
E000976

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RMP Grant Funding (as of 12/31/72)

Number of Grants		56	
Number of projects funded out of grants		978	
Number of positions supported by grants:			
Number of Program Staff	1400		
Number of Project Staff	2292		
Total positions supported by grants		3692	
Projects level			$64.6
Core Support			41.9
TOTAL			$106.5

FY73 Amended Budget:

	1973 Estimate	1974 Estimate	Increase or Decrease
Grants and Contracts	$55,358,000*	-0-	-$55,358,000

*Includes $2.5 million for emergency medical services systems.

Emphasis of RMP Grant Funds

(Dollars in Thousands)

	FY71	%	FY72	%	As of 12/31/72	%
1. Patient Care Demonstrations, which directly benefit patients	$14,256	20.3	$ 32,700	29.5	$31,700	29.7
2. Manpower training and utilization	12,429	17.6	21,239	19.2	20,000	18.8
3. Continuing Education of existing health professionals	7,677	10.9	10,788	9.7	10,300	9.7
4. Health Services Research and Development	2,193	3.1	2,696	2.4	2,600	2.4
5. Program Staff Activity	33,743	47.9	43,560	39.2	41,900	39.3
a. Program Direction and administration	(9,111)	(27)	(11,761)	(27)	(11,313)	(27)
b. Project Development, Review and Management	(7,423)	(22)	(9,583)	(22)	(9,218)	(22)
c. Professional Consultation and Community Liaison	(8,773)	(26)	(11,326)	(26)	(10,894)	(26)
d. Planning and Feasibility Studies	(6,074)	(18)	(7,841)	(18)	(7,542)	(18)
e. Central Regional and Other Services	(2,362)	(7)	(3,049)	(7)	(2,933)	(7)
TOTALS	$70,298	100.0	$110,983	100.0	$106,500	100.0

HIGHLIGHTS OF

LEGISLATIVE AND ADMINISTRATIVE HISTORY

OF REGIONAL MEDICAL PROGRAMS

1964 DECEMBER — The Report of the President's Commission on Heart Disease, Cancer and Stroke presented 35 recommendations including development of regional complexes of medical facilities and resources.

1965 JANUARY — Companion administration bills--S.596 and H.R. 3140--were introduced in the Senate by Senator Lister Hill (Ala.), and in the House by Representative Oren Harris (Ark.), giving concrete legislative form to presidential proposals.

OCTOBER — P.L. 89-239, the Heart Disease, Cancer and Stroke Amendments of 1965, was signed. The Commission concepts of "regional medical complexes" and "coordinated arrangements" were replaced by "regional medical programs" and "cooperative arrangements," thus emphasizing voluntary linkages.

DECEMBER — National Advisory Council on Regional Medical Programs met for the first time to advise on initial plans and policies.

1966 FEBRUARY — Dr. Robert Q. Marston appointed first Director of the Division of Regional Medical Programs and Assoc. Director of NIH.

APRIL — First planning grants approved by National Advisory Council.

1967 FEBRUARY — First operational grants approved by National Advisory Council.

JUNE — The Surgeon General submitted the Report on Regional Medical Programs to the President and the Congress, summarizing progress made and recommending its extension.

1968 MARCH — Companion bills to extend Regional Medical Programs were introduced in the House by Harley O. Staggers (W.Va.) (H.R. 15758) and in the Senate by Senator Lister Hill (Ala.) (S. 3094).

OCTOBER — P.L. 90-574, extending the Regional Medical Programs for two years,was signed. Changes were: include territories outside of the 50 States; permit funding of interregional activities; permit dentists to refer patients; and permit participation of Federal hospitals.

1970 JAN.-OCT. — Bills extending RMP introduced; hearings held.

OCTOBER — P.L. 91-515 was signed into law. New provisions: emphasis on primary care and regionalization of health care resources; added prevention and rehabilitation; added kidney disease; added authority for new construction; required review of RMP applications by Areawide Comprehensive Planning agencies; emphasized health services delivery and manpower utilization.

