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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS

REVIEW COMMITTEE

Rockville, Maryland
Friday, 5 May 1972

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Conference Room G-H
Parklawn Building
Rockville, Maryland
Friday, May 5, 1972

The meeting reconvened at 8:45 o'clock, a.m., Dr. Alex M. Schmidt, presiding.

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OKlahoma

P R O C E E D I N G S

DR. SCHMIDT: Well, good morning. I think we might get started.

If it is acceptable to the review committee, I have been asked to chair this one session this morning and have been instructed to try to get the group through our last four proposals in time so that we might go on and discuss some of the general issues that our former chairman charged us with last night.

So let's begin with Oklahoma. We may have to rearrange the order slightly as we go on. If someone would pass Dr. Scherlis the microphone down there, we will see if Oklahoma is okay.

DR. SCHERLIS: I had the opportunity of chairing a site visit to Oklahoma in July of 1971. There were many items which were pointed out at the time of the site visit, and these included comments as far as what areas particularly needed strengthening.

I will refer to what the status is now as best I know it in terms of the leadership.

Dr. Groom has been coordinator of the Oklahoma Regional Medical Program. When we had visited him, an assistant director, extremely active and very productive individual, had resigned. That was Mr. Hardin.

The previous leadership, as far as the RAG was concerned, was also subject to change. Dr. Johnson, who had been

a particularly strong individual, was leaving to be replaced by Dr. Strong, and there was some question as far as his ability and his interests as far as RAG went.

So there was a problem with the leadership from the point of view of Dr. Groom's general attitudes and interests from the point of view of staff which had been leaving and has continued to leave, problems in terms of RAG.

So this was a strong point of our concern and something which we did discuss at great length at that time.

We were also concerned about the strength of the core. There was a problem as far as having adequate representation on RAG and we had pointed out that it should be more involved as far as monitoring the program. There was very little indication, as far as its goals and objectives having to be in line with what are the present directions of RMPS.

There was a problem at that time of subregionalization, a problem of the Oklahoma Regional Medical Program working more closely with other Federal programs which were going on in that area. There were significant strengths. Their coronary project was one which spread pretty well throughout the State. There were subnetworks, and subregionalization at least in that particular program was really a very good one.

There was evidence of their working in a pretty good way with the medical school of the university. We met with Dr. Kelly West who did an excellent survey as far as health

needs in Oklahoma, but this had not been put into any discernible use as far as the Oklahoma Regional Medical Program was concerned.

Following the site visit, communication was made through the usual channels with Dr. Groom to indicate what some of the strengths and weaknesses of this program were. This, as I said, was through usual channels and followed by channel communication.

I received a letter, having chaired the site visit, from Dr. Groom, asking me if I shared the conclusions that Dr. Margulies had expressed in the analysis of our site visit report. I did not file a minority report at that time.

Following our meeting, there were certain changes which occurred which have been, I think, important as far as being of a constructive nature is concerned. One was that there was a so-called Macer committee. This was a group from Colorado, Wyoming and elsewhere, that went into the region apparently at the invitation of the Oklahoma Regional Medical Program and went over some of the aspects of the Oklahoma Regional Medical Program which had been pointed out to the region in the site visit.

There have been other changes which appear to be, I think, helpful ones. First of all, as one looks at their present application, it is in much better form than their previous ones have been. At the present time, they are applying -- and it is a rather ambitious request, particularly in terms of what happene

as far as the recommendation of the last visit was concerned -- for their 04 year for a total of $1.5 million, out of which $724,000 is for core, a continuation of some aspects of their coronary programs in the fourth year of some $28,000, and the rest is a series of some 14 or 15 individual projects, many of which are related to subregionalization, Ada, and elsewhere in Oklahoma, $35,000, $40,000 to $50,000 each; rehabilitation program in service education, a screening program, an educational program centered around the VA, an application for emergency medical service which will not be considered since that is being looked at in a separate way, pediatric nurse associate, and so on.

It is a large variety of programs which are not being submitted. Unfortunately, in reviewing their application, it is apparent that they have not really met the deficiencies which have been pointed out previously. This is apparent if anyone had been on the site visit. It is certainly well pointed out, I think, as far as the staff review is concerned,which I think is a very good document and really indicates what the strengths and weaknesses are.

They have, as I have said -- and this is on the positive side -- set up Tulsa as a subregion, and this had been of some concern. When we were there, of course, Tulsa did not seem to be adequately represented. Although the projects, they have shown ability to cut some off. They had originally had 11

projects implemented when the regions became operations. Three they terminated in two years, four at the end of three years, and as I have said, continue the coronary care and one or two core projects.

There has been some information which was just given to me yesterday. There had been some indications that Dr. Groom will probably resign, and it is my understanding he has now sent such a letter to RAG. And there is already, I understand, attempts being made to replace him and have a successor.

So I think in evaluating the region, we are in a peculiar position of, first of all, not knowing who the coordinator is. And recognizing the fact that while the goals and objectives previously were not really in line with what usually RMPS goals and objectives are, they have now drafted a complete series of new goals which have been approved and which I saw yesterday and seem to have adequately expressed the direction.

However, there is the problem as to what sort of leadership they will have from RAG because Dr. Strong has replaced Dr. Johnson who is the new strong individual.

In terms of the actual support that they requested, I think one has to look at what should be done in Oklahoma which is to take some time for actual operational efforts and try to really reorganize their entire staff, and whoever replaces Dr. Groom will not alone have some problems but will have some, I think, strong points. Because in looking over their staff at

the present time there are several vacancies at a good professional level which can be filled.

I think Oklahoma has a lot to build on in the sense that they do have a good record of an excellent coronary care program, one of the better ones which has spread out, so there is an active subregionalization evaluation.

Evaluation appears to be good. The methods of review are good. They have been hampered by a change in leadership. At the present time they are hampered by the loss of Mr. Hardin who has been extremely active.

The problems, I think, in not having moved into new directions -- Dr. Groom has very marked strengths in the area of continuing education but not in the outreach program that the Oklahoma Regional Medical Program really has required. I think whatever recommendations are made -- and I would like to withhold those until there has been secondary review -- will have to be in terms of what is a rather fluid condition in that region at the present time.

So can I defer to the second reviewer before I make a recommendation as far as level of funding.

DR. SCHMIDT: Fine, thank you.

Dr. Ellis.

DR. ELLIS: Dr. Scherlis has gone over the program extremely well and had the advantage of making the site visit, and I didn't. But I concur with what he has said.

much of the continuing education really is not educating the physicians and other professionals about the goals and objectives of the Regional Medical Programs. And I was just wondering -- there is going to be a great need to strengthen the leadership, and I am wondering how, since a person who is not a physician seemed to have been the person who carried the program on, and we seem to be having such difficulty with these coordinators, if another administrative mechanism could not be worked out utilizing perhaps a physician as a consultant to -- could we not try -- an administrator who would have the capability of really planning things that would make the Regional Medical Program a meaningful part of the health delivery system there.

I get the impression that this is still a great lot of a university program that is not really moving, and I am not sure the people have heard the message which RMP has to give.

I really think that this program needs to have careful guidance and complete reorganization. I can't see that we can keep going on with these kinds of coordinators who really don't lend anything to the program, and I recognize that this is a conservative area. It has been repeated over and over again in the write-ups. But it seems to me with proper communication a different administrative mechanism could be set up which would be entirely acceptable to conservatives and also it would seem to me that part of the continuing education might be directed to the RAG.

This has been done in a few places, and to see the change in attitude when this type of thing goes on is good because unless we get the other disciplines, the allied professions, I can't feel that any real progress is going to be made.

Now, talking about the pediatric nurse practitioner program is fine, and I certainly am for this, but I was distressed to read that the nurse is not playing a really active role in the discussion, and this is nursing service in the main and I would wonder about that.

Also, I think that the core staff remains rather narrow in a large number of the programs because if real change is to be made in the lives of the individuals to be served directly and indirectly, I think we have to connect with social services in a way which is not clear to me here, and also it might be good to really talk about the health education in a little different way. And I think that this program could be reconstructed. And since its major leadership has not been from a physician but rather this has been a confirming kind of leadership, maybe the reorganization could be worked out along these particular lines.

DR. SCHERLIS: There has been a significant problem in leadership. I think Dr. Margulies and others who are familiar with the area understand I have understated it because it is a necessary thing to go into problems, particularly since Dr. Groom has just resigned.

I am concerned about RAG. We met separately with Dr. Johnson who is an extremely capable physician in Oklahoma who had been chairman of RAG. And in every way that he could, he both assured us and has assured the so-called Macer Committee that he would be very active.

The Macer Committee, I think, did an excellent job. It is a good example of how a region near-by can be a help to another one. They reviewed their problems and pretty much state as you have, and as I have, what the problems are in that area.

Mr. Hardin,who has been extraordinarily strong and represented leadership that Dr. Groom didn't give, has accepted a position of responsibility with the university, administrative vice president or something of this sort, and is no longer available. And I think what this region has to find is a strong individual who will be active.

We did meet with the vice president of Health Science on the campus or university who I think has a real understanding of what the needs are of the Regional Medical Program, and I think has been helpful in getting them through some of their changing leadership at this time.

Looking at the core personnel, there are eight or nine vacancies, and there have been some resignations in additic to this. So a new coordinator has an opportunity to really restructure, as you pointed out, core and individual projects.

If I can make a formal recommendation at this time,

I don't think it should be supported. The core has a great many empty slots in it, and there is adequate room, by filling those slots, by using funds available, I think through taking a year off from just individual projects and doing some planning.

The level which staff review recommended has a good deal of logic behind it, but what they have suggested is they be given the funds they should have gotten for 03 year before they were cut, and this comes to something like $839,000. It is significantly less than what they asked for, which is $1.3 million. But with a new coordinator coming in I would think the worst thing we could do would be to give them some of these projects on an operational level and review them separately. I don't think that's the way to go at this time.

I would therefore recommend a much reduced budget in the order of $839,000 which would match their 03 year, with strong recommendations that they not only find a good coordinator but they give him the necessary support to restructure the Oklahoma program.

It has good strengths which can be utilized. But one of the problems has been that Dr. Groom has not been, I think, as involved as he should have been timewise, which has been a very significant problem and one of the reasons that a strong individual like Mr. Hardin could be the force that he was and, secondly, he came there at a time when RMP was basically interested in continuing education in that area. And this has

been the main thrust and that is where the thrust has remained.

Is there any staff comment on this?

DR. MARGULIES: I would like to comment just briefly. We have met twice with the Vice President for Medical Affairs, Dr. Eliel. And he is a different kind of person who has been very busy trying to do some things in the university, has gone far enough so he understands the potentialities of Regional Medical Programs.

Interestingly enough, Dr. Ellis, he is thinking about what kind of leadership and organization that is needed there is very close to what you were talking about. They are on their research committee looking at competence which does not require an M.D. They are looking for someone who can give it a different sort of leadership.

I think possibly the most hopeful thing about Oklahome is that Dr. Eliel and the people in Oklahoma more and more define the role of the University Health Science Center as an institution to serve the State of Oklahoma, and he understands that, and he feels, as do other people, that the Regional Medical Program represents the kind of link they have to have if they are going to be an institution of community service.

I think in the best university RMP arrangements that is the concept which dominates events. Dr. Eliel understands i He also wants to avoid having university dominance so that the environment, if the selection of the coordinator is successful,

is very promising.

This doesn't get around to the problem of the Regional Advisory Group but I think that when you get those two forces working effectively the Regional Advisory Group may function much more effectively.

DR. SCHERLIS: I think the other strengths are Dr. Kelly West who tends to maybe act as a consultant. His report on some of the health needs of Oklahoma is one of the best that we have seen and, interestingly enough, was never referred to in any of our formal meetings. We just happened to find out about it casually and could be one of the strong points of the entire site visit. He really defines what a lot of the health needs of the State are.

Also, another strong point is Dr. Johnson, and he again tends to remain active, but he is no longer head of RAG, but had assured us he would set up some form of advisory committee ongoing activity as far as the group is concerned.

So there are significant areas that can be a real credit to the Oklahoma program. This is one reason why I hate to see a more drastic cut made. I think this cut is strong enough. I think there are enough funds for restructuring and replanning, yet at the same time giving them more would mean saddling them with projects they have to support for a few more years, and probably use good people. And they don't have that many available.

DR. SCHMIDT: We have a motion, Dr. Ellis. Do you second that?

DR. ELLIS: Yes, I do.

DR. SCHMIDT: All right. We have a second to the motion. Any discussion?

DR. KRALEWSKI: What is their organizational relationship to the medical school? Are they in a department or do they report to the vice president?

DR. SCHERLIS: You see, earlier, when Dr. Groom came there, he was essentially recruited by the medical school. This is where his strength was, as a cardiologist, and very active in teaching at the university, and he came essentially for that reason.

DR. KRALEWSKI: Well, the basis of my question is in terms of their ability to get a good coordinator, if they are going to have to get a guy who has certain academic qualifications or are they --

DR. SCHERLIS: It is through the University of Oklahoma who is the grantee organization, but again I want to emphasize what Dr. Margulies said, the relationship is an excellent one.

This is not going to be, as far as we can see, judging from Dr. Eliel's statements. This isn't going tc be a program I think completely dominated by the medical school. The point you made, this is a very strong point as far as the vice

president of the university is concerned. I am not concerned about this being a dominated program.

DR. SCHMIDT: I remind everybody of the rating sheets. If anybody turned their's in and needs a fresh rating sheet, raise your hand.

Is there other discussion?

Joe.

DR. HESS: I would just like a little further clarification on the recommendation for $839,000. If I understood you correctly, you were suggesting that there be relatively little funding for projects, is that correct?

DR. SCHERLIS: Yes.

DR. HESS: And as I look at the budget breakdown here the 04 year request for Core is $677,000. Their current year funding is $354,000. And then there is the request for $629,000 in operational activities, the past year spending $384,000.

Can you describe all these vacancies in the Core staff? And what I am having trouble with is understanding why you justify that much money.

DR. SCHERLIS: You say your feeling is that that much is too high or too low.

DR. HESS: Too high.

DR. SCHERLIS: You think it's too high?

DR. HESS: Based on what you said before.

DR. SCHERLIS: I tried to use the following ground

obviously too much. I think to strip them so they can be essentially at the level where they were in the 03 year again is too restrictive. I think they have to be at about that level so they can restructure, and to have enough -- If we are going to talk about subregionalization in getting this started as a part of the reorganization, I think they have to put some money into that.

