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HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

National Advisory Council on Regional Medical Programs

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Wednesday, 9 February 1972

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National Advisory Council on Regional Medical Programs

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Conference Room G/H
Parklawn Building
Rockville, Maryland
Wednesday, February 9, 1972

The meeting convened at 8:40 o'clock a.m., Dr. Harold Margulies presiding.

I N D E X

P R O C E E D I N G S

DR. MARGULIES: I think in the interests of time and with the assumption that the other members of the Council who are coming will soon be here, I would like to start today's meeting beginning with some items left over from yesterday.

We did not ask you to take action on the minutes which were circulated late, and they have now been circulated. You have had an opportunity to take a look at them. If you find them acceptable, I would appreciate a motion.

DR. MILLIKAN: So move.

DR. OCHSNER: Second.

DR. MARGULIES: Is there any discussion, additions, alterations, deletions, from the minutes?

(No response.)

All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

We have gone over the possibilities of dates, cross-checked with conflicting meetings and so forth, for the rest of 1973 which would mean dates in February and in June. The ones we have selected I recognize will always produce some problem for some people, but they are February 7 and 8 and June 5 and 6.

DR. OCHSNER: Of next year?

DR. MARGULIES: Of 1973.

That doesn't change this year's dates.

DR. ROTH: Is February 7 and 8 Wednesday and Thursday?

DR. MARGULIES: Right.

DR. OCHSNER: June 5 and 6, the same as this year.

DR. MARGULIES: Tuesday and Wednesday. They happen to be, yes.

I would like to have Dr. Pahl read the new, revised resolution which was under discussion on the HMO yesterday. It is an important one, and the wording is significant. So if there is any discussion on it, this is the time for it.

DR. PAHL: This is short so I will just read it, but we can type it again and hand it out if you would like to study it.

Delegation of Council authority for approval of HMO grants: The Council shall discharge its responsibilities in regard to recommending RMP grant support for HMO feasibility studies and organization and development efforts by delegating to a subcommittee of the Council full authority to work with the Director, RMPS, and to approve applications for HMO grants.

DR. MARGULIES: Any discussion?

DR. ROTH: Move it be approved.

DR. MILLIKAN: Second.

DR. MARGULIES: All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

I think I will wait just a few minutes to give you whatever additional information I can from the meetings which carried me away yesterday. It won't be earth-shaking so you can wait.

There are two other actions. One of them carryover from the last meeting of the Council. I spoke to you yesterday and indicated we would bring this up again.

You will recall that when the Connecticut Regional Medical Program was reviewed, the ratings which they received, the Council questioned. They questioned it because they felt that the review of the Connecticut RMP that was conducted in the Council would suggest that the rating would be higher than the one which was finally assigned to the program. They asked us to review the records and see how with careful analysis of the ratings the Connecticut program would finally come out.

We have done that. We have gone over the figures as carefully as possible in the process of analyzing all of the appropriate information on all programs. And it comes out with what is essentially a relatively high B rating.

Now, as I indicated yesterday, this is the expression of the rating given it as a part of the process of review by the review committee and is brought to the attention of the Council for its acceptance or rejection. We are interested in keeping that kind of a rating system intact and useful as a numerical expression of judgment about a program. We are not interested in making it inflexible or in suggesting that it indicates more than it does indicate, which is a kind of numerical expression of what is for the most part a subjective analysis. So by putting numbers down, one doesn't change the fact that much of it, if not all of it, is subjective.

It was, as I recall, fairly high in the B rating. It did receive a strong review here. It was a rather contentious review at the time that the review committee went over it.

The Council at this point can accept the rating or it can reject it and ask that the program be given some other kind of consideration. And it is up to you to act on it.

I know that I recall clearly that this program was reviewed and presented by Dr. Millikan, so,Clark, you may have some feelings about it as a consequence of this action.

DR. MILLIKAN: Yes, I do. I wouldn't give it a B rating; I would give it an A or an A plus rating. I think it is one of the outstanding programs in the USA.

DR. MARGULIES: It is up to the Council to take what action it wants because final judgment is here, obviously.

DR. MILLIKAN: Harold, I think it is a very difficult thing at this point in time without an opportunity to review in the context of this setting some of the phenomena that have gone on in Connecticut for the Council really to make a judgment about something like this. I think it is very difficult. Do you feel that you know enough about it, for instance, on sort of a spot notice to make a comparison?

I am kind of talking out of both sides of my mouth. On the one hand, I disagree with the review committee because I happened to be on a project site visit and have been there another time in addition to that site visit. On the other hand, I would raise a query about the fairness of just a quickie change in their number without the Council getting into some involvement in looking at the Connecticut program in depth.

I have my own feelings about it, and they are very definite, but --

DR. MARGULIES: Well, Council at the last time when the review was fresh in its mind and had been going over the program in real depth questioned this rating. I think under the circumstances, what you are telling us is that the rating which it received should not be used by us as a dependable guide in judging the program or in providing it with support

because it is not as accurate a reflection of its maturity and effectiveness as one would find in other kinds of program reviews. But you would prefer not to try to give it another number which would be absurd because it would be playing games or another rating which is hard to do.

DR. MILLIKAN: About the only point on which the Connecticut RMP could be faulted at the time of that indepth review situation had to do with the interrelationship between the State medical society and the RMP. And there were those who felt that the RMP personnel had not gone the full distance that they might have gone in attempting to create a better feeling and understanding with the State medical society. There were others, including namely Dr. Wittman, that felt that the Connecticut Medical Society position was really being verbalized by a very small number of folks who continued to be adamant about the intrusion of any kind of Federal program.

DR. ROTH: Just one man, really.

DR. MILLIKAN: Really, he is a spearhead, but the reason for bringing this up is I understand via the grapevine there is some getting togetherness of the State medical society and the RMP at this point in time; that there is a new president of the State medical society; and that there is under way at least the planning for launching a mutual program under the RMP in Connecticut.

Now, is that correct?

DR. MARGULIES: Well, it is partially correct. They have asked for support, but it has not come through the RMP. It has come through the request for contract which in itself struck us as rather odd. But maybe because they felt that they would not receive the support if it came through the RMP.

DR. MILLIKAN: Is it an RMP/State medical society effort? I don't know.

DR. MARGULIES: Basically, it is, but it is really not. It is a way of sort of getting around whatever kind of new position they think we may have placed on them.

Well, if I get your feeling and if the Council assents, I think that what we should do is accept the sense of the Council, which is that this is a good program and that the rating is not fully dependable and should not be used as the basis for restricting support for the Connecticut RMP and try not, in other words, to alter the records as they now stand.

DR. MILLIKAN: That is my feeling.

DR. MARGULIES: But I am willing to entertain other ideas. You know you are perfectly free to change it if you want to. It is your judgment.

DR. MILLIKAN: What was the numerical rating on it? I have forgotten.

DR. [illegible]AHL: I believe it was 311.

Judy, do you recall?

MRS. KYTTLE: 311.

MRS. WYCKOFF: Could you review for us briefly just how these ratings are going to be used in a practical financial way?

DR. MARGULIES: The rating does make some difference, and Mrs. Wyckoff has raised the issue for us. We do depend upon this relative ranking, as I am sure you realize. And that is going to be the next item for action. It has been a major consideration in the spending plan for the Regional Medical Programs.

When we looked at our increased level of funding and decided how it could best be used to strengthen RMP's you will recall that yesterday I said we would restore cut funds to those which had been reduced almost a year ago and we would then give increased funding levels on the basis of relative ranking which means that a program which is rated A is much more likely to get more generous treatment than one rated B and certainly more generous than one rated C.

So that the relative ranking of these programs even though it is rather arbitrarily categorical makes a difference in the kind of support. And it is essential that we have that kind of objective measurement when we make that decision. So we don't have the slightest interest in trying to play

around with the numbers.

We also don't want to assume that these numbers are inflexible or accurate beyond any other judgment.

DR. MILLIKAN: As I mentioned earlier, if one looks at programs as A, B, or C, and with the experience of a number of years looking at these things, I would put this one in an A or A plus category. And from a number standpoint on a comparative scale, I would give it a number that would bring it to that rank.

This is my own opinion about it, whether it takes a 400 or 439 or whatever.

DR. MARGULIES: I don't think we would want to do anything with the numbers.

Judy.

MRS. SILSBEE: Dr. Margulies, it might be helpful to Dr. Millikan to know that the site visitors as a group had rated the region. And their figure that we did a study on came out 389. And that would be an A rating.

DR. MILLIKAN: I am glad to know they were accurate.

(Laughter.)

DR. MARGULIES: Clark, there is no reason why if you want to you can't make a motion that this be given an A rating and forget the numbers.

DR. MILLIKAN: I move the Connecticut Regional Medical Program be placed in the A category of programs.

DR. KOMAROFF: Second.

DR. MARGULIES: Is there any further discussion?

(No response.)

All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

MRS. KYTTLE: We find ourselves perhaps in the same position with western New York. Western New York's rating was arrived at at committee and Council took another action on it. And it is in a B category.

DR. MARGULIES: Yes, we brought that up yesterday. But we took some action on that which is really to put that rating in abeyance and ask the review committee to reconsider it in light of the new changes which have occurred. And I think that is probably more appropriate action because the review committee was not apprised of all the new developments which Mrs. Mars pointed out yesterday.

Russ, you aren't supposed to hear that. You didn't hear that.

DR. ROTH: I didn't hear it literally.

DR. MARGULIES: Let me bring another matter to your attention. I spoke with you yesterday over the fact that we would have to ask you to consider different levels of approval for certain programs which with increased funding

at our present levels would exceed Council levels of approval.

Now, I have the authority which I don't want to use to go above Council levels by something in the range of 5 percent which I could use if necessary. But I would prefer to bring these back to you individually -- they are all programs fairly fresh in your minds -- and tell you what the staff recommendation is for increased funding and what this would imply in terms of new levels.

There are a total of about 8, and each one of them is fairly clear cut. I would like to have some action on them. I can go through them. If you want to take bloc action, you can. If not, you can do it individual action either to accept or reject.

Let me do it this way: Let's go by A programs, B programs, and C programs.

The A programs which would require some action on your part are Wisconsin, Iowa, Mountain States and Washington-Alaska. In each case, the staff funding recommendation exceeds the last authorized Council level.

In the case of Wisconsin, there is an increase of funding which is approximately $265,000. It would require a change of the Council approved level from approximately $1.5 million to approximately $1.8 million. Much of the increase would be used to fund priority projects. And there is a kidney activity which is included in that funding.

In the case of Iowa, it would require an increase of the Council approved level from approximately $701,000 to $850,000 which would include some kidney activities, but would also include some approved but unfunded activities which have been previously reviewed.

In the case of Mountain States, it would require an increase of from $1.6 million to $1.95 million. There would be about $75,000 in kidney activities. The application to be reviewed in June requests support for area health education centers, kidney, manpower development, HMO, which are in line with the State admission of RMPS. It is, as you know, a very productive program. And thatincrease would be approximately 20 percent above their present level.

In the case of Washington-Alaska, the additional funds which would be available would be for a pediatric pulmonary project and for the re-establishment of their regional offices in Spokane and southeast Alaska. And that would require an increase of funding from approximately $1.7 million to $1.8 million.

DR. MILLIKAN: I move that these changes in funding be approved by Council.

DR. OCHSNER: Second.

DR. MARGULIES: Is there any further discussion?

(No response.)

All in favor say, "Aye."

(Chorus of ayes.)

There are two currently in the B category. One of them is Inter mountain, and the other is Tennessee Mid-South. The Tennessee Mid-South level is approximately $2.45 million. It would require an increase to $2.7 million. And the total increase for them would be in the range of about 11.3 percent. It would allow them to expand the activities which have previously been reviewed and approved. The Tennessee Mid-South program would actually require an increase of approximately $200,000, much of which is for a kidney project.

DR. OCHSNER: I move approval.

DR. MILLIKAN: Second.

DR. SCHREINER: We are going to review the Intermountain one.

DR. MARGULIES: Yes, but this is with reference to their current level which would be immediately increased. The Intermountain will be reviewed for future funding.

DR. SCHREINER: Is there any recommended level for that?

DR. MARGULIES: It would be an increase in Intermountain from $245,000 to $269,000.

DR. SHCREINER: For what?

DR. MARGULIES: Primarily for an expansion of existing activities rather than for any specialized project.

It has been moved and seconded. Any further discussion?

(No response.)

All in favor say, "Aye."

(Chorus of ayes.)

We have two more which have been rated C. These are rather special. Both of them have been reviewed fairly recently. One is Indiana.

Actually, I don't see any need for increase. I think mainly it is a matter of letting you know what we plan to do with those programs.

I see what happened. I am sorry. It does require in both of these cases an increase of funding because there was a later action by the Council which reduced the level of approval below what it was prior to the cut, if you follow me. Let me go over this again.

In 1971, there was a funding level which was approved. That was cut when we had a reduction in grant funds. In a subsequent review, the basic approval level for that program was reduced so that we can't restore it to the previous level because the Council level has gone below there. So we need to restore those programs to the precut levels.

One of them is Indiana in which action reduced it from $1.12 million down to $861,000. It would have to be increased to get them back to where they were to the level of

$1.12 million. And this would allow for some kidney activities and for some expansion of core staff which Indiana needs.

The other would be New Mexico which was sharply reduced by a review action last year from $1.036 million to $796,000. It has undergone an amazing rejuvenation with a new coordinator. This is in a short period of time.

I know Bland is looking gay over there because they have got a neurosurgeon in charge. But in fact, he has done extremely well, and we looked to this program to be a remarkably good one in the course of time.

So this would simply require restoration of the Council approved level to what it was at the time prior to the time that the cut was made.

DR. KOMAROFF: So move.

DR. MARGULIES: That would be to $1.036 million from $796,000.

DR. MILLIKAN: Second.

DR. MARGULIES: Any further discussion?

(No response.)

All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

There are just two things I would like to say

very briefly about the discussion I had when I left the meeting yesterday to talk about in the morning emergency medical services and in the afternoon area health education centers. There will be, I believe, in a very short period of time a distribution of information on the emergency medical services which will allow for people to respond to a request for proposals because these will be carried out initially under contract activity and will be operated as you heard yesterday out of the development part of the HSMHA program as a cross-HSMHA activity. This does not restrict the RMP from reviewing and supporting emergency medical services activities which come through the RMP route and for which we may have funds available.

And I think it is likely that there will be some expansion of those activities and that there will be some request for supplemental awards and some which will come to Council for their action by the time the next meeting occurs. That will be kept separate from the $8 million which we discussed yesterday, but we certainly are not going to discourage that kind of a development.

As you know, we already have millions of dollars in various portions of emergency medical services and various programs. And some of the RMPs have placed emergency services as a very high or even top priority.

The area health education center discussion did not

reach a final status so that we are in any position to deliver a position paper. However, there were some basic concepts agreed on which are completely consonant with the position paper which we distributed earlier at the time of the coordinators conference.

It is now agreed between us and NIH or was yesterday that the area health education center was not a satellite of a university health science center, that it would represent something developed out of a combination of community interests which would include provider institutions, individual providers, educational institutions, designed in such a way that they can address educational and service problems with a close affiliation with CHP review and comment; that the educational activity would lay great stress on middle level manpower and would be tied in with the ways in which services are being provided as a consequence of the educational activities.

Those are elements which we have fought for very hard and which were accepted. They are to make them clear in contrast with the concept that an educational center activity would depend upon what someone described as the trickle down theory in which you train a large number of people and hope that somehow they get to where they ought to be and do what they ought to do. That concept has been rejected as has been the requirement that the affiliation with the uni-ersity health science center is essential.

Rather, it is desirable. And it is desirable so that there can be effective tie-in, so that you can use university resources, have residency programs, undergraduate training and so forth, but the main energies and the development of such a center will be community based.

Now, from that point on, we ought to reach a more complete understanding of how we will function and should be in business in a relatively short period of time. But that is as far as I can go because that is as far as we went yesterday.

That is merely for information. If you ask me anything more, I can't expand on it because there is no point in talking about how I hope they will agree, that is how far we were.

MR. MILLIKEN: In other words, Harold, further movement in the States will wait until this is clarified.

DR. MARGULIES: Well, not necessarily. I think programs which are moving toward an area health education center should be encouraged to do so because whether you are talking about a total center or elements thereof, they are so natural an expression of RMP activities in any case, to say, "Don't move in that direction," would be to say, "Don't go on being an RMP," for many of them. So that we will continue to encourage that kind of motion.

And as I indicated yesterday, the amount of money

we have set aside for it really represents a kind of minimum obligation in the administrative process rather than a limit to what we can do either for EMS or for area health education centers.