REGIONAL MEDICAL PROGRAMS
APPROPRIATIONS AND BUDGETARY HISTORY

(Dollars in Thousands)

	Fiscal Year 1966	Fiscal Year 1967	Fiscal Year 1968	Fiscal Year 1969	Fiscal Year 1970	Fiscal Year 1971	Fiscal Year 1972	Fiscal Year 1973
Authorization.....	$ 50,000	$ 90,000	$200,000	$ 65,000	$120,000	$125,000	$150,000	$250,000
Amount appropriated for grants.....	24,000	43,000	53,900	56,200	73,500	99,500	90,500	N.A.
Amount actually available for grants 1/.....	24,000	43,934	48,900	72,365	78,500	70,298	135,000	51,836 *
Amount actually awarded for grants.....	2,066	27,052	43,635	72,365	78,202	70,298	110,983 2/	-

1/ Includes unspent funds carried forward from previous year minus amounts held in reserve by the Office of Management and Budget.

2/ Does not include earmarked amounts for Emergency Medical Services ($8.0 million), Cancer construction ($5.0 million), Health Maintenance Organizations ($9.2 million), Contracts ($1.2 million), and evaluation activities ($.6 million).

* Amount available per amended FY 1973 budget.

D.

DEMOGRAPHIC FACTS

There are 56 Regional Medical Programs which cover the United States, Puerto Rico, and the Trust Territories of the Pacific. The Programs include the total 1972 population of the United States (estimated at 207 million) and vary considerably in size, funding, and geographic characteristics.

* LARGEST PROGRAM

  In population: California (20 million)
  In size: Washington/Alaska (638,000 square miles)

* SMALLEST PROGRAM

  In population: Northern New England (445,000)
  In size: Metropolitan Washington, D.C. (1,500 square miles)

* GEOGRAPHIC BOUNDARIES: Number of Programs which primarily

Encompass single states	34
Encompass two or more states	4
Are parts of single states	11
Are parts of two or more states	7

* POPULATION: Number of Programs which have

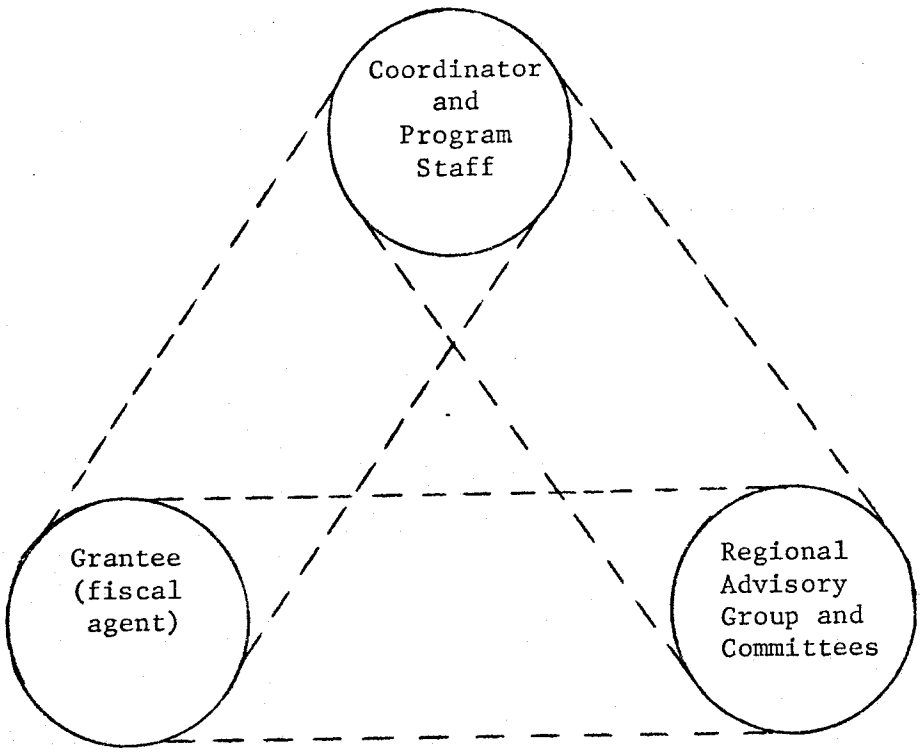
Less than 1 million persons	5
1 million to 2 million	11
2 million to 3 million	14
3 million to 4 million	7
4 million to 5 million	8
Over 5 million	11

* FUNDING LEVEL RANGES: Programs with

Less than $500,000	4
$500,000 - $999,999	19
$1 million - $1,499,999	8
$1.5 million - $1,999,999	17
$2.0 million - $2,499,999	4
$2.5 million and above	4

* MEDIAN FUNDING LEVEL: $1.1 million

ORGANIZATIONAL STRUCTURE OF A REGIONAL MEDICAL PROGRAM



Responsibilities and Relationships

There are three major components of a Regional Medical Program at the regional level: The Regional Advisory Group; the grantee organization; and the Chief Executive Officer (often referred to as the RMP Coordinator) with his or her program staff.