The number was derived from what they had been awarded before it was cut by the council, an across-the-board action. So what we did was restore the 03 year, knowing that since they don't have that many projects continuing they can hopefully support a couple of new ones in that, and to give the new coordinator something to work on, frankly.

I think if we begin by giving him very little, he isn't going to have a program that is feasible, nor could we attract a good coordinator to the area.

But I think there is enough in that so we could get a couple of good projects going and restructure the core. The number was derived from what they had in the 03 year prior to the cut.

DR. HESS: Is that different from the $738,000 shown here on the sheet?

DR. SCHERLIS: Yes. They had originally been given $839,000, and it was cut to $738,000. It was cut at the council level across the board, is that right?

MR. SAYS: Twelve percent.

DR. SCHERLIS: So they had been given $839,000, and it was cut across the board. Logically giving them that just indicates that's the level they had before and would continue for another year until such time as they have shown by their growth in program that they deserved or merited additional monies.

DR. HESS: If I understand it correctly, Dr. Groom has recently resigned. They don't have a new coordinator.

DR. SCHERLIS: He is going to stay on board, isn't this correct, until there is a replacement?

MR. SAYS: Yes. It is my understanding Dr. Groom has a contract with the university until the end of June. They have already interviewed at least two candidates, non-physicians at the doctoral level, but I don't anticipate a replacement on board until July 1.

I would like to throw out one comment that might help you some in terms of the funding.

DR. SPELLMAN: Could you speak a little louder?

MR. SAYS: As is indicated in the recommendation by the SARP, the action did not include consideration of Project 25, the emergency medical system, which will be taken up on the 15th by an ad hoc group of the council, and that is $140,000, which was their number one activity.

They will also be submitting supplemental applications for several local health manpower systems, each for

$50,000 or less, June 1. So there are some other proposals that will be in the hopper to be acted upon by the June council.

DR. SCHMIDT: Sister Ann Josephine.

SISTER ANN JOSEPHINE: Dr. Scherlis, you have indicated that you feel by putting the funding at the level of $839,000 they'd have some money so that the new coordinator could continue a few projects.

I am beginning to wonder, as I listen to these reviews, whether we shouldn't feel that it is not only satisfactory but probably in many cases advisable where programs in the condition this program seems to be from the review, that a very worthwhile activity for a new coordinator is reorganization without the distraction of projects. And I would like to make a few points.

You know, you have to believe me, I love doctors, but I think that possibly in this program --

DR. SCHERLIS: I'm afraid to listen to what is going to follow.

(Laughter.)

DR. SPELLMAN: You protest too much.

SISTER ANN JOSEPHINE: I really do.

(Laughter.)

I have been grappling with this for some time and trying to relate from my daily experience some of the problems that I am seeing in this program. And I think that all of us,

while we talk about health care, are disease-oriented. And as we are disease-oriented, in the medical profession you are diagnosis-oriented and make the diagnosis and then move on from there.

And at the same time, within the last year we have been grappling with a total program evaluation, and I just don't think we feel real comfortable or flexible or probably are as able to handle this kind of concept as we can a task-oriented concept where we are looking at one thing at a time and making a decision, and moving on to the next.

And this may well be an inherent weakness in the program that maybe is supported to an unrealistic degree by the professional orientation of the leadership of the medical profession. And I just throw it out as a possibility.

DR. SCHMIDT: The only comment I have about that would be that in addition to the leadership of the Regional Medical Program, obviously there are some troops out there in the trenches that have been brought along by the coordinator. And when one talks about stopping the projects, he is talking about some of the people who have gotten up the projects in good faith, and sometimes at some expense to their own thing that they were doing.

So that there might be some breakage kind of accidently that would give a new leadership a lot of problems with loss of confidence in the people that he is going to have to

turn around and work with.

So if you do stop projects prematurely, some of the people who are the project types might suffer and may be less willing to come along with a new and strong leadership.

I would rather favor phasing out and giving people some time to fire their staff -- you know these sorts of things have to happen. So I think we should be cautious about this. I was just thinking, with apologies to Mitch, I suppose that a poor quality granting agency might be termed a sick provider.

SISTER ANN JOSEPHINE: Dr. Schmidt, as I say this I don't mean to do it in any one step and do anything drastic, but I think it is something maybe we need to consider as a group. Maybe we don't give sufficient recognition to the need for time to stop and maybe reorganize while business does go on.

And I think that the health of the program isn't in the number -- we all know this -- of projects and maybe sometim even as we make the site visits, you know you have to plant the seed and change attitudes. And I feel the same way about the Federal Government. I think we rush from one program to another And at the last meeting I was just forced to express again my concern that we destroy the possibility of continuity of programs by this kind of thing. I get the feeling we may be doing the same thing here.

DR. SCHMIDT: The point of discussion, really, I think, is the level of funding. That is what we are on now.

DR. BESSON: I would like to reiterate what is implied in Sister Ann Josephine's comments by pointing out that there are some questions even in the area as to whether it is reasonable to support projects really because they represent the hard work of some people who develop them. And while I am sympathetic with the notion of providing some wherewithal for a new coordinator and, let's say, a refurbished outfit to work with, I think we run a little bit of a hazard in perpetuating mediocrity by providing funding for this kind of an organization.

I would just like to read to you some of the comments I noticed in SARP's comments, that they referred to a disparity between the A and B agency approaches to some of these projects.

And as I got the application to look at, what this disparity was, apparently, the Area Health and Hospital Planning Council had some question about viability of some of the projects and the approach of the RMP toward approving these projects.

Yesterday I made the comment that there was a built-in bias to having RAG approve of the labors of their own people, and I think that is so. We have seen constant evidence of it.

The A agency here apparently has that same bias. They are hardly going to be in a position to turn away funds if their approval would bring those funds into the area. So they are almost a pro forma review and common function.

But this particular group says in reviewing these projects they approve some and they approve others in principle

and reject others. And the comment here is in terms of the projects rejected. And I am reading from the B agency comments.

DR. SCHERLIS: B agency from where?

DR. BESSON: Tulsa.

"Projects Rejected. The Board felt the health benefits likely to be accrued versus the expenditures anticipated were not compatible. It was also felt that communications between the applicants and various interests within the region to be served were minimal; that the projects were by and large ill-defined in terms of methodology, and methods for evaluation were not in evidence.

"Also a major concern to the board was the failure to have proposal advocates in attendance to answer questions. The board recognized the imposition that would be placed on applicants but also noted its own imposition in terms of performing the review without sufficient information."

Then they go on to say that in the future they hope RMP would consult with them to keep the projects a little bit more relevant before they reach their decision.

That is the first time I have seen an honest comment in any of these pro forma approvals by any agency at the peripheral level. I think it's very much in keeping with the comments Sister just made, and I wonder whether the bolder approach that we had with Mr. Parks' comments about Northeast Ohio yesterday of just phasing them out isn't the other point of

view to the one that was presented by Dr. Scherlis.

DR. SCHERLIS: First, let me emphasize I have hardly been considered an advocate of the Oklahoma Regional Medical Program by the Oklahoma Regional Medical Program, so I am not appearing here from the point of view of advocate.

There are certain things I think should be pointed out. That is, that the Oklahoma Regional Medical Program has not had the active participation or cooperation of the Tulsa group -- bear me out on this. The distance between Oklahoma City and Tulsa has been a rather large one in terms of the Regional Medical Program.

Their new plan includes subregionalization with Tulsa being actively involved as part of the regional effort. So this is recognized, was talked to as a point by our site visit group. And looking at some of the projects that we are talking now about eliminating, one of them relates to programs for education in Tulsa.

I would not like to see the evidence that you have given submitted as a failure of the Oklahoma Regional Medical Program. I have to ask how many project directors appear before B agencies to discuss their projects, and I think you come up with a fraction of one percent. I think that would be a rather accurate estimate. Maybe a little bit more. I may have to move the decimal point over a bit, but I would hate to see that used, and particularly since there is the Tulsa-Oklahoma City

situation.

I would again submit I am not an advocate of Oklahoma except trying to look at it from the point of view of the strengths that they have and trying to build on them. I don't think a sum of $800,000 is excessive in terms of core and in terms of subregionalization and in terms of a couple of projects which appear to be viable ones. I don't think this is a region where we can now say, "You have done an awful job. Get rid of your coordinator. Restructure and set up different relationships with the medical schools," and so on. They are getting a new coordinator.

Dr. Eliel, I think, is a real asset to the group. I think they have strengths that they can use. I think they are beyond getting a warning. They have had warnings for the last two years, and it is obvious they have finally moved in a very strong and positive direction. I don't think this is quite in the order of going to a group and saying, "You have an awful coordinator, you have poor structure, poor organization, and redo it completely." They are. And I think they need some help to accomplish it.

Do you want to comment on the Tulsa situation?

MR. SAYS: Yes. Since the site visit, the Tulsa subregional office was staffed and got into full swing. That office truly represents three CHP areas, each having their own council with pretty good consumer input. There is a local RAG,

a local advisory group to that RMP subregional group. And in looking at the analogy that we have done here of the ratings, there are four projects that relate to the subregional, the Tulsa area subregion, and they were all approved by the A and the appropriate B agencies.

Now, since the submission of this application, there has been a lot of work done out there, and mainly because of the efforts of Dr. Cooper, a young planner who recently came on board and is working out in the local level in Tulsa.

I have the minutes of a meeting that was held March 18. It was initiated by the Oklahoma RMP. Without us calling their attention to the disparity in coming to grips with project activities to be supported by ORMP, they recognized this themselves. And at least from the minutes that I received, I think they are attacking this problem. And by the time we site visited, it would be prior to the applications about a year-and-a-half, I guess, I think they will have solved many of these problems. Staff will be monitoring this operation in the meantime.

I think their relationships, while not the best, have improved, and individuals on the core staff, I think, are very sensitive to this. And with a new coordinator, I think that much of it will be corrected.

DR. BESSON: I won't belabor this much. I know we are talking about a motion on funding level, but I think there

is a principle involved here I would like to explore a little bit further. And that is Dr. Scherlis has mentioned we have won them on more than one occasion. I think of the relationship between RMPS and the regions as being one of a limited leverage. We do have a leverage of funds, and we do have a leverage of education, and we are not going to make that core strength if we provide the water unless they have the same perspective about the problems that we do, let's say assuming that we are the enlightened ones, and there is some question about that, too.

But I think we have to accept the limitations of our leverage and say that unless there is a spontaneous generation of interest and organizational implementation of principles manifested in projects, we are just not going to be able to exert enough of the leverage from here on what is happening in Oklahoma. And I think we have to look at our methodologies for how we do exert that leverage, and maybe we are over-using our thinking about funding levels and what we can do by telling them, "Well, here's some money," or "We will withold that money."

Maybe what we ought to do as an RMP is organization in relation to the regions so if there is a disparity in how they go about their business, if there is a disparity in the leadership that is available, maybe we are not doing our job educationally rather than just from the point of view of funding.

DR. SCHERLIS: I think what should be emphasized is that their relationship hasn't only been with a letter. Two,

they had the Macer Committee which had a real impact on their group. Their leaders, not just their coordinator, but Dr. Eliel -- they have recognized, as attested to by their change of coordinators, what one of the basic problems has been. But he provided what has been referred to by many of the people there as absentee leadership. And the whole feeling when you dealt with the Regional Medical Program was a pessimistic one, the whole aspect of this was a rather gloomy one.

This has been altered,as I have said. In that area there has been utilization in terms of projects, in terms of involving Tulsa, Ada and other health centers programs which really give a great deal to build on, and they have gotten the message. I don't think we are in a position of saying they will understand if we cut their money. It was cut at the site visit drastically. They applied for a triennium. They were given a one-year support at a very, very drastically reduced level. So they have gotten the message, I think. Their change of leadership is an indication.

DR. SCHMIDT: Phil, do you have a comment?

DR. WHITE: I was going to ask how many dollars were involved in the projects?

DR. SPELLMAN: And how many vacancies are there in the core and how many projects will be phased out in this? Maybe this will give you some idea of how much money there is involved.

DR. SCHERLIS: There is only one project that is continuing, and that is in the fourth year, and that is $27,000 for some aspects of coronary care, case records, and evaluation. So after that, there are zero projects, isn't that correct? Everyone they have applied for is beginning a fourth year.

MR. SAYS: No.

DR. HESS: On the sheet here there are four continuing projects.

DR. SCHERLIS: That's right. There are four.

DR. HESS: And the amount is something like $103,000 continuing projects.

DR. SCHERLIS: Right. There are two educational ones, there's a rehab, aid to continuing education. There are three or four continuing education programs in that. These are subregionalization programs.

DR. HESS: But if you add that to their current budget which includes eight vacancies, that adds up to $506,000, if my arithmetic is correct.

DR. SCHMIDT: They are looking at page 7 of the salmon sheets. Just keep flipping your salmon sheets to page 7 and you will see the budget breakdown.

DR. HESS: The core request is $724,000. The current year's expenditure of $354,000, if I understand you correctly, includes eight vacancies which are not going to be filled immediately July 1.

DR. HESS: They are funded at the level of $354,000, and did you say they have --

DR. SCHERLIS: I am looking at Form 6 in the application.

DR. HESS: I am looking at this previous 03 year operational award which says $354,000.

DR. SCHERLIS: Which page are you on?

DR. HESS: Page 6 on the salmon sheets it says "Previous Yr's Award 03 Operational Year," Core is $354,000, and I assume that is what they are funded at. And within that $354,000 there are eight vacancies.

DR. WHITE: That doesn't seem reasonable.

DR. SCHERLIS: I am sorry I misquoted. Looking at the vacancies, the turnover has been very rapid. Do you know what the vacancy figure is?

MR. SAYS: No, I don't. I think the current professional staff number of positions is 15 or 16 or 17. Those are the type people.

DR. HESS: Is this $354,000 what they are awarded for the 03 year?

DR. SCHERLIS: Yes, that is the 03 year, that's right.

DR. HESS: That is accurate. So what you are saying is that the eight vacancies perhaps is not accurate but there are some vacancies.

DR. SCHERLIS: That's right.

DR. HESS: Within that $354,000.

DR. SCHMIDT: Dr. Ellis.

DR. ELLIS: I would like to say if we are going to do a good job of reorganization and restart and possibly have a non-medical coordinator, he should have the same opportunity that the other people have had before, or she, as the case may be, to try to be innovative and to get a staff which will solidify.