MRS. WYCKOFF: Each State still gets $250,000 on this, is that what you meant yesterday?

DR. MARGULIES: The question that was raised was how this affected the resolution which was passed which gave us some freedom to provide support for planning and development of area health education centers. I think that is still a very useful kind of resolution to pass, but the way in which we utilize it is going to have to be determined by the potentialities which grow out of this current series of discussions.

If the possibilities for area health education centers as finally agreed on between the two agencies would limit the number very sharply, which appears possible, then we would, of course, use these funds very sparingly because we don't want to raise a lot of hopes and not be able to do anything about them. So we would have to be fairly deliberate about how we used it.

The fact that many regions would request a total of $250,000 for that kind of an activity does not necessarily mean we would be responsible. We would have to do it in accordance with what appears to be the likely route of

development.

One of the things one has to recognize in this, particularly HEW has to, is that we are talking about a little of investment which is not growing, but which is fixed for fiscal '73. It is the same as for this year. And if you are going to support something which is new and which has an expanding idea and your funds are not expanding, you have to be quite careful how you go about development.

DR. PAHL: Perhaps we can turn to the review of applications since we have still a rather full agenda. Perhaps we might take up Metropolitan D.C. since Dr. Ochsner has a late morning departure. And we will ask Dr. Schreiner to perhaps catch a second cup of coffee while we discuss that.

(Dr. Schreiner absented himself from the room.)

Dr. Ochsner is principal reviewer, Dr. Roth back-up reviewer. And Mr. Stolov from our staff.

Dr. Ochsner.

DR. OCHSNER: The site visit was held here in Washington on December 16 and 17.

The committee is composed of Dr. John Kralewski, who was the chairman and did a superb job acting as chairman, and the other members from the review committee as consultants were Dorothy Anderson and William Hilton. The other consultants were Dr. Houstis, Dr. Shapiro, and Dr. Kountz

On the RMPS staff, Mrs. Silsbee, Dick Russell, Jerry Stolov and Matthew Spear.

We all met on the first night before the meeting and discussed policies, what we would do, and then the following two days were filled with conferences with the core staff and with otherpeople who attended.

As you know, this RMPS has been in difficulty since its beginning, probably for a number of reasons. It is a complex area consisting of a high income, predominantly white, suburban area of two States and an urban area of the District of Columbia which has a majority of black citizens. This has made it more difficult.

Yet, the RMP had further difficulty because of the grantee organization which was the District of Columbia Medical Society which initially dominated the program.

Apparently the District of Columbia Medical Society took over the function of the RAG, and the RAG in the beginning had very little or nothing to do with it.

There are three medical schools in the area, and they, too, dominated the program as well. And there is very little coordination between them, the reason these grants were for categorical diseases which were sponsored largely by the medical schools.

The regional advisory group has not been very active up to the present time, although they have just been

reorganized, and they promise now it will become more active. It is largely composed of appointees by interest group agencies with minimal number of minority group represented. This struck us very emphatically. As a matter of fact, we have serendipitously found out about a lady who had not been invited to the session, and we invited her, a Mrs. Bullock, who is quite an individual. She is very much interested in the minority groups in Washington. And why she was not invited to sit in with us, I don't know. But she apparently has been quite an active person or she attended only one meeting, but she made quite an impression upon the other members of the RAG at that time, this together with the fact that the grantee organization largely dominated program made the RAG quite sterile and inefficient.

However, as I said, the RAG has been reorganized, and they have promised now they will be more active because the District Medical Society of the grantee organization has now decided they will have nothing to do with it except act as grantee organization.

The RAG has a number of functioning committees, working committees, and they are beginning to assume the responsibility.

The core staff organization is cumbersome, and there is apparently not much coordination between the staff members. Dr. Wentz who is the coordinator inherited most of the core

staff made up largely of people retired from the services or retired from other jobs, and I got the impression a good many of them were tired as well.

Most of the obvious end of a lack of coordination and cooperation is the inability of the RMP to get a satisfactory kidney program functioning. We all have heard here about how there have been many attempts to get the kidney program functioning, but it has apparently been impossible to get the groups together and working in a coordinate manner. This is largely because the members of three medical schools could not agree.

It is a feeling of the site visit team that the Metropolitan Washington RMP appeared to be just getting off the ground rather than one that had been functioning well for a number of years. The site visit team felt there was a lack of overall thrust by the RMP, and the continuing education program was being developed on a very segmented basis with little coordination into the overall thrust.

It was the consensus of the site visit team that the core staff was not functioning as an integrated unit, but the staff members were beginning to appreciate their obligation. They have recovered from their frustration, and they brought this up all the time to us by changing from the categorical disease orientation to the project grants.

The site visit team was very much impressed by

Miss Elixabeth Lee in charge of patient education who is apparently doing a superb job in developing educational practices for patients with chronic disease, emphasizing the role of the nurse as the primary health provider and patient teacher.

We are concerned about the lack of minority representation on the core staff. Of the 21 professional core staff, there are only three minority employees.

The Metropolitan Washington RMP has been most successful in its effort to establish normal relationships with other organizations. This was to be commended.

As a result of the study, the site visit team recommended that Metropolitan Regional RMP be funded at a reduced level for the coming year to permit further consolidation of resources within the program, yet allow the program to initiate some critical efforts.

We recommended the core allocation be $477,000, the continuation projects $205,000, contracts $125,000, and the kidney consultants recommended that it be $200,000 for the next year. And they also suggested that for the second year, this be decreased to $140,000 and the third year $30,000.

We also recommended that a site visit in another year to evaluate the progress be made.

DR. PAHL: Thank you, Dr. Ochsner.

Dr. Roth.

DR. ROTH: Well, I would concur with the recommendations. As one who participated in a previous site visit for Metropolitan D.C. and thereby annexed an interest in the program, it is curious to me that the reactions expressed by Dr. Ochsner now are almost precisely the same that we had on my original site visit two years ago. It is that hopefully you are just about ready to turn the corner and do better. And I think this RMP epitomizes the problems of virtually all the RMPs that have a metropolitan area as their heart and center and almost entirety.

As of the end of this month, they will have received if my addition is correct $4,828,572 in funding. And you would think that with this length of track record that evaluative techniques would enable you to point out some perhaps not specific, but reasonably well defined good that had been accomplished with this amount of money. And it is very difficult to do so in Metropolitan D.C. And yet I think it is not for lack of trying.

The allegation initially was really in my impression -- maybe it is the way you said it, Dr. Ochsner -- that at first the medical schools grabbed the money and expressed the interest and started running off in several different directions without cooperation. Then it passed to the medical society, and now the pendulum is swinging the other way and they are trying to disassociate the medical society.

There have been efforts to involve all the factors in the delivery of health care, and they have been reasonably successful in terms of getting people to attend meetings and talk about these things, but it illustrates the basic problem that the objective isn't to make the ghetto a healthy place in which to live, it should be for the elimination of the ghetto and that there are broad sociological problems involved in here that no medically oriented medical provider program has any possibility of solving.

And so you go back and you look at it and it is strikingly deficient in accomplishments. But I think that if this has a chance of survival, this is just about its last chance. If we withdraw support, then I think the medical schools and the medical society and all the providers would finally give up to the frustrations that have beset them over the last four years. And I do think it needs support and hopefully this time we are at the corner.

I would second the recommendation.

DR. PAHL: Thank you.

The motion has been made and seconded.

Mrs. Silsbee.

MRS. SILSBEE: Were you recommending the site visitors recommendations or the review committee's? Because there is a difference.

DR. OCHSNER: Beg pardon?

MRS. SILSBEE: Were you recommending the review committee's recommendations or the site visitors' recommendations?

DR. OCHSNER: I think they were the same.

MRS. SILSBEE: No.

MR. STOLOV: Dr. Hinman has a comment on the differences between the site visitors' and the committee's recommendations. It is on the last page, I believe, of the blue sheets.

DR.OCHSNER: You mean decreasing amount in the kidney?

MRS. SILSBEE: Right, sir.

DR. OCHSNER: That is what I recommended.

DR. PAHL: It is the chair's understanding that the motion is to accept the review committee's recommendations. Is that correct?

MRS. SILSBEE: Yes, as far as I know. Dr. Ochsner just stated that.

DR.PAHL: Dr. Roth, that is the motion you seconded, to accept the review committee's recommendations?

DR. ROTH: Yes, and I would understand this is subject to the decision yesterday that the second year level of funding does not necessarily apply.

Now, is this a specific exception to it, the second year reduction in the level of funding?

DR. OCHSNER: The second year applies only to the kidney. We didn't recommend anything as far as any second year. But the kidney group did recommend that there be a decrease.

DR. PAHL: The policy that we accepted yesterday would not be pertinent here because it is one-year funding for the RMP. The second-year funding is related only to the kidney project and, therefore, we would be accepting the levels recommended by the review committee for the second-year funding on the kidney unless it is otherwise decided.

DR. ROTH: My personal preference would be to not restrict the second year, but follow the principle that we adopted in general and not make this one of the specific exceptions. Because I just can't get away from the fact that in the capital city of the greatest nation in the world, we have such inadequate kidney facilities.

DR. OCHSNER: More crime, too.

DR. ROTH: Well, I wouldn't try to tackle that, but wecan do something about kidney facilities.

DR.OCHSNER: They finally got together.

Jerry, do you want to speak to that?

MR. STOLOV: Dr. Hinman.

DR. HINMAN: I would like to speak to that, Dr. Roth.

Certainly, I agree with your intent there. The

problem that we have run into in attempting to work with the kidney groups in the District of Columbia has been that the parochialism that the rest of the RMP shows is still evidenced. The proposal that they submitted that would include the second and third year would have our money going into supporting a second and third transplant center without necessarily any justification of it on the basis of patient need. It was for this reason that the committee recommended the marked diminution of funding for the second year.

This would not preclude their coming back for additional funding if they could get a program that had good planning for regionalization. But it was the consensus at review committee time and those of us on the staff that if we approved essentially level funding for kidney, we would be in essence endorsing a second and third transplant center, possibly even transplant centers at the National Naval Medical Center and Walter Reed. So there was a possibility ofeven five transplant centers and no evidence that the load would necessarily exceed 100 transplants per year.

So our concern was to see to it that they had sufficient funds to get started this year and not close the door on the second and third year.

DR. MARGULIES: Dr. Merrill.

DR. MERRILL: I have another question perhaps Dr. Hinman could answer for us.

We have in the kidney budget $100,000 for kidney transplantation and tissue typing, $75,000 for dialysis, the major thrust of which I think most of us agree should be to take care of patients prior to and after transplantation. And yet it is stated on page 21 there is only one transplant surgeon whose enthusiasm is "somewhat restrained." And although Dr. Hufnagel is definitely committed to transplantation, I know his enthusiasm is also somewhat restrained. And I wonder how they propose to operate such a transplant program.

DR. HINMAN: If you will look at the blue sheet which is the last addendum, we have recommended that a single transplant center with at least one full-time transplantation surgeon be available with the idea being that the encouragement would be this man would spend the majority of his time in kidney transplantation to try to turn around this lack of enthusiasm.

It is a complicated situation. There is a man in training to become a transplant surgeon who would be available a year from now at another medical school which would complicate the direction. There have been transplantation surgeons in military facilities who moved and they are recruiting to replace. It is an extraordinarily complex problem as you are aware.

We are hoping that with this recommendation, number one which you see, that says that their support of a

second center be limited until the first one approaches a minimum level of 50 and they should then plan for 50 to 100 transplants per year for any additional center that would be supported by RMP funds.

We hope the regions would take this and bring together the principles from the two medical schools involved in kidney activities and reach some agreement.

The problem of where the tissue typing center will be is another one, as you are aware. It is possible that it could be housed at one of the Department of Defense activities as opposed to one of the private institutions. That is why we have not committed that it has to be at a particular place.

Certainly, I would be willing to come before you and recommend additional funding in the future if we can see that we are getting a regional approach. What we were getting was fiefdom approaches, to be blunt.

DR. OCHSNER: John, to enlarge on your criticism about Charlie Hufnagel, I did not sit in with the kidney group because the kidney consultants did, but I got the impression from what they said to us Charlie Hufnagel was very enthusiastic about the transplant program. Am I wrong in that?

MR. STOLOV: Mr. Russell was in on the site visit.

MR. RUSSELL: I am trying to place the institution

from which Dr. Hufnagel comes.

DR. OCHSNER: Georgetown.

MR. RUSSELL: Yes, if I remember correctly, he was. But the surgeon whom they had in mind to take over the responsibility of organ procurement was the one who didn't come through very strongly.

DR MERRILL: Dr. Ochsner, as you well know, cadaver transplants are apt to become available chiefly during the meetings of the American College of Surgeons and university surgeons. So you need more than one transplant surgeon. I wonder if you have only one whose enthusiasm is somewhat less than wholehearted, should we make this kind of support, adequate support, a contingency for our financial support, or do you visualize that the financial support will in turn encourage the acquisition of transplant surgeons?

DR. OCHSNER: I got the impression, as I said, without sitting in with them that for the first time, the group in Washington have gotten together and decided they are going to wholeheartedly support this thing. Am I wrong in that, Dick?

MR. RUSSELL: This was the impression we got.

DR. OCHSNER: That is the impression I got from those that were sitting in on the deliberations. I got the impression for the first time they were willing to get together and cooperate.

DR. HINMAN: This was true at the time of the site

visit. And the subsequent supporting documents that followed it -- we are not sure exactly where they originated -- showed a little breakdown in that original agreement. And we are trying to get it back into the verbal agreement.

I think if dollars flow that we can get back to the agreement that was evidenced at the meeting that Dr. Ochsner is referring to at that special site visit. We are encouraged that progress is beginning to occur, but we hate to commit a second and third year, Dr. Roth, that might give the implication of explicit approval for a second and a third transplant center at this time when they have done a total of 40 transplants over the entire period of time in the Metropolitan Washington area, over the last five years, and only ten in Georgetown.

I certainly don't think it is reasonable for the region to plan additional centers when they don't have anywhere near capacity.

DR. ROTH: I was just going to say parenthetically I ought to have been talking more to John Merrill over the last few years apparently because I have been brainwashed by my medical associates in kidney disease to take the position that we surgeons are the easiest part to come by in a program, but you need all this medical expertise and immunological support. And a mere cut and strip transplant surgeon is the least essential part of the program. So I am

glad to hear John take this position.

DR.OCHSNER: That is still true, you need a good vascular surgeon, and that's all you need.

DR. HINMAN: Dr. Roth, in defense, as a nephrologist, I ask you to admit the surgeon is the rate limiting factor here because it takes an aggressive, dedicated, evangelistic surgeon to procure the organs necessary for the transplantation.

DR. MARGULIES: Is there further discussion?

DR. PAHL: Before coming to the question, I would point out that the review committee assigned this application a priority of 207 and would assume unless otherwise indicated that the motion accepts that rating together with the committee's recommendations.

Mr. Milliken.

MR. MILLIKEN: I am concerned about something else in the report that may or may not be related to what we were just discussing. And this is a lack of any central cooperative direction and activity.

And I am just wondering what this Council and the staff has to go on for expectation, for delivery on this kidney program, for example, with this loose focus that seemingly may not get any better, and it may.

DR. MARGULIS: Are you raising the question with regard to the kidney activity or the RMP? Because I think

we have to accept the fact in these circumstances we are really talking about the kidney activity as a separate kind of an issue from the RMP. They are both tough. We have been dealing with this kidney proposal now for a very long period of time. And if the staff is being cautioned about their sense of any progress, it is because of the long history of it.

There was in the opinion of the people who made the site visit a new kind of sense of what has to be done. And we have been so concerned about it that they have gotten that message.

They did want to get approval for three transplant centers. We are making it clear to them one is as far as we can go. And we are not so sure you can manage that one. And so we are going to be looking very carefully at how well that one comes off.

DR. PAHL: Is there any further discussion by Council or staff?

(No response.)

If not, all in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

We would like now to turn to the application from

Louisiana with Dr. Komaroff as the principal reviewer and Dr. Merrill as back-up reviewer and Miss Houseal from our staff.

And will someone please have Dr. Schreiner come back into the room?

DR. KOMAROFF: The Louisiana Regional Medical Program began planning in January, 1967, but didn't get under way operationally until March of 1970. The reasons for the unusually long planning period were two.

First of all, there was unusual resistance from the State medical society.

And, secondly, they had a point when the region did pull itself together and become ready to go operationally, Federal funding limitations made that difficult.

