Patients in that area by the Mountain States RMP.

* $125,000 by the Medical College of South Carolina which is jointly supporting with the South Carolina RMP a Coronary Care Training Project, a Pediatric Cancer Education and Service Program and a Demonstration Hemodialysis Unit.

* Contributions totalling $60,000 were raised through the efforts of the state cancer society, medical society and health department in Alaska in connection with a Cancer Detection Program sponsored by the Washington/Alaska RMP, which included the establishment of a cobalt therapy facility and unit in Anchorage.

Not all fund contributions have been for RMP-sponsored projects. In Missouri, for example, the state legislature recently appropriated and made available through the Missouri RMP, $60,000 for continuation of direct care of kidney patients receiving hemodialysis at the Kansas City General Hospital; this action became necessary as Federal funds were being phased downward. In this instance, the Region served as a "broker" and in effect received what amounted to a "grant" from the legislature for this specific activity no part of which is supported by RMP grant funds as such.

Explanation and Comment

Reported data on these contributions is probably somewhat "soft" owing to a variety of reasons, including differing interpretations as to what constituted contributions and the problems of estimating the dollar value of contributions in kind. Even fund or cash contributions present certain problems. For example, the Michigan RMP reported that the state health department has made $2.4 million available for support of a joint project centered around the refining of procedures for the collection and analysis of morbidity and mortality data. Whether this should be counted as a contribution to the Michigan RMP is perhaps questionable.

On the other hand, this may balance out on the whole -- some have been generous in their estimates, others conservative. Ohio Valley and Metropolitan D.C. reported no contributions.

Questionnaire Reference: IV.A.3 and IV.B.13

Analyst : Harold F. O'Flaherty

January 1970

STAFFING OF OPERATIONAL PROJECTS

A total of 2,286 full and part-time professionals and non-professionals have been employed in connection with RMP-supported operational projects. While the majority (1,331) were part-time, nearly 1,000 were employed on a full-time basis. A breakdown by professional (or occupational) category follows:

	No. of Staff		No. of FT Equivalence		
Category	Total FTE	% Of FTE Total	Total (FT & PT)	Nos. FT	Nos. PT
Physicians	178	13%	621	57	564
RN's	248	19%	361	189	172
Allied Health	210	15%	299	170	129
Other Professional/Technical	384	29%	590	282	308
Clerical	334	24%	415	257	158
TOTALS	1,354	100%	2,286	955	1,331

Highlights

Professionals and technical personnel account for over three-quarters (1,020 FTE or 76%) of the total staff employed in operational projects. Nurses (19%) and physicians (13%) constitute the two largest single professional categories in terms of full-time equivalents. Other highlights include:

* These project staff were drawn from 675 hospitals and 291 other institutions and organizations (e.g., medical schools, universities, health departments).

* Nurses, allied health personnel, and clerical staff are chiefly full-time, whereas physicians and other professional and technical staff are chiefly part-time. In the case of physicians, less than 10% of the total were employed on a full-time basis.

* Part-time staff are on the average spending 30% of their time on RMP-supported projects.

* In addition, a total of 20,916 consultant days were utilized. Of these only 8,353 days were paid and 12,563 days were contributed. Of interest is the fact that if each contributed consultant day was assigned an arbitrary value of $50, the contribution to the 39 operational programs would exceed $600,000.

Explanation and Comments

These data were obtained from the 39 regions which had achieved operational status as of June 30, 1969, and reflect a total of 380 operational projects. In terms of averages, there are about 6 full and part-time staff per project, and roughly 3.5 full-time equivalents.

The category Other Professionals/Technical includes such personnel as engineers and computer programmers as well as sociologists, psychologists, economists, and other related disciplines.

