
E001217

FEDERAL NEEDS

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

Monitoring of the quality of health care and efforts to promote quality assurance are receiving increasing attention at both the national and community levels. This is reflected in the legislative proposals under debate this past year, including (a) the Professional Standards Review Organizations, involving mainly the medical societies, and which would be responsible for assessing the quality of care delivered under Medicare and Medicaid; and (b) the Quality of Care Commission outlined in S. 3327 which moves toward a national focus on regulating quality.

It is possible to look at quality assessment efforts comprised of three basic components: (1) development of the quality assessment system itself, including technical assistance to start it at the State or local level; (2) the actual operation of a quality monitoring system; and (3) corrective action which is taken as a result of areas of deficiency pointed out by the monitoring system.

To date, RMP has been mostly involved in corrective action to meet obvious problem areas. This has centered on patient care demonstrations involving new techniques and innovations in health care patterns, educational efforts aimed at correcting identified areas of deficiency, and a variety of systems changes which can improve resource allocation. RMP has also been involved with the development of standards and

guidelines for high quality care in particular disease areas, and contracts with major medical societies to identify criteria for good medical practice.

During FY72, RMP started to work in the area of developing quality assessment systems, or at least raising the level of health care provider understanding and experience of the objectives and techniques of quality monitoring as rapidly as possible. RMPS plans development this year of an inter-regional program for development of quality of care consultative services. The first inter-regional effort is that of the 14 Southeastern RMP's and their Committee on Quality of Care Assessment. This Committee and activity is seeking to determine the most satisfactory method of developing the expertise and direction needed to provide technical support to the providers of medical care in the Southeastern U.S., and its first conference involved a number of representatives from State medical societies.

A National Meeting of RMP Coordinators on Quality of Care will be held in January 1973, to develop a common frame of reference and policy for implementing a quality of care program. This will be followed by inter-regional sectional meetings to apply these policies to their own particular regional problems. It is planned that at least half of the RMPs would gain capability for technical assistance on monitoring the quality of health care by the end of 1973.

There has been little consideration so far in RMP of moving beyond the developmental and technical assistance role to having a direct monitoring responsibility for quality of care. There is no uncertainty

about the need for RMP to concentrate on improving the quality of medical care. There is a need to more clearly determine the extent to which RMP efforts will be turned in this direction and the scope of programmatic efforts which should be maintained or initiated.

2. Local Implementation of CHP Plans and Priorities

Depending on the nature of decisions made about the future role of the CHP agencies, there will probably be the need for some sort of implementing agency or agencies to take those actions and promote those activities necessary to accomplish projects and agreed upon plans. Such an implementing body would need to be responsive to the priorities and plans which had been developed by the CHP agencies.

Planning-Implementation-Direct Operations may be viewed as constituting a continuum. While these functions can and need to be distinguished from each other, they also must be related and linked to each other.

(a) Planning seeks to determine what needs to be done, to establish priorities. It must be essentially an open and political process, with access and accountability to the public.

(b) Implementation is the functional responsibility for seeing to it that things do get done, determining which among a number of alternatives for achieving the same end are feasible or best. Implementation in this sense requires professional and technical competencies and resources.

(c) Operations is the actual doing whether that be the construction of an extended care wing for a community hospital or the diagnosis and treatment of an individual patient by a physician in his office.

An implementing agency would be involved in a number of different functions, some closely related to planning and others closer to operations. These might include:

(a) Developing options for achieving specific ends, objectives and priorities within the resources available; and laying out the consequences of priority efforts in one direction for other areas. This relates closely to the planning function.

(b) Educating and informing health provider groups and institutions--those who eventually will be responsible for the doing, or operations -- as to the health priorities and plans which have been developed and agreed upon.

(c) Promoting and programming the development of resources and services required to meet priorities established by the planning agency. This is the positive and special contribution of the implementing as opposed to the planning agency. The planning agency, given "review and approval" authority can in effect say "NO" to proposed activities and undertakings that are not in keeping with its plan and priorities. That in no way insures that high priorities will in fact be achieved, however. Rather it is a safeguard that lower priority undertakings will not be achieved at the expense of higher priorities. To move toward actual accomplishment will often require technical assistance in developing appropriate programs and projects, which the implementing agency can provide.

(d) Operational planning and development at those times and in those places where there are no groups, institutions or organizations to respond to the implementing agency's positive programming efforts. Any implementing agency will upon occasion have to assume some operational responsibilities, to in effect spawn or nurture new activities if certain priorities are to be met,

Regional Medical Programs tend to fit rather naturally into the implementor role, although this has not been in conjunction with CHP plans or priorities in particular. Reasons for looking toward RMP's as implementing agencies include the linkage with the provider community, which will eventually be responsible for actual implementation; their current existence as viable, functioning organizations covering the entire country; and their past experience in this role in terms of patient care demonstration projects, emergency medical service systems, and program staff activities in promoting a range of new initiatives such as HMO's and quality assurance efforts.