It is now coming towards the end of its first two years of operational status, and it requests triennial support and developmental award and continued support for the four projects, activation of two previously approved but not funded projects which we will discuss in more detail in a minute, and the initiation of six new projects.

A site visit was made in December. I was a part of that team, and the site visitors and review committee concurred in their perceptions, but differed somewhat in their recommendations. Everyone was agreed that the region has several strengths.

The first of them is that the goals and objectives are well described and compatible with national priorities, particularly the rhetorical emphasis on service to the poor and minority groups.

They have collected a superb data base, and they have used this data base as a service to other operating agencies in the region.

They have surveyed physician resources, allied health manpower needs. They have created a fine surveillance system which has allowed for the planning of an improved immunization program for children throughout the State. They have done a study of radiation therapy needs in the State which apparently has led several proposed supervoltage facilities which were duplicating to discontinue their plans.

They have also done a good job of identifying alternative funding sources for phasing out projects. They have been of great assistance to the A and B agencies in the State.

Their core staff is clearly very capable and has recently passed with flying colors the HEW audit. They are beginning now to stimulate projects more in line with their own priorities of the kind that we are thinking of as progressive such as shared services for rural hospitals, consumer education and a citizen advisory bureau.

The coordinator, Dr. Sabatier, is also a clear strength, having done what many people thought as an impossible task of pulling together the previously dissident elements of the health establishment in Louisiana.

There appear to be several weaknesses that concerned the site visitors. The first was that the advisory group seemed weak, and its executive committee met only infrequently. And as a whole, the advisory group was not involved in planning or monitoring activities, and although they expressed a desire to do so clearly had no plan or understanding of how they would go about doing that.

There also was a particularly ambiguous and I think disturbing relationship between the advisory group and the grantee, not unlike the kind that Dr. Watkins described yesterday in Greater Delaware Valley where the grantee has the authority to approve or veto RAG membership, RAG bylaws and also to veto RAG action on project proposals.

Now, the grantee has never exercised that veto right, but it undisputedly has the authority. And this raised for the site visitors again the five year old question as to what the precise relationship is between grantees and advisory groups. I understand that a clearer statement on that and long overdue statement is now being considered by HSMHA. And I hope it is forthcoming.

The other major weakness was that there is no

action plan that the region has clearly developed. In other words, they have a fine planning data base and well-stated objectives, but they haven't taken the next step to actually implement or describe how they would implement action plans based on those two planning bases. There is a clear discrepancy, in fact, between their planning data which shows not surprisingly the need for primary care services in the State, but their own stated priorities to fund projects that are really specialized care facilities.

The core staff has five planners, but only one person who can be thought of as an implementer.

And one further piece of concern was that the chairman of the State agency planning council clearly thinks that RMP ought to be the planning body and CHP the action or implementing body in the State.

A last area of weakness is that there is a poor representation of minority groups both on the advisory group and the core staff and that the project activities, while many of them are designed to support the charity hospital system, give little evidence that black physicians, poverty agencies, or community groups, spokesmen from the poor, have been involved in planning of activities for the poor.

As a result of these perceptions, I make the following recommendations:

The region is not ready now for triennial status or

developmental awards and probably should be site visited next year.

Secondly, the site visitors and review committee proposed a funding level of $1 million for the next two years which is up $260,000 from their current funded level. This seemingly arbitrary number actually was worked out fairly carefully to allow for an expansion of the core staff, a continuation of several worthwhile projects and begin several of the proposed new activities in the region.

There is a major issue with regard to two projects that puts this Council in a bind. And there is also a kidney project which Dr. Merrill will discuss momentarily.

In November of 1970, this Council established a policy against funds for established coronary unit technology and equipment. In February 1971, at the next Council meeting, I think the Council inadvertently approved a coronary care unit project and a pediatric pulmonary project at Charity Hospital which were each about a half-million dollars. And those funds were essentially for equipment and renovation. No dollars, however, were available at the time so neither of these activities has gotten off the ground. But the region now really wants to get the coronary care unit project going.

Review committee points out that this project is not in line with the region's own main need for primary care,

is not perhaps the best way of spending these large amounts fo dollars for the delivery of care to the poor in the State and doesn't develop a regionalized facility for either training or service in coronary care units.

They recommended that a ceiling of only $25,000 be placed on this project which we have previously approved for $500,000. I would prefer to deny funds for equipment and renovation, but not place any specific ceiling in terms of their personnel support for this activity. I would like to send the message that only a very modest expenditure for the coronary care unit project would be allowed and express the hope that that Charity Hospital facility will become the nidus of a regionalized training and service program and then when we see them again next year see what they have done with that recommendation rather than try to guide them too specifically.

There is a second related issue here which doesn't boil down to dollars, but which concerns me. And I would like to raise for the Council's consideration whether we are talking about supporting this coronary care unit project or renal disease project we will discuss in a minute.

Louisiana has a huge charity hospital system. I believe, and maybe Dr. Edwards can correct me, it is the largest charity system per capita base of any State in the union. It is effectively a dual health system, and it is

one in which I would imagine the poor would always be limited to a kind of second-class care if it were perpetuated.

Therefore, what Regional Medical Program policy ought there to be in regards to funding projects that support the perpetuation of a dual system of care which seems to me not only undesirable, but immoral? I don't really think that RMP will affect this kind of system one way or the other and that only a national health insurance plan will ever allow for the integration of this large system into a single system of care. And it is the main system for the poor in the State. But it seems to me to raise a moral question that the Council might consider.

Maybe the answer is that when the financial leverage outside of RMP becomes available, Louisiana RMP and other regions with large charity systems will then have a great challenge to try to do the leg work of pulling together a dual system into a single system of health care.

DR.PAHL: Thank you.

Dr. Merrill.

DR. MERRILL: The notes I made in reading over the proposal and the reports were very much along the lines that Dr. Komaroff has stressed. I felt that there was in the application a little redundancy, but I think that is all right. I think the word "dissemination of care to the indigent" was used at least 50 times. I see no reason it shouldn't be,

perhaps.

I did think as Dr. Komaroff does there was a lack of real specifics in terms of what was going to be implemented. And I felt as he did that there had been considerable improvement in a really difficult area after a tough start.

And I, too, was struck by the dual approach to the medical problem. However, in the case of the kidney, I think that problem has been raised and has been rectified.

I would like to turn now to the kidney proposal itself. I think the kidney proposal in and of itself is one of the most impressive proposals that I have read in this area. It is totally comprehensive. It is specific and does something that most of us have not been able to accomplish. At least it proposes to do so. I believe it will be able to do so. And that is, it stresses a central transplantation center, but decentralization after this specific episode in the so-called life plan.

In other words, of the six community centers in the six regions, there will be community centers in each one in which dialysis will be utilized. These people will be trained at the Charity Hospital. They will wait there for cadaver transplantation when it becomes available and suitable matching occurs at Charity. But even more important, following that, they will go back for continuing care to the local community. So this will not be simply a gathering in of

everybody all over New Orleans into the Charity which is one of the strong points, I think, of the whole grant.

The specifics, I think are remarkable. I know some of the people involved. They are extremely good and I think quite capable of carrying out what they say they will.

I am interested also in the fact they have made a very realistic approach to phasing out this program by means of other fund sources. And they spell this out. They just don't say, "We are going to get other sources." They talk about State legislation or about third party payments, about Medicare, Medicaid, and so on. And they are very specific.

They have even gone so far as to incorporate in this proposal one of my pets. And that is, they have a working arrangement with one of the military establishments for the retrieval of organs by helicopter. I happen to know that both the Coast Guard and the Air Force are actually interested in this. Their job is to scramble and be alert and do this kind of thing. And they certainly have been utilized enough, but here in Louisiana, this approach has been utilized. Apparently a working arrnagement has been made.

Now, there has been as Dr. Komaroff has touched on, the problem of duality. And a letter had been written, I gather, objecting to the original plan simply because it was aimed only at the indigent. In a subsequent letter, Dr.

Gonzalez who is head of the nephrology program states that all of these people will be taken care of regardless of the state of their finances.

And he also answers a number of objections which had been raised by the site visitors having to do with evidence of concrete cooperative arrangements between the affiliated hospitals letters attached which substantiate there will be if funds are available. These arrangements almost certainly will be approved.

The deletion of a proposal for a master of public health nurse training that was not budgeted, so that objection is really not a valid one.

And they agree that they will as the ad hoc committee, I think, wisely recommended phase in these regional centers with not more than three to four units initiated during the first year which I think is an extremely important point since obviously it would be difficult to set all six in motion at the same time. And they have modified the budget to reflect these changes.

So I think this is an excellent proposal. I think the head of the kidney, director of the department of nephrology, has responded adequately to the criticisms that have been raised. And I would think that it has every chance of success, and I would certainly think it ought to be funded at the suggested level.

DR. PAHL: Dr. Hinman.

DR. HINMAN: Dr. Merrill, I hate to be in a position of disagreeing. I agree with all your technical comments. The concern, the part that we feel is not answered, is addressed in the first paragraph of that addendum which is page 9, 1. The system that Dr. Gonzalez and the Louisiana Regional Medical Program has recommended is one that will be based at the Charity Hospital. The system will accept indigent patients or those patients whose assets or third party payments mechanisms will not provide them the opportunity to receive the care privately. Other patients will be referred to the private sector. There is no integration with the dialysis center that is at Shreveport which is a private one at the present time. And there is no integration with the N.O. Dialysis Center or the other New Orleans dialysis centers or New Orleans transplant program as based in the hospital or the VA hospital which has a dialysis center.

Our concern is that the recommendation as it presently stands and the commitments which they have presently in writing would perpetuate a two-class nephrology or end stage renal disease treatment system. The patient ouside of the New Orleans area who was not medically indigent would have to find a private method of care. And this seems intolerable to us on staff to endorse that system. It would seem that there should be some method whereby the State charity system

in these outlying dialysis centers -- and it is a beautiful plan, the plan is gorgeous, don't misunderstand me, but it is going to force the private sector to set up competing dialysis centers in the other remote areas the way it presently exists. And it was for this reason that we were quite concerned about the project.

DR. MERRILL: Now, I remember seeing somewhere in Dr. Gonzalez' letter -- I, too, was concerned about this as Dr. Komaroff, I know -- I thought that I had seen, a specific statement to the fact that he would cooperate with the private centers. There are letters from Shreveport saying they will cooperate.

DR.HINMAN: They will cooperate in exchange of training programs. They would cooperate in organ procurement, but that first paragraph on page 9, 1 there, it says:

"Firstly, this proposal is concerned only with the population presently treated by the charity hospital services. The patients accepted by our program are indigents or medical indigents. Exceptions have been made in the past at the request of referring physicians, mostly from other dialysis centers in the State."

That is the one ray of hope I see.

"These exceptions usually concern patients who, although not entirely indigents, have assets or third party insurance coverage which do not suffice to assure continued

financial solvency of their dialysis and transplantation therapy charges elsewhere. Referral of patients with adequate financial means will continue to be channeled to the private dialysis centers as usual. This referral pattern will not change and physicians in the regional centers or elsewhere in the State who may handle the initial care of these patients and their subsequent referrals may wish to refer these patients to the private community dialysis services directly."

They are cooperating on organ procurement and on training.

DR. MERRILL: I don't have that addendum.

DR. HINMAN: It is the yellow staff observation sheet. It is page 9 at the top, next-to-the-last page. It is the top of the addendum.

We communicated to Dr. Sabatier our concern about this after the staff review of the kidney proposal. We asked for an explanation, and they went back and sat down and talked. And they came back with this addendum which we felt did not address the issue adequately.

Frankly, I think the program is good enough that there should be some means of salvaging something out of it. The end of the blue sheet, I think it is, that makes the recommendation.

Is that where the recommendation is, Donna?

If you all concur with the review committee

recommendations that the grant request be turned down because of this duality, we would then propose by the contract mechanism if we could get them to agree to it to go in and fund and get the thing started.

DR. PAHL: That is on the last paragraph of the blue sheet.

DR. HINMAN: This was our clear intent not to let this thing die if we can somehow convince them that they can't use our money to perpetuate a two-class system in something especially as expensive as end stage renal disease.

DR. MERRILL: What I was looking at was paragraph 6 on page 5 which states:

"It was agreed that the centers -- private institutions, that is -- should have some input into our project and may be referred to the regional centers from the private centers in the City of New Orleans."

DR. HINMAN: But the thing that bothered us, and I don't know whether it is purely semantics -- we didn't think it was -- "It is appropriate these centers should have some involvement in our education program. It is thus planned to involve these private centers in assisting in the education and on-the-job training."

DR. MERRILL: It was my understanding from this letter -- and you obviously are closer to it than I am -- that the letter from Gonzalez, paragraph 6, page 5, was

written specifically in response to the criticism that you have raised and that his answer to this is contained in the phrase that these patients may be referred to the regional centers from the private centers in the City of New Orleans.

DR. PAHL: Dr. Merrill, Dr. Everist says he has an observation to make. Perhaps it will help.

Dr. Everist.

DR. EVERIST: I think, first, briefly, to be realistic about this, over half the beds in Louisiana are charity hospital beds. This is half the population being cared for.

Secondly is that we are well aware of the dual system and think it is immoral and certainly it is rank in this day and age. And we are trying to change it. But the way we will do this will be to make these charity hospital centers the centers of excellence so when we do change, we will be able to get people who have not in the past utilized these services. Because they are half of all we have. So they have to be made in the future centers of real excellence to be superior to those that are not charity hospital beds.

And the third thing is that this is rhetorical. These people have written these things because it would be impossible not to write them and stay in business in Louisiana. But the facts of the matter are that if I want a patient in a service that is not available immediately anywhere else and

the people are millionnaires -- for example, the pulmonary disease centers, there are no others in the State -- I refer patients that are quite affluent to those centers at the charity hospital. And they are cared for and charged. But if this were to be put on paper, sent to Washington and read by the Council of Regional Medical Programs, RMP would no longer be in business in Louisiana.

I hope that clarifies some of the problems.

DR. MARGULIES: I think that is a great contribution because we have got sort of a reverse situation in which we are afraid we are going to do too well for the poor, but there are really two problems.

One of them is this dual system. And as Bruce has pointed out, we might have the interesting phenomenon of the well-to-do fighting to get the services that the poor get because they are better which would be an interesting situation.

What Ed is concerned about, and I am not so sure that in this proposal we can deal with it effectively, is the danger of a multiplicity of services with all of the excess costs duplication and so forth which are involved. But to reverse this attractive proposal with that consideration is something which would be difficult to do, I think.

DR. PAHL: Dr. Schreiner.

DR. SCHREINER: I am very glad to hear Bruce speak

up because there are two ways to go about achieving this goal which was mentioned which is certainly ideal. You can go about it by saying you will hold back and wait ten years or go about it by starting something. I can remember when Frank went down there and when blacks and whites were coming in through two separate doors. They were getting dialyzed together. This was one situation where they went to the washing machine together.

So if you have a need, something that is fulfilling a real need, you are going to start better, I think, and constructively that way than sitting back and saying nothing is going on until the world becomes perfect.

It seems to me some of these specialized units are the very way to achieve the thing you want to achieve. You get a situation which is so good everybody has to use it. And there will be some people just like there were some people who built private schools, but after a while if the schools are good, then that situation disappears.

I think you will have a few private dialysis centers set up in the country and places like Shreveport, and they won't do well because they won't have as good people and they won't have as well-trained personnel. But they were seeing private patients in the renal unit five years ago at Charity.

DR. MARGULIES: I didn't want to cut off discussion

on this, but we have a rather tight schedule, particularly because we have Dr. Vaun here who is going to assist us with the Illinois review because the Council members are not present. So if we can complete action on this as rapidly as possible, we can preserve his time because he has another appointment.

DR.PAHL: Before asking Dr. Komaroff perhaps to phrase a specific motion incorporating the points of this discussion, I point out for the record that this application had a rating of 240 by the review committee in accordance with the recommendations as stated.

But would you please state for the record a revised motion?

DR. KOMAROFF: My recommendation is to approve the review committee's recommendation with the exception that no specific ceiling be placed on the funding for the coronary, pediatric, pulmonary units, only a statement that renovation and equipment costs are no longer part of RMPS policy and that a very modest expenditure is recommended.

And with regard to the kidney, I will punt that part of the recommendation.

DR. PAHL: Let us take that as a single motion first.

DR. MILLIKAN: Second the motion.

DR. PAHL: Is there further discussion on that motion?

(No response.)

All in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

Motion is carried.

Dr. Merrill, may we please have a recommendation for the kidney aspect of the application?

DR. MERRILL: May I ask just one question first?

DR. PAHL: Please.