In my mind, unless there is some money there for this to have him look at the needs of the people, he will be so handicapped that he will not be able to even begin to build a permanent structure.

We have heard that the vice president is willing, and is anxious, in fact, to try to go along with this, and I suggested before that it is necessary to look at the kinds of educational activity,continuing educational activity which is going on.

I notice that in other connections, much of the continuing education that is going on has been the same thing we have been doing for 25 years, really, not involving anybody except one discipline, not one cross-discipline at all, not explaining concept at all. And I am just hopeful that as we do this it will have real meaning for the Regional Medical Programs and for their ability to really structure programs of

service to people. And I think if we reduce this to an extent where they cannot get some guarantee of staff where people do not feel that they are in a permanent situation that we will defeat our purpose.

DR. SCHMIDT: I believe that the issues are drawn fairly clearly here. There is a principle involved. There is also the level of funding that I think has been discussed enough to at least test the sense of the committee.

Joe, I would like to limit this to new issues, new comments. We are beginning to circle a little bit.

DR. HESS: I just wanted to emphase that the funding level which would permit continuation of core staff out of the current level of funding, plus continuation of the projects, is $506,000. I think we need that as background information to any action on the recommendation.

DR. SCHMIDT: Fine. The motion on the floor is for approval at reduced rate. They ask for 1.75 total. The motion on the floor is confirmation of the SARP's recommendation of $839,000.

Unless there is an objection, I will ask for a vote on this motion. If you wish to reduce the level of funding, you will vote no to the motion. A vote "yes" would mean a level of $839,000.

MR. PARKS: Wait a minute. We may not be for it at all, so I think a negative vote should be presumed just to reduc

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DR. SCHMIDT: A negative vote defeats the motion, and we will need a new motion on the floor which could include zero level funding.

DR. BESSON: I know you are looking at the clock and ready to vote on this motion, but I would like to just on this motion again refer to the principle. And that is now, as I read the application further -- and I apologize to Dr. Scherlis because he has been on the site visit and knows the area very well and I am just speed-reading now -- but in reading the comments of the RAG chairman about the direction of ORMP, it may be that the problems that they are having --

DR. SCHERLIS: Which chairman is this? Dr. Johnson or Dr. Strong? It is very relevant. These are two totally different individuals.

DR. BESSON: Dr. Johnson. Is that good or bad?

DR. SCHERLIS: Dr. Johnson is one of the strongest features of RAG. Of the whole program in the State, he is one of the strongest features.

DR. BESSON: Well, the question I am raising is whether what we are seeing here in the difficulty that the Oklahoma region is having is not symptomatic of a national problem, and that is the demand that we've made on the regions to shift their emphasis out of category and continuing education to a whole new ball game. And maybe the anxiety that is being produced in the regions is being manifest in the disorganization

and lack of leadership. And in reading this summary by the RAG chairman, apparently they have had a great deal of dispute in their discussions about what direction Oklahoma Regional Medical Program will take.

Dr. Groom is a cardiologist. He said, in your site visit you reported he felt the function of the Oklahoma RMP was continuing education and categorical, and he just didn't understand public health and didn't have anything to do with it.

Now, this is reiterated apparently at the conclusion of their discussions where the RAG chairman says it all boils down to the fact that Oklahoma Regional Medical Program has elected to continue its relatively direct pursuits of its original purpose.

Now, that means that there is a paradox in what we are asking them to do and faulting them for and what their perceptions are and what their aims are. Or it may be, therefore, that they really, in spite of the fact that we think that everybody should have gotten the message by now, they really haven't accepted this new role.

DR. SCHERLIS: When I began my introduction several hours ago, I commented on the fact that they just recently accepted completely reoriented goals and objectives and said these were much more in direction as far as RMPS is concerned. This just happened how long ago?

MR. SAYS: We just received them this week.

DR. BESSON: So this is out of date.

DR. SCHERLIS: Yes, I said that since the time of this submission, two important events have occurred. One, the resignation of Dr. Groom; two, the drafting of new goals and objectives by the Oklahoma Regional Medical Program.

DR. THURMAN: A whole new issue. Could you clarify for us one thing and that is how strong --

DR. SCHERLIS: I am having difficulty with anything. I would like doctor's assistance.

DR. THURMAN: I still refuse to step down. Can you clarify for us how strong really Dr. Groom's resignation is -- I'm looking beyond you, Len -- because he has resigned before.

(Laughter.)

Going back to what Dr. Besson said, I would be a little more comfortable if I really knew the day he was out of the ball game. I don't mean to be ugly. I'm just asking for information.

MR. SAYS: I think his letter to the RAG, which we have a copy of, carries no doubt he will be leaving. Dr. Margulies may have more input.

DR. MARGULIES: I think there is no question that he has resigned. We pursued that with some vigor and it is formal and final.

I might just comment in terms of what kind of influence this type of review has on accepting new directions

without the necessary club of money, full review some time, or we could do it for you. What has happened to a long list of traditionally unacceptable coordinators in the last year-and-a-half, especially those who reached prominence during the period of earlier development of RMP which was categorical and project dominated, and who were dealt with with regularity, you will find that with the exception of one or two they have resigned.

DR. SCHMIDT: I know that I can't go into the State of Indiana for a little while. I asked one of my department chairmen for his resignation by letter. He gave it to me with an effective date of 31 July 1978.

(Laughter.)

I am trying to figure out what to do with that.

Let's test the sense of the committee then. I think everyone has an understanding of the motion. Unless there is strenuous objection, I will call for a vote.

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

(Chorus of "ayes.")

Opposed, "no."

(Chorus of "noes.")

All in favor, please raise your hand.

(Show of hands.)

I get seven.

Opposed?

(Show of hands.)

Six.

DR. SCHERLIS: The chairman has a right to vote. I don't think you should be deprived of a vote because you're really a member of the group.

DR. SCHMIDT: All right. The chairman in this instance exercises his right to vote or not to vote. He votes to create a tie, and thus defeats the motion, and I will not vote, so the motion is carried.

Are there other comments?

One thing I learned I had to do was memorize Robert's Rules of Order. I'm assuming this committee operates by Robert's Rules of order, is that correct?

DR. MARGULIES: As long as you are in the chair, yes.

DR. SCHERLIS: As interpreted individually.

DR. SCHMIDT: There is a new edition of Robert's Rules out that is a most excellent book in case anyone hasn't seen it.

We will move on then from Oklahoma to Puerto Rico. Miss Anderson.

MISS ANDERSON: I will try and make this brief. We are talking about Puerto Rico now.

I have a problem, not being on a site visit, to talk to the RAG members and the coordinator and staff about the program, so I was dependent upon the written reports of the staff and the previous site visit in 1970 by Dr. Lemon.

I didn't have a chance to talk to Jessie Salazar but I did talk to George Hinkle and I appreciate his comments regarding their recent visit there in December to assist the new coordinator in developing his anniversary review application.

Apparently Dr. Fields and Jessie Salazar and George Hinkle and Robert Shaw did a very good job as the anniversary review report is quite complete and up to date.

Briefly, the profile of Puerto Rico is as you have in your book. It's a small island with a heavy census of over 2.7 million, and the health statistics in regard to mortality rates is a fairly healthy place to be in regard to heart disease cancer and stroke.

Fortunately, they seem to have some very good educational facilities and institutions. They have a school of medicine. They have a school of public health that is accredite They have ten schools of nursing, five at universities, one at junior college and four at hospitals.

There are two schools of medical technology, and that pretty well completes the educational aspects. They do have 18 nursing homes, and the American Hospital Association reports 59 acute care and long-term hospitals in the area.

But in addition to this, they also have municipal hospitals and district hospitals. And there are 78 of those. And as I understand, some of those are just one- and two-bed affairs, but they are considered hospitals and they do give care

I do not know the staffing patterns of these smaller places. Incidentally, Puerto Rico is made up of 75 municipalities, and of the 75, 73 of them have hospitals of some sort. So there is some type of public care.

The private hospitals are mainly in the cities and they have 50 percent of the beds. And the public hospitals, as I mentioned, are in the various municipalities also.

Now, in the coordinator's report he really spelled out the new goals and objectives as clearly as possible and they do go into the direction of RMPS planning. The main thrust is in regard to education and health manpower, health delivery services systems, and the collection of data and statistics. He emphasized increasing availability of care and enhancing the quality and moderating the cost of health care.

Now, some of the accomplishments they have done in this short period of time are quite dramatic. And I would like to mention a few of them to you. They are all listed on page 5 of the salmon report. But they have been very much involved with other official agencies, governmental and also non-profit organizations, in cooperating and developing proposals and projects.

They have expanded their services not only in San Juan and the bigger cities but also in the rural areas and villages. They have had active participation in their program from the Health Department, Department of Labor, labor unions,

community and civic organizations, as well as related health organizations. They are trying to obtain funds from various resources in the community. There is a problem. This area has quite a bit of poverty, and they do not have the resources that many other States of the Union have. So I think they are a little slower in doing these things.

The region's continued active involvement and emphasis devoted to looking for other sources of support is on-going. A point I was impressed with was the comprehensiveness of the educational aspects of ongoing activities that include education not only for the provider but also the community, the patients and their families.

Also another plus is the fact that they are trying to develop leadership roles for paramedical type persons and people.

The continued support, as was mentioned here, is being established as part of their policy and is included in all the proposals that they are planning. Actually, to date there has just been one proposal that has been discontinued and is being carried on by the health department.

As far as minority concerns, I would like to state the goals and objectives are directed to all the people in Puerto Rico. Through intensive efforts toward regionalization, decentralization of treatment centers, continuation of health providers in isolated areas and educational programs directed at

both the patient and the patient's family, all interests are considered to be served.

I was interested in and requested the interest of minorities on the staff. All of the staff is made up of Spanish surnames, and as Puerto Rico has a few other minority groups which are the other side of the coin, such as black people from the Virgin Islands and Caucasians living in the community.

Also they have other minority interests such as allied health and nursing who are not recognized on their staff or their RAG. But I think this is the area that they are working on. I was surprised this is the first review I have seen in which the females are not minorities on the core program staff. On this program staff the females are a majority, 8 to 6.

The coordinator, as I mentioned, is a newly appointed coordinator as of December '71, and he is a dentist and is apparently very aggressive and very progressive. His special interest is in education and he has had experience in health manpower and is on some national committees with the National Institutes of Health. So I think he has a feeling now of local needs but also national trends and interests.

He has reorganized the program staff and and is more closely allying the staff's missions and responsibility to the new direction.

He has been involved in revising the RAG by-laws to

increase the consumer representation at all socioeconomic levels. He realizes that the RAG has been inadequate in the past, and he is getting more involved in the activities of the program. As the staff reports, he has gained the confidence of the staff and the community, and they feel that he is really moving the program along very nicely.

The program staff is almost new. There are many resignations due to reduced funding, and the demoralization in regard to their feelings of not being so optimistic about RMP's future, but now they are developing their staff again.

And the staff is being focused on three main areas: health, education and manpower; administration and health services, and planning and evaluation. We hope to have them add more allied health people in nursing to their staff and nursing. At the present time they have 32 positions budgeted and only 21 filled.

A staff person is assigned to the RAG in order to support their various task forces and also to help them in developing plans of action.

On the RAG there are currently 28 members. There are 4 vacancies. And of the RAG, 4 of the members are women, and they are pretty well spaced, with 20 people from the northeast, 2 from the south and 1 from the west, and they are planning now to add better geographic representation.

And also in the new by-laws they are going to include

the public and consumer categories which shall include at least ten health services for consumers proportionately representative of all socioeconomic levels of Puerto Rico.

The RAG used to have two meetings a year and attendance was very, very poor. Now they are scheduled for four meetings a year and the meetings are going to be rotated around the island in order to have better attendance and representation.

It is understood that the RAG has accepted their new roles and responsibility and are willing to move ahead.

The RAG has twelve standing committees, and in reviewing the literature I found that only three of these committees have met during the past year. The one committee that was most active is one on continuing education and has 15 members and met 10 times.

The project directors committee, which is a new committee, has 13 people who are involved as project directors, and they have met nine times recently. And this is a new innovative program that has been established by the coordinator to help the project directors to understand more about RMP and the goals of RMP and helping these coordinators to work together and possibly do more coordinating of their programs and projects and in exchange of information, and that I thought was a very big step forward.

I think also this adds to, in reviewing the literatur

the enthusiasm and dedication that the various proposers seem to have toward RMP and their projects.

There is another committee, the planning committee, of 13 people, and that met 3 times recently in regard to short-term and long-term planning for the region. The remainder of the committees were just on paper and were not active.

The grantee organization, according to the report, is the University of Puerto Rico, and apparently the relationships are very cordial and the university does not add any pressure or direct guidance to the group. They are quite independent.

The participation of the RMP is that there is very active participation of the various health agencies on the RAG. The program staff planning studies are planned in cooperation with the State Department, prepaid health insurance organization, the Puerto Rico Hospital Association, the Department of Health, and the San Juan Municipal Government and other municipal governments.

The Veterans Administration there is active in doing continuing education programs and other programs in the community, and they are working closely with the VA in regard to this. They have joint activities with the Puerto Rico Medical Association, and the coordinator is a member of the Committee fo Medical Education.

Local planning -- they have regular meetings, as we

mentioned, not only of the RAG but of the Department of Health Communications, with the RMP staff, to avoid duplication of activities. Also CHP and RMP are meeting together at regular intervals.

RMP has been appointed a member to the Municipal Advisory Board of the planning office for the area of San Juan.

The Central Program Staff Planning and Evaluation Section has served as a consultant and taken steps to provide requested consultation services to the Planning Board and Department of Health in Puerto Rico.

They are also planning to develop a consortium of the various health agencies in the island, and to combine their efforts in regard to data collection and interpretation.

And another recognition of their local planning is a development of conferences and seminars with the various health agencies and groups in the island. And what they are trying to do now is to classify the various health service personnel and reorganize the educational system to meet the new types of health delivery. Also they are planning an Area Community Health Education Center.

The assessment of needs and resources is reflected in the health professions human resources inventory that has been completed and is transferred to the local Comprehensive Health Planning for sharing with them and RMP and they plan for regular up-dating of this material. I mentioned to you earlier that

they are developing a consortium of health educational agencies.

The core staff has planned activities and studies to gather additional basic information for the development of the operational plan for the next trienniumm. Many of these studies are referred to and a direct result of the Program Master Plan developed for the region.