- Regional Advisory Group: The Regional Advisory Group has the responsibility for setting the general direction of the RMP and formulating program policies, objectives and priorities.

- Grantee: The grantee organization manages the grant of the Regional Medical Program in a manner which will implement the program established by the Regional Advisory Group and in accordance with Federal regulations and policies.

- Chief Executive Officer (Coordinator): The grantee's full-time employee who has day-to-day responsibility for the management of the RMP; he is also responsible to the Regional Advisory Group which establishes program policy. The Chief Executive Officer and his program staff provide support to the Regional Advisory Group and its subcommittees, including local advisory groups where they exist.

Regional Advisory Groups

* PURPOSE: The Regional Advisory Group (RAG) is the organized voluntary body of health providers and consumers in each RMP which has responsibility for program and project determinations and overall program direction.

A Regional Advisory Group, through membership composed of representatives from most health interests as well as many consumers in the Region, attempts to identify critical health needs in the area; develops, reviews, and approves appropriate activity proposals designed to meet those needs; and monitors and evaluates funded programs. The Regional Advisory Group has final decisionmaking authority concerning program content and policy in each RMP.

* SIZE:

FY'69 2,500 total membership
45 average group size

FY'70 2,700 total membership
48 average group size

FY'71 2,743 total membership
49 average group size

FY'72 2,667 total membership
48 average group size

* RANGES, FY 1972

Size	No. of RAGs
10 - 39 -	21
40 - 69 -	27
70 - 99 -	6
100 -129 -	1
130 -159 -	1
Total	56

* COMPOSITION: Regional Advisory Groups are composed of volunteers, both health care providers and consumers. Makeup of these groups has changed somewhat over the years since Regional Medical Programs have been in existence. Medical center officials, for example, have decreased from 16% to 9% of the representation. Consumers, on the other hand, have experienced increasing representation from 15% of the 1967 membership to 25% by the end of fiscal year 1972. Practicing physicians have also generally increased.

Category of RAG Representation

	1967	1971	1972
Practicing Physicians	23%	28%	27%
Hospital Interests	12	13	12
Medical Center Officials	16	8	9
Voluntary Agencies	12	8	7
Public Health Officials	7	5	6
Other Health Workers	8	11	7
Members of the Public	15	21	25
Other	7	6	8

COMMITTEES AND LOCAL ADVISORY GROUPS

* PURPOSE: Regional Advisory Group committees have major responsibilities for: (1) Program activity development and review; and (2) monitoring and evaluation of funded activities. Most are composed of experts in a given field and as such have significant influence in terms of the scientific and professional competence of program activities. The last two years has been a marked increase in the number of planning, review and evaluation committees, giving these functions an added and much needed emphasis.

  Local Advisory Groups, although they are tied to the Regional Advisory Group (in many instances membership of the bodies overlaps), serve primarily in a liaison and program development capacity at the community level. Generally, they attempt to foster cooperation among local health organizations and consumer groups, and in many instances provide linkages with CHP area-wide groups. Local groups serve as reactors to community needs and problems and relate these, as well as possible solutions, to decisionmaking bodies at the regional level.

* NUMBER AND SIZE: Comparison 1969-72

1969: =	864	10,163 Total Membership
1971: =	875	12,426 Total Membership
1972: =	850	12,315 Total Membership

Note: Total membership of these groups overlaps considerably with Regional Advisory Groups; in addition, committee memberships overlap to some extent with each other, so that totals shown are based on numbers of memberships rather than numbers of individual members.

GRANTEES OF REGIONAL MEDICAL PROGRAMS

* PURPOSE: Each Regional Medical Program is fiscally administered by a grantee which may be a public or private non-profit institution, agency, or corporation. The grantee is responsible for management of the RMP grant in such a manner as to implement the program established by the Regional Advisory Group and in accordance with federal regulations and policies. This includes primarily fiscal control, fund accounting, and administrative support.

