
E000975

1. PURPOSE

REGIONAL MEDICAL PROGRAMS

I. Program Purpose and Accomplishments

The Regional Medical Programs seek to strengthen and improve the Nation's personal health care system in order to bring about more accessible, efficient, and high quality health care to the American public. To accomplish these ends the Regional Medical Programs:

- Promote and demonstrate among providers at the local level new techniques and innovative delivery patterns for improving health care, with particular attention to those diseases which are major causes of death and disability.

- Stimulate and support those activities which will both help existing health manpower to provide more and better care and will result in the more effective utilization of new kinds and combinations of manpower.

- Encourage providers to accept and enable them to initiate regionalization of health facilities, manpower, and other resources so that more appropriate and better care will be accessible and available at the local and regional levels.

- Identify or assist to develop and facilitate the implementation of new and specific mechanisms that provide quality control and improved standards of care.

The RMPs develop their programs through a consortium of providers who come together to plan and implement activities to meet health needs which cannot be met by individual practitioners, health professionals, hospitals, and other institutions acting alone. The RMP provides a framework deliberately designed to take into account local resources, patterns of practice and referrals, and needs. As such it is a potentially important force for bringing about and assisting with changes in the provision of personal health services and care.

Legislative Background

The initial concept of Regional Medical Programs was to provide a vehicle by which scientific knowledge could be more readily transferred to the providers of health services, and by so doing, improve the quality of care provided with a strong emphasis on heart disease, cancer, stroke, and related diseases. The role of RMP, as originally conceived, was to assist the health professions and institutions of the Nation in their efforts to organize and develop preventive, diagnostic, and treatment services directed toward the control of

these categorical diseases. This original mission strongly reflected the program's origin, the President's Commission on Heart Disease, Cancer and Stroke which submitted its Report in December 1964.

The first authorizing legislation (P.L. 89-239), enacted in October 1965, considerably modified the concepts contained in that Report and many of its recommendations. Whereas the Commission had envisaged a linked network of specialized, treatment centers and diagnostic stations, the legislation enacted reflected an awareness of the need to involve all health providers and institutions in an attack upon this problem and a recognition of the potential which regionalization of service patterns and education would bring. It embodied the concept of regional "cooperative arrangements" among providers as the principal means for achieving that, and stressed the linking and improved utilization of existing resources (e.g., facilities, manpower) rather than the creation of new ones in reducing the toll from those categorical diseases which account for 70 percent of all the deaths in America.

The implementation and experience of RMP over the past eight years, coupled with the broadening of the initial concept especially as reflected in the last legislative extension (P.L. 91-515), has clarified the operational premise on which it is based -- namely that the providers of care in the private sector, given the opportunities, have both the innate capacity and the will to provide quality care to all Americans given an instrument or mechanism appropriate to that task. The most recent legislative extension, signed as the Health Services Improvement Act in October of 1970, contained the following emphases:

- A recognition of the need "to strengthen and improve primary care and the relationship between specialized and primary care," and "to improve health services for persons residing in areas with limited health services."

- An authorization for grants or contracts to support studies and demonstrations "... designed to maximize the utilization of health manpower in the delivery of health services."

- A similar authorization "... to assist in meeting the costs of special projects for improving or developing new means for the delivery of health services ..."

In sum, the legislative changes reflected the current concerns with the health care system, namely the need to improve availability of and access to high quality health care, and to make more efficient utilization of the range of health manpower and other health resources that exist or that are being developed.

It thus became abundantly clear that for the RMP's to effectively address categorical disease problems and needs frequently required more comprehensive approaches. There has been a growing recognition that within the context of its emphasis on heart disease, cancer, stroke, and kidney disease, the Regional Medical Programs must share with all health groups, institutions, and programs (private and public) the broad, overall goals of (1) increasing the availability and accessibility of care, (2) enhancing its quality, and (3) moderating its costs -- making the organization of services and delivery of care more efficient. What this has meant in more specific, operational terms is that RMPs increasingly have focused their attention and efforts on helping develop the resources needed if those broad goals are to be achieved and initiating and demonstrating new ways of delivering and organizing health care services.