DR. MERRILL: It is stated in the letter by Dr. Gonzalez that Shreveport will cooperate and that private patients may be referred to the regional centers. Now, do I understand there is some question about that? And is this the basis for the problem?

DR. PAHL: Dr. Hinman.

DR. HINMAN: Yes, sir, that was the basis for our concern.

DR. MERRILL: Even though he specifically states this will occur?

DR.HINMAN: Yes, sir. There was still some question in our mind it would actually happen.

With Dr. Everist's reassurance of the realities of life, certainly I feel much more comfortable.

DR. MERRILL: Well, with that reservation of Dr.

Hinman's and mine, could I propose that they be funded for one year at the proposed level and that the progress be reviewed with regard to funding second and third years?

DR. MILLIKAN: Second the motion.

DR. PAHL: The motion has been made and seconded to fund the kidney proposal for one year with review before committing funds for the second and third years. Is there further discussion by Council or staff?

Dr. Millikan.

DR. MILLIKAN: A question, John. Does your motion kind of tacitly include the idea that our concerns be communicated to them?

DR. MERRILL: Well, it already has been communicated to them. And Gonzalez has responded.

DR. MILLIKAN: No, I mean the Council's concern as of now that we are uneasy about this situation and want them to simply know it.

DR. MERRILL: I think this is such a concern in spite of Gonzalez' reassurance, it should be sent to them again, restressed to them.

DR. MARGULIES: Well, then, the purpose will be before continued funding to take a look at how effectively they are operating with particular attention to the issue which was raised.

DR. MILLIKAN: To all the people of Louisiana is what

we are talking about.

DR. MARGULIES: Right. That will be included in the comments to them as Council concern.

DR. PAHL: Is there further Council or staff discussion?

(No response.)

If not, all in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

I think we will now turn to the Illinois application. And I am very pleased to be able to introduce to the Council and welcome to our Council meeting Dr. William S. Vaun, Director of Medical Education, Monmouth Medical Center, Long Branch, New Jersey, who participated with Dr. Brindley and Dr. Sherliss in the site visit on December 15 and 16. And as you know, Mr. Ogden and Dr. Sherliss are unable to be with us and Dr. Vaun has very kindly consented on a moment's notice to come from Long Branch to the Council meeting and has a meeting elsewhere in Washington here later this morning.

So without further ado, we would welcome you and would be pleased to have you report on the Illinois application.

DR. VAUN: Thank you. I hope you remember that as

I lean heavily on the script, and I hope I won't deflect from what the site visit felt was a very strong and effective program.

The site visitors, as you know, are Dr. Scherbis, the chairman, Dr. Brindley, and myself, and RMP staff, Frank Nash, Eugene Piatek, Margaret Hulburt, Dr. Gimbel, and Maurice Ryan.

The coordinator, core staff, RAG, and project personnel were very well represented throughout our visit.

The site visit was conducted following receipt of the Illinois RMP triennial application which includes request for support of core, projects, and a developmental component. The charge to the site visit team was review the program for region's overall progress.

Examine the experience and achievements of the ongoing program.

Determine how this experience had modified or will modify program goals, objectives, and priorities.

To consider the region's prospect for the next three years.

And to arrive at a funding recommendation based on the intrinsic qualities of the program.

The site visitors were favorably impressed with the progress made by the region since the site visit of December 1970. The region has established goals and priorities

which are congruent with national objectives and are directing the proposed activities toward accomplishing these goals.

The RAG, since reorganizing according to new bylaws effectively represents key health interests in the region and is quite effective in carrying out its responsibility. It was clearly demonstrated to the site team that the RAG is the decision-making body of IRMP in all matters regarding program goals, objectives and priorities, operational procedures, management and evaluation.

RAG chairman was considered a highly capable, dedicated and effective individual. There is extensive involvement of RAG membership at all levels of decision-making process of the region, including committees, evaluation, etc., was noted.

The site visitors recommended that the region add more representatives of minority groups to RAG.

The executive director and coordinator was considered by the site visitors to be a highly capable individual with a good understanding of operational framework within which the program goals and objectives are to be accomplished. He has assembled a very capable and energetic core staff to which he provides excellent leadership and direction.

The region has the good fortune to have Dr. George Miller available and actively participating in the program as

core project director and as a member of the review committee. Dr. Miller did visit with the site team for quite a period while we were there.

The site visitors believed the region has done remarkably well in bringing together disparate forces in the region and gaining their active cooperation in the program.

The CHP agencies, A and B, have been slow to develop in Illinois, but IRMP has made a significant contribution toward the development of these B agencies now in existence.

While the site visitors were most favorably impressed with the direction and success of the program which can be attributed to the leadership of the executive director, the capable core staff, progressive RAG chairman and the interest and dedication of the RAG membership, the following aspects of the program were identified to the region during the site visitors' feedback session as needing improvement or strengthening;

One, increased minority representation on the RAG.

Two, more clearly defined subgoals and objectives including ones for core activities and the educational support resource activity.

Three, increased planning and activities directed toward subregionalization of the program.

The region indicated it was aware of these points

and that the actions necessary to carry out the recommendations would be initiated.

The goals, objectives, and priorities were reformulated at the meeting which included RAG and core staff. They are well stated in the publication from which I quote, "The objectives of the region are a single standard of high quality health care, provided with maximum effectiveness at minimal cost, and accessible to all. The region seeks to reach these objectives by supporting and engaging in activities aimed at" -- I hope you will forgive me if I don't read them all, but I don't wish to take your time reading a great deal of what you have already been able to review. So I will skip that portion and go on down to emphasize that the goals to us seemed somewhat global, and we stressed to the coordinator and the RAG that they should establish some subgoals, more specific goals.

The region was responsive to this suggestion, and it was the opinion of the site visit team that this deficiency was a temporary one since broader goals have been only recently defined.

Site visitors agreed that Dr. Creditor is the effective, dynamic force behind the Illinois Regional Medical Program. I have had the privilege of knowing Dr. Creditor over a period of years, and I can certainly attest to this personally.

Dr. Creditor assumed full-time duties as executive director in June of 1970 after retirement of Dr. Wright Adams. Dr. Creditor has been responsible for creating a new look for the RMP in addition to creating a new look for himself with a beard and all and has been instrumental in working with the RAG, committees, task forces, and staff in setting new program goals and priorities. He has done an exceptional job in bringing together the many forces in the region.

Site visitors were impressed with the range of professional and discipline competence and the administrative and management capability of the core staff.

I already alluded to the bylaws revision in April of 1971. This reduced the membership and scope of responsibility of the Board of Directors of the corporation which serves as the grantee for Illinois.

The bylaws now require the board to consist of 9 members, 6 of whom shall be representatives of the schools of medicine and osteopathy, and two of whom shall be representatives of teaching hospitals. Directors are elected to the board for three years, and the terms are staggered so that the terms of three directors expire at each annual meeting of the board.

Duties of the board again, I think I need not read that to you unless there are questions later on.

The site visitors agreed that IRMP has an excellent

RAG with superior leadership. It was noted, however, as I mentioned before, that the interests of minority groups are probably inadequately represented.

We were quite impressed with the review process, evaluation and continuing, ongoing management of all the projects. As a matter of fact, we were very impressed with the funds that they were able to recapture through this evaluation process to use in other areas.

Their project surveillance, as I say, is excellent. A staff member is assigned to each project and is program director. In addition, an evaluation team is selected to monitor each project. The evaluation team consists of the program manager who is a representative of staff, a member of the evaluation committee who is a trained evaluator, a member of RAG, an outside substantive member with expertise in the program, and the financial manager of IRMP.

They have an evaluation checklist to make this a very objective experience, and we were quite convinced it is an excellent process, indeed. Those of us who have seen other RMPs were quite impressed with what has been accomplished in a major metropolitan area with many medical schools.

I heard comments this morning of problems that exist in other areas because of these factors. And I think we identified that IRMP has done an excellent job of bringing together the many medical schools in the areas and the health

care forces in a rather large metropolitan area together with the other problems of the State of Illinois -- namely, a large rural area to consider.

The site visitors, after a lengthy discussion were convinced the region has an adequate data base for the identification of needs, problems, and resources. New activities proposed by the region, both core and projects, are consistent with the identified needs and priorities.

It was quite interesting during the first part of our visit some of the members of the site team were somewhat apprehensive about the data base. We didn't think there was one. As a matter of fact, neither the core nor the coordinator made a big issue of the material they did have on hand. At the end of a day and a half, however, it was quite apparent they had more than they let on. And we were quite impressed with the data base. The data base is excellent.

The educational support resource which is a significant item in core was examined, and the unique resources of the facilities of the University of Illinois Medical Education Department, under the leadership of Dr. George Miller, are being utilized by IRMP as a source of technical assistance for program planning and evaluation. Current areas of interest include physician self-assessment programs and the problem oriented medical record.

The site visit team recognized the tremendous

potential benefits available to IRMP from this resource and fully support its plans for continuing support. It was recommended, however, considering the large sum of money involved, the IRMP should develop more specific goals and o-jectives for this activity in order to permit more adequate evaluation.

Recommendations of the site team are as follows:

One, approval of the program for triennial status.

Two, approval of the developmental component request, consistent with the recommended overall program funding recommendation.

Three, approval of the request for core and projects in a reduced amount.

Level of funding: For 03 year requested $2,840,269. Recommended $2.65 million. 04 year requested $3 million. Recommended $2.8 million. 05 year requested $3.2 million. Recommended $3 million.

The site visitors were in agreement that the region has the capability, maturity, and program need to justify the recommended amounts. The reservation of the sitie visitors and their reason for recommending a level of funding below the level requested was the amount budgeted for support of problem oriented medical records activities and the ability to expand core effectively as requested.

The site visitors believed this part of the plan and the amount requested to be somewhat overly ambitious and recommended the region approach this part of the program initially on a reduced scale to provide an opportunity for evaluation prior to full-scale operation as proposed in the application.

In summary, we were very impressed with what Dr. Creditor has been able to accomplish in the greater metropolitan Chicago area in Illinois. We are impressed with their programs, we are impressed with their evaluation procedures which are some of themost effective I have yet reviewed.

I think the decrease in funding on the basis of this problem oriented medical record will not hurt their overall objectives. And we are fairly confident they will be able to accomplish the objectives of that program also despite these modest decreases in funds.

DR. MARGULIES: Thank you very much. And thank you particularly for coming through on short notice. As you already know, we have neither of the people present from the Council who were involved with the review of this program, and this has been a great contribution.

Mr. Nash, would you like to add to the review?

MR. NASH: No, except to say that the review committee accepted and endorsed the recommendation of the

site visitors. I don't have the priority ranking or the rating.

DR. MARGULIES: 373.

MR. NASH: Which is a fairly high score.

DR. MARGULIES: I would like to just add something from my own involvement with this program and from the history which some members of the Council have of the Illinois program.

It did begin very shakily, had a bad early history for a lot of reasons. And when we talk about looking at the beginnings of a program and judging where it went from there, I think that needs to be borne in mind because it was taken from what was a really inadequate program which had Council deeply concerned to a level of the kind of respectability that you have heard in this review.

I happened to be there at one of the retreats which the program had with the regional advisory group at a place which is known as Starved Rock. I think they picked it deliberately to impress me with the need for more money.

But what intrigued me was that the regional advisory group in that session was doing among other things a priority selection process which was based on previous decisions which they had reached. And they knew why they had reached the decisions. They were aware of the fact that they had reached the decisions. And when various individuals

were looking at projects, they kept coming back to the process they had already gone through. They were a part of it. There was just no doubt about it. And it was one of the most if not the most actively involved regional advisory group I have had any experience with. Of course, that experience is relatively limited.

In order to get a motion on the floor, we will have tohave one of the other members of the Council pick up the cudgel and make the motion so that we can get on with any further discussion.

DR. SCHREINER: I move the acceptance.

DR. ROTH: Second.

DR. MARGULIES: You have moved the acceptance of the recommendations of the review group?

DR. KOMAROFF: One question. How much would the problem oriented medical program be reduced roughly in this?

MR. NASH: I would say roughly $200,000.

No, not that much.

DR. KOMAROFF: $240,000 is what they are asking.

I am a true believer. I would hate to see them cut too badly.

MR. NASH: Actually, we didn't make a specific dollar recommendation for the amount to be reduced. We envisioned or recommended to the region they approach this a little more slowly and so left the decision up to the

region as to how many dollars they would put in that particular activity.

DR. MARGULIES: Any further discussion?

(No response.)

It has been moved and seconded that the recommendations of the review committee be approved. All in favor say, "Aye."

(Chorus of ayes.)

I am sorry, Frank.

MR. NASH: There is one other thing perhaps Council might want to consider. This program has also a kidney project. And one component of that is ALG. We made no consideration or recommendation as far as --

DR. MARGULIES: I think the previous position we have taken on ALG will take care of that, Frank.

All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

I would like to say one other thing just in passing. We still have some kind of territorial discomfort between the Illinois RMP and by States. It is not resolved. It is getting along relatively well, but it may reappear as an issue one of these times.

I would like to suggest what we do next is there is

coffee back there, we want to keep things moving, we need to get the Ohio program next, we want maximum Council involvement with this one. It is very important. Why don't we get the coffee, bring it back to the table and continue with the activities?

(Whereupon, a recess was taken.)

DR. MARGULIES: We are going to bring up next the discussion of the Ohio programs which have been on the agenda now for several meetings of the Council.

(Mr. Milliken withdrew from the room.)

By way of quick background -- I am sure it will be covered by the discussions which are going to be made here -- Dr. Everist, would you come up -- the problems in Ohio were precipitated by the fact there were and are three programs there -- Northwest Ohio, Northeast, and Ohio State, located respectively in Toledo, Cleveland, and Columbus, with some portion of the State covered by the Ohio Valley RMP which is primarily in Kentucky. Because all three of the Ohio programs were rated very low -- in one review cycle were rated at the bottom of all the programs which were reviewed -- and because the general state of development was poor, we at the request of Council began trying to negotiate with the Ohio programs and approved arrangement which would allow the programs to somehow come together and serve the interests of the State more effectively for the regional medical program

process.

There have been extensive efforts on their part to bring about some changes. These involved primarily at our insistence their own efforts rather than ours. However, we did give staff support on request and kept out of the way as much as possible.

They did over a period of time, then reach some tentative conclusions. And in order to make the Council as fully aware as possible of where they stood and what they proposed, we asked Dr. Millikan and Dr. Everist who had just finished his long and magnificent term on the Council to go out there and spend some time with the Ohio people and report to us.

So, Clark, if you will initiate the discussion, we will ask Bruce to join in.

DR. MILLIKAN: Becuase of his objectivity, elegance of language, lack of bias, and experience, I would like to defer to Bruce and have him give us a distillation of his reactions and our reactions which are essentially identical.

DR. EVERIST: Dr. Millikan and I had an opportunity to talk afterwards so that the pronouns you see in the printed report have been changed as I go over this for you, so that we now agree totally. We were there on January 10 and 11 along with members of the staff.

It is our general impression that the State of Ohio

with the exception of the Cincinnati area encompassed by the Ohio Valley RMP, has never taken Regional Medical Programs seriously and that they have dragged their feet, making reluctant gestures toward devising any kind of effective program, either during the categorical phase of our efforts or more recently with the new direction. However, we think there are differing reasons for their inability to act.

I sincerely believe that the Ohio State RMP and the Northwestern Ohio RMP have not clearly understood their mission at any point in time. Whether or not this has been due to the lack of leadership, the lack of a coordinator in Northwestern Ohio or the weakness of the coordinator in Ohio State, we do not know; but we received the distinct impression that they were rudderless and confused. Despite this impression, we feel that Dr. Pace has the potential of developing into an adequate leader if he is given the support of continuing funds and a vote of confidence from RMPS.

We also received the impression that with the exception of Dr. Hall, his staff has not been outstanding; and if he is given a few prerogatives, he may be able to rectify this situation in short order. With considerable reservation, we predict at least a functioning RMP in the new Ohio RMP, which is the new name they have decided upon, and we recommend that every effort be made to enlighten them, to aid them and to have hope for them.

The situation in Cleveland seems to us to be far different. Here we think the medical hierarchy has never accepted RMP, would have been greatly pleased if it had never come about and is only now tolerating it because it is a source of funds when other funds are drying up. We think the Northeastern Ohio RMP must be put on very strict probation in a manner so well enunciated by Dr. Millikan during our visit there. Their recalcitrance appears to be crumbling, and their leadership to be waning.