Some of the things that they are planning to do in their studies are to survey the number of licensing, the problems of licensing and health professions, the planning cost study and outpatient clinics. They are planning a study on inventory audio-visual resources in Puerto Rico and listing hospitals that are accredited. And they have quite a list of things that they are planning to do in this coming year.

Now, in regard to management, it appears to be pretty well organized, well managed. The staff is assigned to monitoring the various proposals and provide support to the projects. They have monthly meetings of the project directors, as I mentioned to you earlier, with the coordinator and the staff.

Also progress reports and expenditure reports are reviewed, mainly the expenditure reports are reviewed, by the RAG annually and by the staff quarterly, and project reports are reviewed by the staff bi-monthly.

As far as evaluation is concerned, evaluation procedures are required for each project. And they are well written into the project. All projects are evaluated by the program

staff and consultants, and evaluation is of both a qualitative and quantitative nature.

During the past year evaluation reports have been completed on six projects. The program staff is actively working towards completion of the development and implementation of the total program evaluation plan. And it is anticipated this plan will be completed during the coming year.

Now, the action plan has been established and is considered to be consonant with the national goals and the goals of the region. The region plans to continue currently on-going categorical activities and has restated its goals and objectives in terminology agreeable to the RMPs published missions. It is noted the activities appear to be in complete agreement with these goals. The new proposals are going in the new directions.

The on-going activities are most comprehensive with respect to patient services, education of health providers, patients and families and community health manpower utilization and establishment of new skills and new types of personnel.

Their dissemination of knowledge is being extended into the community, and we mentioned this earlier about not only the professionals but also the consumers and patients and their families. And they are planning in the coming year to have post-testing for all the continuing education programs, to have pretesting and post-testing, in regard to the knowledge, attitudes and any change in practice that occurs.

The utilization of manpower facilities seem to be improving and they are interested in developing health personnel in new skills and training. The health assistants and family health workers are being used in the community in rural areas and are recognized as being valuable in increasing the productivity of the physicians and other health manpower.

The improvement in care, I think, in reviewing some of the proposals, you will find the pediatric cardiovascular program, they have been testing children from prekindergarten age to sixth grade, and have developed clinics and areas throughout the island. They usually start out with one clinic or one area, and then after that proves to be successful they multiply themselves in other areas.

The hematology and chemotherapy and blood banking program has developed monthly clinics in various parts of the island, and other parts, more inhabited parts, weekly visits to areas for examination, teaching and treatment of these children.

Another example is pediatric pulmonary center has developed continuing education for health professionals, community people and family conferences. And you just go down the list of their other proposals, and these just naturally fall into the area of improving patient care.

Now, the short-term payoff, as far as activities are concerned, are the courses for the development of professional

and community leaders in the areas. I think it is one very good example. Also the training of local health education coordinators in the rural areas and the training of health consumer orientation.

The regionalization is with the staff located in San Juan, and the new coordinator wants the staff there at the present time. They are establishing subregional offices in other towns.

The project activities are located in many other areas throughout the island. The do consultation and give help to the Virgin Islands in regard to their RMP program.

As we mentioned earlier, the other funding is being included in their plans and at the present time only one proposa has been funded by another agency.

I was wondering, maybe Dr. Spellman would like to add some more.

DR. SPELLMAN: Very little. I think Miss Anderson has given a very comprehensive report and I have very little else to add. I think that the picture I get from reviewing this is that the new coordinator is a young, energetic, ambitious man who is obviously committing full-time to his task. And I think his report is an excellent one and he projects optimism.

The supposition that essentially each of these projects will be on-going and supported largely by the governmen each enterprise he proposes will be sustained by government

support, and that projects already have budgetary allocations, for example, to absorb the new health careers training.

Everyone of the projects, whether they are inventories of health facilities or whether they are continuing education for nurses or physicians or new health careers, are designed to have a rapid, almost immediate impact on provision of health services even if they aren't in the first instance directly measurable.

There is the implication that subregionalization will be effectively implemented through these district hospitals which are physically spread throughout the island, although he doesn't specifically define this as regionalization strategy.

I think that virtually all of this reflects the impact of Dr. Fernandez, and I gather essentially the entire staff is new because the old staff resigned with the cutting of the RMP budget. So in a real sense it's a highly promising new program which is going to be essentially dependent more than most on his leadership.

The only other comment I'd like to make is the composition of RAG. In his report he recognizes the inadequate representation of consumers. The fact that all of them have Spanish surnames throughout this is a kind of a nationalist pride, I think, and a certain degree of innocence in which it expresses, I think, excessive optimism. But I think that this under-represents, obviously, ethnic and population groups in the

island that have some interest besides their origins in the Spanish culture.

I think he acknowledges this and has promised once again that the expansion of this will be truly representative of the whole island.

I think all of this is consonant with the new goals and objectives of RMP, and I think the whole restructuring in this rapid period of his on-coming is, I repeat, highly commendable of what he is likely to achieve.

I don't think I have anything else to add.

DR. SCHMIDT: Do you have a recommendation?

MISS ANDERSON: Well, the staff recommended a budget of $1,496,631 as direct cost amount. It was recommended the funds be provided to support for the program staff at an increased level for eight ongoing operational projects and two previously approved but unfunded projects and one new proposal.

Also the increase of geographic scope of new activities to be initiated is concentrated in the south and west health regions of the island.

Maybe some member of the staff may want to clarify this some more.

DR. SPELLMAN: I would like to make one other comment. Maybe the staff could enlarge on this.

I sense that the hope for comprehensive accessible health services in Puerto Rico are going to be dependent on

governmental sponsorship.

You also get the impression the ownership of these hospitals by private physicians create very little contribution from the private sector to a really enlightened kind of health care system.

And taking up what Sister has just mentioned, my guess is that much of the hope of this may be the fact that Fernandez is a dentist and young and not afflicted with much of the preoccupations of the private sector in Puerto Rico, and in this sense I would think that they have got a better chance than they would if the leadership were much more dependent on its support from existing health components.

I have never been there; I have never site-visited; so I don't know.

DR. SCHMIDT: Am I correct in assuming that the recommendation is for the level of funding requested?

MISS ANDERSON: Yes.

DR. SCHMIDT: All right. That would be an increase in Core from $248,370 to $447,597, and operations from $594,000 to $1.04 million. Is there staff comment?

MR. HINKLE: The budget aspects of it -- I might first speak to Dr. Spellman's concern about the private sector. That is one of the concerns of past reviewers, and I think Dr. Fernandez is pretty much aware of these. And as I read some of the on-going projects for the third year, they are planning to

move from the health center where they were initially set up out into more isolated areas, and some of the private hospitals are also mentioned. And I feel as they move out into these more isolated areas, they will bring in the private physicians.

Currently they start with the project in the health centers, which are mostly government supported. Once they get their base established, they move out into isolated rural areas.

But Dr. Fernandez seems to be aware of all the past criticisms, and in his brief term he has initiated some proposed amendments to the by-laws, some of which were referred to, and these were also taken into consideration in the past criticism. He is aware that the RAG in his opinion hasn't been as active as it should be. He has set up a liaison person on his program staff to more actively work with the RAG and bring them into daily operation.

He has also set up his committee of project directors so that they can get a more overall view of the total Puerto Rican RMP program instead of just their own.

I believe what I am trying to say here is that based on his reaction to past criticism in the brief time he has been on board, I feel he would also move these things out more into the private sector.

I have only been to Puerto Rico one time myself, and just in December, and reading this application, most of the

comments reflected here came direct from the application at face value. As I read it, as I'm sure some of you did, there are many areas I would like to delve into much more deeply when I get an opportunity to go down there.

DR. SCHMIDT: I detect a very wistful note in all of these plaintive statements that I am just reviewing this from paper and I've not been down to Puerto Rico. We maybe should have the committee convene in San Juan in order to give this program a good going over it obviously needs.

Is there a second to the motion that we had? I didn't hear one.

DR. SPELLMAN: I second it.

My only question about the level of funding is whether or not this rather striking increase of operation of activity is warranted. I just don't know. There are a large number of projects.

DR. SCHMIDT: The first sheet in this big black book full of computer printouts that you were briefed on before, the first quarter's sheet from Puerto Rico -- it's tabbed just behind Puerto Rico '65 -- does give a nice breakdown of the funds awarded in 01-02, and requested in 03, and one or two of the projects do go up considerably. For example, Project No. 010, the request goes from $107,400 to $148,900, and I assume that this is because of expansion into other areas of the island.

So they are asking for increased funding of their ongoing projects. I suppose the only thing that bothers me a little bit is that they aren't aggressively moving these projects out into other sources of funding. But on the other hand, there aren't any other sources of funding in the island for these projects to go to, and I think there is somewhat of a peculiar personality of the island that must be taken into account here. I have visited it, not under RMP auspices but under others, and would make that comment.

Sister Ann Josephine.

SISTER ANN JOSEPHINE: Dr. Schmidt, I wonder if someone would talk to this project they are apparently asking to be funded, computerization of dose distribution.

DR. SCHMIDT: The question is the computerization of dose project.

Bill.

DR. THURMAN: Sister, the major basis for this is that Puerto Rico from the standpoint of cancer has been an untapped resource for research and development. What they have done, as indicated in the past, is they have had a cancer hospital and a university hospital, and the two have never seen eye to eye about the price of anything. And what they are trying to do -- the project has always been in the cancer hospital -- they are trying to bring it more into the university hospital, and in so doing they are bringing on people who will be better able to establish a dose in the university hospital that can

then be put into the periphery and delivered into outlying area units as well, primarily in radiation therapy but also chemotherapy and related things.

It's over-priced for its effectiveness. I would make that as a very critical judgment with no basis in fact. But it is over-priced in its effectiveness, as are several other of these projects. And I think that basically their concern is that they need to have the money in case they do get the job done. I don't believe that they will have the money. I don't believe they will get the job done. But this one is over-priced. We have seen units like this in several institutions in this country, and all of them have contributed. Puerto Rico has been a real ideal spot for us in the field of cancer because it has been so untouched in so many ways.

MR. HINKLE: May I make a comment, please.

Dr. Spellman, this dose distribution, one of their previous, I believe, projects when we had project review. When the region came in they asked for $89,000 for the first year, $57,000 for the second, and $58,000 for the third. The National Advisory Council increased their first request from $89,000 to $160,00. The second year will drop down. They felt they needed a little more money for equipment the first year.

DR. THURMAN: I don't mean to stand in the face of the National Advisory Council, but on the other hand, almost all of these projects have been over-priced for what was necessary

to be done. Puerto Rico -- I have site visited this for the National Cancer Institute. That is the only reason I am speaking with some degree of assurance. But the Puerto Rico idea is to put it into this component of hospitals. Dr. Spellman has indicated there's real concern about many of these private hospitals. And if you go back to this specific project, there's a request for a terminal in one of these private hospitals that has three beds. I don't believe that's too rational, and I think this is why in general it's over-priced.

DR. SPELLMAN: That's my feeling. I think they should be supported, and generously supported. I just wonder, really, though, whether they are going to be able to spend that much money operationally, given the jump they are making, and that is why I was hoping staff would give us some idea. He has only beenthere a very short time. This is a substantial increase in operational projects.

DR. KRALEWSKI: I have several concerns. I sympathize with the economy of the area, and I recognize that everyone is backing this leadership, and the fact is that the guy might do a really good job.

But what we are doing here is substantially increasing the budget of this program at a time where they will be coming in for a three-year application next year. So we are giving them all this right now, and next year they will be coming in for a three-year program. And if they tie into all of

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these projects, they are going to be tied into a lot of activity here at a time when they are supposed to be outlining a three-year plan.

It seems to me that is going somewhat in the wrong direction.

Secondly, these projects that they have outlined here don't appear to be terribly exciting. And when reviewed in the context of their economy with a great deal of poverty, the fact that they have many underserved areas that really need help. What they are doing here is dealing with continuing education similar to that, but really nothing terribly innovative.

And then thirdly, along the lines that have been mentioned, I don't know if they will be able to spend this kind of money. You mentioned that they have some agencies in the co staff now and they are going to expand that tremendously. I wonder if they are going to be able to handle this kind of increase to be able to do justice with it at this time in their development.

DR. SCHMIDT: Joe.

DR. HESS: I had a somewhat related concern. I was trying to harmonize the project titles, at least -- we don't have descriptions of the projects available -- the project titles and the budget, and the action, brief description of their action plan. Some of the other things described here is the direction in which they are going in the budget. And

look at the essentially doubling of the operational activities and what that is going for. And I assume that much of these new kinds of things that are talked about are subsumed under the core budget which again is not clear.

But I have a similar kind of uneasiness about where the program is going as shown on these projects that they are wanting to fund versus what it says in the descriptive material.

DR. SCHMIDT: Len.

DR. SCHERLIS: I guess there's such a thing as a halo effect. If you have a good coordinator everything takes on a glow, and if you have no coordinator or changing coordinator things don't look quite as well. I can comment on that further, but that is apparent.

(Laughter.)

Strength of this committee, I will word it that way.

In looking at the new projects, if they reflect anything they reflect committee retrenchment of what were the good approaches of categorical grant requests three or four years ago. As I add this up, of the new funds requested, some $339,000 go into the following: dose determination, for malignancy, screening and early diagnosis. This is a public education project to teach 300,000 men and women how to look for cancer. That is project No. 17 which is $78,000. And Project 12 is prevention diagnosis and treatment. This is to establish a cancer information center, and that comes to a sum of $100,000

I just question if this new direction really reflects any impact he has been able to have yet. It is too early to do that. But I think $360,000 for such cancer-oriented activities, and what I think -- what little I know about Puerto Rico -- would be a great area to do more imaginative things.

I wonder if you might just speak to the value of the two programs, one in public education and the other one, not just in terms of what it would accomplish but mostly in terms of the health dollar that could be best expended in Puerto Rico.

I have a gut reaction that Puerto Rico looks good RMP-wise, but at the same time it isn't such a warm glow in my abdominal area. It is an occasional pang of consciousness.

As the chairman said yesterday, it's good and it's bad.

DR. SPELLMAN: I agree. I think these new projects are the least relevant. The ones that I was speaking about are really the ones which are ongoing, and I would agree they have the least applicability to the goals and objectives of the progra

DR. THURMAN: Sister, let me go back and say all my comments were predicated on -- I thought the computerized dose was $89,000, and actually it's $160,000, and that therefore makes my comments much worse, not better.