Questionnaire Reference: IV.A.2 and IV.B.7.a-e

Amalyst: Harold F. O'Flaherty

Supporting Table

A Breakdown of Staffing Patterns By Full-time & Part-time

	Over-all Total	% of Over-all Total	No. Full-Time	% of Total	No. of Part-Time	% of Total
Physicians	621	26%	57	2%	564	24%
RN's	361	16%	189	8%	172	8%
Allied Health	(299)	(14%)	(170)	(8%)	(129)	(7%)
Dentists	8	1%	2	1%	6	1%
Physicial & Occupa. Therp.	77	3%	31	1%	46	2%
Medical Technicians	62	3%	49	2%	13	1%
Other Technicians	124	5%	72	3%	52	2%
LPN's	28	2%	16	1%	12	1%
Other Professional/Tech.	(590)	(25%)	(282)	(12%)	(308)	(13%)
Other Professional	454	20%	225	10%	229	10%
Engineers	136	5%	57	2%	79	3%
Secretarial & Clerical	415	18%	257	11%	158	7%
TOTALS	2,286	100%	955	41%	1,331	59%

January 1970

RMP-CHP RELATIONSHIPS

The relationship between Regional Medical Programs and Comprehensive Health Planning agencies are quite varied, ranging from close cooperation to an almost total lack of contact and familiarity with CHP agencies and operations. Most regions cite general cooperation such as overlapping membership on advisory councils or "frequent staff conferences," rather than specific instances of substantive interaction, such as joint support of developing projects. However, as noted below and in the Supporting Anecdotes, a number of regions and both state and areawide comprehensive health planning agencies have engaged in joint planning and data collection efforts and/or have defined common subregional areas for planning and other purposes. Financial and other support also has been extended to developing areawide agencies by a number of regions.

There is little or no concrete evidence of overt conflict or suspicion as has been alleged from time to time. Rather, general cooperation, tentative involvement, avoidance of any open conflict, and the adoptions of a "wait and see" attitude characterizes the situation.

Highlights

Relationships with state comprehensive health planning agencies show the following characteristics:

* In 53 of the 55 regions there is either overlapping membership between the Regional Advisory Group and the CHP State Health Advisory Council or, as in the case of New York, where there is a high level RMP advisory committee to the State Health Council. This overlap includes both ex officio representation of program staff on the counterpart councils, as well as common membership by other persons in both groups. (For examples see Supporting Anecdotes, I.A.)

* Twenty-three (23) regions have undertaken common data collection activities with the state CHP agencies; and 14 indicated sharing or joint participation in special planning studies with the state CHP agency. (For examples see I.B.)

* In six regions the state CHP agency and the RMP have defined common subregional areas for planning and operations. These are Connecticut, Greater Delaware Valley, Illinois, Kansas, North Dakota, and South Carolina. In New York the geographic areas covered by the 6 RMP regions are similar to the state health planning regions. In a number of other places, the state CHP agency and the RMP are encouraging the development of 314(b) agencies which may serve a common review and planning function for both programs.

Relationships with areawide comprehensive health planning agencies have been somewhat slower in developing, perhaps in large part because nearly two-thirds of the 106 currently funded areawide agencies have been in operation for less

than a year. (In 9 regions there still are no areawide agencies. These are Albany, Colorado-Wyoming, Hawaii, Metropolitan Washington, D.C., Mississippi, North Dakota, Puerto Rico, Susquehanna Valley, Western Pennsylvania.) The potential for cooperation and close working relationships is great though, as the following would seem to bear out.

* Twenty-six (26) of the regions had either interlocking membership or related membership between the Regional Advisory Group and the Areawide Advisory Committees. In one region, Memphis, they are the same group.

* Eleven (11) regions stated that they participated in the development of areawide agencies and in four cases provided developmental funds. (For examples see II.A.) Further assistance can be anticipated since almost one-half (50) of the areawide agencies have grants of less than $50,000.

* Seven (7) regions have had cooperative data collection and planning studies similar to cooperative efforts at the state level. (For examples see II.C.)

* A number of regions have established local planning and/or action groups which serve as subregional offices for the program or on a voluntary basis act as review and program development bodies. These groups review projects, assess local needs, encourage project development and generally coordinate RMP activity at the local level. In some cases they have developed new groups to carry out these functions. In other cases they have used areawide agencies for these tasks or have encouraged the RMP group to become the 134(b) agency. Where two separate groups exist the RMP encourages cooperation between the two and where appropriate requires review of RMP activity by the areawide agency. (For examples see II.B.)

