
E001201

DECISION PAPER ON REGIONAL MEDICAL PROGRAMS

SUMMARY

Program Description

In considering Regional Medical Programs -- its current status, criticisms voiced about it, the program's principal features and strengths -- there are some fundamental characteristics about the program which derive from both its early history and program experience since then which need to be considered:

* RMP is primarily linked to and works through providers, especially practicing health professionals and community health care institutions, largely in the private sector.

* It essentially is a voluntary approach drawing heavily upon existing resources. The voluntary nature is reflected in the 2,700 practicing physicians, hospital administrators, other health professionals, and public representatives who serve on the Regional Advisory Groups, and some 12,000 other representatives of health interests who serve on RMP task forces and committees.

* RMP is oriented toward problem-solving efforts. Most of its planning centers around particular needs and operational problems, rather than being on-going broad-based planning and data systems.

* The initial concept of RMP and the early legislative history placed a strong emphasis on moving the "latest advances" in heart disease, cancer and stroke out to greater use by health practitioners, so as to improve patient care.

* The implementation and experience of RMP, coupled with the broadening effect of the last legislative extension (P.L. 91-515), have moved the program toward a greater emphasis on primary care and ambulatory care. There has been a growing recognition by the RMP's that in order to effectively address categorical disease problems and needs frequently requires more comprehensive approaches, that the unavailability and unaccessibility of primary care insofar as many groups and areas are concerned precludes direct categorical services.

* This shift in emphasis is reflected by recent funding patterns. In FY72, 61% of operational activities were comprehensive or multi-categorical in nature, while only 39% had essentially a single disease focus (e.g., kidney disease, cancer). That represents almost a complete reversal over the previous year, FY71, when the figures were 37% and 63% respectively.

* Program staff and program activities have generally accounted for approximately 40% of the RMP budgets. Only about half of this,

however, represents program direction or project development and monitoring. The other half is engaged in feasibility studies for larger-scale operational projects and professional consultation to community health groups and institutions.

* 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.

* RMP has moved toward becoming a largely decentralized program. Each RMP, with its broadly-based Regional Advisory Group, is being given the primary responsibility for decisions with respect to (1) the technical adequacy of proposals and (2) determining which activities and projects are to be funded with the limited funds awarded to them annually.

* Furthermore, under the selective funding policy, the individual RMP's are ranked, and proportionately greater fund increases are provided to those RMP's which have demonstrated outstanding maturity and whose proposals are most nearly congruent with the expanded RMP mission and national priorities.

Criticisms of Program and Responses

1. There has been a lack of any overall program strategy and direction, or specific mission for Regional Medical Programs.

   -- The mandate of RMP as defined by legislation has always been broad. This has been both a source of strength, allowing the regions flexibility to move into a wide range of areas, but also a source of criticism in the sense that a particular RMP focus has not always been identified. RMPS has made an effort over the past year and a half to define its role more specifically, including development of a Mission Statement which identifies substantive objectives as primary areas of focus for the RMP's, namely:

   . Innovations and improvements in health care delivery systems.
   . Manpower development and utilization activities.
   . Quality assurance - development and implementation of new and specific mechanisms that provide quality assessment and assurance.

   Despite this effort, new legislative developments and a lack of agreement among interested parties requires a more definitive statement setting forth the central focus of RMP.

2. Regional Medical Programs have been non-responsive to national priorities.

-- RMP responsiveness to national priorities, at least on a short-term basis, is demonstratable in a number of program efforts. After Emergency Medical Services was highlighted as a national health priority in the President's Health Message in January 1972, within six months some 36 RMP's had responded with over 50 EMS proposals. This led to awards of $8.4 million to 28 regions for new EMS projects in FY72. The RMP's also responded rapidly to the HMO development initiative, with more than half initiating HMO-related activities without additional grant inducements.

3. The major educational and training thrust of RMP is not appropriate. More specifically: (a) RMP support for the subsidization of continuing education for physicians is inappropriate; and (b) RMP's are involved in some of the same activities which BHME is sponsoring.

-- RMP support for continuing education (at a level of approximately $12 million in FY72) has been more for development of such programs rather than "subsidies" or stipend support. Funding is generally limited to a three-year period, and stipends are not authorized for short-term or long-term continuing education activities. There remains the question of whether continuing education should continue to receive Federal support for development.

There are areas of overlap with BHME although it tends to focus more on productivity, while the RMP focus is on improving utilization. The entire health manpower area is one in which there needs to be a sorting out of functions and areas of responsibility.

4. There is an inordinate "overhead" cost of supporting the RMP's in terms of their program staffs and related activities.