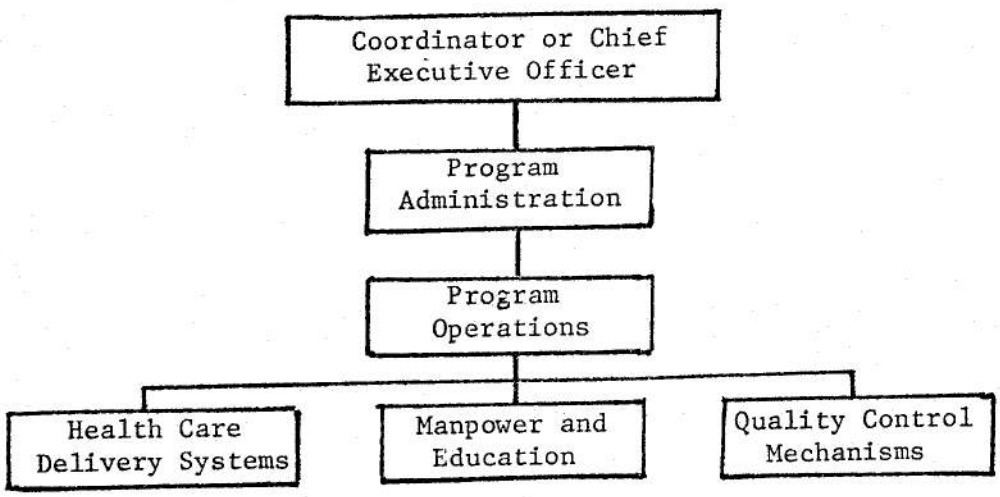
Categories of Grantees, Fiscal Year 1972

Grantee	56
Universities	33
Public	(26)
Private	(7)
Other	23
New agencies/corporations	(16)
Existing corporations	(3)
Medical societies	(4)

PROGRAM STAFFS

* PURPOSE: Program staffs are the salaried employees of the 56 Regional Medical Programs. Their functions include planning and development studies, feasibility studies designed to assess the potential of prototype programs for larger scale application, and professional consultation to community health groups and institutions. In addition, they are responsible for operational project development, review and management, including the provision of staff support to the Regional Advisory Group and its committees.

* SAMPLE ORGANIZATION CHART:



* SIZE: Comparison of staff size in full-time equivalents, fiscal years 1969-72:

FY 1969 - 1,546 total
28 average staff

FY 1971 - 1,640 total
29 average staff

FY 1972 - 1,374 total
25 average staff

* COMPOSITION: Program staffs attract persons with a variety of professional and technical competencies. Staff composition as of June 1972 included the following specialties and categories:

Education	111	Administration/Management	119
Medical Sciences	149	Other Sciences	76
Health-Related Occupations (e.g., health planning hospital administration)	123	Public Info./Relations	52
		Other Prof. and Technical	110
		Secretarial/Clerical	569
Social/Behavioral Sciences	66		

1,375 F.T.

PRIMARY PURPOSE OF RMP OPERATIONAL PROJECTS
(FY 1971 and FY 1972 With Net Change in That Period)

Primary Activity	FY 1971* No. of Projects	FY 1971* Amount (in thousands	FY 1971* %	FY 1972* No. of Projects	FY 1972* Amount (in thousands	FY 1972* %	Net Change Amount (in thousands	Net Change %
Training Existing Health Personnel in New Skills a/	144	$10,154	22	200	$13,266	17	$ 3,112	+ 31
Training New Categories of Personnel b/	16	921	2	55	3,566	5	2,645	+287
Continuing Education c/	149	9,578	21	186	12,031	16	2,453	+ 26
Patient Care Delivery Demonstrations	104	10,008	22	158	17,098	22	7,090	+ 71
Combination 1/2 Training 1/2 Patient Care Demonstrations	90	8,887	20	185	14,611	19	5,724	+ 64
Coordination of Health Services	56	2,965	7	142	11,055	14	8,090	+271
Research and Development	35	2,772	6	51	2,559	3	(213)	- 8
Data Collection/Statistics	(Not included in data)			30	2,354	3	2,354	-
TOTAL	594	$45,285	100%	1,007	$76,540	100%	$31,255	+ 69%

a/ New Skills for Existing Personnel - training aimed at enabling the person trained to assume new responsibilities in the already chosen career field or adding skills in a different but related health field (e.g., coronary care training for nurses, career mobility for licensed practical nurses).

b/ New Personnel - development of training programs for such new categories of personnel as physicians' assistants, nurse practitioners, and community health workers.

c/ Courses aimed at maintaining or improving the level of practice of the health professional.