Concrete opportunities for even closer coordination and collaboration and possibly consolidation have begun to emerge in several places. The governors of South Dakota and Vermont have been exploring ways in which the relationships between RMP and the state CHP agency might be formally structured; and in Nassau-Suffolk RMP, the RMP Program Coordinator is also serving as the acting Project Director of the Nassau-Suffolk Comprehensive Health Planning Council.

Explanation and Comments

While most of the quantitative data on relationships reflects the situation through June 30, 1969, data on the status of the areawide planning effort and some of the supporting anecdotal material is more current than that.

Questionnaire Reference: V.B.2. and 3.

Analyst: Theodore L. Koontz and Lawrence M. Witte

Supporting Anecdotes

I. Relationship with State Comprehensive Health Planning Agencies

A. Overlap between RAG and State Health Advisory Councils

1. In Arizona, State law requires that the State CHP Advisory Council include the entire Arizona RMP Regional Advisory Group.

2. In Connecticut, there is substantial interlocking directorate between Connecticut RMP and CHP. Dr. Foote (State Health Officer), Dr. Fritz Redlich (Dean of Medicine at Yale), Dr. John Patterson (Dean of Medicine at the University of Connecticut), Dr. Stewart Hamilton (Director of Hartford Hospital), Mr. Charles Treadway (President of the Connecticut Hospital Planning Commission), Mr. Manton Eddy (Chairman of the Advisory Board of CHP 314(a) and Mr. Arthur Rogers (Chairman of the Advisory Board of CRMP) serve on the boards of both agencies.

3. In New York a State Joint Council on Regional Medical Programs has been established which includes representation from the six RMP's in that State, the New York Medical Society, the Hospital Association, the New York State Department of Health, the Cancer Society, and the Heart Association. This group provides liaison at the State level between the RMP's and the State Health Planning Commission.

B. Data Collection-Joint Planning Studies

1. The State Health Commissioner for Statistics is the Chairman of the Regional Characteristics and Medical Manpower Committee of Indiana RMP, thus assuring cooperation in obtaining statistical support from the State Board of Health. Indiana RMP has paid the salaries of one secretary and one systems analyst, housed at the State Board of Health, who develop baseline data for this committee. Now pending before RMPS is a proposal to develop a health data bank to be funded by both RMP ($84,851) and CHP ($50,000).

2. Intermountain RMP staff have participated in a CHP task force which includes representatives from Utah State University, the State Division of Health, major hospitals and consultants in industrial engineering and computer science. The task force has compiled recommendations on data needs for CHP and coordinated them with those developed by IRMP. Plans are being developed for a cooperative program where IRMP will collect, with CHP assistance, data to meet the needs of both programs. Although it is seen that ultimately such a dark bank will be operated by others (health department of states in the region), the development of a useful system and its demonstration will probably require two to three years of cooperative effort under the leadership of IRMP.

3. Arizona RMP has a staff member who serves as chairman of a combined CHP/ARMP committee charged with setting up adequate data collection mechanism, giving particular attention to avoid overlap between the two programs. There will be a bill placed before the Arizona Legislature this coming session to set up a central data collection agency for both programs.

C. Other Examples of Coordination

1. Arkansas RMP and CHP share conference room space, library and business machine facilities in a commonly used area. RMP and CHP offices adjoin. CHP and RMP share all data collected in surveys and studies. By virtue of adjoining offices, the CHP and RMP staff members are closely associated, and the activities of each are well known to the other.

2. South Dakota. Dr. Robert H. Hayes, Associate Coordinator for South Dakota (Nebraska/South Dakota RMP), is a member of the South Dakota CHP State Health Planning Council. He also serves as Chairman of the Manpower Committee and the Indian Health Committee for that group.

3. In Oregon the Governor's Comprehensive Health Planning Committee sends 314(e) project applications pertaining to heart disease, cancer, and stroke to the Oregon RMP categorical committees for review.