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

There has not been a particularly great emphasis on designing the products of health services research and development for widespread implementation at the local level. Much of what is locally developed does not take advantage of experiences elsewhere in the country.

This area of widespread introduction of innovations into the health care delivery system is one in which RMP is already somewhat involved, but which could be expanded upon and made more explicit. This would be in keeping with one facet of the original RMP mandate which was to promote the latest advances, and it would also provide a needed compliment or "outlet" to HS' research and development efforts.

The RMP's have been working more closely with the National Center for Health Services Research and Development recently, particularly in relation to developing the Experimental Health Services Delivery Systems. Links with NCHSR&D have been and need to be further strengthened so that innovative concepts can more readily be made ready for practice and implemented in private delivery systems. The advantages of total national coverage and the inclusion of all levels of providers are apparent. It is most likely that this should be a special facet of the major RMP mission rather than the central emphasis per se.

4. Promotion of/assistance to new Federal initiatives (e.g., HMO's, Emergency Medical Service Systems).

As new Federal initiatives are decided upon, their success depends a great deal on having agencies at the local level which can respond quickly and effectively to initiate new program activities.

For a variety of reasons, the Regional Medical Programs are able to function well in responding to such new Federal initiatives:

- They are linked to the provider community which allows them to highlight new initiatives and seek provider involvement.
- They are functioning organizations with staff, committee structures, and operating experience, which allows them to begin work on new initiatives and implement program activities quickly.
- The RMPS policy of selective funding tends to reward those regions which are mature and responsive to national priorities and concerns.
- The RMP grant structure, allowing for both operational project activity and program staff activity provides great flexibility to the individual RMP in how best to respond to a particular initiative.

The RMP effort in responding to the emergency medical service system initiative and the HMO initiative seem to bear out their ability to react quickly and flexibly to new initiatives.

5. Vehicle for large-scale implementation of community-based disease control programs, such as hypertension and end-stage renal disease.

Given recent Congressional action in terms of the National Cancer Act and the National Heart, Blood Vessel, Lung and Blood act of 1972, one possible area of focus is on community-based disease control programs. In part because of its legislative background, there are some proponents of having RMP give emphasis to large-scale implementation and support of disease control programs.

Such disease control programs might best be carried out by a mechanism which has close ties to community health institutions, rather than by one of the national research institutes. Use of the RMP mechanism would help ensure that the disease control activities undertaken would be more nearly integrated with or linked to the larger health care delivery system and private provider sector at the local level.

Another area of possible emphasis relates to the guidelines for high quality care in particular disease areas developed under RMPS auspices. The best example is the contract with the Inter-Society Commission for Heart Disease Resources. The purpose of the contract and the Commission was to establish guidelines for the prevention, treatment and rehabilitation of patients with cardiovascular diseases. Several RMP's have designed major program efforts around these guidelines. They represent excellent vehicles for meaningful disease control projects which would strengthen rather than fragment the delivery system.

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

There is currently a very tenuous connection between the educational sector, more specifically the medical schools and other health personnel schools, and the patient services sector in the form of community hospitals and the practicing physicians. The educational sector tends to project its plans on the basis of shortages of specific personnel; the patient services sector, on the other hand, tends to look at gaps in health services, either in terms of specific population groups or geography. There is not a well-formed attempt to relate education to the health service delivery needs of an area.

Regional Medical Programs can play a part in this effort by developing an improved feedback loop from the patient service sector to the educational sector, so that the focus of the latter is concentrated on gaps in health services, many of which might be filled by existing manpower.

The definition of health service needs should involve participation of a wide range of health service and educational institutions, such as community colleges, hospitals, health professionals and consumers, as well as the medical centers. A community-based identification of health service needs should logically precede any determination of the numbers and types of health personnel needed and how they should be trained. It may well be determined that what is needed is not necessarily more manpower but better organization and utilization of manpower resources that are already available.

Both RMP and CHP can promote this approach of community involvement in the identification of needs and in implementation of program and educational activities which seek to address those needs.

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

There is a continuing need for the development of improved institutional linkages to increase the productivity of each of the participating institutions. Such linkages extend their capacity where limited services already exist, and provide for increased availability and accessibility where such services do not exist.

Regionalization and new organizational arrangements are major themes of Regional Medical Programs. Working relationships and linkages among community hospitals and between such hospitals and medical centers are among the primary concerns of the program. The linking of less specialized health resources and facilities such as small community hospitals with more specialized ones is an important way of overcoming the maldistribution of certain resources, and thereby increasing their availability and enhancing their accessibility.

The development of regionalized professional and institutional linkages aids in linking patient care with health research and education within an entire region to provide a mutually beneficial interaction. It also helps to emphasize the delivery of primary care at the local or community level, while promoting specialty care as the province of the medical center and larger community hospitals.

Kidney disease is one area in which the development of integrated regional systems can prevent the duplication which has so frequently wasted our limited resources. Dialysis and transplant centers can be planned in regional/national networks to maximize access to

life-saving services. It provides the opportunity for a planned and organized model of how such scarce resources can be linked together efficiently.