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RLF

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PROPOSED OUTLINE FOR RMP DECISION PAPER

I. NARRATIVE DISCUSSION

A. Program Description: Brief, summary touching upon:

1. Legislative and administrative history/evolution.

2. Current status of RMPs in terms of

a. structure and process

b. program activities

3. RMPS-RMP nexus highlighting

a. national review and funding process

b. decentralization

B. Criticisms of Program: Identification of major criticisms, their bases/sources, and including when appropriate brief rejoinders to "set the record straight."

1. Lack of really any overall program strategy and direction, specific mission, etc.

a. Local laisse faire/Brownian movement

b. No "agreement" at national level (e.g., HEW, HS) as to RMP role. General agreement by all concerned that RMP needs to be tied to a larger national purpose, but none as to what more specifically that should be.

2. Non-compliance with, non-responsiveness to national priorities

3. Major educational and training trust of RMP inappropriate, not valid

a. Subsidization of continuing education for physicians specifically

b. Turf issue vis-a-vis BHME generally

4. Inordinate "overhead" cost of supporting RMPs (Program staffs, and related activities)

5. Involvement in planning, which is CHP's bag.

6. Provider/medical school domination

7. Continued centralization of program administration and management at Federal level.

    a. Too little RO involvement

    b. Council has too much say-so

8. Inadequate demonstration/documentation of substantive accomplishments

9. Categorical nature

C. <u>Program Strengths</u>: Enumeration of the major strengths of RMP on which there is general agreement, consensus.

1. Constitutes a functioning and acceptable link between the Federal government and providers of care

2. Provides a forum and mechanism for productive dialogue and cooperative action between and among formerly disparate health interests and groups at the local level.

3. Supports and strengthens institutional reform in health arena

4. Strengthens local initiative and non-dependency

5. Bridges the services-education/town-gown chasm

6. Enhances local health planning, both its capacity and potential pay-off

7. Increasingly problem-oriented (e.g., EMS, quality assurance).

8. Provides a good fulcum for increasing the leverage of limited Federal health dollars.

9. Flexibility

D. <u>Federal Needs</u>: Identification of those major, rather specific Federal health needs that RMP might reasonably be expected to contribute to.

1. Implementation of quality control/assurance mechanisms

2. Mechanism(s) for conducting pilot experiments, demonstrations, and reforms within the system. This includes community-based test beds for <u>valid</u> R&D efforts.

3. Local implementation of CHP plans and priorities.

4. Promotion of/assistance to new Federal initiatives (e.g., HMO, EMS, AHEC).

5. Vehicle for large-scale implementation of community-based categorical control programs (e.g., hypertension, end-stage renal disease)

6. Feedback loop from the service to the educational sector, those institutions responsible for the production/training of health manpower

7. Stimulation and support of greater sharing of resources and services among health institutions aimed at moderating cost increases.

II. ISSUES AND OPTIONS

A. Issues

B. Options

Both of these are pretty well laid out in the Berman and DuVal outlines.

III. APPENDICES