We would not quibble over Dr. Gover's age -- 77 incidentally. He is still in good working order, and if he is the catalyst that is necessary to get some kind of positive chemical reaction in that area, we should not interfere. In other words, we think it will take a stick and not a carrot to bring Northeastern Ohio into the fold.

What is most saddening about the Northeastern region is the failure to produce in such a perfect place for an RMP. They have everything going for them -- money, talent, and a workable area. We don't think they should be given the leeway that we might extend to the rest of Ohio with its diverse and problematic areas, such as the one around Athens, which is a very poor area in the southern part of Ohio. It has almost an ideal distribution of sizable cities with Akron, Canton, Youngstown and Ashtabula; so, to be so perfectly proportioned, it seems unreasonable that they have not been productive. We

were impressed during our stay there with the verbal commitment of the university's representative. We feel that they will become more active than they have been in the past.

In summary, we endorse the rearrangement of the Ohio RMP's, excluding the Ohio Valley RMP. The merging of Northwestern Ohio and Ohio State and the isolation of the Northeastern Ohio RMP seems to be the only reasonable, demographically feasible arrangement considering the differing personalities in the areas. We would endorse Dr. Pace and accept Dr. Glover with a strong personal respect for both. We would suggest flexibility for the new Ohio RMP and rigidity in the demands for performance for the Northeastern Ohio RMP, keeping the latter on a short tether and the former on a longer one.

DR. MILLIKAN: I wanted to be sure I knew what that last sentence meant. It turned out it meant what I thought it meant. That means fund Northeast Ohio year by year for the moment to see whether the new coordinator turns that program into something worthy of the name RMP. And it means fund the Ohio RMP on a longer basis. That is a short test and long test.

It is perfectly obvious there are all kinds of problem here, but this is the distillate of our visit and our feelings about the situation for the moment.

DR. MARGULIES: I probably should have given you a little further background because I have overlooked some of the earlier actions of the Council which should be stressed, particularly involving Northwest Ohio RMP in Toledo where, in effect, the Council has said as long as --

Let's see. They were given a planning grant in January of 1968. Second planning award was issued in January of 1969. There were site visits which were very distressing. There was a continued comment on the lack of capabilities of the coordinator, the new associate coordinator. There was concern over the attendance at staff meetings, about the limited consumer input, about the lack of involvement of the medical college in Toledo. And there were some very serious managerial problems in Northwest Ohio. So that in effect the Council put Northwest Ohio on probation,

on severe probation, indicating that something had to happen or they were virtually going to go out of business. So this program has been held at a point of bankruptcy for some time.

In order to get the three to be highly attentive to the questions which we had raised and which started with the suggestion they consider a single program for Ohio, we limited the funding of all three to six months. When that six months was up and they had been making some planning progress, we extended it long enough for us to consider their proposal which is under consideration now which is in essence, as I understand it, Clark, a new Ohio program which combines the areas covered by Ohio State and Northwest Ohio and the continuation of Northeast Ohio, but on a --

DR. MILLIKAN: A year to year basis.

In your hands, there are being placed recommendations having to do with the merger or amalgamation of what has been called Northwest Ohio and Ohio State.

Incidentally, the fiscal agent for this new program will be the Ohio State University Research Foundation. And you may have a comment you want to make about this.

I believe you were satisfied that the basic administrative talent in that organization appears to be entirely competent to handle the money. And I believe that it was your feeling and the feeling of all of us that it

would be important that all methods practiced and all fashions for the distribution of that money be centralized in the hands of the Ohio State University Research Foundation.

MR. GARDELL: We have requested an audit department audit of those programs, both of these programs, which would be conducted probably within the next two weeks. This is very important because of some of the recordkeeping problems that at least the Northwest program has had. And they are very willing to have this.

We have already conducted a management survey at Northwestern as mentioned, and we are scheduling now one prior to the merger for Ohio State. So that the Research Foundation when it takes over will have as clean a slate as we can possibly hand to them. And they are concerned that it be clean.

DR. MILLIKAN: There is one further comment. We have really kind of summarized in rather short fashion the activities of a couple days and a good many hours of discussion. And it is like that old business of what are the alternatives. And at this point in time it looked to us that in order to get on with RMP functioning in the State of Ohio, this series of proposals is about the extant alternative.

The other look at this would be to cut somebody off and phase them out. And they are at least at this point in time making efforts to move ahead.

And going back to Northeast Ohio, there is now on site a coordinator who has been formally in action since January 1, 1972. The action is started, his acclimatization and knowledge collecting about December 1 in '71, and I think we need to see what will happen to that.

So this is the reason for the recommendations that we are making.

DR. EVERIST: I think Dr. Margulies need have no regrets for our not being aware because we were of all the problems that had happened. And the background information, I think, was fairly complete. And the learning experience of these people following Dr. Millikan's two very great lectures -- they were not veiled threats, not even a diaphanous veil. They were very clear and to the point that the folks better shape up in Ohio. And I think they received the message without any question. This particularly was true in Cleveland.

MRS. MARS: Why shouldn't there just be one Ohio program? Why should we still continue with two? Has anyone got a map of Ohio here? That is a geographical question.

DR. MILLIKAN: This has to do with local politics and personality structures.

DR. MARGULIES: Our proposal was they try to.

MRS. MARS: Do they have to play politics?

DR. MARGULIES: The only way we would have had one was impose it upon them which is the only way.

DR. MILLIKAN: It is not legal.

DR. MARGULIES: We want to do it legally. They have to make the choice, and we pushed them as hard as we could. However, the implication in this action, as I understand it, is that that idea is still in our minds. And the decision is to look at Northeast very, very carefully and to continue the possibility of having a single program as time goes on.

Isn't that approximately right?

DR. MILLIKAN: Correct.

MR. GARDELL: You may just want to mention the fact that the interest in the State itself for wanting to come up with a single program, in the background behind the scenes, they are trying to work with us to accomplish this.

DR. MARGULIES: That was the other kind of element that got in there. What we started out with was a decision based upon the Council's concern with these three programs because we were dealing with all Ohio. They quickly tried, a number of people did, to interpret this as our demand that it be by State boundaries which is not our intent because the portion of the program which is being served by Ohio Valley RMP is very happy with that arrangement. That is primarily Cincinnati and had no desire to change it. There was no point in interrupting a good segment of the program just because people were talking about State boundaries.

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We had to keep reminding them that it was the programmatic deficiencies with which we are concerned, not an arbitrary geographic boundary. But that interest is still present, and we will have to continue to deal with it.

Lee, I wonder if you would like to add further to the review?

MR. VAN WINKLE: No, other than speaking to the Research Foundation. They were in just this past week. And not only did we think they are highly competent, but they are quite concerned. And their attitude is if this isn't a good program, they don't want anything to do with it. They say that they have been quite successful in what they have done, and they don't want to take on what they would consider a losing concern.

So I would suspect they are going to do a little more than just manage the fiscal matters.

DR. MARGULIES: There is one other thing which we should be very open about, and which needs to be avoided at all costs. And that is a continuation of business as is with a kind of superstructure which is a facade of amalgamation. It is particularly pressing as it involves Northwest Ohio where there has been no doubt in the minds of many of the reviewers the present people involved with program direction are totally inadequate. They have been identified repeatedly as at the bottom of the list.

7 This has been discussed with the grantees. They have admitted the fact. I think they have in essence two coordinators in Northwest Ohio RMP, neither of whom is contributing anything. And the dean is very distressed over it and doesn't know what to do.

So when you see the final recommendation, it will be as strongly stated as possible. But behind it lies that concern.

Lee.

MR. VAN WINKLE: Yes. As a matter of fact, they have come in with their application. And what we suspect is true, they have retained the two existing structures precisely as they were with staffing and all and calling them subregions. And they have now set up that superstructure that we anticipated they might. And I think that was the reason for the staff recommendations to not allow that to happen.

DR. MARGULIES: Bland, I think you have been there, haven't you?

DR. CANNON: I haven't been there, but I have repeatedly reviewed the applications in assignments in the past. And I would say that all that we suspected was true in the Millikan efforts to report. And I would favor the recommendations.

DR. MARGULIES: Would you like to make the motion that you want to make now?

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DR. MILLIKAN: Well, here are staff recommendations which have been passed out to you concerning the amalgamation or merger of the Ohio State and Northwestern Ohio Regional Medical Program into the Ohio Regional Medical Program. I move the approval of these recommendations.

There will be another motion in a minute.

DR. MARGULIES: Would you read them?

DR. MILLIKAN: Yes.

It is the recommendation of the staff that:

1. The Ohio State and Northwestern Ohio Regional Medical Programs merge into a single Regional Medical Program under the Ohio State University Research Foundation as the grantee agency. Council should commend these two Regional Medical Programs for their long and tiring efforts in requesting and effecting this merger.

2. The effective date for this merger be September 1, 1972. This appears to be a reasonable time frame and is necessitated by the need to extend the present programs for a July 1, 1972, to a September 1, 1972, start date under the proposed three cycle review.

3. A detailed plan for effecting this merger, showing organizational structure and staffing pattern be submitted to Regional Medical Programs Service by July 1, 1972.

4. A single coordinator be appointed for the newly formed Regional Medical Program.

5. The administrative functions provided by the Ohio State University Research Foundation not be duplicated in the newly formed Regional Medical Program.

6. All Core staff in the newly formed Regional Medical Program be payrolled by the grantee agency, the Ohio State University Research Foundation, in an appropriate salary structure as determined by the grantee agency.

7. All Core staff functions be centralized in a single location and any indicated need for housing Core staff in other than the Regional Medical Program location will have to be fully justified in the plan for the merger which is to be submitted July 1, 1972.

8. If it is proposed to house Core staff at other than the Regional Medical Program location, they should not be made a formal part of an existing organizational structure other than the newly formed Regional Medical Program.

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And you see the obvious intent of some of these things to produce a really new setting.

DR. SCHREINER: Do you really want to say the efforts have been tiring?

DR. MILLIKAN: They have been tiring of somebody.

DR. MARGULIES: I accept that as a motion.

DR. MILLIKAN: I moved that. I don't know whether you got a second or not.

MRS. MARS: I will second it.

DR. MARGULIES: Is there any further discussion?

(No response.)

All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

Now, you still have --

DR. MILLIKAN: Now, a second motion. I move that the Northeast Ohio Regional Medical Program be funded at its current level on a year-to-year basis with a project site visit for staff review of progress being made in late 1972 -- you may want to debate that date, late 1972 -- and that depending upon the result of that review, further effort be made to produce amalgamation or a combination of Northeast Ohio with the Ohio Regional Medical Program.

I am putting it dependent upon. That is the end of

the motion.

DR. MARGULIES: Is there a second?

DR. CANNON: Second.

DR. MILLIKAN: The reason I phrased it in that fashion is if you were to consider Ohio, for instance, in similar fashion to some other very populous area like California, for instance, you could make a case for subregionalization or subareas. And Northeast Ohio constitutes that kind of phenomenon with Cleveland as its nidus. And the large cities around it and the flow pattern as far as training and medical referral and so forth is concerned sort of is in that same kind of direction.

All I am saying is if they do a good job, if they get on with the RMP concepts and activities in Northeast Ohio, I don't see why they shouldn't stay like they are. That is the main thing. That is our purpose. If Glover and Durang and so forth can really get this thing moving, I wouldn't put any special pressure on them to change.

DR. MARGULIES: According to my rough calculation, for what it is worth, if they finally go through this period of time in Northeast Ohio and a year later become eligible for triennium, at the end of that triennium, the coordinator will be 82 which should be a new experience.

DR. MILLIKAN: There are a lot of things that have been said here today. Some of them, however, are included

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in the handouts. And this has to do with the attitudes and influence and past impact of the chairman of the RAG on the whole situation in Northeast Ohio. And it may be that there will be a change in that situation also. So who knows? But for what we are really saying in the motion, it is let's continue the funding at the current level for a year and somehow take another look.

I didn't want to tie staff's hands by making it absolute there be a project site visit, but there be either a project site visit or staff review.

DR. MARGULIES: Lee.

MR. VAN WINKLE: It is maybe not legal, but still entirely possible to do this at a later date by merging with the situation. Because we know, as a matter of fact, they did approach the Toledo group and offer to merge with them if they would exclude the Columbus group.

DR. MARGULIES: That is part of the whole story, not to mention the internal Cleveland problems.

DR. MILLIKAN: There seems to be some undercurrent.

DR. MARGULIES: Any further discussion?

(No response.)

All in favor of the motion say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

Ingle Brenton, is a significant step. He is a very brilliant young man, and I think that he adds greatly to the depth of their staff and ability of their staff.

So the site team, exclusive of the kidney project now, I am talking about, recommended funding as you see set forth. That is $1,552,706 for 04 and $1,673,750 for 05 and $1,713,150 for 06.

And if you would act on the recommendations of that portion of it, I will discuss the kidney portion separately.

DR. MILLIKAN: I will second the motion.

DR. SCHREINER: Are you moving the site committee level or review committee level?

DR. CANNON: The level of the site and the review committee are the same if you take out the kidney program. And that is what I am moving. I am not considering project 43. I am goingto discuss that separately.

DR. MARGULIES: It makes me a little nervous to speak of another Phoenix when you are talking about Florida, but this one is another one that has arisen out of the ashes of a program that was in real trouble, unusually torn apart. I think some of you remember in the earlier days when there was an application to separate the program, and no one was speaking with anyone else. And there wss a bad arrangement with the medical schools, without the medical schools, and it was really torn apart.

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Thank you very much, Bruce.

DR. PAHL: I think the record should show Mr. Milliken went out of the room during the course of this discussion. And if someone will please have him come back, we will proceed to the last of the triennial applications, the "Florida" application, with Dr. Cannon as the principal reviewer and Mrs. Wyckoff as backup reviewer, Mrs. Parks from our staff.

DR. CANNON: Well, it was a very rewarding visit to see the growth and progress that Florida RMP has made and the support that the site team visitors gave the program and in its funding, and then to be supported by the review committee for further commendations leaves little to be said except that we congratulate them on their improvement. And if you want to know specifically some of the areas of improvement --

Where is Mrs. Parks? I don't see Mrs. Parks.

But for instance, they had a little lock-up with the university at Gainesville. And it is this very strong man who is chairman of the RAG group named Hampton. And anyway, the dean is leaving at the university at Gainesville. It appears that the little difficulties with the university will be smoothed out.

I don't think that anything but congratulations can be given them on restructuring their RAG and grantee relationship. I think the core staff, the acquisition of

Not the least of their achievement -- well, the biggest achievement -- is really to develop some integration of programs. Their interests are exciting. Some of the things they want to do, for example, in the nursing homes and some of the approaches they have made are very rewarding.

Incidentally, they have Herman Hilleboe down there on ostensibly half-time which with his kind of energy is about 125 percent of anybody else's.

They looked at the problem of neonatal deaths. And instead of saying, "O.K., we are going to have centers into which people can be brought very promptly," they looked further to see why it is that the death rate was so high. They found among other things the referring institutions were not recognizing neonatal distress early enough. They didn't know how t- take care of them. So they took on the responsibility in making sure that the people who were there were better trained so that they could recognize the problem earlier, transport the patient effectively, and then have gone back to the original training programs to see they are not learning the things they need to learn in the schools of nursing to handle this kind of a problem.

That is a different spirit in Florida from what it was originally when it was very closely associated with some rather proprietary interests.

DR. CANNON: I can go into detail about the

emergency medical program and many other facets, but I think all of us have reviewed this application before. And if you read these three different groups, you get the sense that everything is good.

DR. MARGULIES: The program has as its first priority the improvement of emergency medical program throughout the State.

DR. CANNON: Which is a jump ahead of what we did in St. Louis.

DR. MARGULIES: Would you like to add to that or Mrs. Parks?

MRS. PARKS: I didn't hear what the discussion was. I just came in.

DR. CANNON: Yes, where were you?

I thought that all of us were impressed with the progress they have made. And I thought the little things we pointed out to them were not significant so far as if you compare them with the progress they are making in this on the State construction, staff and program departments.

DR. PAHL: Before asking for the question on the motion made by Dr. Cannon, I would note that the review committee gave this a rating of 352 in which their recommendation did include the approval for the kidney project.

Is there further discussion on the motion?

(No response.)

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If not, all in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

Now, Dr. Cannon, may we have the discussion on the kidney aspect of this proposal?

DR. CANNON: On the kidney, the request was the first year for $660,000 and second year $688,000, the third year $720,000.

In the review -- and I wasn't there when this was carried out -- Dr. Lewis' comments were this budget should be trimmed and made certain recommendations which I think were accepted by the site team visitors. And the site team, Dr. Lewis, came up with an amount for the kidney which follows.