I think, Leon, in answer to your feeling about why they have gone so strong in cancer is that everyone in the Unite States has faced the fact that Puerto Rico is our last untapped

frontier in many of the areas that we should have tapped before in cancer detection and treatment. This is an improper term at the Federal level, but they have a pipeline to the National Cancer Institute, and I think that this in many ways is reflected in their interest in having RMP money take on some of these projects. I think that it is an overweight, yes, and they do have a considerable amount of money from other sources.

SISTER ANN JOSEPHINE: You know, it's interesting in the statistics of the area that the median age is 18.5, and it would seem to me it would be an exciting area to develop education programs so we could begin the intervention thrust before we're treating disease.

DR. SCHMIDT: We have a seconded motion on the floor for a level of $1,496,631. The chair would accept a substitute motion.

DR. SPELLMAN: I am trying to add up the sum of these new ones, and the ones related to cancer, and I am going to just produce one in a minute.

DR. SCHMIDT: We have a little bit of a time problem here, and I think we do want to take about a very quick ten-minute coffee break, so we will declare a recess and I will appoint a committee of the primary and secondary reviewer over coffee to come up with a level after the presentation of Missour We will table this for the time being.

DR. SPELLMAN: I think we have one. $1.1 would, I

think, do it.

DR. SCHMIDT: All right, $1.1, and this is generally acceptable. You know, it's marvelous. You mention coffee and things move right along.

All right, then, the primary mover has amended the motion to include approval at a level of $1.1. Are we ready for a vote on the motion then? I see assent.

All in favor, please say "aye."

(Chorus of "ayes.")

Opposed, "no."

(No response.)

DR. MARGULIES: I just wanted to make one quick comment. We won't hold you up very long. It has nothing to do with this particular application, but another activity of Puerto Rico which I think you would all find interesting.

Some years ago they became particularly alarmed in Puerto Rico with a number of physicians who could not pass local examinations or the ECFMG. They have been educated primarily in Latin America and Spain. This was three-and-a-half or four years ago, and I suggested a plan of action which they then followed through on and got a contract from the National Center for Health Services R&D to involve the medical school in a program of supplementary education for these physicians who had gone to great personal expense and a lot of deprivation to get their MD's and couldn't practice. And the results have been

excellent. They have been retested, with a special test set up by the Educational Testing Service that has been cross-checked against the ECFMG examination. And when I last heard, they had salvaged about 64 physicians who are now available to practice in Puerto Rico who otherwise would not have been. They are now going to expand that program which I think is a heartening kind of an activity.

DR. SCHMIDT: We will reconvene for Missouri -- Dr. Besson has to leave early -- sharply at 10:45.

(Whereupon, a short recess was taken.)

DR. SCHMIDT: Dr. Brindley is ready to begin with Missouri, if we could take our seats and begin.

To relieve anybody's anxiety, I will be prepared to do South Dakota in one minute 32 seconds. I timed my presentation. And South Dakota should be relatively easy to do, I think.

DR. SPELLMAN: Is that what you are going to do now?

DR. SCHMIDT: No, we'll do Missouri. Dr. Besson has a time constraint.

DR. BRINDLEY: Okay, Missouri. I will try to give you a reduced summary.

As you know, Missouri has been a complicated region. It was started off with the expectation that the level of funding would be higher than later proved to be realistic. They did make commitments in large amounts to computer and bio-engineering projects. They have continued to support those.

They now have asked for some more monies. A site review has been made to evaluate these programs and to see should these monies be made available, should the level of funding be increased, and should the developmental component be added.

The current year's award is $1,947,417. They had requested $5,061,962. Council had a recommended level of the 06 year of $2.5 million. The committed level is $1,825,417. It is of interest that of this committed level of $1.8 million, the Missouri RMP did allocate $300,000 to the computer and bioengineering projects.

Three months after they received their funds, they made the decision to continue to support the automated physician assistant proposal in Dr. Bass' office rather than to phase it out, even though the council had recommended that it should be phased out.

Missouri RMP then requested a supplement of $122,092 to permit the continued operation of the automated physician's assistant project for the six-month period, January 1 through June 30, and council disapproved this request. I won't give you all those reasons right now.

They considered then the contract mechanism, as to whether this might be a good way in order to support this. And subsequently, a contract was let by RMPS for support of this because they felt at that time that redeployment of Federal resources allocated to aerospace and military technology would soon initiate new programs in this field and that some monies

were justified in this area. So a six months' contract was made for approximately $122,000.

Also they submitted the automated physician's assistant project of the National Center for Health Services R&D and subsequently a study section of this organization considered the request and disapproved the APA proposal.

I want to go over a few things quickly with you, if I may.

We received from the study group letters from each one of the reviewers in which they gave their opinions. And in summary, they were all pretty much against it. As a matter of fact, they recommended that funds not be allocated, and that a developmental component not be allowed.

Now, to hastily review the things we are talking about, a site visit was held on April 4 and 5 to review the technical activities for the Missouri RMP. And these projects included the automated ECG in the rural areas, the biomedical information services, the automated physician's assistant, and the development of these activities have been supported by the Missouri RMP already for five years, an expenditure level of approximately $7.5 million. They are presently being supported through grant and contract funds at a level of approximately $422,000.

The reviewers were critical of the project progress and recommended reduction of RMPS support.

If you look at the automated ECG in the rural area, this has been supported by RMPS for five years. It is focused on making remote electrocardiographic interpretation available to small hospitals located in rural areas of Missouri.

Now, they purchased 17 carts that would make the ECG's transmit them to the University of Missouri who would interpret them, and the reports be given back to these peoples. And now they have reduced this to 9 carts, and they felt this was an important thing to them. I talked to Bill Mayer. He feels that if this were supported for one more year, they could then become self-supporting.

Now, the reviewers didn't share that conviction. They were concerned, did not think it could become self-supporti

The carts rent for approximately $300 a month which is paid for out of Regional Medical Program grants. It is presently supported by more than one source. They get $96,000 from RMPS, $40,000 from the University of Missouri, and a contract for translation of the program into Fortran from the National Center for Health Services Research and Development.

Now, there are a lot of interesting things. When they talked to the cardiologist, Dr. Sandberg, he admitted there were errors in the interpretation in about half of the cases, and then about 20 percent of these that the error would be of clinical significance. He thought they could achieve economic viability if they added some other tests that could be

obtained at the same time.

So he talked about exercise ECG, phonocardiogram, spirometry and pacemaker analysis.

The consultants had reviewed it, looked into this, went over there and went over it. They felt that the spirograms probably would add very little useful information in the communities if this information would be utilized, and that actually a time vital capacity test would probably be just about as good.

As a thoracic surgeon, I might add I don't think that's always true, but those are probably not thoracic surgeons that are interpreting the spirograms.

Phonocardiogram, they thought it would be difficult to record, and that the local physician would have some difficulty interpreting it, and it probably wouldn't have a great deal of clinical significance.

The exercise ECG that was used in preparation for coronary artery surgery, and pacemaker analysis would not help the cost effectiveness, and they didn't feel there was very much of a reasonable market for it.

Now, they intended to spread this responsibility out and probably use some more cardiologists. There are three cardiologists in the University of Missouri that interpret these and one proposal was maybe we should use some more cardiologists throughout the State. They haven't really done much of that

yet but that is one proposal that has been considered.

They felt it was probably not of much value in interpretation of arrhythmias, and at the time of the last visit there was great doubt as to whether this ever would become economically feasible.

They thought about charging a fee of $5 for each one of the ECG's, and this $5 might or might not include the fee for the cardiology interpretation. It wasn't very clear in any of the information we had.

In conclusion, they really thought probably this could be done better and for less money with some of the commercial services that already are available where they could use analog transmitter services through the telephone and have the cardiology interpretation, and if this was an excessive amount of money that was being used, and they weren't getting their dollar worth of value out of it. They concluded that the present mode of computerized interpretation of ECG's is neither particularly useful nor economically viable.

Each one of the consultants that wrote back a letter about this was really very critical and apparently unanimous in their concept that this should not be supported.

They did make another suggestion that perhaps it might be well to consider an allocation of some monies possibly around the $60,000 range to see if a less expensive method could be devised where they could make available to the smaller

communities ECG consultation and review of ECG's.

A biomedical information service is a fact bank and it's operated by the Missouri RMP in conjunction with the University of Missouri Medical School Library and the School of Engineering. It is designed to provide specific disease information from recent journals and texts. It has continued in operation for the past nine months. Also I think connected by phone line with the University School of Pharmacy in Kansas City as a resource on drug reaction and also with Mercy Children's Hospital in Kansas City for poison control advice.

They estimate that it costs about $100,000 a year to support this. At the present time, the University of Missouri has been contributing around $2500 a month in support of the fact bank. They made a survey to try to find out how many folks were using this. You might criticize the survey since they only asked 59 physicians out of the 6,000 in the State, but they did use that as an index. And they concluded that 58 percent of the physicians might accept it. Five hundred doctors have used the service so far.

The supporters of the project have inferred they believe this could be paid for by physicians subscribing to it at the rate of $60 per physician per year. The reviewers felt that this was an optimistic conclusion and did have some difficulty in obtaining this many people that would provide the $60.

It was interesting that most of the inquiries were

received from physicians in Columbia, and very few from the outlying areas of the State.

It was the consensus of the site visit team that there was very little insight concerning the difficulties of marketing a fact bank on a break-even basis and very little comprehension of all of the technical difficulties of indexing a large library. They concluded that it was too expensive for the output, and the physicians of the State would be much better served by using the National Library of Medicine assets.

The also stated they felt that no RMP support was justified by this activity.

The automated physician's assistant is something we have talked about every time we have talked about Missouri. We are up to bat one more time. And this is a five-year request for $3 million for a one-year funding level of $538,000. And this is to develop and use technological innovations to improve medical care delivery in a rural area through the use of an automated system of patient data handling.

This is in the office of a private practitioner by the name of Dr. Bass in a relatively small community. He apparently does have a large amount of very sophisticated equipment. It is used primarily in evaluation of patients that are seen for the first time. There's a lot of data here saying how many patients that that consists, but it is actually not very many, probably not more than two a week.

The cost is quite excessive. There's a great deal of doubt about how much good it helps anybody, either the patient or the physician.

I won't go over again the things that are recorded unless you wish to, but the major thrust involves automation of collection of certain information components at the time of the first visit. It includes an automated medical history, the entry of physical examination findings from a structured check list. The nurses actually record this data after Dr. Bass has seen the patient. The entry of clinical laboratory data which consists primarily of an SMA-12, and X-rays reports which are sent back from the University of Missouri. Automated ECG. He also has access to the fact bank in helping him with diagnosis and recommendations of treatment.

It has been proposed that perhaps it might be well to expand this program in the University of Missouri in two areas: One into a family practice type clinic, and the other one into a thoracic surgery clinic.

The reviewers that saw it were not too impressed. If you want to know the details of the technical parts I can give them to you. They screen their patients for vision, hearing, breathing function, blood pressure and electrocardiogra The vision is evaluated by a Titmus vision tester, hearing with a Tracor audiometer, breathing with a spirometer. All of them have been modified for digital recording. They do record the

blood pressure by an air shield method and found it wasn't very good, so now they take the blood pressure manually.

The electrocardiograms are done with the Marquette Electronics cart. They do use the SMA-12. There is very little method in there to record any subsequent visits. There is very little effort about correction of any data.

I can give you the names of the investigators but I don't think they would change your conclusions any. But they see about two patients a week. It's very rudimentary in nature. To make a long story short --

DR. BESSON: Did you say $3 million?

DR. BRINDLEY: They estimated it cost $60,000 a year just for the computer time, and that the total technological cos might be as much as five times that. And the cost of the patien would be somewhere between $165 and $175 per patient. You could do a pretty good examination for that.

They suggested maybe there might be two others things that might be tried, neither one of which sounded very good. The might make a satellite station similar to Dr. Bass' clinic in another area without a physician. And it wasn't very good in Dr. Bass' clinic, and it is hard to see how it would be any good anywhere else.

They also suggested that you might develop a modular system for $180,000 and use an IBM System 7. But the reviewer never did get a very clear answer about what the goals were, ho

you were trying to go about it, how you might achieve these goals, and how it would actually improve health care. It would cost at least $2,000 a month to keep it up.

So the conclusions of the reviewers was that these were not good proposals. Technologically they were not well conceived. The medical supervision was not good, that it had not been as useful as it would need to be to justify this cost, and they did not recommend that we give any funds for Project 72 which is the automated physician's assistant, or to 75 which is biomedical information service.

There was a difference of opinion as to whether any money should be given for the automated ECG in the rural area. There has been a suggestion that we might consider the $60,000 to see if a less expensive method could be devised to provide this assistance to the rural communities.

And as you know, a second request was for an increased level of funding from the $1,904,417 to $4,460,852.

When we made a site visit to Missouri, we found their goals to be very broad and vague, poorly defined, that they largely were related to projects rather than to programs, that they largely depended upon interested physicians, mostly physicians, in communities to submit plans for projects, and if they proved to be good ones and the idea to obtain regionalization was to use a similar thought and see if you could set it in another area.

That program consists primarily of accumulation of projects. Evaluation was largely evaluation of projects, and they had a great deal of difficulty in phasing our or modifying poor projects. Sometimes it would take them three or four or more years to do this, and they were very reluctant to change them once they had accepted them.

The coordinator seemed to be a fine man, but actually his administrative ability was not as good as it might be. He is not a very strong administrator.

The staff is large, maybe too large, for what they should be doing. It largely is related to projects that have been developed in the past for which they felt some commitment. The staff review when they saw them did not feel that they had improved this enough to where they would be justified in the greatly increased level of funding, nor did they think we were justified in recommending a developmental component.

I did speak to Bill Mayer -- off the record.

(Discussion off the record.)

DR. SCHMIDT: Dr. Brindley, I will apologize to you, and I will also apologize to Jerry because he does have a time constraint.

DR. BESSON: Let's leave that flexible. I think this is much more important.

DR. SCHMIDT: I was trying to read where you were approaching you might make a recommendation. Are you approachin

that point?

DR. BRINDLEY: Yes.

DR. SCHMIDT: Would you object if I turned to Dr. Besson who does have a time constraint, and let's get his overview on this and then we'll come back to you.

DR. BRINDLEY: Right.

DR. BESSON: Getting out of Missouri is like getting out of Vietnam, except that we can make the decision right here.

DR. SCHMIDT: Can we make an assumption of what is coming from that?

(Laughter.)

