E001213

REGIONAL MEDICAL PROGRAMS DECISION PAPER

I. RMP ALTERNATIVES

A. MISSION

ISSUE

What should be the future mission (role) of RMP?

OPTION 1 - A principal agency responsible for implementing change in local delivery system (implementing agencies for CHP and other HSMHA components, NIH, etc.). (Eliminate restriction on interference with practice of medicine and categorical emphasis.)

PRO

1. Clearly separates planning from implementation.
2. Consistent with HSMHA's mission in delivery reform.
3. Gives it specificity without unnecessary restriction.
4. Has been successful in past in implementing role.

CON

1. Makes it hard to evaluate.
2. Hard for Federal direction.
3. Possibly unpopular with AMA and other lobbying groups to eliminate restrictions on interference.
4. Dependent upon emergence of an effective local planning process.
5. Would impose an untested responsibility on RMP's in terms of relationship to CHP agencies.

OPTION 2 - Continue as is -- flexible, variable, broad authority which encourages providers to use their own initiative to bring about change they support.

PRO

1. Consistent with HEW/HSMHA philosophy of decentralization and local initiative.
2. Allows flexibilities so that the program is able to meet local needs in a local manner.
3. Maintains flexibility for responding to changing national priorities.

CON

1. May not be highly responsive to HEW priorities.
2. Evaluation is more complex when program is investing in a variety of activities.
3. Provides Federal support for some projects and reforms for which providers should bear the cost (e.g., continuing education of physicians).

OPTION 3 - Restricts Option 2 to "categorical areas" (Heart, cancer, stroke, kidney).

PRO

1. Political and professional constituency easy to identify and highly supportive.
2. Easier to account for expenditures
3. Provides opportunity for working relationship between NIH research and development activities and HSMHA focus on delivery activities.

CON

1. Tends to fragment delivery system - obstruct efforts to improve access.
2. Inconsistent with HEW position on limiting categorical approaches to solving problems.
3. Raises question of duplication of effort and funding with NIH.

OPTION 4 - Improving the utilization and productivity of manpower.

PRO

1. Consistent with HEW philosophy of cost containment and delivery reform.
2. Progress in this area cannot be achieved without the input and involvement of providers.
3. Encourages a closer relationship between the production of health manpower and their actual performance or utilization (relationship between education and health services delivery).
4. Provides the opportunity for a closer working relationship among a variety of manpower activities (BHME, VA, OE, Labor) and HSMHA delivery system reform activities at the community level.

CON

1. Could be done well only with a consistent Federal health manpower strategy. Otherwise might produce scattered, inconsistent activities.
2. Creates resistance from educational institutions which regard this as their area of responsibility.
3. Creates bureaucratic turf problems à la AHEC's.

4. Increasing productivity raises the question of whether we really know enough to accomplish this, and if we do, can we really capitalize on it - manipulate the system enough to use it.

OPTION 5 - Agency Responsible for aiding local groups to organize and audit review activities aimed at assessing and assuring quality of care throughout the country.

PRO

1. Necessary to develop mechanisms for measuring quality that are workable and acceptable to providers and the community.
2. Necessary to provide corrective action in response to deficiencies identified by quality monitoring.
3. Only provider influenced groups will be effective in this area.
4. Efforts to develop peer review mechanisms require extensive resources and technical assistance to raise the level of understanding of quality monitoring and start initial development at the State or community level.

CON

1. Difficult to measure results.
2. The costs of this effort might better be borne by provider groups than HEW.

OPTION 6 - Agency responsible for monitoring quality of care.

PRO

1. Federal need to take more positive leadership to provide an alternative to or implement PSRO's and Quality Assurance Commission

mechanisms, which completes the cycle of : (a) development of monitoring systems; (b) actual monitoring itself; and (c) corrective action in areas of identified deficiency.

2. All pro-arguments in Option 5.
3. Logical existing institution which relates to a greater range of provider groups than just medical societies as in PSRO's.

CON

1. Not all RMP's are equipped to handle this responsibility.
2. Raises the question of whether providers should be involved in regulating their own activities.
3. Monitoring or regulatory power would jeopardize relationship that RMP's have developed with providers.
4. Would probably limit RMP to that activity as would set it up in antagonist role with provider colleagues.

OPTION 7 - Eliminate the program completely.

PRO

1. In times of budget stringency, some money could be saved.
2. Provider dominated groups will not bring about major change in delivery system.
3. See criticisms of Program in Section I of narrative.

CON

1. Has taken 5 years to develop an acceptable link between Federal government and providers of care which would be lost.
2. Provides a flexible implementing mechanism at the community level to work on problem areas.

3. May not be politically viable.

4. See Program Strengths in Section I of narrative.

RECOMMENDATION:

Primary Mission ____________________

Secondary Mission ____________________

Not Recommended ____________________

RATIONALE:

CONCUR ____

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NONCONCUR ____