Patient Care Demonstrations Which Improve Quality, Accessibility, and Organization of Health Services 12/72

	No. of Projects	Amount
Coronary and other intensive care activities.....	95	$6.2 Million
Expanded and improved ambulatory care in neighborhood health centers, clinics, and outpatient departments.....	213	18.1 Million
Expanded and improved home care and long-term care	79	4.8 Million
Other activities such as mobile units, specialized care services, and non-intensive in-hospital care.....	141	10.0 Million
Emergency medical services.....	61	10.7 Million

RMP Grant Activity in Categorical Diseases
(As of December 31, 1972)

Disease Category	Number of Activities	Amount
Hypertension	7	$806,746
Heart Disease	93	4,865,557
Cancer	84	5,408,714
Stroke	58	3,956,861
Kidney Disease	79	6,673,646
Pulmonary Disease	31	2,462,200
Diabetes	11	682,926
Sickle Cell Anemia	2	131,414
	365	24,988,064

CATEGORICAL DISEASE EMPHASIS OF RMP OPERATIONAL PROJECTS
(FY 1971 and FY 1972 With Net Change in That Period)

Disease	FY 1971* No. of Projects	FY 1971* Amount (in thousands)	FY 1971* %	FY 1972* No. of Projects	FY 1972* Amount (in thousands)	FY 1972* --%	Net Change Amount (in thounsands)	Net Change %
Heart Disease and Hypertension	156	$11,684	26	124	$ 7,439	10	($ 4,245)	-36
Cancer	89	6,208	14	98	6,526	9	318	+ 5
Stroke	65	5,499	12	57	4,192	5	(1,307)	-24
Kidney Disease	22	1,518	3	74	6,246	8	4,728	+311
Pulmonary Disease	22	2,479	5	35	2,875	4	396	+16
Diabetes and other related diseases	19	1,055	2	42	2,315	3	1,260	+119
Multicategorical/ Comprehensive	221	16,843	37	577	46,947	61	30,105	+189
TOTAL	594	$45,286	100%	1,007	$76,540	100%	$31,255	+ 69%

*Total current funding level, which includes some funds obligated in prior years.

SPECIAL TARGET POPULATION BY RACE OR ETHNIC GROUP
(RMP Operational Projects for FY 71 and FY 72)

Race or Ethnic Group	FY 1971 No. of Projects	FY 1971 Amount (in thousands)	FY 1971 %	FY 1972 No. of Projects	FY 1972 Amount (in thousands	FY 1972 %	Net Change Amount (in thousands	Net Change %
Black	29	$ 3,933	9	69	$ 8,202	11	$ 4,269	+ 109
American Indian	4	312	1	8	682	1	370	+ 119
Spanish American	4	168	-	27	2,176	3	2,008	+1,195
Oriental	1	188	-	0	0	-	(188)	- 100
Other/Combined	8	832	2	43	5,962	8	5,130	+ 617
Not Relevant	548	39,852	88	860	59,518	78	19,666	+ 49
TOTAL	594	$45,285	100%	1,007	$76,540	100%	$31,255	+ 69%

K.

COURSE REGISTRATIONS IN RMP-SPONSORED EDUCATION ACTIVITIES FY 72
(Listed by Type of Training Received and Discipline of Recipient)

DISCIPLINE	CONTINUING EDUCATION a/	NEW SKILLS FOR EXISTING PERSONNEL b/	NEW PERSONNEL c/	TOTAL No.	TOTAL Percent
Physicians (MD/DO)	46,328	10,140	-	56,468	29%
Dentists	1,442	197	-	1,639	1
Nursing Personnel	36,301	25,072	146	61,519	32
Allied Health Personnel	23,011	12,362	1,205	36,578	18
Hospital/Nursing Home Personnel	10,414	694		11,108	6
Medical, Dental and Nursing Students	6,106	1,139		7,245	4
Other	8,582	9,579	1,064	19,225	10
TOTALS	132,184	59,183	2,415	193,782	100%

a/ Continuing Education - courses aimed at maintaining or improving the level of practice of the health professional.

b/ New Skills for Existing Personnel - training aimed at enabling the person trained to assume new responsibilities in the already chosen career field or adding skills in a different but related health field (e.g., coronary care training for nurses, career mobility for licensed practical nurses).

c/ New Personnel - development of training programs for such new categories of personnel as physicians' assistants, nurse practitioners, and community health workers.