-- Program staff and activities generally accounted for approximately 40% of the total funding level. This is not all overhead, however, as it is often identified. Approximately 27% of the program staff budget goes for program direction and administration, and another 22% for project development, review and management. The other 51% of these funds is used to fund a variety of small scale feasibility and developmental studies designed to assess the potential of prototype programs or techniques for larger scale application, or for professional consultation and staff assistance to other health programs and institutions. Most of the recent HMO-related activities of an educational nature, for example, were undertaken by RMP program staff with funds budgeted for general program activities.

5. RMP is involved in planning, which should be the responsibility of the CHP agencies.

-- The majority of RMP planning and health data activity is really operational planning and centers around particular needs and problems,

rather than being on-going broad-based planning and data systems. Most of the planning and inventory studies, funded in recent years at a level of about $4 million, are set up to lead to specific operational proposals dealing with suchissues as unmet educaticnal and specialized facility needs of a region. At the same time, it is probably necessary to reinforce the distinction between the planning function of the CHP agencies and the operational or implementing function of the RMP's.

6. There is a lack of coordination between the planning done by CHP and the operational activities of the Regional Medical Programs.

-- At least two sets of problems are involved here. First, the development of actual CHP plans and priority statements at the areawide level has been rather slow, leading to inadequate criteria against which to judge RMP and other HSMHA proposals. A preliminary survey of CHP review and comment letters on RMP projects indicated that less than 5% of unfavorable project reviews were based on comments that the project did not fit in with community or CHP plan priorities. Most of the unfavorable comments related to technical reasons such as cost and method of operating the project.

Second, there is not adequate evidence that the RMP's are giving full consideration to CHP agency comments. There needs to be a tighter mechanism to make certain the RMP's are involving CHP at an early stage and making greater use of the CHP comments in developing their program plans and application packages.

7. Regional Medical Programs is dominated by the medical schools and/or providers.

-- Although medical school domination was common in the early years of the program, this has markedly decreased as the more broadly-based Regional Advisory Groups have matured. In terms of RAG composition, between 1967 and 1971 medical center officials have decreased from 16% to 8%, while consumers have increased from 15% to 21%, and practicing physicians from 23% to 28%.

In addition, RMPS issued a policy statement in May of 1972 entitled "RMPS Policy Concerning Grantee and Regional Advisory Group Responsibilities and Relationships." It delineates the functions of both the RAG and the grantee, making the basic point that the RAG has responsibility for setting program direction, policy and priorities, as well as approving grant applications.

The statement that RMP is dominated by providers is certainly true, and this is considered one of the strengths of the program. RMP provides one of the major links between both the Federal government and providers of care, and between the major provider groups and the consumer-oriented CHP agencies.

8. Regional Medical Programs have not decentralized to a great enough extent.

-- RMPS has made a strong effort during the past two years to promote decentralized decisionmaking. 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 RMP's. Now Regions are, if their own review processes meet defined minimum standards, given primary responsibility for deciding (a) the technical adequacy of proposed operational projects, and (b) which proposed activities are to be funded within the total amount available to them. In addition, the National Advisory Council and the national review process are now assessing RMP's largely in terms of their overall program and progress. No longer is the technical adequacy of individual projects or discrete, singular activities the primary focus or concern.

9. There has been inadequate demonstration/documentation of substantive RMP accomplishments.

-- Part of the problem relates to documenting accomplishments of this and other HEW programs involved in social change and institutional reform. RMPS has been working over the past two years to develop its Management Information System. That system is now capable of presenting descriptive data covering all 1,000 operational components on a national basis. Descriptor summaries can present the number of projects and funding level by such groupings as primary activity (e.g., training, patient care demonstrations), sponsor, and disease category. In addition, following-up on a FAST Task Force recommendation, work is proceeding on a Management Reporting and Evaluation System which will eventually link each of the RMP's to the national information system. This should improve both documentation of RMP accomplishments and decisionmaking tied to program planning and evaluation.

10. Regional Medical Programs emphasize the categorical diseases to too great an extent.

-- With the broadening of the initial RMP concept in the last legislative extension, the program has moved toward a greater emphasis on primary care and a more comprehensive approach to health problems. In FY 1971, for example, only about one-third of the nearly 600 RMP-supported operational projects were comprehensive or multi-categorical in nature; the bulk, nearly two-thirds, had essentially a single disease focus (e.g., heart disease, cancer, stroke). By the end of FY 1972, however, well over one-half of the 1,000-odd RMP projects were of a comprehensive or multi-categorical nature, as indicated by the summary table below:

	FY71 No. of Projects	FY71 Amt.	FY71 %	FY72 No. of Projects	FY72 Amt.	FY72 %
Single, categorical disease focus	373	$28.5M	63	430	$29.6M	39
Multi-categorical or comprehensive	221	16.8M	37	574	46.7M	61

The shift of priorities is also reflected in the large percentage of funds now being directed toward projects emphasizing primary care. In FY72, this included some $10.7 million for Emergency Medical Service Systems (approximately 14% of operational project funds) and some $18 million for over 200 projects emphasizing ambulatory care (approximately 24% of operational project funds).