4. In Ohio, Sewall Millikin, Chief of the Office of Comprehensive Health Planning, has met with the Regional Medical Program Coordinators of the Ohio programs (Ohio State RMP, Ohio Valley RMP, Northeast Ohio RMP) to discuss mutual planning activities, data collection methods and operational proposals. A considerable amount of RMP planning data on health manpower, health facilities, and health services have been made available to the CHP state agency. Conversely, CHP has entered into a contract with an independent corporation to perform a health manpower and facilities survey for Ohio, which will be made available to the four Ohio Regional Medical Programs. Two workshops on health planning have been sponsored by the Ohio Comprehensive Health Planning Agency with the cooperation of the four Ohio Regional Medical Programs.

II. Relationship with Areawide Comprehensive Health Planning Agencies

A. Support for Developing Areawide Health Planning Agencies

1. Greater Delaware Valley RMP has awarded funds to three committees in the region to be used in developing planning proposals for 314(b) agencies.

2. Intermountain RMP staff and members of the RAG developed the application for the Weber Basin Health Planning Council in Ogden, Utah. Furthermore, they were involved in efforts to recruit staff and develop a functioning organization.

3. Louisiana RMP has been instrumental in helping to establish 314(b) agencies throughout the region, which also serve as LRMP planning and action groups. In addition, LRMP funds have been used to help support these agencies during their early development. In many cases, it is only because of this assistance and support that local areawide health planning councils have been able to reach a stage of development sufficient to apply for status as an official 314(b) agency. In addition to financial support, LRMP provided them with health related data applicable to their planning activities. (Dr. Sabatier has asked that his region not be mentioned by name in this regard.)

4. Northwestern Ohio RMP assisted in the preparation of a statement of description of purposes and a program of the proposed Northwestern Ohio Areawide Comprehensive Health Planning Agency. Since the agency was funded, representatives of the NWORMP are liaison members of the Councils of the Lucas County Planning Committee and the Areawide Comprehensive Health Planning Agency.

5. Tennessee Mid-South RMP is participating in the creation of one office for CHP and RMP, public health services and health activities of the Appalachian Commission in Upper East Tennessee. The RMP Area Coordinator for Nashville has been actively involved in developing the advisory committee for the South Central Area of Tennessee. RMP funds were used for the first organizational meeting in August, 1969.

6. Western Pennsylvania RMP RAG Chairman and the RMP Coordinator participated in the first meetings called by the Alleghany County Health Department to explore the implications of P.L. 89-749. Western Pennsylvania RMP sponsored, in cooperation with other agencies, a day-long informational and organizational meeting for more than 400 persons, invited from 31 counties in Western Pennsylvania. Staff was lent by RMP to follow-up on the initial meeting and the Coordinator and the Director of the RMP served on the CHP steering committee, which directed the preparation of the application. In addition, RMP funds were used to support efforts to draft the grant application.

7. California RMP reported that the RMP staff helped the local CHP committees in Riverside and San Bernardino Counties get organized and is now advising committees in Inyo and Mono Counties.

B. Relationships between RMP Local Advisory Groups and Areawide Agencies

1. Georgia RMP has established numerous Local Action Groups throughout the State. These are usually hospital oriented groups which as a minimum include the hospital administrator, the chief of staff and the chairman of the board of trustees of the hospitals in the area. When a LAG has developed an operational project, it must have it approved by the local CHP (b) agency, if one exists. In its communications with the LAG's, Georgia RMP has urged the formation

of these groups even in the absence of available Federal funds. There is a particularly close relationship between the RMP and the Community Council of Atlanta, Inc. This group serves as both the local 314(b) agency and as the RMP LAG. During the developmental stages of this program, Georgia RMP provided funding for half the expenses of the Council and supported full funding for two hospital home health services coordinators there from July 1, 1968, through June 30, 1969.