DR. PAHL: Page 4.

MRS. PARKS: $223,500 for the first year.

DR. CANNON: Yes, $223,500 for the 04 and $178,000 for the 05 and $150,000 for 06.

Subsequent to this and the acceptance of it, the staff has been in negotiations with the staff in Florida because, you see, Dr. Lewis' restrictions of budget were on the following bases:

The budget is largely unjustified and requires a great deal of reworking.

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And the number of personnel slots should not be funded through this grant.

The salaries for surgeons, for instance, fellowship salaries, transplant nurses and all those that were funded in it, he thought shouldn't be.

The budget for Gainesville area includes funding for nephrologist, transplant surgeon, neurologist, funding for other members of the transplant team, all of whom should be paid through patient costs, and a similar criticism for the other.

And then paring the budget down, apparently there was some discrepancy that the staff worked out later and came back with a recommendation of increasing that basic fund for the kidney program to $375,000 for the 04, $313,500 for the 05 and $251,625 for the 06.

I don't know how as a Council member I can tell you which to go for. I can say that when we looked over the program, some of the evaluations must be subjective. And I think Dr. Lewis maybe didn't have the opportunity to work out the details in time of what funding should be for the program to be effective. And the staff made some suggestions of advice that the region should be encouraged to support two full transplantation surgeons at the two ongoing transplant centers. That is Gainesville and Miami. The reason for this is the necessity for a full-time commitment to organ

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procurement as well as the development of a competent transplantation team.

Second, the region should be encouraged to work with the Florida Kidney Foundation to improve the opportunities for home dialysis training for those patients in whom transplantation is not indicated.

And the region should place an early emphasis on attempts to find third party mechanisms for funding organ procurement.

Concerning a transplantation center in Tampa, the statistics yet do not support the establishment of that.

And I would, knowing the medical school development stage, they are only approved for 24 centers in 1972, projected '72. And that will tell you they are just getting started, and they do not have at the present time potential of taking on this problem.

It may not even be needed.

DR. MARGULIES: Our discussions with them evolved around some of the same issues we have discussed before. We did not feel as did some of the people who were commenting on it that having a half-time transplant surgeon is adequate. This really requires full-time effort. I don't know why we get into that difference, but it is the same kind of consistent energy and enthusiasm that has to be supported that we have talked about before.

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They have a very clear-cut concept of how they want to move toward Statewide dialysis programs, and they are not as far along with home dialysis as they wish to be, but they know exactly where they plan to go. And this has something to do with our intentions also.

And then we did feel that their arguments for giving support to the present cooperative efforts which they have between the three centers were valid. And we didn't want to close the door on a third transplant center, but it seemed to us reasonable to restrict their interest to what the capacities and the projected patient load might be in the State. And it was much of that which entered into this final altered figure plan that staff came up with.

Ed, maybe you might want to add to that.

DR. HINMAN: Two other things. This is a coordinated program to the approach to treatment of patients with end stage renal disease.

Item No. 2 here has a typo and left out the reference to the Florida Kidney Board. Florida recently has passed a law and has a kidney board that has some funding that will start paying for the service aspects of the care for these patients. And it was our feeling that they needed the initial investment to get the staff on board, to get the resource developed so they could provide the care so they could then get the money in to reimburse and pay the salaries.

We agree with Dr. Lewis the long-term support of the transplant surgeons is not appropriate, but you have to have the transplant surgeon before you can get the money in to pay for them. This is the reason we recommended the increased dollar amount.

And there was one other recommendation, Dr. Cannon, on the bottom on page 2 to try to hold them to one tissue typing center throughout the State if at all possible.

DR. SCHREINER: I think that is a good point. People are to doctrinaire about this excluding professional salaries. If you are going to be seeding a program, if you are going to say you start from zero and go to 50 at the end of a year, if the guy was absolutely perfect, he would do an average of 25 the first year. If he went from zero to 50 in the course of 12 months, that means the average for that year has to be 25. If he charges $1,000 apiece, that is $25,000 a year, and you are not going to get a good transplant surgeon for that. So it is silly to say you don't pay salaries.

DR. HINMAN: Their procurement efforts are fragmented at this time and need a lot more coordination. And that is one of the other reasons we thought an initially fairly high investment to allow them to get that off the ground because that would be rate limiting, again if there is not a flow of harvesting of an adequate number of organs.

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DR. MARGULIES: Are there any other comments? We can comment on it beforehand.

Dr. Merrill, Dr. Schreiner.

DR. MERRILL: I agree.

DR. SCHREINER: I would like to compliment about the constructive aspect of the staff review.

DR. MARGULIES: Bland, would you like to make a comment?

DR. CANNON: The only thing I think the staff should again talk to Dr. Lewis. I don't know whether that was done or not. I think in all fairness to him because he spent time and effort in trying to arrive at what he thought was the proper decision. And I really think the staff ought to discuss it with him.

Maybe you did and I don't know.

DR. PAHL: Has this been done, Dr. Hinman?

DR. HINMAN: Not this last set of recommendations. There have been two subsequent discussions to that, and we will discuss it again before anything goes out.

DR. CANNON: I would say a contingency be the discussion be carried out with Dr. Lewis and get his agreement. Can you have that? Do you see it is necessary?

DR. HINMAN: You have a problem if you make it a contingency. What if he says, "I don't agree, don't pay those surgeons' salaries," we have some philosophical

difficulty here, Dr. Cannon. Our whole approach is we think our dollars should be invested in getting those resources available so you can give the patient care and that the funding will come after you have the patients in the system.

DR. MARGULIES: Actually, they had another consultant there, Dr. Flannigan from Arkansas, who basically supported this position. So what we have so far as the consultants are concerned is difference in philosophy.

DR. CANNON: That is where our two gentlemen who are assigned to this problem should come in and tell us what to do.

DR. MERRILL: I would like to add my support, then, for Dr. Hinman's position and Dr. Schreiner's position. I think as in the three times I have been here, I have seen a little change in philosophy which I think is commendable in the fact that one has got to have seed money to get people there and get them working full time. Because the medical schools simply cannot do this any more. And you have heard this morning a couple of examples of people who are trying to do this part time in the situation which I think greatly impaired the efficacy of the proposal.

So that I would wholeheartedly concur with the support of personnel, professional personnel, necessary to begin and carry out this program.

DR. CANNON: Then, I will move that the funding for

Project 43 be on the recommended basis of the staff last information sheet. And that is 04 year $375,000, 05 $313,500, and 06 $251,625.

DR. PAHL: Is there a second to the motion?

MRS. WYCKOFF: I second.

DR. PAHL: The motion has been made and seconded. Any further discussion?

(No response.)

If not, all in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

May we now turn to Intermountain application with Dr. Schreiner as principal reviewer, Mrs. Wyckoff as backup reviewer, and Mrs. Murphy from our staff. This application was given a 296 by the review committee.

DR. SCHREINER: Intermountain, as you know, is one of the first regions to become operative and represents Utah, parts of Nevada, Montana, Idaho, Wyoming and Colorado, and has about three-quarters of a million population and about 50 percent urban, if you put urban in quotes.

The staff review has recommended funding $2.478 million out of a request of $3.025 million. As you will notice in our action taken this morning, we put the current level back

up to about $2.7 million.

In general, I think that I agree with the review with a few basic exceptions. And this would have to be, I guess, subject to comments of the people who have actually been out there recently which I have not been.

My impression is that the new coordinator who replaced Dr. Hilmon Castle is being reasonably well received and is having acceptance in the subregional program and seems quite effective in its development. For this reason, I would just question about why one would want to reduce the developmental component for a new administrator that you are happy with. I would think that unless there is some strong staff input that I would think that one of the best weapons that a new coordinator could have would be his developmental component to work with. And if everybody is satisfied he is a good man, I would be willing to gamble that much on the development program.

The other question has to do with the kidney projects. I was very disappointed in going through this to find that there appeared to be a big block in communication. And I can't help but feel that either there is a block somewhere in the administration of the local regional program, that staff is not getting to communicate with the providers, or that the site visitors are not communicating with the providers.

You have got some very fine people out there. Dr. King Smith is one of the outstanding transplant surgeons in the country. Dr. Kolff who is the father of the artificial kidney is there. Dr. Bloomer has a first-class program in the VA. And they have laid out a very nice project. And the design of the project which I went back into the project book and looked at is quite good. Yet, somehow there appears to be almost total absence of communication in view of what is going on in that particular area.

The comments of the review regarding the perfusion apparatus, I also find pretty superficial. They are on the basis that they already bought the machine, and they shouldn't have done that without having a technician first. Well, that is really not out of line. The business is done. An organ perfusion is a complicated piece of machinery -- a pump, oxygen. In the first place, this is a 6- to 12-month lead time to order one. So if you want to have one, you have to get the order in now, not wait until everybody is on board.

Secondly is the usual procedure is to bring it into a unit, work it on dogs, train your professional staff. And then when you want to take it into the human, use the operating room, you are not going to necessarily use the same techniques you are using in the dog lab.

If you are going to regionalize this to have organ procurement, I think it is a perfectly normal sequence of

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events to have a machine first and then request a perfusion technician. But just throwing it out on that basis alone is bad. They may have some other reasons I would like to hear, but if that is the reason, I don't think it is valid.

So I would like to replace that one and move the recommendations of the review committee.

DR. PAHL: Thank you.

Mrs. Wyckoff, do you have any comments?

MRS. WYCKOFF: I had one question about the multiphasic screening project. As usual, I am deeply concerned about follow-up, and I was comparing it with the Illinois multiphasic screening project where a very careful evaluation of the whole thing has been built in. And follow-up is an extremely important part of the Illinois project.

With this, they seem to be shopping around primarily for material for the multiphasic screening project as though they were up in business just to process people, but what comes out of them afterwards is a matter of little or no concern.

Speaking as a consumer, I am very concerned about this. And I would like to see some real discussions go on with them as to the follow-up. They have spent quite a bit of money tooling this thing up similar to the Nashville situation. And I understand that just last month, they processed their first 25 patients. And they have had quite a large budget

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if you notice over the last two years.

So I think this thing should be put into the evaluation meeting you are going to have on multiphasic screening, but that negotiations go on now to make sure they have some follow-up built in.

DR. PAHL: All right, perhaps we could.

DR. MARGULIES: I would like to just comment for a moment. I think that is the multiphasic screening that is in the neighborhood health center.

MRS. WYCKOFF: Yes, it is.

DR. MARGULIES: The real delay there was in the development of the neighborhood health center which has been in operation only a relatively short period of time. And there was a long negotiation. It is a combination of OEO funded activity with some tie-in with Blue Cross and Blue Shield. And the reason for the delay is there.

On the other hand, it does represent one of the problems of Intermountain which is that they developed this as high level of skill and a good bit of interest in hardware and developed some professional expertise over the years, but they have never been able to acquire the collateral skill of dealing with communities other than professional communities. They are weak on getting out and hearing from people and being responsive to the communities which they serve away from a relatively limited professional environment.

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At the time that I visited with them, this issue came up. They are aware of it, but I don't know that they have dealt with it very effectively.

I wonder if the staff has some further comments.

DR. SCHREINER: I might just comment they are dealing with a traditionally self-sufficient community which has studiously avoided Federal funds for welfare projects. And maybe it is not quite so easy.

DR. MARGULIES: I am not thinking so much in those terms as just the general regionalization of the program.

DR. PAHL: I would like to ask Miss Murphy to comment on the developmental component aspect of Dr. Schreiner's concern.

MISS MURPHY: They on the SARP had recommended $150,000 limit. They felt that would give them enough latitude.

DR. PAHL: The point I was raising is why did the review committee recommend the lesser amount? What were the considerations which led the review committee to reduce the sum?

MISS MURPHY: Mr. Posta.

MR. POSTA: Doctor, may I add a little bit to shed some light on the situation? When the staff actually reviewed this before it went to SARP, staff recommended to the SARP panel that the same funding level be maintained for

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the 06 year. As we know, the funding level for the developmental component started with $75,000. When, shall we say, the working staff went to the senior staff of the SARP committee, SARP suggested in effect that the full 10 percent or the requested amount be honored. That, in turn, went to the review committee to in essence complement it with what a working staff had recommended to maintain the current funding level for the sixth year plus the requested amount which would be in this case about $140,000.

They felt that perhaps the region, since this is their 06 year, has not really faced the current philosophy or so to speak turned the corner to get into those particular programs that were more in keeping with their own stated objective. They had certain obligations to fund those programs that this Council had approved several years before. But in essence since that date, we have called the region and have found out that they do have well over $100,000 up for review at their local RAG in the developmental component aspect.

And of the 10 developmental component programs that have already been approved by the RAG, 8 of those have centered as a basis of operation away from the medical school.

I think heretofore one of the criticisms of this particular program was that an awful lot of the RAG operating capital was going into the medical school itself. And I think that we can probably confirm that about half or 48 percent is

30 going directly into the medical school.

So to apply more directly to your question, I think the recommendation that the review committee gave of $150,000 was more or less a compromise of the two proposals.

As an acting branch chief, I think that Dr. Schreiner's comment is most appropriate here. This region will be facing triennial application this time next year. And I do think that if we get away from this funding tradition that this region has had in putting so much money over the long period of time at the medical school that the bigger developmental component more flexible level would be justified. And still it would not treat this particular region any different than any other region that I think we have approved in the area developmental component by not laying any restriction on them.

DR. PAHL: Thank you.

DR. SCHREINER: That makes me feel better, and I will keep my motion.

DR. PAHL: Has the motion been seconded?

DR. MILLIKAN: Second.

DR. PAHL: Dr. Hinman.

DR.HINMAN: I would like to make a comment about the kidney. The information that was available to us on the kidney, Dr. Schreiner, project 25A, which is in a currently approved three-year project so the money for the next year

31 has in essence been approved, in the past seems to have taken the direction of the activities that would normally be found in the Kidney Foundation chapter, i.e., physicians' lounges, screening at State fairs, things of this nature, which did not impress us as really getting at the heart of the issue of the care to the patients. So we commented on 25A that we were concerned about the direction they were going and hoped we could work with them to get back toward patient care activities.

Project 25B, the majority of the funding in that was for ALG production. I thought I had full notes -- I just was checking -- with me. We can't find our last reference as to what it was. It was something about the organ preservation and techniques, either where he was based or lack of relationship to the program. There was something about it that left us with the feeling this would not really augment proper utilization of the Belzer appratus. The fact this sequence was reversed was a note. It was not the reason it was turned down.

DR. SCHREINER: That was really the only comment I could find that they used this as the reason.

DR. HINMAN: You hit it right on the head when you said there was a communication difference between Rockville, Salt Lake City, and the actual proponents here. And the best information we could come up with did not support that this

was goingto fit into a well-thought-out regional plan. And we recognized the competence of Dr. Kolff and Dr. Reemstma* in the region. We don't want to hold them back, but we didn't think the money was going to help solve their problems. And that was the reason for the turndown.

DR. SCHNEIDER: I wonder if maybe we can't make a recommendation. Maybe this new fellow has been so used to staying away from the medical school in this major part of the program, he is doing the same thing in the kidney program. And a transplant program has to have a focus obviously. And to take it out to this mountain area, a lot of these people are going unnecessary distances.

I know some of the people in this region are going to San Francisco for transplants. And I think that somehow the transplant group hasn't been brought in. I don't know whose fault it is. I am just saying I think we ought to send that message out. They may have taken the directive overly literally with respect to this.

DR. MARGULIES: As the problem is one of understanding what is going on, that can be resolved by finding out what is happening.

DR. BAHL: Is there further discussion?

DR. SCHREINER: I will modify my motion and skip the techniques, but keep in the developmental component. If the technician is good, they ought to be able to pay for the

*Dr. Reemstma is no longer in Utah.

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developmental.

DR. MILLIKAN: A question. The panel assigned a rating of 296 on December 20, 1971. Did the review committee assign a rating?

DR. PAHL: They accepted the staff rating, is that correct?

MR. CHAMBLISS: Yes.

DR. MILLIKAN: This is interesting, then, and also concerns me. At one point in time, this was generally thought of by some of the project site visitors, at any rate, as an outstanding regional medical program. And this isn't reflected in that rating.

DR. MARGULIES: Yes, it concerned us, too, Clark. We got the impression that they were still dependent upon what they had done a little too much and weren't really building new and stronger directions. And that will happen with an early, quick start.

I think they have reached a rapid peak and settled down, but I think the projects are good for the program over time. I agree the coordinator has really good possibilities.

DR. PAHL: If there is no further discussion, all in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

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The motion is carried.