Current Program Status and Characteristics

There currently are 56 functioning RMPs, nationwide coverage having been achieved by 1968. All but two, South Dakota and Delaware which reflect recent break-a-ways from larger Regions, are fully operational. Their summary characteristics and features are as follows:

- The RMP's are primarily linked to and work through providers, especially practicing health professionals and community health care institutions, largely in the private sector.

- They essentially represent a voluntary approach drawing heavily upon existing resources. The voluntary nature is reflected in the membership of the Regional Advisory Groups, which have responsibility for setting program directions and priorities in each Region, as well as approving individual project applications. About 2,700 practicing physicians, hospital administrators, other health professionals, community leaders, and public representatives presently serve on the 56 Regional Advisory Groups. Practicing physicians constitute the single largest group (28%); public representation has continuously increased over the years (21% presently); conversely, medical center officials have steadily decreased (currently 8%).

- Well over 12,000 physicians (50%), nurses and allied health professionals (23%), and others currently serve on other RMP task forces and committees (e.g., health manpower, hypertension) and local and area advisory groups.

- Thirty-eight (38) encompass one (e.g., Maine) or several whole states (e.g., Washington-Alaska). Of the remainder, 11 are parts of single states with Pennsylvania, New York, and Ohio

accounting for nearly all of these; and seven are parts of two or more states (e.g., Bi-State which encompasses metropolitan St. Louis and Southern Illinois). There are only three areas of significant overlap.

- The Regions range in size from Washington-Alaska (638,000 square miles) to Metropolitan Washington, D.C. (1,500 square miles); and in population from California (over 20 million) to Northern New England (under 500,000).

- Thirty-three (33) of the grantees are universities, of which 26 are public (e.g., University of Missouri) and only seven are private (e.g., Albany Medical College). New corporations specifically established to administer an RMP (e.g., Michigan Association for RMP) are grantees in 16 instances; previously existing corporations or consortia (e.g., WICHE) in three; and state medical societies in four. Over the past years there has been a modest but continuing trend toward new corporations.

- The concept of time-limited support has always been central to RMP. Thus, incorporation within the regular health care financing system of RMP-funded projects and activities is an important measure of success or failure.

- In improving the accessibility and availability of care, as well as its quality, RMP has concentrated almost exclusively upon resources/services development. It has not been significantly involved with the direct provision of services, or their payment.

Program and Operational Activities

Because of experience gained in implementing the operational programs, and the broader legislative mandate of 1970, Regional Medical Programs have expanded the areas of focus on which the individual programs are concentrating. The shift in emphasis is reflected in the range of operational projects being carried on across the country. During 1970 and 1971, some 600 operational activities were on-going, while in 1972 this number rose to 1,000 projects. The four basic areas of program concentration during this period are:

- Innovations and Improvements in Health Care Delivery Systems -- New techniques and innovative delivery patterns that lead to improved accessibility, efficiency and effectiveness of health care are being developed and tested under RMP auspices:

  - Emergency Medical Service Systems - some 28 emergency medical service system components were funded in FY72 at a level of $8.4 million. Special attention is given to assuring that such systems are integrated with the total health care delivery system of a community or region, and include the best techniques for care of patients with acute cardiac problems and strokes.

- Out-Patient Care - almost one-fifth of RMP operational funds are now in ambulatory care activities such as neighborhood health centers and out-patient departments of hospitals.

- Improving Availability and Accessibility for Minority and Inner-City Populations - In fiscal year 1972 activities directed at special target populations such as Blacks, Spanish-Americans, and Indians more than doubled, from 46 projects and $5.4 million to 147 projects with $17 million in RMP funding.