2. Greater Delaware Valley RMP has been working with several LAG's or areawide planning committees related to 314(b) agencies. The areawide committee (LAG) serving the East Central Pa. Area (comprised of Monroe, Carbon, Schuylkill, Berks, Lehigh and Northamptom Counties, with a population of 1,012,600 and representing 13% of the region) is structured to serve Comprehensive Health Planning, as well as the Regional Medical Program. This committee is titled, "The East Central Pennsylvania Committee for Regional Medical Program and Comprehensive Health Planning." The committee has been endorsed by the Program Committee to serve the Area for the Regional Medical Program. It has developed a proposal which has been approved by the Harrisburg, Pennsylvania Office for Comprehensive Health Planning and has been submitted to the PHS Regional Office in New York. The committee serving the South Central Jersey Area (comprised of Burlington, Camden and Gloucester Counties, with a population of 881,900 and representing 10% of the region) originally structured itself with the intent to serve Comprehensive Health Planning, as well as the Regional Medical Program. As the committee progressed, it was determined that they would serve the Regional Medical Program only; however, the committee is represented on the membership of a more recently formed committee for Comprehensive Health Planning, which plans to apply for a grant as a 314(b) agency to serve Burlington, Camden, Gloucester, Salem, Cumberland, Cape May and Atlantic Counties.

3. In California, the North Coast Health Facilities Planning Association, Inc., the 314(b) agency for Humboldt, Del Norte, Lake Mendocino Counties, also serves as the RMP local advisory committee.

C. Cooperation in Data Collection and Special Planning Studies

1. The Northeast Ohio RMP performed data collection and evaluation for the United Community Council of Summit County (Akron-Portage 314(b) agency) relative to long-term chronic disease needs. Furthermore, they supplied most of the health data and organizational base for Cleveland's Metropolitan Health Planning Corporation's operational grant application and have recently received a grant request from that agency for an inter-university health manpower development project.

2. Northwest Ohio RMP and the local areawide planning agency, Health Planning Association of Northwestern Ohio, are studying the feasibility of a multiphasic screening program for residents of the Model Cities area. The NWORMP and the Northwest Areawide Health Planning agency also developed an Emergency Medical Care Council for Northwest Ohio to establish better cooperation between community hospitals within the region in health care planning.

3. The Ohio Valley RMP and the Louisville,Kentucky CHP, Falls Region Health Council, Inc., performed a joint study of patterns of hospital care in the Louisville area.

4. Oklahoma RMP and the Southern Oklahoma Development Area (SODA) supported a community stroke planning study in Ada, Oklahoma, encompassing six hospitals in five surrounding counties.

5. West Virginia RMP and Health, Inc., the 314(b) agency in Parkerburg, are accumulating and organizing information for a community services manual, listing all community health related organizations. Furthermore, the feasibility study of the Medical Self-Audit Assistance Project had the Hospital Planning Council of the Kanawa Valley, a 314(b) agency, as the grantee organization.

January 1970

RELATIONSHIPS WITH OTHER FEDERAL PROGRAMS

Nearly all regions (48) report relationships with other Federal programs (exclusive of CHP) at the regional or local level. These relationships range from planning interface -- that is, overlapping memberships on, or interaction of, their respective committee structures -- to joint funding or conduct of activities.

A total of 179 relationships with 25 different Federal programs were cited. A few regions (e.g., Arizona, Connecticut, Mississippi, New Jersey, Tennessee Mid-South) have relationships with as many as 5 or 6 other Federal programs; nearly all have developed relationships with at least one or two.

Highlights

RMP relationships most frequently cited were with the Veterans Administration Medical Program through VA hospitals in the regions (36); the Model Cities program (26); OEO Neighborhood Health Centers (20); state Hill-Burton agencies (12); Children and Youth programs of HSMHA (14); and the Appalachia Regional Commission (8). Since both OEO Neighborhood Health Centers and Children and Youth Health Projects are often located within Model City Neighborhoods, these three categories overlap significantly. Combined, they would easily comprise the group with the largest number of relationships with Regional Medical Programs.

Some examples illustrative of the range and kind of relationships with other Federal programs are as follows:

* The New Jersey RMP is closely coordinating its planning activities with Model Cities in that State. It has a full-time Model Cities coordinator on its staff and has assigned health planners to the Model Cities programs in Newark and Hoboken. A number of regions have materially assisted with the development and preparation of the health portion of Model Cities plans (e.g., Wayne State component of the Michigan RMP in Detroit).