May we now turn to the Susquehanna Valley application with Dr. Cannon as the principal reviewer and Dr. Schreiner as backup reviewer, Mrs. Faatz from our staff. And the review committee gave this application a 244 rating.

DR. CANNON: Let's deal in generalities for a minute. As all of you know, Susquehanna Valley has been one of the troubled areas in RMP, and we have been there and finally accomplished a great deal in a site visit that was -- when was that -- about a year ago. At that time, we told them to find a coordinator. We told them to redirect some of their programs and change their RAG. We told them a lot of things.

But the most important thing was that we thought they needed an M.D. coordinator who could break some of the barriers, the relationships with institutions, providers, and the medical school. That wasn't an easy thing for them to do since the Penn State Medical Society was the grantee and they had placed one of the associate executive directors as the coordinator of the program.

Following a visit disapproving funding and restricting the funding that they had, they did accomplish a change. And they have now aboard a physician, and they have a new RAG chairman. I have talked to both of these men in St. Louis. I was impressed. I knew George Williams before. He is an attorney, Philadelphia lawyer, retired to the hills.

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And the doctor is a young man who seems to have an awareness and a perceptivity about RMP that I think is encouraging.

Something else has to happen in that region, and that is going to happen 9 months from now. And that is that the fellow who is dean of that medical school must retire. We all know him in medical education, and we know that nothing can change until he is out. So far, there is that relationship, and he has 9 months more.

So I would look at this next year for Susquehanna Valley as potentially a bright year, and I would like to give the new coordinator and the new RAG chairman the opportunity now of making significant headway in being the kind of RMP regional program that we could be proud of.

It is sort of like, if you will think of it, and the best way to express it is for a long time, as an old cotton farmer, the program has been one of restriction of how much cotton you could plant. So a lot of us turned to cattle farming. And we make up these programs, and we get them about February.

Last year, not only did they take off the ceiling but assured good prices. So everybody regrouped and tried to go back into large cotton farming. When you do that, you can't do it without money because you have gotten rid of your equipment. You don't have the labor. And so you go to the bank and say, "I need advancement of X number of dollars in

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order to put my operation in effect so that I could plant cotton and harvest it and realize the gain."

Really, they have been cattle farming in Susquehanna Valley. We have told them now there is a new direction to the program, learn to do emergency service, AHEC, HMOs, all that. I kind of believe we ought to give them the opportunity to make a go of it.

With these generalities, let's go to what is here in the book. I had discussed this matter with Mrs. Silsbee because she was on the site visit. They have requested $1,400,466. The staff and the review committee have suggested that we give them an initial award for this 04 year of $480,405 with $100,000 in waiting in the hands of the Director to place it in the program.

My impression of this is this is an inadequate amount, $100,000, to change from cattle farming to cotton farming. And I have a feeling we ought to invest more money initially in the 04 grant with the stipulation that this additional funding above, let's say, $480,000 would be for innovations and new direction and not to boost up some of their projects, ongoing projects, which would be left out, which has a certain amount of validity and support.

Now, this is going to be guesswork, the amount to recommend. And I really don't know how to go about it. And that is the reason I sort of wanted to Judy up here. I have

felt perhaps, looking at their request, we might fund them on the base of -- See, originally, they had $650,000. I would suggest maybe $750,000 on the basis that this additional money be used and then put another lump sum in the hands of the director for additional funding up to another $100,000. And that would be a possibility that they could receive $850,000.

I got a looking from that end of the table which seemed those figures are out of line. I really don't know how to arrive at the recommended amount. And the reason I approved this in generalities was because I think it is going to be a judgment factor. But I don't think holding $100,000 in minimal funding is quite the way to go about it.

What I am recommending is we give them more money initially and have some additional funds. But from the initial grant we give them, there is a contingency, this additional money, above $480,000 to be used for new projects, new innovations, new directions, of the program.

DR. MARGULIES: Would one of the boll weevils at the end of the table care to comment?

DR. PAHL: Perhaps you want to hear from the secondary reviewer, from Dr. Schreiner, first.

DR. SCHREINER: I was going to ask the site visitors whether they had come up with any detection of some new cotton planting aborning. That is, any ideas that have been

38 kicking around that they got from all the people that they talked to and said, "Yes, there is a germ."

I agree with Bland's analysis that if you are going to turn a region around, you have to give it the wherewithal to do that. But I think you ought to see at least a spark on the horizon of some things.

DR. MARGULIES: There is also the alternative of inviting a supplementary request.

Judy, do you want to comment?

MRS. SILSBEE: The site visit, Dr. Schreiner, was made over a year ago so we don't have recent information. But the reason staff had recommended the $100,000 with sort of a string attached to it was because we were faced with an application that included some very strange projects that had just been carried over. And we were worried about that aspect. If we gave them money without having the stipulation that it be used for cotton rather than cattle, we wouldn't know what we were buying because the regional advisory group had already approved of these things. There was evidence there are people out there that want to do things like computerize EEG and EKG and so forth.

DR. CANNON: It is an act of faith, you see. The coordinator wasn't on board when we were there. As a matter of fact, he just came on board in January.

MRS. SILSBEE: He had nothing to do with this

39 application here.

DR. CANNON: I am only saying in my talking to the coordinator, and I hope Harold talking to the coordinator, he sees a glimpse of a bright future. Then, if you do, I think you have got to have a little faith that this is the way to go about it.

DR. MARGULIES: I talked with the grantee agency along the same lines. They felt they would not really be able to generate enough of a new program until the man was on board.

If what you want to do is give a level of approval which is above what they can handle, then, of course, I have the discretion of making a grant award now and if they do better a supplementary one later with the understanding that is what you have in mind. And this would have the same kind of an effect as the supplementary award, but would indicate your confidence at this time.

DR. SCHREINER: My reading came out maybe a little less generous than Bland's. I think that would be a better way of doing it because I would hate to have them get the thought that they had somehow impressed the Council.

DR. CANNON: Well, they have impressed me, George. I will admit it is pretty hard to either fire a coordinator or get rid of him. We don't fire or hire. But we were trying to get rid of one out in Ohio for a hell of a long time and even sent Dr. DeBakey out and a technical team out and another

40 kind of team. So it is not an easy thing to do. And we really gave them a pretty direct approach to it, and he was sitting right there. You just can't hire the kind of people you want to work with providers unless they have the qualifications.

He is just not going to be able to hire a doctor, not being a doctor. And he is not going to be able to get his foot in hospitals, medical schools, and county medical societies. And he is just bound in.

Now, I think it was a significant step that they made that this took this action. Behind that, there are some very good, bright men involved in RMP. I mean given part-time activity and all they needed is to improve the kind of staff -- that is, open some new portholes in order to look out.

DR. SCHREINER: I would agree to raising the ceiling with the methodology that Harold mentions. It sounds to me like the best methodology. He can hold back part of this.

DR. MARGULIES: I could be guided by this discussion perfectly well.

DR. MILLIKAN: Where do you want the ceiling -- $750,000?

DR. CANNON: I would say $750,000 would be just $100,000 above the $650,000.

DR. MILLIKAN: As the ceiling.

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DR. MARGULIES: Is that a motion?

DR. SCHREINER: Second.

DR. MARGULIES: Any further discussion?

DR. CANNON: Is there any supplement to that? Aren't we going to give them another parcel?

DR. MILLIKAN: $750,000.

DR.CANNON: O.K.

DR. SCHREINER: He has his parcel.

DR. MARGULIES: They can come back.

Any further discussion?

DR. MILLIKAN: Question.

DR. MARGULIES: All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

I would like to make a side comment now. There was a column by Mr. Raspberry in the Washington Post not long ago which was a very interesting one -- he is one of our better columnists -- in which he was saying there is a form of discrimination which is rarely, if ever, discussed. And that has to do with the discrimination in hiring practices against employing ugly women and that ugly women are generally discriminated against and not employable because people want pretty women around them.

And I realize we have been fully guilty of this in

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the Regional Medical Programs as witness Bland Cannon's constant desire to be properly surrounded. I am not proposing any program change. We will think about it seriously, though.

DR. CANNON: That was on the record, wasn't it?

(Laughter.)

DR. PAHL: I think we may now turn to the application from Alabama with Dr. McPhedran as principal reviewer, Mr. Milliken backup reviewer, Mr. Jewell from our staff if he can hobble over to the table, and to note for the Council that this application was reviewed through the SARP committee only and received a rating of 292.

That is the staff anniversary review panel.

DR. ROTH: What is a mini-SARP?

DR. PAHL: That is apparently a term that was coined -- I saw it the other day -- for our internal --

MR. CLANTON: Internal staff kidney review panel.

DR. MARGULIES: When you get to the tubule, you will have to have another name.

DR. McPHEDRAN: The Alabama Regional Medical Program, my neighbors to the west, having applied for and gotten triennial status as approved by this Council a year ago, now returns with an anniversary application. This is for their 04 operational year. They are currently in the 03. 03 is the first of the triennial.

And they are requesting funding in an amount of

$2.092 million which by my arithmetic last night is 26 percent above the current Council approved level of $1.65 million. The numbers here are difficult, and I will return to them later in the summary.

The Council approved level is considerably above the actual funding level, both this year and in committed funds for 04 year, for example. So that the amount that they are requesting funding is really far above their actual level of funding right now. We can review those figures later on.

This request that is being made is for an expansion of core for continuation of 6 ongoing projects, for reactivation of two approved, unfunded renewals -- these are projects that were previously in operation and have been allowed to lapse for a year -- for activation of 8 previously approved, unfunded projects, and for money for developmental component, developmental component having previously been approved when triennial status was brought about a year ago, but there was no money allocated for it.

I am not really clear about this, maybe Mr. Jewell can straighten me out about this, but in fact no developmental component money was spent by this region or has been spent, although they were approved. I think they were approved and unfunded. Is that correct?

MR. JEWELL: That is true.

DR. McPHEDRAN: And they were seeing if they could

find other money.

Now, having made this request, what the staff and advisory review panel has done is to recommend still another figure, $1.12 million, approximately. That is less even than the Council approved level for 04 year and approximately half what the region is requesting in the 04 year.

This program was last site visited, I think, a little over a year ago. And I took occasion to speak to Dr. Everist when he was here this morning about the site visit we have now for this anniversary application. And he concurs with staff's feeling that on the whole, this Regional Medical Program staff has a considerable potential. Many of the members of the staff that are there now actually are quite new, but they seem to have generated some really intelligent ideas, fitting in with the new national priorities. And, of course, they have also inherited these previously approved and unfunded projects.

Now, I don't think that we know just whether the fact that these are approved unfunded, a sort of political problem for this new program staff, or just why they are making this anniversary application. Because it does seem that in making it this way, they are departing from their own established new priorities, established by them apparently in conference with a large regional advisory committee. Their priorities which were established at the end of '70 and

RAG meetings in 1971 are five and are listed in several places in the material you have.

One, disease prevention.

Two, manpower development.

Three, health care delivery to poor and urban and rural poor.

Four, cost containment of all health services.

Five, public education.

And their objectives stated in general terms conform approximately to those priorities except that disease prevention which is the first priority is not even mentioned. It isn't really cited in the statement of objectives.

Now, in addition to that, they have developed a priority rating system of one to five in which number one is good and number five is poor and which I think is different from this priority listing. In other words, I think that this is just a numerical rating system, and the results of the rating system of several projects we are talking about are given in the original review material which you have.

And the gist of what I have to say about that is what staff also says. That is, the priorities assigned with these approved, but unfunded projects on the whole are low by their own rating system. And yet we are being asked to make an increased award so that these things can be funded. These are low in the opinion of their staff review, their

executive committee review and their RAG review. I haven't gone through the figures on all of them, but that is about the size of it.

So that the staff anniversary review panel thought the request for this money to fund these projects was in sharp contrast to other directions in the program that seemed to be new and perhaps more to the point. That is, other objectives like what they propose to do with developmental. One proposal for developmental funding was to initiate or to assist in planning of a health maintenance organization in a very depressed urban part of Birmingham. Still another was for a hypertension identification and control project utilizing paramedical personnel in Lowndes County which is rural poor. And I can cite other instances like that.

Certainly, the region has some important accomplishments. They have been very much interested in emergency medical services. Their accomplishments are cited in the material, and I won't go into it here.

I have something to say here about representation of minorities in this whole application. I think that there are only five black members of RAG in 54. In RAG a size of 54 is a little disappointing considering the stated interests of this regional medical program in getting minorities into the program.

Now, I have heard it said elsewhere that it is

47 difficult to get members of regional advisory groups representing urban and rural poor. And I am sure that may be so. But I can think of some sources that I know about that might be tapped to provide satisfactory RAG members. And I would like to be asked about this if anybody has a mind to do so.

So having said that, I would go back to the funding recommendations and staff anniversary review apnel recommendations that a level of $1.115 million be established for the 04 year. And bear in mind that the actual committed funds for 04 year as Mr. Jewell has summarized it -- excuse me, the committed level of $741,000 for core. But I have forgotten. That is the total, $741,000. So that this recommendation of this staff anniversary review panel is still well above the committed level. And in making this recommendation, staff anniversary review panel specifically accepted the request of Alabama for an increased core staff.

In other words, staff anniversary review panel and I also are in accord with that request. And also, they want to include the developmental component, agree this should be funded. So that this recognizes and applauds the direction of core staff, especially as expressed by the developmental component, but remain reluctant to fund the previously unfunded projects or to refund these two projects that were allowed to lapse.

Apparently they had their reasons for allowing them

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to lapse. And I suppose that may be those reasons are still reasons. So I would recommend the adoption of the recommendations of the review panel report which applies $1,115,000 for the 04 year. And I assume that that applies also to the 05 year.

Isn't that right, Mr. Jewell?

MR. JEWELL: Yes.

DR. MILLIKAN: Second the motion.

DR. PAHL: Is this the second-year request?

DR. McPHEDRAN: It is the second of the triennial, yes.

DR. PAHL: So it would apply to the third year.

DR. McPHEDRAN: Yes.

DR. PAHL: Wouldn't the Council's approval level of the 05 year apply to the third year? But the motion is to the funding level only for the 04 year. So you are not making any recommendation on the funding level for the next year? They will have to come in again with a specific application.

DR. McPHEDRAN: I think what staff personally felt, and I agree, is that they are capable of devising new activities that would really be more consistent with their stated priorities and goals. And this is the whole point.

DR. PAHL: Was there a second to the motion?

DR. MILLIKAN: Yes.

DR. PAHL: Is there further discussion?

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Mr. Milliken.

MR. MILLIKEN: I am concerned, and I need more information. From what I read in the staff report concerning the use of core staff loaned out to CHP research agencies. There seems to be a lack of information just what it is they are doing, how this relates to a statewide health information system, how it is used, which to my mind raises the question what is the input of consumers in this whole activity, and is there another vehicle for this if this arrangement is in default in terms of having consumer input. And I just wonder if --

Well, I guess I will just leave it with a question.

DR. MARGULIES: I think staff could respond to it, but what they are intending on that, Sewell, is the use of RMP staff to do the necessary organizational work to get a B agency established rather than to operate a B agency and then to withdraw that support when the B agency is established.

But perhaps Mr. Jewell would like to comment further.

MR. JEWELL: Mr. Milliken, you have raised a good point thatstaff had. The application itself was void as far as telling their story.

Now, you have to realize that we have amost a brand new young staff down there, some about the time they came on board. And I think there is one person there that has a

little tenure outside of the coordinator. There is a paucity of information, just exactly what you say.

Now, when we reviewed this as a SARP, I requested and got additional information in the mail at 11 o'clock the night before SARP met. So SARP didn't have a chance to see this, either. But we will point this out to them that if you do something, you have to blow your horn a little bit because these questions will come up.

MR. CHAMBLISS: Let me see if I can answer the first part of your question. And I believe it is a fact that the RMP staff is staffing the CHP offices at the subregional level. I think this is a matter of record and a matter of fact.

We do have some questions there, but realizing that this is a rather resource limited area, we felt that until that B agency is strong enough to walk that the support thatit would get from the RMP was proper.

MR. MILLIKEN: I have no concern about that, but my concern is that if a large amount of core staff time is going into this, then what are the needs for beefing up core staff to do the kinds of things that core staff needs to do in terms of additional resources?

MR. CHAMBLISS: This was one of the staff's concern. But the additional core would be used to establish more subregional offices. That is one of the uses to which it

51 would be put.

Can you speak further to that, Mr. Jewell?

MR. JEWELL: Really, Mr. Milliken, it is an unusual situation. There are really two core staffs -- the central core staff in Montgomery and the core staff as you pointed out in B agencies. These are funded, a leader or whatever they call them.