DR. BESSON: There are two parts to this request. One is the bioengineering and the other is continued support in the deveopmental component.

The bioengineering is very simple. The technical site visit said no, and the only disagreement is whether they should get $60,000 or not for the automated ECG. And as I went through a careful analysis to try to justify the $60,000, I must agree with SARP and say that that's not justified either.

So my general impression is that as much as we could phase out of the ridiculous kinds of requests that we keep getting from Missouri, the more we should.

As far as committed support is concerned, they present two plans, Plan A and Plan B. Plan A is $1.8 million, and Plan B is for $4.4 million. They ask for a developmental component

as well, and part of our decision as to which plan to support involves our approach towards whether they are ready for a developmental component. And as I went over the individual projects to assess that, I came up with a very negative opinion as to their readiness to have a developmental component. I could bore you with the details, but I think just their approach to the bioengineering phase itself should be sufficient indication of their lack of maturity, at least so far as not only the new direction of RMP but even the old one. And with all due respect to our recently eulogized chairman, I must disagree with him and perhaps his paranoia is only because he is so deeply involved in the program.

But I would then not be in favor of awarding the developmental component, and of the two plans that they offer, under Plan A there is a commitment of $1.825 million that has already been made. Plan B, the $4.46 million, I think should be outrightly rejected. If we accept Plan A, that gives them -- and we also reject the bioengineering -- there is an additional million under Plan A that would not be funded therefore. That would give them an additional $1 million to use for other projects.

MISS HOUSEAL: That's inaccurate. There would be approximately $200,000 to $300,000 under Plan A that would be freed up. The $1 million is out of Plan B, and that was the plan presented to the site visitors.

DR. BESSON: That's right, Donna. The $1 million would be what they were requesting under Plan B of the $4.4 million, but if we accept their Plan A but deny them their bioengineering, those three plans, 69, 72 and 75, come to a sum total of $200,000.

We cannot deny them that $200,000, though, because that is already committed. Therefore, they would have the option of using that $200,000 for other projects. But nevertheless, in keeping their funding at $1.8 million instead of the $4.4 million that they request, we are in effect cutting them down about an additional 40 percent from the request from the $4.4 million to the $1.8 million by keeping them at a level funding.

So in effect, the suggestion would be to reject the bioengineering request,to reject the developmental component request, and by keeping them at a level funding, indicate the displeasure of this committee and our hope that they might terminate the bioengineering activity.

DR. SCHMIDT: Thank you.

Are there any staff comments on that?

MISS HOUSEAL: There are a couple of corrections to the record. The $3 million request for five years of computer activities was what was presented to the National Center for R&D. The request to RMP was for one year only at this point. So that the R&D, what they reviewed at their study section

about a month ago was the $3 million, five year request.

With regard to the EKG, the site visitors felt that on the basis of what the region was charging now and the number of subscribers they had, that they could not reach a level where they would become self-supporting in another year. The site visitors felt that the most valuable thing they could provide would be an overread or a consultation service to the rural physicians. And they thought if the project were totally re-directed that this would be worthwhile or worthy of support. They felt that the region had the resources to do this, and it would be something that would be worthwhile.

DR. SCHMIDT: Thank you. Dr. Brindley then.

DR. BRINDLEY: Yes, sir, I was going to get around to that and I think that's good. I would move that we recommend $1,825,417 as our funding, that we deny the developmental component.

DR. SCHMIDT: All right. This is consistent then with what Dr. Besson outlined, is that correct? So that you second, Jerry?

DR. BESSON: Yes.

DR. JOSLYN: May I ask, does that motion include a denial of the three projects that are now within the $1.8 budget? In other words, the computer projects, that $200,000 could not be used for the computer projects but could be used elsewhere. That was stated in what you were saying but not in

what Dr. Brindley was saying.

DR. SPELLMAN: I think the implication is there but I don't think you could deny them.

DR. BESSON: I think we could disapprove of those projects which is what I think the question was.

DR. JOSLYN: I think the site visit committee felt that a disapproval of those specific projects was needed in order to change the direction of those projects. In other words, just allowing the funding that even remains in the A budget would allow a continuation of the projects in the direction they are going.

DR. SCHMIDT: Then the specific question would be the disapproval of which projects then?

DR. BESSON: Projects 69, 72 and 75.

DR. JOSLYN: Those projects are the automated EKG, the biomedical information system, and the automated physician's assistant.

DR. SCHMIDT: Dr. Brindley is primary mover. What is the intent of the motion?

DR. BRINDLEY: I would like to include that in the motion.

DR. SCHMIDT: That is included in the motion. Is that acceptable to the seconder?

DR. BESSON: Yes.

DR. SCHMIDT: Is there further discussion then?

MR. PARKS: My unreadiness goes to the whole project, I guess, because I have some questions about what it is that we are doing here and what is it that apparently RMP is committed to.

I happened to run a scan of the full application here and it raises some very real questions. First of all, I find the so-called minority participation to be so small as to be totally nonexistent. With respect to that I would say directly and frankly it is a shame, and a shambles.

On the other hand, the participation of the grantee in the operation of this with respect to the staff listing of positions, which is on Form 6 which lists the core personnel, I would daresay with a scan like this that the personnel is close to the 90th percentile from the University of Missouri. This is highly suspect. Yet, when I look at the report of the RAG, the very first thing that they outline with respect to their programmatic relevance is the fact that they have addressed themselves with a high blood pressure program, which is a serious problem primarily among the black population of Kansas City. And then the rest of it goes off into a number of other projects.

Again I find in the opening page of the application an announcement that this is the Missouri Regional Medical Prog heart disease, cancer and stroke. Going back into the programs that they intend to continue, I am not sure that I find that

there is a shift in emphasis that corresponds to the so-called change or new national emphasis.

So with respect to this, I understand that we are committed to them at this point on some kind of a continuing or triennial commitment. But I raise some very serious question as to whether there is minimal compliance with those basic conditions that are necessary not only to obtain but to sustain the eligibility as a grantee or regional medical program operate as this one is.

DR. SCHMIDT: I think it would be appropriate for staff to note these particular comments very, very strongly, in that they be conveyed and the concern of this committee in this area be conveyed very strongly to the region.

Jerry.

DR. BESSON: I would like to respond to Mr. Parks' comments because I think again they raise a principle that disturbs me personally greatly in our relationship with a totally untenable region such as Missouri is. And that is how we have managed to remove ourselves from the decision-making process. Three years is a long time, and if change is occurring as exponentially as it is currently to have committed ourselves a year ago when we may have just felt in a more salubrious mood and maybe a little more generous to this level of funding, and now coming back to see the intemperance of the region and funding the program in the face of council disapproval, and

their cheek in presenting a budget like this with obvious changes in national mood, yet we are left powerless to do anything about it. We have to fund them at a level of $1.8 million because that was committed a year ago.

Our only action on this application, Mr. Parks, can be to disapprove the request for these three projects, disapprov the developmental compent, period. We can't do anything more, but you raise the fundamental question, I think, of the inappropriate stance that this review committee and therefore council has now placed itself in relation to a rapidly changing program by fixing itself to a three-year commitment with peripheral decision and no decision-making power left at this level.

DR. SCHMIDT: Sister Ann.

SISTER ANN JOSEPHINE: I would like, in conjunction with Mr. Parks' question, to raise a question that probably we are going to be facing -- maybe we won't be on the committee any more, but we will be facing it somewhere down the pike. And that is the total funding of medical education as it relates to the faculty.

Mr. Parks points out that 90 percent of the personnel on the program, on the RMP program, are from the university. I think that it would behoove all of us to read the recent Millis report on irrational public policy for medical educatio and its financing, or somewhere down the line we are going to be sorry we permitted this type of investment in underwriting

faculty salaries, and the unrealistic development of faculties beyond the financial capability of funding them when the Regional Medical Program is phased out into another type of program. And as we know historically what Federal programs do, this is going to happen, and I think it is terribly important that we realize we are contributing now to a stance that has to be taken on medical education. It has to be adequately funded but from the right sources so we are going to have a continuity of funding.

DR. SCHMIDT: Staff?

DR. JOSLYN: I have been with RMPS for less than a year, and I am not knowledgeable of all the politics and constraints and all, but I would hope that this review committee or National Advisory Council or some board would have the power to have some effect in Missouri, and I think this is what I hear people saying, particularly Dr. Besson, at the table. And I think that something needs to be said besides a letter of recommendation which has gone out the last four years. I don't know whether this takes this committee having its next meeting in Missouri with national television coverage, or what, but I guess I'm just asking: Is there any way this committee -- and Dr. Margulies and I have talked about it, and I don't want to bate it if it's not appropriate, but I would hope that the committee can move this region. It has some positive aspects. Some of these have not been brought out. But it does have some

positive aspects, but it is misguided in other areas, and I think those have been brought out and they have not been moved in the past. I would like some innovative way to move them, and hopefully this committee might do that.

DR. SCHMIDT: I'm sorry we can't. We're committed to meet next in Puerto Rico.

(Laughter.)

Joe.

DR. HESS: I would just like to say that I share the concerns being expressed around the table. One of my early site visits was to the Missouri region, and I see that many of the things we identified then were matters of concern are matter of continuing concern and nothing much has happened.

And in connection with this discussion, I wonder if it is possible under current policy, or if a new policy should be created to make it possible, to put a very large red flag on this anniversary approval and say that if certain actions are not taken by next year, that in spite of the triennial status that there will be funding cut-backs.

Now, that may or may not be a new policy, but if it requires new policy, I think perhaps this is an issue we ought to raise for discussion here and pass on to council.

DR. MARGULIES: I'm in full sympathy with your concern, but I just have a trace of the historical perspective in this, too. I would like to point out to you that this program

reached zenith of its categorical activities under the old processes under which this review committee operated, and it was this committee that put them at the extraordinary level of hardware activity which has generally dominated it. And it is only now, under these circumstances, that you first begin to look at the program. It is only now that you begin to raise questions about minority representation. It is only now that you begin to look at the grantee structure. It is only now that you look at the question of university domination and of the presence of RMP paid people on the faculty. It's now that you can begin to deal with it as a total structure. And what you're hesitating about I don't understand. In the past all you did was go from project to project, and under those circumstances it reached a total hardware level of something in the range of what? $4.5 million, $5 million, $6 million?

DR. JOSLYN: Yes.

DR. MARGULIES: And it was recently that you began to look at it as a programmatic structure. You are in a much better position to act on this as a total program than you have been at any time in the past.

DR. BESSON: Except that we are constrained totally by the triennial review process and the fact that we can say nothing about this program except within the limits of denying developmental component and denying these bioengineering processe And I say that's not enough. I think the program is changing

too rapidly for us to be tied in to a three-year anniversary review. And I think that policy must be reexamined in the light of rapidly changing events. It's inappropriate. It's unresponsive. It leaves the change lag too great. If you are chastising this group for reaping the fruits of some action it took a year or two ago, I'm making the bid for making this organization much more responsive, and immediately so.

DR. MARGULIES: And I'm asking you why you don't just take the action you keep talking about. What are you hesitating about? There is nothing special about a triennial review. You have this program to look at now. Why are you leaning back?

DR. BESSON: Well, maybe we should have some more information. Could you outline for us what we can do about Missouri other than the motion?

DR. MARGULIES: You have a full range of recommendations. You can do what you think is best.

DR. BESSON: Are we not enjoined from interfering with the committed support?

DR. MARGULIES: The support is committed on a year-by-year basis. The triennial review anticipates a continuing level of commitment if the program meets its responsibilities. If it does not, then it does not get the level. It's merely a matter of continuing it under those circumstances.

DR. BESSON: Okay.

DR. SCHMIDT: Len.

DR. SCHERLIS: Several things. One is that several of us have over the past several years been very concerned about the involvement of the Regional Medical Program in computer activities which appeared to be looking for programs so that one could use tools rather than trying to meet health needs and finding that computers were of assistance in this regard.

Several years ago -- I guess it was several, when we had categorical review by a heart committee that looked at all the heart programs and cancer committee -- at that time I was a member of a committee chaired by Paul Hugh, and subsequently I chaired a committee. And on each occasion we wrote a letter to the council -- I don't think you have a review committee at that time -- saying we wished to have the council have an ad hoc committee formed to draft a statement on computer EKG because we felt frankly this was very much at that time being misused. The committee finally met a few months ago. And this was an action we had requested because we were very concerned about the involvement of RMP in hardware at that time.

We also sent a statement asking for mobile ambulance units in coronary disease, and that one I guess never quite got help. But the feeling we had in the area of cardiology was there was a gross misuse as far as computer equipment was concerned.

I completely share the recommendations as far as EKG

here is concerned. They could do the same thing as far as helping some rural physicians by having a telephone at one end and sending the EKG directly to a physician or Xeroxing it and sending it over. The use of a computer here is a Cadillac to do the work that somebody could on foot. And I think it's an expensive example.

So I think as far as the excessive hardware in Missouri, we all bear responsibility for it, but all of us had seen this coming and had tried to get some directions about how much hardware was going to be purchased.

I would hope the committee at this point -- and I would lean back to the original recommendations and think in terms of cutting that recommendation financially, significantly, even beyond the limit that was suggested.

DR. SCHMIDT: Dr. Thurman.

DR. THURMAN: In view of the discussion, I would like to offer a substitute motion, and that is that we disapprove this application with the intent that there be a site visit within the very near future, disapprove it with the understanding that Dr. Margulies would agree to continue to fund it at the present level until such time as that site visit could be carried off, and many of the apprehensions that have been listed here today be specifically charged to that site visit group.

DR. SCHMIDT: And the site visit would be charged with making recommendation then for funding level, and so on?

DR. THURMAN: It's my understanding it is within Dr. Margulies' power to continue funding this at the present level to let them go on until such time as the site visit could be organized to address many of these problems. And therefore we would not be jeopardizing the eventual future of the Missouri Regional Medical Program should it adhere to many of the things we might suggest at that time.

DR. SCHMIDT: We have a substitute motion on the floor, then, for disapproval with funding maintained administratively.

DR. THURMAN: Excuse me one second. Miss Anderson had an addition to my substitute motion.

DR. SCHMIDT: I'm sorry, that is out of order.

DR. SCHERLIS: Point of information. My reading of that would be that you would be including ongoing support for the very projects we suggested they not fund, if you make it at the same level. Would it be feasible to drop that level down excluding the support of the automated EKG processes?