* The Tennessee Mid-South RMP through Meharry Medical College is funding the multiphasic screening component and materially assisting with the evaluation of the OEO Neighborhood Health Center in Nashville.

* The South Carolina RMP and State Board of Health are jointly working with the Medicare program in that State on studies dealing with home health agency problems and reduction of patient care costs.

* In the Colorado-Wyoming RMP a Veterans Administration Hospital refurbished a section of its facilities for use by the RMP as a coronary care unit.

* The Bi-State RMP is meeting with the Model City agency, the Urban Renewal Program and other programs in DHUD regarding health needs of the poor.

Explanation and Comments

Generally speaking, a "relationship" is defined as a specific single activity performed jointly, or in cooperation with another Federally supported program by a region. This does not include relationships with CHP, which are treated separately.

It is for all practical purposes impossible to make any qualitative distinctions about these relationships. It is assumed, however, that minimal relationships of the planning interface kind, while not necessarily a prerequisite to, may in fact facilitate further and more substantive relationships or cooperation over time.

Questionnaire Reference: V.B.3

Analyst: Eugene J. Nelson

January 1970

REGIONAL SIZE AND BOUNDARIES

The 55 regions vary widely in population and area. The largest in terms of population is California with about 20 million persons, and the smallest is Northern New England (primarily Vermont) with about 425,000 persons. The average size is about 3.7 million, and the median is 2.7 million. Their population ranges are as follows:

Population	Number
Less than 1,000,000	4
1,000,000 - 2,000,000	11
2,000,000 - 3,000,000	16
3,000,000 - 4,000,000	6
4,000,000 - 5,000,000	7
Over 5,000,000	11

In terms of area, regions also vary widely. One of the largest is Washington-Alaska with about 638,000 square miles, and one of the smallest is Metropolitan D.C. with about 1,500 square miles. Several regions are primarily rural in character, such as Mountain States and North Dakota; others are primarily urban, such as Metropolitan New York; but most, such as California, Georgia, Illinois, and Michigan, have both extensive urban and rural populations. The definition of regional boundaries has not changed significantly since the regions first delineated their boundaries for planning purposes. Only two regions reflect significant changes:

(1) Hawaii, which added Guam, American Samoa, and Trust Territories because of their inclusion as a result of the last RMP extension (P.L. 90-574).

(2) Metropolitan New York, as a result of the decision by Nassau and Suffolk Counties to form their own region.

Of the other 9 regions listing changes, most were a matter of adding or subtracting specific counties largely because of areas of overlap with adjacent regions.

Highlights

* As currently defined, 36 regions are essentially coterminous with one or more states. Of these, 31 follow the boundaries of a single state; and 5 follow the boundaries of two or more states.

* The other 19 regions are parts of one or more states. Eleven (11) are essentially parts of single states; and 8 include parts of two or more states.

* The 31 regions which follow the boundaries of a single state are, of course, coterminous with the planning area of the state comprehensive health planning agency.

* Five (5) regions and 1 subregion in California have very similar boundaries to areawide comprehensive health planning agencies. These are: Nassau-Suffolk, New York Metropolitan, Northwestern Ohio, Rochester, Western New York, and Area VII (La Jolla) in California.

* Four (4) regions and 4 subregions of California have boundaries fairly similar to two or three such areawide agencies. These include: Central New York, Greater Delaware Valley, Northeast Ohio, Ohio State, and Areas I (San Francisco), II (Davis), III (Palo Alto), and IV (Los Angeles) in California.

* In nine (9) of the 55 regions, there are no areawide comprehensive planning agencies to date.

* The areawide comprehensive planning agencies are somewhat concentrated in certain regions, in that 39 of the 106 existing "B" agencies are located in 8 regions.

Explanation and Comment

The definition of regional boundaries is regarded by most regions as a flexible determinant of regional activities, rather than as a fixed, geographic limit for activities. Many discussions among neighboring regions have resulted in the development of operational projects which cross regional boundary lines and thus are designed to capitalize as much as possible on regional resources to meet local health needs.