- Manpower Development and Utilization -- Regional Medical Programs is promoting a broad array of manpower activities, designed around the central concepts of enabling existing health manpower to provide more and better care, and training and more effective utilization of new kinds of health manpower. The basic concept of RMPS efforts in this area is that better use can be made of existing manpower assets.

  In FY72, some $13.3 million was being spent for training designed to provide existing health personnel, principally nurses, with new skills (e.g., pediatric nurses), and an additional $3.7 million was for training new categories of health personnel (e.g., physicians' assistants). Only $12 million of the total was for general continuing education activities, some of which, an estimated 25-33%, was for nurses and other non-physician categories of health personnel.

- Regionalization and Kidney Disease Programs -- Kidney disease and heart disease are special categories in which the development of integrated regional systems can prevent the duplication which has so frequently wasted our limited resources. In the field of kidney disease, for example, RMP is in the process of developing regional/national networks of dialysis and transplant centers, so as to maximize access to life-saving services enhancing quality and efficiency.

  Between FY71 and FY72 there was a fourfold increase in the funding of operational projects concerned with kidney disease. By the end of FY72, 29 Regional Medical Programs were supporting end-stage renal activities at a funding level of approximately $6 million, in contrast to a level of $1.5 million in FY71.

- Quality of Care -- RMP is concerned with both the quality of health services provided through the individual patient encounter, and in efforts to improve quality assessment and assurance programs.

- Quality of Health Services - Efforts to improve the quality of health services delivered have centered on patient care demonstrations involving innovations in health care patterns, education efforts aimed at correcting identified areas of deficiency, and a variety of systems changes which can improve resources allocation. Between fiscal years 1971 and 1972, patient care demonstration projects rose from 150 and $15.4 million to 250 and $31.4 million, an increase of over 100 percent.

- Quality Assessment and Standards - During 1972 there has been an increasing emphasis on developing practicable methods for assessing the quality of medical care in various types of delivery systems. Three particular areas of effort are: (1) the development of standards and guidelines for high quality care in particular disease areas; (2) contracts with major medical societies to identify criteria for good medical practice; and (3) surveys to identify hospitals which make available the most advanced techniques for treating heart disease, cancer, stroke and kidney disease.

  Guidelines have been developed by the Inter-Society Commission on Heart Disease, for example, on effective management of heart disease. Several RMP's have designed major program efforts around the guidelines and others are highly interested in doing so. They represent technically sound, rational vehicles for meaningful control projects which would strengthen rather than further fragment the delivery system.

In addition, a significant portion of the overall RMP effort is through program staff and program activities, best defined as those functions central to the operation of an RMP. They 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.

Expanding emphasis is on developing the complementary roles with Comprehensive Health Planning and other local health agencies. Increasingly, the Regional Medical Programs, with their strong provider links, are being viewed and used as an important technical, professional and data resource by State and Areawide Comprehensive Health Planning agencies in their planning for personal health services. In turn, Regional Medical Programs are looking to Comprehensive Health Planning agencies to express the health needs of the total community from the consumer's point of view and in effect to help set priorities for the Regional Medical Programs efforts.

The range of activity open to the RMP program staffs has broadened considerably as the national program has moved toward a greater decentralization of authority and responsibility. A major step in this direction was taken in mid-1971 with the decentralization of project review and funding authority and responsibility to the 56 RMPs. Each RMP, with its broadly-based Regional Advisory Group, is being given the primary responsibility for deciding (1) the technical adequacy of proposed operational projects and (2) which proposed activities are to be funded within the total amount available to them.

In addition, Regions are now being ranked or grouped in terms of quality — (A) those which have demonstrated the greatest maturity and potential, (B) those which are generally satisfactory in their performance and progress, and (C) those which are below average. This in turn has permitted RMPS to implement a stronger policy of selective funding.

Under this selective funding policy, which was formally initiated in FY72, those Regions which have demonstrated outstanding maturity and potential and whose proposals are most nearly congruent with the expanded RMP mission and national priorities, would be awarded proportionately greater fund increases.