DR. THURMAN: As a discipline of Robert, I can also say I can accept that in my substitute motion, and would expand my substitute motion to include the recommendations previously listed. And that is that none of these three projects be permitted continuing operating money at Dr. Margulies' discretion.

DR. SCHMIDT: Is there a second to that motion then?

MISS ANDERSON: I will second it.

DR. SCHMIDT: The motion is seconded, and I presume understood. Would you like to modify it further?

MISS ANDERSON: No.

DR. SCHMIDT: That incorporates it.

MISS ANDERSON: Yes.

DR. BESSON: Perhaps we can have a clarification that this is an action that cannot be, because of Catch 22, rejected by council.

DR. SCHMIDT: Was that a question?

DR. BESSON: No, I would like to have a comment by Dr. Margulies that what we are doing is not going to be hung up on a technicality.

DR. SCHMIDT: I presume this could be rejected by council.

DR. MARGULIES: Of course.

DR. BESSON: Barring that, is there any reason why what we propose is going to be rejected by council for some technicality. If they reject it on principle, then that's debatable, but if it's rejected on a technicality that we can't do this --

DR. MARGULIES: The only technicality which might arise would be the need, because I cannot do exactly what you said. I cannot continue the program beyond its fiscal year without the council giving approval of an award level. So that

they would have to set some level at which they would operate. I don't have the authority to continue to award a grant unless the council has approved, but that would be the only technicalit As a matter of principle, they can endorse this action, or reject it, of course, because that's their legislative prerogative.

DR. BESSON: So we have a level of $1,625,417, is that correct, Donna?

MISS HOUSEAL: Yes.

DR. SPELLMAN: But I think the rejection and the prospects of rejection in principle would be diminished to the extent that the report to the council clearly states all of the considerations which have gone about. The only one I would add to that, I think this kind of unreal commitment, to Kansas City on the one hand, and clearly a system of program that has throughout responded to an essentially rural constituency, using urban methods, hardware, extraordinarily expensive programs where an individual physician almost operates a multiphasic screening operation at an enormous cost.

DR. SCHMIDT: A brief staff comment?

DR. JOSLYN: In light of the many past site visits and the data you have, I would just like to question what data you expect to gain from a site visit that will alter your position. And secondly, I would like to ask whether or not behind the recommendation for the site visit is a hope to move

the region, which is what I was addressing before. And I think merely requesting a site visit is another long chain of site visits.

DR. SCHMIDT: There are site visits and site visits, and I believe that some of the site visits we have made have not really been so much to gather data as to provide data. And we go back to what we were talking about before, that there have been a number of site visits, and my most recent one, I suppose, being an example that resulted in quite an upheaval and change of direction in the region and so on. I believe it is this sort of site visit that was recommended.

Joe.

DR. HESS: I would just like to get some clarification on when that site visit was projected and what it was designed to accomplish.

DR. THURMAN: I think it's projected as soon as the staff can arrange it, Joe, because I think basically by not approving continuation of the triennium, I share Jerry's concern about what the council is going to say about that, but in not approving that we are creating a little bit of an administrative morass, and therefore the site visit would have to come as quickly as staff could arrange it. And specifically the site visit would be as Mac has indicated, to approach the problems of why they weren't approved. And I think that in that light the site visit will be a fairly critical site visit.

DR. HESS: My question, then, is this a better way of trying to accomplish our goal than cutting back the funding having the advice letter and staff contact and so on, the messa carried that way, with the provision that there be a site visit a year from now after the message was carried back and they have had some time to reorient. And then a site visit team would go in with the purpose of seeing what they've done about the advice that they were given.

I'm wondering if that wouldn't be a better use of the site visit mechanism?

DR. BESSON: When you made the motion, Bill, I deferred to you, but I had a different approach to this other than a site visit, which would accomplish what Joe has now raised. And I thought, well, a site visit may act as our way of telling them directly face to face just what RMP is concerned with. But it may be that if we let them know by the funding mechanism, and my motion was to have been to cut them down not from $1.8, minus the $200,000, which was the bio-engineering, but down to an arbitrary lower figure, $1.5 millio let's say, which would have given them a message that we are objecting not only to their bioengineering, and therefore cutting down $200,000, but we are objecting over and above that.

Now, if that can be done with an advice letter, and then tell them this region would be reevaluated by a site visit after you have had time to reassess the impact of this change

in RMPS policy about the triennium review, then that might give the council an opportunity to establish an entirely new approach to triennial review which we haven't taken yet. But deferring it to a site visit, it almost implies we are not meeting the problem in a head-on fashion; we are not doing anything. Well, I guess in cutting down the $200,000 in funding level --

DR. SCHMIDT: Jerry, we are also disapproving the application.

DR. BESSON: No, we are disapproving the application entirely.

DR. THURMAN: That was implicit in the motion, and Dr. Ellis and I were raised to use the term, I think if we did an advice letter we would be patting them on the fanny, and that's all we would be doing.

DR. SCHMIDT: The motion is for disapproval of the application, with just funding being sufficient to keep them from going down the tube completely.

DR. BESSON: But the application is what? For developmental component and these three projects. Is that right? That's all that the application is. And an increased funding level.

Well, we are denying the increased funding level; we are denying the developmental component; we are denying the bioengineering. But we are saying more than that. Disapproval of this application doesn't get to the heart of what's wrong

with Missouri.

DR. THURMAN: I think if the site visitors had the courage of their convictions, and the wisdom of this review committee behind them, they would get to the heart of Missouri.

DR. BESSON: But you reassured me by disapproving this application that we are changing policy, and we are telling them that we disapprove of Missouri's general program. But we are not doing that by disapproval of this application because this is an interim application that only asks for three additional bioengineering projects, plus a developmental component. Is that correct?

MISS HOUSEAL: When you say interim, I'm not sure what you mean. This is an application for the next year's support that includes funding for core and their projects, including the support for the three computer activities and the developmental component. It's for one additional year, the second year of their triennium.

DR. BESSON: It's a different impact, though, in keeping them at a level funding, and in concomitantly disapproving this application, than in disapproving what they are doing which doesn't appear on this.

MISS HOUSEAL: Do you want an application before the site visit goes out, or do you just want the site visit team to go out and get further information and then carry a message to the region?

DR. MARGULIES: I think what you're doing in effect, if I may say so, is saying that you are withdrawing the previous approval of a triennial award, and that what you want to do is send some people out there who know what they are talking about to give them an understanding of why. And the site visit is sort of broad term, and what you are really advising is that they be given straight information on what they are going to have to do to have a Regional Medical Program.

DR. BESSON: If those words are included in the substitute motion, disapproval of the previously approved triennial award, then there's no problem, I think.

DR. THURMAN: Them I'm perfectly willing to accept it as Dr. Margulies has phrased it, because that was my intent.

DR. SCHMIDT: Do you have a comment?

MR. GARDELL: If you disapprove the application, regardless of what council does, we cannot make an award without an approved application. So we would have to get something from them between now and September 1 to make an official award.

DR. BESSON: I like the most recent wording better.

DR. SCHMIDT: All right, the most recent wording is adopted by the mover and the seconder as part of the motion.

Now, the funding level we are talking about is $1,625,000.

I think we are in a sense moving toward testing the question.

John.

DR. KRALEWSKI: Let me see if I understand this. We are suggesting now $1.6 million, a site visit, a new applicatio which we possibly will deal with before September.

DR. MARGULIES: No.

DR. KRALEWSKI: And that funding level is going to be $1.6 regardless of the site visit, or would you clarify that for me?

DR. MARGULIES: The point is good, because you are going to have to decide at what point you want to reconsider. If you withdraw triennial approval, and if you say there must be a site visit and a new application, then you may want to set a time for a subsequent meeting which is out of phase, if necessar to see if they can come back with some reconciliation in it and new directions. Otherwise, it is pretty infeasible to ask them to come in with a totally new application with about two to thre months to do it. It wouldn't be realistic. You wouldn't get anything good out of it.

DR. THURMAN: May I ask the question for information? What good would a new application do at this point in time? My intent was that we would visit to do what you said in your last statement. A lot more information on paper that is garbage is still more garbage. So it would do us no good to have another application, and if nothing else would raise their frustration level almost beyond acceptance.

So my intent in the motion, which obviously has never been clear, was that we would have a site visit reasonably soon, and that in that interim there would not be a new application, but that instead, within the power of your office and the council, that funding at the previously approved level, 1.6, not the 1.8, would continue until that site visit could be again reviewed by this comittee which would then be in September

DR. SCHERLIS: That is my understanding.

DR. MARGULIES: If you don't include an application, then it could be done.

DR. THURMAN: I am perfectly willing to have the motion voted on on whether everybody wants another application, but to commit more words to paper doesn't change the course of the program.

DR. BESSON: I think as far as John's comment is concerned, I think the words Harold used "as soon as feasible," is the only reasonable approach; staff should arrange it at the earliest opportunity, and we should visit, and then give them an opportunity to resubmit a new application after that message is clearly verbally given.

DR. SCHMIDT: We could withdraw triennial status, and then set a lower level for the second year, 1.6. And that's what we're doing.

DR. BESSON: When is their anniversary?

MISS HOUSEAL: Their year starts September 1, 1972.

They would then be coming in with another application, a year from now.

DR. SCHMIDT: That's reasonable, then.

DR. BESSON: So the new level of 1.6 would begin September 1972. The site visit can be held at any time. They would have ample time then for a new application.

DR. SCHMIDT: That's correct.

DR. SPELLMAN: A year hence.

DR. SCHMIDT: Joe.

DR. HESS: I would again like to raise the question, and perhaps direct this to Dr. Margulies. Do you feel that it takes a site visit to get the message across to Missouri, or are there other established administrative mechanisms that can be just as effective in getting the message to Missouri without a site visit?

DR. MARGULIES: I think it takes at least a site visit, and a very carefully selected one. Yes, I think that could be helpful, particularly if it is in the framework of reform. And it has worked in the past. There are unusually resistant factors that we are dealing with here, but we will deal with them as best we can.

DR. SCHMIDT: All right. It's getting on. I believe we are ready to test the substitute motion then. Unless there is strenuous objection, I will put the question.

All in favor of the motion please say "aye."

(Chorus of "ayes.")

Opposed, "no."

(No response.)

All in favor of Sister Ann chairing the site visit say "aye."

(Laughter.)

MRS. KYTTLE: Donna, are we thinking alike on what we have written here, withdrawal of the triennial status, funding level for the upcoming year of $1,625 million, an early site visit, rejection of developmental component, and rejection of the bioengineering proposal.

DR. MARGULIES: Could I make one comment. This is a very convenient time for me to do it -- we should have done it the very first -- which is to let you all know what I hope you do know, and that is the newly appointed Deputy Director of the Operations Division is Judy Silsbee. This is a notable achievement. I bring it up at the present time, not because I just thought of it, but because it seems to me that one of the things she could do to really contribute and show how wise we were in choosing her is to lead us out of the Missouri wilderness.

That's combined with the announcement of the fact that we're awfully happy to have her in this job.

MISS ANDERSON: Mr. Chairman, I hope that in this next site team the members would be selected to reflect the new direction of RMP.

DR. SCHMIDT: I think there is a lot hidden in that remark. I'm not sure I understand the full flavor of it.

DR. BESSON: Mr. Chairman, one other thing. Now that we are through with Missouri, I wonder whether this would not be an appropriate time, since we obviously have been operating under inadequate information as to what our responsibilities as a review committee could entail, to ask whether we couldn't have a staff clarification by memo to review committee, perhaps council, outlining exactly what your prerogatives are currently. We've got kidney, emergency medical services, anniversary review, our relationships with SARP and staff, the regions. I think that would be very helpful to delineate our areas of responsibility.

DR. MARGULIES: I think that is a very good point because these have accumulated, and to put them all together in one document would be very appropriate.

DR. SCHERLIS: We have a manual of operations.

DR. WHITE: I would think it terrible if we had to have guidelines as to what we can do and can't do. What we can influence or not influence may be a different thing. But council has to abide by whatever its decisions are going to be and they must adhere, presumably, to whatever policy it establishes to guide its function. But I would hope this committee could remain totally independent and recommend to council anything it pleased to recommend. Whether they accept it or

not is a different proposition. We may be speaking in an increasingly higher-pitched voice, but we've got to be heard.

DR. SCHMIDT: I think I can read Harold better than I can from previous doctor associations, and so on, but I think that was the message he was giving us earlier today, and was sort of behind my comment yesterday, that you are what you do. And I think Harold is saying that this committee really should not hold back from doing what it feels is right and proper in flexing its muscle. I don't think anybody has taken our muscle away legally.

If the thrust of Jerry's request is to get a clarification of the charge to this committee, rather than guidelines or constraints or whatever, I believe that that would be a fair request. I occasionally get requests from committees to recharge them or clarify their charge.

Len.

DR. SCHERLIS: Two brief points. The reason I was agreeing with what Jerry said was more in line with a definition of terms, particularly with new members, and what it means to a region to be told they have a triennium. I am not talking about proscribing the limitations of activities of this committee but just getting down the jargon on what this means in terms of whether these are contracts or not.

The other point I wanted to raise was that while this is valuable, I find it less value to me than would be another,

either substitutive or additional form of information. When you are constricted to a certain number of letters to describe a project, even the title doesn't come through completely. While we don't look at individual projects, the flavor to me of whether a region has certain directions lies in a little paragraph discussing each individual project. Now, this doesn't mean the entire project or anything else.

But the former yellow sheets I found to be invaluable and frankly I got lost in a lot of material which I find less clear and more obfuscating than helpful in terms of the following.

I would like to see, for example, as far as Missouri is concerned, a paragraph about each one of the projects that they have which I find difficult to obtain even from the total application from the terms of their descriptions. What I am asking for is what is present in only a few of these regions at this time, a small paragraph describing the individual project.

I wish there could be some staff comment on this because I find the flavor of a region lies in what it is doing, not what it tells me it's going to do. Its goals and objectives, they all read alike now, they've got this clearly, but as far as the projects, this is how they translate it.

Is this a fair statement?

DR. SCHMIDT: There are many heads nodding in assent

around the table.

Bill, do you have a comment?

MR. HILTON: Yes, I have a concern closely related to that one. I was interested in background information, and I know that going through the various briefing documents provided on each of the regions, they vary somewhat in quality, and while there appears to be a move to uniformize at least certain of the material in accord with our criteria for evaluation, I find it helpful to be able to refer to background, demographic, geographical information. I find that is not consistently represented and not always presented with equal thoroughness.