MR. MILLIKEN: Developmental.

MR. JEWELL: No, there is a head man and secretary. I am sorry, I am just stuck for the word. A project director or executive director and secretary in six areas in Alabama now. Part of the core staff increase would be to fund two more, the two remaining B agencies. And this will completely umbrella the State.

Then, the other part of the core money will be for the central core. And with the lack of resources in Alabama, they really have within the umbrella forces working from both ends, the central end and from the B agencies, the way I understand it, sir.

MRS. MARS: Why shouldn't the B agencies pay us for these people, the use of these people.

MR. JEWELL: This is a question that will be raised, Mrs. Mars, the perpetuality of supporting these people.

DR. MILLIKAN: Fifty percent support.

MR. JEWELL: No, sir, 100 percent to two people.

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MRS. MARS: How long does this arrangement have to go on?

MRS. WYCKOFF: Until they raise the funds for CHP, I suppose.

MR. CHAMBLISS: That is a good question. Let me just deal with another aspect of your question, Mr. Milliken.

You raised the issue of consumer participation. And that is one that I am not sure that we are totally clear on either. There is a question as to whether the proper interplay would exist between the provider community and the public. And I think that is what you are getting at.

MR. MILLIKEN: That's right.

MR. CHAMBLISS: We are not sure of that. Maybe Mr. Jewell could add something to that.

MR. JEWELL: I am sorry, sir, I don't know. Are you speaking in the B agencies, sir?

MR. MILLIKEN: Yes.

MR. JEWELL: The extent of consumer participation in B agencies, I am sorry, sir, I don't know. I have heard them speak to this, and they are constructed as the law requires. I really have no further information, sir.

MR. MILLIKEN: I would like to suggest that the Council might consider that staff provide some assistance to this regional agency to look into the -- I presume there is an A agency, a CHP A agency, that should have some resources

53 available to help clarify this and to give some further support to the B agencies to get some clarification and some maybe memorandum of agreement. But I would put it wholly on the basis of assistance and not anything except assistance.

DR. MARGULIES: I think your point is well taken, and we need to address it. One of the problems with this Alabama program is that it represents good program and rather poor grants draftsmanship. And some of these elements have been left out. But even if they were in, I think we have to pursue the question, not only in Alabama, but elsewhere.

DR. PAHL: Is there further discussion?

(No response.)

If not, all those in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

May we turn now to the New Jersey application with Dr. Millikan as the principal reviewer, Dr. Chase as the backup reviewer, Mrs. Faatz from our staff, and to note that the review committee gave this a rating of 412.

DR. MILLIKAN: The application you have in your book is an anniversary application within the triennium for

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the second and third years of the triennium.

Now, maybe, Mrs. Faatz, you can help me out. I see running through here the figures 2,990 and 2,900. And I don't quite understand this.

This summary sheet, the very first portion in your books, is an item requiring Council action. This is an anniversary application within an approved triennium, and it comes to Council for action for the following reason:

"The staff anniversary review panel requests Council to establish an approved level of $2,990,000 for the second and third years of the triennium." That is the fourth and fifth year of the whole thing.

Item submitted for Council's information:

"The region requests $2,900,000 for the upcoming 04 year and the panel recommends approval as requested."

Is that information thing actually a ceiling you want to put on?

MRS. FAATZ: Yes. What happened was last year the region submitted a triennial application, but because nobody was exactly sure how these things worked at that point, they did include future support for core and developmental component and some continuing activities. So the site visitors', committee's and council's recommendation for the second and third years of the triennium didn't take those program components into account. So the Council recommended level for the first

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year of the triennium was about $2,990,000, and we are assuming they meant that for the second and third years.

The other recommendation of $2,900,000 is what the region is requesting to be funded for the second year of the triennium. And the committee has recommended that they be funded at that level.

DR. MILLIKAN: Thank you.

The pink sheets contain the summary of the staff anniversary review panel, December 20, 1971. If you look through this, you, of course, get the impression this is a uniquely outstanding RMP. The panel assigned it a rating of 412. The review committee concurred in the staff anniversary review panel recommendations as given in some detail on the blue sheet.

And, Mr. Chairman, I simply move that the Council approve the recommendations concurred in by staff anniversary review panel and the review committee.

DR. PAHL: All right, is there a second to the motion?

MR. MILLIKEN: Second.

DR. PAHL: Dr. Chase.

DR. CHASE: I have nothing to add. It is obviously an outstanding program.

DR. PAHL: Are there other comments by Council or staff?

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(No response.)

If not, all in favor of the motion, please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

I think we would like to reconstitute Dr. Cannon and Mrs. Silsbee team and go to Delaware next since Dr. Komaroff is out of the room.

And this is located in the back of your books under the pink tab "Special Actions" or "Special Business."

DR. CANNON: I was not here yesterday, Dr. Watkins, when you presented Greater Delaware, but I really don't think there is any problem between Greater Delaware and this request. The problem is a personal trap that I find myself getting into in dealing with this application.

Way back when these two programs were being thought of, some of the staff -- if Ken Baum was still around -- I was very much in the fight to keep CHP and RMP a regional program and not a State program. And I find myself on the losing end with CHP, but continued to think of RMP as a regional program.

Now, my running contest is with Dr. Wilson who has for quite a few years now thought of the programs as coming

57 together as State programs or State boundary programs, although one under the aegis of the Federal Director and one under the aegis of State funding direction.

Some sly fox has placed Delaware in my folder because they can see they have me in a trap. I am going to surprise them because, first of all, I am going to say we commend Delaware for attempting to coordinate two Federal programs. Both by design should not be the same and both by design should be in a cooperative endeavor to improve the health care. So their effort to withdraw from the Greater Delaware and to form a cooperative effort of two programs is commendable, and I heartily approve and recommend this approval.

Where I get locked up -- and this is my escape -- is that I do not think that the Regional Medical Programs should ever be put under State authority. That is a political State authority.

And if I read all the correspondence I could gather that I didn't have after I came up, including the letter from Governor Peterson in which he refers to the conversation with Dr. Wilson and Dr. Margulies, I am not satisfied that the proposed Delaware Health Authority, Incorporated, which will be the grantee agency, is anything else but an arm of the Delaware Health Department.

Now, if they can separate that, which they say they can't do because their State laws do not permit them to set

58 up a separate authority, then I say I am against the program. I am against the recommendation.

So to the Council, my advice is this: Commend them on their decision to separate the Greater Delaware Valley, commend them on their plan of coordination between CHP and RMP, and then bring in the R&D programs and any other Federal programs under a separate authority, but that this authority cannot be a political arm of the State of Delaware. It must represent the people. It must represent all facets, providers, consumers, different stations in life, but they all should have primarily one concern. And that is what is best for our community, what are best health decisions for our community.

As you know, this was the intent of the organizational structure of the Memphis Medical Center Board. My recommendation is that.

DR. MARGULIES: Mrs. Silsbee, you have been crossing the Delaware standing and sitting. Would you like to comment in general on that particular issue?

MRS. SILSBEE: Dr. Cannon, I will put it this way: The primary impetus in Delaware was to form its own regional medical program. And in so doing, they encountered Rockville. And in order to get what they want, which is a Delaware Regional Medical Program, they feel that they have to at least explore some of these other aspects. But their real

59 motivation as clearly as I can tell from working with them was to get their own regional medical program. And this seemed to be the means by which they could do it.

DR. CANNON: There is very much going for that except they cannot have as the grantee agency and the honest decision-making body regarding all Federal programs being an arm of the State government. And this is my contention that if they are willing to change their laws or the interpretation of their laws so they can form a free-standing grantee agency which will be their Delaware Health Council, Inc., then I am very much for everything else they recommend. I think the bylaws for the RAG and RMP are great. Once you get RMP under State political jurisdiction, you have lost it.

If this is the first step, I can recommend this quickly for Rhode Island because, my God, I say Rhode Island ought to get out. They have got an A agency for the State. Old Joe Cannon -- no kindship -- they have got an interest in their State, an esprit de corps about it. They could very well follow Delaware immediately.

In Missouri, they are all set up to go. Apparently Vern had that setup a long time ago.

I am saying if we believe in RMP and we believe it ought to be directed from this level, then avoid letting any regional group get under the jurisdiction of the State political machinery.

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DR. MARGULIES: So what you are saying without, I guess, yet having had a motion --

DR. CANNON: I am sure you can say it better than I said it, but that is what I mean.

DR. MARGULIES: I only have to say it briefer -- that you approve the application of Delaware as a regional medical program if the grantee agency is a free-standing agency and is not part of the State government.

Dr. Watkins, you wanted to comment, I believe.

DR. WATKINS: Yes. I don't have the sophistication of Dr. Cannon, but I was on a site visit, and we got the impression that Delaware was a stepchild of the GDV RMP. And the fact that Delaware has a subtle type political sophistication, we feel it should be given the privilege of the first State to be removed, remembering only one thing, that if this will cause fragmentation of the RMP in the future that this might not be agreeable.

However, I understand that we have a precedent to this with Dakota (?) and Nassau in New York. Is this true, we do have a removal of other RMPs in the past?

MRS. SILSBEE: As far as grants are concerned.

DR. WATKINS: If there is a case of a State that is sophisticated enough politically and otherwise, not disagreeing with Dr. Cannon, but in fact agreeing with him, it is ready for an RMP, the fact it claims now to be a stepchild

61 the fact there is such dominance of the medical school complex in Philadelphia, I think I would recommend its removal, too, and be made a separate RMP.

DR. SCHREINER: It wouldn't be a problem if it were the subregion of an outstanding, but --

DR. CANNON: I am in agreement with Dr. Watkins, but the problem isn't anything to do with that. I believe Delaware could have a better regional medical program. There is one deficit. There is no medical school. Jefferson Medical School has an ongoing program with Wilmington. Wilmington has four hospitals that have come together in an associated group with different management and an improved situation there, good training programs for some professionals, but they don't have the physician in the State training. So when they separate, they are going to be in a little bit of a difficult position with a medical school relationship.

That is really minor compared to the proposal in which they establish the Health Authority, Inc., under the State Government of Delaware. And it is the grantee agency of RMP. This is where we have got to say no.

Now, if they can set up a grantee agency and separate -- it should be incorporated, and it should represent the same kind of community decision-makers we need on any of ourprograms.

MRS. MARS: That part certainly shouldn't be difficult

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to do, I wouldn't think.

DR. CANNON: Well, in the correspondence, Mrs. Mars, the Governor asked his attorney, the State Attorney, to interpret the statutes. And he was informed that if they set up, they participated in setting up this, that they would have to be under the Commissioner of Health of the State in that arm of the department.

DR. MARGULIES: They also got bobby-trapped a little bit, Bland, because they came in with the intention of having a regional medical program which would have ties with CHP, but which would in fact meet your requirements. And having done that, they were given more advice than they asked for when they came here. And this was in the direction of developing a State Health Authority. And what they have been trying to do is respond to a variety of directions.

The advice which you have just given, if the Council agrees with it, I think they can respond to with no difficulty.

DR. MILLIKAN: Is that a motion?

DR. CANNON: Yes, that is a motion.

DR. MILLIKAN: Second the motion.

DR. PAHL: Further discussion, Mrs. Silsbee?

MRS. SILSBEE: Is it premature to ask for a funding recommendation as requested?

DR. CANNON: I move the funding as requested on the

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contingency this other thing is done.

DR. MARGULIES: What is the level requested?

DR. PAHL: I think what Mrs. Silsbee is perhaps asking is whether the Council wishes to move that the funding be approved as requested or whether staff be given the opportunity to negotiate within that level whatever may be appropriate.

DR. MILLIKAN: The first two are mutually exclusive. The funding as requested is to this grantee. We can't do that.

DR. CANNON: We can't fund it until they establish an agency to accept the grant, but if they do establish the agency that meets the requirements, I move the funding be $389,050 or less.

DR. PAHL: Based on negotiation by staff?

DR. CANNON: That gives you the opportunity of negotiating any way you want to up to that amount.

DR. MILLIKAN: Second.

DR. PAHL: Is there any further discussion?

(No response.)

If not, all in favor of the motion please say, "Aye."

(Chorus of ayes.)

DR. MARGULIES: Let me ask a question. Was that specifically for planning? That is implied in the motion that is for planning? Because this is a new RMP.

DR. PAHL: Opposed.

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(No response.)

Motion is carried.

Now, we may come to the last application, that of Northlands. And we will have to ask Dr. Millikan to step out of the room while Dr. Komaroff as principal reviewer and Mr. Torbert from our staff present the material to Council.

(Dr. Millikan withdrew from the room.)

The review committee gave this a rating of 317.

DR. KOMAROFF: Northlands RMP was approved for triennial status last year. The reason that it comes before us today is a change in operational strategy that the staff assistance review panel wanted us to consider.

Shortly after we approved the region for triennial status last year, they with the RAG had a meeting and decided at that time while not changing the goals and objectives to develop a new operational strategy. What they did, I think is very interesting.

The RAG supported by the core staff described 29 fairly specific high priority activities that they wanted their RMP to get into. They then wisely invited groups from agencies around the region to submit contract applications to do these jobs with the only rules being that they be one year contracts with a ceiling of $25,000. They received fairly promptly 68 applications to do these 29 jobs and accepted and ranked 43 of them.

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The contracts really differ very little from what we have traditionally done as operational projects. Their funds are disbursed similarly to affiliated institutions. They are all reviewed and approved by the advisory group,and they will all be monitored by the core staff and advisory group subcommittees just as operational projects would be.

Among this group of 43 accepted projects, there is a mixture of traditional activities like coronary care unit, nurse training, circuit riding, continuing education, and some more progressive activities such as planning for area health educational centers, training of MEDEX and nurse practitioners and several medical audit programs, most of which focus on the use of the problem oriented record.

Furthermore, these 43 contracts are let to groups widely around the region.

I think the strengths of this approach are the interest, imagination and involvement of people outside the RAG and core staff, that the RAG has gone through the difficult, but rewarding exercise of identifying quite specific priority tasks, and they argued in advance and have been proven right by setting the kind of funding ceiling that they did on each contract, they would encourage non-RMP dollars to be committed by the participating agencies. And in fact, over $300,000 have been committed by outside agencies who want to pursue a task with $25,000 of RMP money.

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The weaknesses of the approach, I think, are very few. There was some concern expressed by staff that there would be difficulty monitoring and evaluating 43 projects. That doesn't concern me, first of all, because the funding level we recommend will reduce the number of projects they can get going to 25, roughly.

And, secondly, we have had a management assessment visit there which indicates they have got a very good core staff.

There has been some concern also that the region's proposal to seek alternative sources of funding only three months before the end of each of these annual contracts might not be early enough and that they should begin to think that issue over earlier. And I support that concern.

So I would recommend that Council adhere again this year to its recommended level last year of $1.51 million. This would allow for a raise of approximately $400,000 from the current operating level. And this is less than, however, the region has requested.

The review committee and the staff anniversary review panel recommended $1.45 million which confuses me. I see that more as an indication to the director as to how much might wisely be allocated, but I think we should stick to our ceiling within which funds can be allocated of $1.51 million.

There is a kidney disease proposal that I didn't

67 have in my packet, and I don't know whether we are supposed to act on it. It has been seen by the ad hoc renal panel and review committee and been disapproved unanimously by both of them. And what action is required on that --

MR. CHAMBLISS: None to my knowledge.

DR. KOMAROFF: Are we supposed to officially dissent to its approval? I just haven't read the proposals.

DR. PAHL: No. Under our guidelines, only certain specific actions have to be brought before you within the triennial period. If there were concern by the review committee or staff about the kidney proposal, we would bring this to you.

DR. KOMAROFF: O.K.

In summary, I think this is an interesting operational strategy. I am not as concerned as others have been about it. In fact, I am excited by it, and I recommend we keep our previous recommendations as a funding level.

DR. MARGULIES: Is that a motion?

DR. KOMAROFF: Yes.

DR. ROTH: Second.

DR. PAHL: Is there Council discussion?

Bill, do you have anything to add?

MR. TORBERT: Nothing further.

DR. PAHL: If not, all in favor of the motion please say, "Aye."

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(Chorus of ayes.)

Opposed?

(No response.)

Motion is carried. And that completes action on the applications.

Does Council have any further business it wishes to transact at this time?

(No response.)

Harold.

DR. MARGULIES: If there is nothing further, I want to thank you again for the hard work of those in attendance. And we will be working with you between now and June and in June. Thank you.

DR. PAHL: The meeting is adjourned. Thank you.

(Whereupon, at 12 o'clock noon, the meeting adjourned.)