11. Since Regional Medical Programs do not always follow State boundaries, this will cause problems in terms of relating to CHP, etc.

-- This does not seem to present very much of a problem since most of the RMP's are already closely aligned with State boundaries. Since 34 of the 56 RMP's already make use of State boundaries, and 4 more encompass two or more entire States (serving 11 States), a policy in this direction would represent only a moderate change. Such a policy would allow a greater congruency with State CHP agencies, allowing greater consistency of RMP priorities to community and State established priorities. On the other hand, in those few cases in which the RMP does not match a State boundary, there is generally strong justification in terms of the natural medical trade area (e.g., metropolitan St. Louis and southern Illinois, Memphis, Metropolitan D.C. area).

Program Strengths

1. Regional Medical Programs constitute a functioning and acceptable link between the Federal government and the providers of health care.

-- The unique characteristic of Regional Medical Programs is that it is primarily linked to and works through providers, especially practicing health professionals. Most of these are in the private sector. Although the basic HEW orientation is consumer-oriented, it is still necessary to deal with the provider constituency which provides the bulk of medical care. If changes are to be made in the health care system, these providers will need to be involved. They contribute to the decisions of what changes should be made, and are most certainly needed to implement those changes once they have been decided upon. While CHP agencies have been the linkage to the consumer community, the Regional Medical Programs provide the major link to the provider groups.

With certain modifications, including improved coordination with CHP priorities, the RMP can be the mechanism which assures provider participation in the implementing process.

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

-- The RMP's are organized in such a way as to encourage providers to work together in a structure which offers them considerable flexibility and autonomy in determining what it is they will do to improve health care for their communities and patients, and how it is to be done. The Regional Advisory Groups, which set program policies and priorities and approve operational project activities, are made up of some 2,700 practicing physicians, hospital administrators, medical center officials, representatives of voluntary health agencies and CHP agencies, as well as members of the public.

Each region also has a structure of planning, technical review, and evaluation committees, involving some 12,000 health professionals and public representatives designed to ensure broad-based participation of health institutions and organizations. The focus of the mechanism is thus to provide a framework within which providers can come together to meet health needs that cannot be met by individual practitioners, health professionals, hospitals, and other institutions acting alone.

3. The RMP's support and strengthen institutional reform in the health arena.

-- Because of the close RMP linkage with the provider community, and because the RMP's are functioning organizations with staff, committee structures, and operating experience, they lend themselves to serving as a local medical forum and sounding board. Thus they are often looked to for information and guidance in terms of major issues being discussed or new directions being taken which will affect the health care system. In this way they provide one of the better opportunities to promote institutional reform at the regional and community level.

Major instances of RMP involvement in institutional reform are the early involvement in initiating HMO-related activities, ranging from direct financial assistance to educational activities, and recent involvement in the quality assurance/control area. Various inter-regional groupings are being formed to raise the level of provider understanding and experience of the objectives and techniques of quality monitoring.

4. RMP strengthens local initiative and non-dependency on continued Federal funds.

-- The concept of time-limited support has always been central to RMP. One measure of RMP's effectiveness is the extent to which RMP-initiated activities have been able to sell themselves in the medical market

place, to stand on their own after several years of support. Based on data available from recent reports, it is estimated that RMP support, in dollar terms, is being phased out within three years in some 75-80% of all operational projects. These same data indicate, again in terms of dollars, that roughly 60% of those projects from which RMP grant support is being withdrawn, will be continued from other sources, albeit at a reduced level of funding. This is an area where even greater emphasis must be placed in designing activities that will be able to sell themselves to the providers of care, the public which stands to benefit from them, and their third party carriers.

5. RMP can act to bridge the services-education/town-gown chasm.

-- One of the strengths of Regional Medical Programs is the ability to bridge the gap between the research-educational focus of the medical centers and the patient service focus of the community hospitals and practicing physicians. Much of this interrelationship has taken the form of operational project activities which deal with patient care demonstrations involving innovations in health care, and educational efforts aimed at correcting identified areas of deficiency.

But to be really effective in improving such relationships requires that there be more of a two-way flow between the two groups than has usually been the case. There needs to be a greater base of community involvement in addressing health care issues. This concept has become the focus of RMP activities in a range of areas, including most recently in the health manpower area. The emphasis is on developing programs that more closely relate educational efforts to the health service delivery needs of an area. 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. Such community involvement in the identification of needs and the application of available health resources is an approach which both RMP and CHP can satisfactorily promote.