Questionnaire Reference: V.A.1.

Analyst: Lyman Van Nostrand

January 1970

SUBREGIONALIZATION

Subregions (or subregional divisions) for planning, administrative, and other purposes have been established or are emerging in 33 regions. Within these regions there presently are 167 subregions. The remaining 22 regions are not presently subregionalized but reported information indicates that most will be within the foreseeable future.

Highlights

The major purposes served by subregionalization are to promote adequate local planning by the parent RMP and to insure maximum grass roots participation and/or liaison at the local level.

The principal basis in 21 regions for subregionalization has been the "medical trade area." Congruency with other planning areas or jurisdictions also has been an important determinant. By design, some subregions mirror CHP 314(b) agency jurisdictions. Others are consistent with planning areas designated by state governors. One region (West Virginia) adopted the planning areas of the State Commerce Office as the basis for its subregions.

Other highlights include:

* While a few regions have as many as 10 or more subregions, and others as few as 2 or 3, most currently have 4-6.

* A simple projection would indicate a total of subregions in the range of 275 to 325 in nearly all regions within the next several years.

Explanation and Comments

Some regions referred to "divisions," rather than "subregions" per se. For analytical purposes, however, these were considered subregions, since reported information indicates that the difference is mostly semantic.

In 8 of the 33 regions cited above, subregionalization was reported as still emerging but with the number of tentative subregions specified and their geography generally indicated. Most regions cited more than a single basis for their subregions (e.g., medical trade area and congruency with other planning areas).

Questionnaire Reference: V.A.2., 3., and 4.

Analyst: Eugene Nelson

January 1970

PROGRAM INFORMATION ACTIVITIES

All 55 regions have carried out a wide range of program information activities designed to apprise physicians and medical societies, hospitals and their administrators and staffs, other health professions and organizations, lay groups and the public about RMP and its activities, to further the organizational outreach of their programs, and to consider specific matters of mutual concern. Over 2700 workshops and conferences have been held and over 5,000 speeches made.

Principle Audience/Participants	Workshops and Conferences		Speeches		Total
	No.	%	No.	%	
Physicians and medical societies	436	(16%)	1264	(24%)	1700
Hospitals and staff	725	(27%)	1485	(28%)	2210
Other health professions and groups	1282	(47%)	1675	(32%)	2957
Lay groups and public	273	(10%)	874	(16%)	1147
Total	2716		5298		8014

Forty-nine (49) of the regions also have initiated newsletters to keep individuals, institutions and organizations aware of developments. Most are issued monthly (18), bi-monthly (9), or quarterly (12). The average distribution is 5,478, with well over half going to physicians, hospitals, and health agencies in the regions.

Highlights

Hospitals and their administrators and staffs were by far the single largest audience (27%) insofar as RMP-sponsored workshops and conferences were concerned. Physicians are the primary audience (45%) insofar as newsletters are concerned. Most regions also send their newsletters to other regions and some, such as North Carolina, regularly carry information about other regions.

The range and scope reflected by the workshops and conferences have been extensive. For example:

* Many regions have sponsored workshops to train physicians and nurses in the care of heart, cancer and stroke patients.

* Many other more specialized workshops also have been held as that of Oklahoma to train medical librarians.

* Seminars on the aging have been held by the Central New York and several other regions.

* Alabama and Intermountain were among a number of regions that have sponsored 2-way radio conferences for allied health professionals.

* Communication and information workshops have been held in Georgia and other regions.

* The Missouri RMP conducted a two-day workshop on health planning which was attended by a number of other regions and CHP agencies in that area of the country.

* The Intermountain RMP sponsored a Colloquium of the Air Series on educational television that dealt with such topics as health costs, care of the poor, and manpower needs with such distinguished guests as Anne Somers, Dr. James Haughton, and Dr. Dwight Wilkin (respectively).

Explanation and Comments

Informal visits and meetings by RMP staff are not included in the data on workshops and conferences and speeches. These meetings totaled 17,465.

Questionnaire Reference: III.C.1. and 2.

Analyst: Lawrence M. Witte