6. RMP enhances community health planning, both in terms of local capacity and potential pay-off.

-- It is becoming clear that the Regional Medical Programs must look to CHPs for increasingly specific health priorities and plans if their funding decisions, which have been largely decentralized, are to have legitimacy within the community. No group representative of the broad spectrum of health providers, the overwhelming majority of whom are in the private (as opposed to public) sector, can hope to abrogate this unto itself.

CHPs in turn need RMP's to assist them in devising workable alternatives and plans that address priority needs and as a mechanism for helping to implement decisions made by the broader community which require modifications that in large measure will be required of

providers and the private sector. Because of its strong provider links, the RMP cannot only act as a forum for institutional reform among those providers (e.g., individual practitioners, hospitals, and medical centers), but it can provide professional and technical competencies, expertise, and skills to CHP and other health agencies and groups as well.

7. The Regional Medical Programs are becoming increasingly problem-oriented, addressing those issues such as Emergency Medical Service Systems and quality assurance which have gained national attention.

   -- Among areas of increased funding emphasis:

   . Activities directed at special target populations such as Blacks, Spanish-Americans and Indians more than doubled in FY72 over the previous year, from 46 projects and $5.4 million to 147 projects with $17 million in RMP funding.

   . Activities to develop rural health delivery systems rose from 57 and $3.1 million in FY71 to 171 projects and $10.9 million in FY72.

   . Support for emergency medical services systems rose from a level of less than $2 million to approximately $10.6 million.

   . Beginning in FY73, RMP is promoting the development of inter-regional resource groups to provide technical assistance and consultation in developing and implementing mechanisms for quality of care assessment and assurance.

8. RMP provides a good fulcrum for increasing the leverage of limited Federal health dollars.

   -- With a small initial input of program staff time or operational project funds, the RMP's have often been able to generate health care activities on a larger scale which brought in funds from a multiplicity of sources. In New Jersey, for example, RMP's four-year old Urban Health Component, funded at $160,000 provides planners to that state's eight Federally-designated Model Cities Programs. To date, the staff has secured more than $8.4 million from sources other than RMP to fund health programs in these cities. In addition, the New Jersey RMP recently signed a contract with the New Jersey Department of Community Affairs to provide health planning assistance to the 16 cities in the state's ten Community Development Programs.

9. RMP provides one of the most flexible mechanisms for initiating health policy and program changes.

   -- For a variety of reasons, including its organizational structure, the increasing decentralization of authority, and the growing responsiveness of regions to national priorities due to the selective funding

policy, RMP is one of the more flexible mechanisms available in terms of responding to shifts in national policy. This flexibility and ability to respond to new directions quickly is reflected in the recent response to the emergency medical system priority in which 36 RMP's responded with over 50 proposals within six months after the President's Health Message, and in the RMP response to the HMO initiative, in which over half of the RMP's initiated HMO-related activities without any additional grant inducements.

10. RMPS is developing a greater ability to turn the individual Regional Medical Programs around to direct their attention to national priorities.

-- Implementation of the selective funding policy by RMPS is designed to promote greater attention to national priorities in that it provides proportionately greater fund increases to those RMP's which have demonstrated outstanding maturity and whose proposals are most nearly congruent with the expanded RMP mission and national priorities. These regions are selected on the basis of a ranking system which uses program review criteria to assess each Region's (a) performance to date, (b) the process and organization that has been established, and (c) its proposal for future activities. Those regions not making adequate progress are given management and technical assistance aimed at improving their decisionmaking as well as the pertinence of their activities.

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

-- 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, and educational efforts aimed at correcting identified areas of deficiency. During late FY72, RMP started to work in the area of 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. 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 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.

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.

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, including their linkage to the provider community, their operating experience, and the flexibility allowed by a grant structure which incorporates both operational project activity and program staff activities, the RMP's are able to function well in responding to a variety of new Federal 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, rather than leading to further fragmentation of the system.

6. Feedback loop from the service to the educational sector, and 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 in conjunction with the CHP agencies, 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.

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. Kidney disease is one area in particular in which the development of integrated regional systems can prevent the duplication which has so frequently wasted our limited resources.

Appendices

1. Original Legislation for Regional Medical Programs - P.L. 89-239
2. Legislative Extension of 1968 - P.L. 90-574
3. Appropriations and Budgetary History
4. Legislative Extension of 1970 - P.L. 91-515
5. Mission Statement for Regional Medical Programs (6/71)
6. Policy Statement on Discretionary RMP Funding and Rebudgeting Authority
7. RMP Review Criteria - used as basis for rating regions
8. Ranking of the Regional Medical Programs as of 9/72
9. RMPS Policy Concerning Grantee and Regional Advisory Group Responsibilities and Relationships
10. RMP Review Process Requirements and Standards - standards governing the decentralization of project review and funding authority to the individual Regional Medical Programs.