Missouri's happens to be one of the better ones I have seen. It provides me with some information. It helps me assess how well the region has made its plans in light of the regional needs.

And I would like to make a bid for staff making a more standard approach in that area, too, everybody provide certain background data on each of the regions, in addition to this additional information about progress.

DR. SCHMIDT: I would agree in many respects the old yellow sheets were a little more helpful to evaluate the summary of the projects rather than to be one more time removed in evaluating the evaluation of a summary of the project.

Before we move to South Dakota, then, there is this issue we have surfaced. Is there any other comment on this

particular one?

All in favor of the motion, say "aye" again.

(Chorus of "ayes.")

Opposed, "no."

(No response.)

The motion is carried.

We will move on then to South Dakota.

I said that I did have a 1 minute, 33 second versio of a review, and was sort of planning on this a week ago, and then McGovern started to win more, and I thought better of this and will give a 5 minute, 21 second version.

This region is not ratable on your sheets this time because what we are reviewing is an application for a planning grant, and the review criteria, et cetera, are so much oriented toward operational that I agree with the staff it's essentially unratable.

South Dakota used to be married to Nebraska, as was brought out yesterday, and early on it was a happy marriage wit good potential, and most people agreed that the couple should produce marvelous projects together.

But South Dakota became a little unhappy. She began to feel that the marriage was an unfair partnership. She did a lot of drudgery without getting too much glory, had a lot of ideas. The good ideas seemed to be implemented in Nebraska and not in South Dakota. She felt neglected and suffered from lack

of affection and attention. Core staff seemed to be developed more in Western Nebraska. All the meetings are Eastern Nebraska. All the meetings were held there and not in South Dakota, which forced South Dakota to come always to Nebraska. Only a few projects got going in South Dakota, and she just felt she wasn't fulfilling her potential as an individual program.

She asked to change the marriage vows more to a partnership contract, and there was some attempt to work this out but it didn't really come to any good end. She did not feel liberated and filed for divorce.

There was a site visit mounted in October of '70 by council to South Dakota to look at this. And the site visit recognized that the RAG for the combined region was too large, was not functioning well, particularly for South Dakota. There were problems with the dean of the two-year school of medicine in South Dakota. There was no full-time coordinator for that subregion, and very little staff expertise in a relatively have-not state. The State had become disenchanted and, save for a coronary care unit training projects, which they are very enthusiastic about, have lost enthusiasm for the activities there.

The recommendation of council was a new region be established, that they be given planning funds, that the corona care training projects which were considered valuable by both t site visitors and the region be continued.

So that on 1 January 1971 South Dakota was officially designated a region. However, they were not funded independently until 1 July '71, and a new and very good coordinator did not come on board until 1 September 1971, and within six months they were charged with coming in with their application.

This planning application, which is asking for very modest levels of support, they seemingly have a good start with some good people. And my recommendation will be the same as the staff's, and that is that the application be approved at the funding level requested.

The coordinator I mentioned is good. They have structured a Regional Advisory Group that is interesting. It is 41 members, 21 being consumers, and serves as the governing body for both CHPA in the State, as well as the Regional Advisory Group. They have worked out a sort of a common cause in which the CHP will be dealing with conceptual planning and general strategical affairs, and the RMP will be implementing and more concerned with tactical aspects.

The two directors, the directors of CHP and RMP are different individuals and they work well together and are communicating well.

The core staff is small but dedicated and competent, and they are building a good staff. South Dakota needs more or less one of everything, and they are trying to bring in competencies needed in the State.

They are somewhat weak now as an organization. They have very little bench strength, as I have intimated. There is no evaluation competence on board right now and an inadequate field staff, but they have plans to obtain these.

The Chairman of the RAG is an excellent person about whom this committee will learn much more in the future.

They have accepted a problem orientation way of planning and have established some early-on goals and priorities listing emergency health service as number one, and this seems appropriate for South Dakota; chronic care, number two; acute care, three; preventive care, four; subacute care, five; and custodial services, six.

They aren't quite sure why they chose these. Some of it obviously is guessing at what the Federal Government wants and yet they have done some good thought in these areas, and again under the planning grant will be refining these and coming up with a program.

Dr. Lowe has an evaluation letter in the application and one is impressed reading the letter. He makes cases well. He has gotten around the State. Just for one example, he has visited every hospital in the State at least twice already. He has been an aggressive, active person, and I think has great promise for becoming a leader in that area of the country.

The reconstituted Regional Advisory Group is quite engaged in the program. They have more than 80 percent attendi

their meetings. And interestingly enough, the divorced partners are seeing each other frequently. They are still dating on occasion and are talking about cooperative efforts between South Dakota and Nebraska where these are appropriate. They are having development meetings for the Regional Advisory Group, even giving them training sessions in management, and this sort of thing that is interesting and kind of acute.

They have some problems, and I have a few questions about what they are doing, but I really don't fear that they will recognize their problems and move to correct them.

I believe that their request for funds to support planning studies and feasibility studies is very reasonable. They seem to have structured a good review system of activities less than $1,000. The coordinator will be free to make commitments of funds. The executive committee of the RAG must be involved in projects between $1000 and $2500, and anything costing more than $2500 will be evaluated by the whole Regional Advisory Group.

They need to develop a program. I think they can. The coordinator comes through, on paper at least -- I have not visited there -- he seems so potentially attractive that I hope that he is used in site visits and brought in here to headquarters and oriented well and supported by staff. I believe they need help from good regions in setting up their processes, but I am kind of excited about what they have the potential for

doing.

My recommendation, therefore, is strongly for approval of this planning application at the level requested, with continuation of the one tripartite project for the remaining year of this project, the coronary care unit, nurse training and other training activities.

The secondary reviewer, Dr. Ancrum.

DR. ANCRUM: Well, only having the same material that Dr. Schmidt reported on, there isn't too much that I can add to it. By and large I concur with all the things that he said about the program.

Looking at the time that they have had to plan and develop potential programs, they have done a fairly good job on it, and I think with realistic approaches. When I first read it, I had questions about the small feasibility studies for developing the programs, but then after reconsidering the manpower available and the population characteristics and density, that this probably was the best way to go about it.

In terms of their minority structure, they seem to be moving toward this direction. They have a small staff now both for their RAG and for their core staff, and they do have two Indians, I believe, on the core staff. And they are making an attempt to get other minorities involved in the program.

DR. SCHMIDT: Thank you. Would you second the motion that was made?

DR. ANCRUM: Yes, I'll second it.

DR. SCHMIDT: The motion is seconded. Are there questions, comments?

Bill.

MR. HILTON: I don't see any mortality data on this region, but I assume with the emphasis on coronary care, that would be the major concern of this region? There are no other area focuses that --

DR. SCHMIDT: I don't believe that's entirely accura This project is a hang-over in a way from the early days a couple of years ago when these were the things to do. It was really the one attractive type of regionalization type of gettin across the State type of project that was mounted in South Dakota, and was considered to be a very good thing to do. And it has been supplying a great need for the hospitals in South Dakota to at least get nurses in that know what to do in certain emergency situations. But this is really not their top need or their top priority, which they have given, at least initially, as emergency health services. You see, this is a planning application, and they will be coming in with the sorts of data that will back up their program in a year when they apply for an operational program. So this is not even in an operational status as yet.

SISTER ANN JOSEPHINE: Dr. Schmidt, I wonder if Harold might want to comment from staff.

DR. SCHMIDT: Harold made a most recent visit out there. Harold?

MR. O'FLAHERTY: I would only echo the sentiments that have been expressed here, particularly with respect to the coronary care unit nurse training project. This was the remnant left over from the bi-State region, and it has been the major entree into South Dakota at this juncture in giving them some continuing visibility. The program has put together what appears to be a good staff. They have set direction. They have set a somewhat unique approach to planning which you may find interesting in that they have established what they call the problems in delivering health care. And related to these problems is the resources that will be necessary to augment present facilities and resources in order that the present delivery system may be enhanced. And it may be more capable of providing better health care.

So they are extremely sensitive to the needs of the health care system. They are working consistently with them. Given the fact that Dr. Lowe came on board September 1, they are moving systematically, albeit deliberately, to develop a three-year plan that is reflective of the needs of the region with a couple of major programmatic thrusts that have been reduced to time phase objectives which would include the terminal points for evaluation. This is the kind of consultation and guidance we have been providing them. This is the

type of thing they see to be their need to develop real programs instead of a conglomerate of disparate projects.

DR. SCHMIDT: Thank you.

Mr. Parks.

MR. PARKS: I wanted to get some clarification on a few things. Dr. Ancrum, I think, according to the report I have here, there are two Indians on the Regional Advisory Group and none on either core or project staff, unless there has been some change.

I think -- well, let me ask a question. Is there some reason why the university medical school is the total source of personnel for this particular project?

MR. O'FLAHERTY: Do you mean, sir, the program staff or coronary care unit project?

MR. PARKS: The program staff for personnel.

MR. O'FLAHERTY: In fact, they have not really been the total support. They have brought on some people that have heretofore not been associated with the university. The director principally was the assistant commissioner of health.

We have addressed this issue with them, of the minority group interests, and you may find this interesting, that Mr. Abel Redfish, who is a member of their Regional Advisory Group, of the Sioux tribe, has been recently appointed as the chief executive officer in the Governor's cabinet for Indian affairs. I had the occasion to spend some time with him

personally two or three weeks ago in South Dakota, and he feels that the region is somewhat sensitive to the needs of the Indians. But he is preparing for me his own independent assessment of the health care status and sensitivity of this program and other related programs to the needs of Indians.

MR. PARKS: That's sort of like the black that they appoint to a government position who is in charge of the black problem. He certainly should address it in a way that is going to be salutary for whatever is going on.

But my question is: You tell me, for example, that Dr. Lowe is connected with, what was it?

MR. O'FLAHERTY: State Department of Health.

MR. PARKS: He is listed her as being affiliated with the University of South Dakota.

MR. O"FLAHERTY: They're the grantee.

DR. SCHMIDT: There's a chance for confusion here. This is a two-year medical school. They do not have clinical departments. The people that get engaged in the projects, because the medical school is the grantee, and pays them, get listed -- and I believe the problem is that these are listed as being associated or affiliated or something with the school, but there really isn't a clinical school, and I believe that the impression that's being given these are all from the school is incorrect by the table that you're looking at.

MR. PARKS: Is that right? Then this is inaccurate.

MR. O'FLAHERTY: Yes.

MRS. KYTTLE: Mr. Parks, it's that the university is the grantee, and when these people join this program they become the employee in that light of the university, because the university receives the funds and pays them, and therefore in that sense they become an employee of the university. I think Jerry Gardell could probably give you --

MR. PARKS: Is it that the program is not a body corporate politic. Is that what you're saying? And the university is and handles it for payroll purposes?

MRS. KYTTLE: Yes. And that's why that column comes up listing them as affiliated with the university, because indeed they are for payroll purposes.

MR. PARKS: Okay. Then your form should be modified, I think, to reflect that kind of thing.

DR. SCHERLIS: Look at the front. You will see that.

MRS. KYTTLE: That is not to say, Mr. Parks, in some programs there are people who are giving x percent of their time to RMP.

MR. PARKS: Well, my question has been answered. And that is that there is a reason why the core staff is listed as university personnel, which was my question.

The next question that I would want to address goes to a comment that Dr. Spellman mentioned yesterday, and that was the fact that a sick physician was a sick provider. And in

the report of the principal reviewer, the suggestion was that there was an adequate and substantial consumer participation on the RAG. And I would like to know just how that's determined.

DR. SCHMIDT: I am not sure I understand the question.

MR. PARKS: I believe you gave a figure --

DR. SCHMIDT: Yes, 21 of 41 people on this body that serves both CHP and RMP are listed as consumers.

MR. PARKS: I was wondering how you determined that they were consumers. When I see categories of representation, I am not able to just gather how that is determined. For example, we have the sales manager for the Black Hills Clay Products, and he is listed as a public member. Is that a consumer? And the retired banker who is a public member. And then the retired Indian agent. I take it these are consumers.

DR. SCHMIDT: The CHP has rules about determining and guidelines for determining consumers or public members, and we accepted their review and designation of this.

MR. PARKS: The reason why I asked was because in scanning this, there is an almost direct connection with what in an urban area would be called a board of trade. For example, the retired farmer, it turns out, is listed as the public member but he is the President of FEM Electric Association, Director and Past President of the Rural Electric Association, and so on. It goes down in here. For example, there's a farmer here who

is listed as a public member. He's the chairman of the Miner County Board of Commissioners.

I am just looking in terms of so-called programmatic direction with respect to attention upon under-served people and populations, whether in fact you have a "consumer" that is representative of that group.

DR. SCHMIDT: I looked through this, and my answer to this, being quite familiar with South Dakota, is that the answer that I accepted was to look at where these people are from. And he is chairman of the Miner County Board of Commissioners, and in Miner County the Chairman of the Board of Commissioners is someone who can read and write and has some free time, and so on, from his farm. He's in Carthage. And if you look at the geographic distribution of these people, they are from Bell Fourche and Mission and Carthage and Rapid City and Brookings and Phillip and Mitchell. They are well-distributed people across the State.

MR. PARKS: The reason I raise the question is that a program in this stage of development which is planning need not get into an operational or formalized state by a body like this condoning the development of the processes which we find in older and more sophisticated programs, to be now in a state of rigor mortis concretized. For example, the question about your minority involvement ought to be raised, and it ought to be monitored very carefully while this is in the

planning stage.

With respect to the composition of the RAG, it ought to be examined very carefully as to the genuineness of the interests that are supposedly represented there.

I think we would be doing, I would say, great honor to the purpose for which we are serving here if, in this planning stage, we did work with them to prevent error rather than a year or so hence, looking at them with a microscope saying that they have --

DR. SCHMIDT: I certainly agree with you and would accept your statements as something that should be conveyed back to the region. I can't probably put my finger right now on why I was led by the reading material to believe that they are very aware of the minority representation problem that they have. There are positive statements that they will involve minority groups in the workings of the program. I think it's in the coordinator's letter.

DR. ANCRUM: It was in some of the material I received, and I don't have it right now, that this was something that had been discussed and there were efforts being made to correct this.

Also, some of the things you brought out about the participation, I was going to point out about the large rural population and the inability of some of these people to participate because of this. I don't know very much about South

Dakota.

DR. SCHMIDT: I hesitate to say why I know a lot about South Dakota because I am ashamed of it. Why I know a lot about it, I spent many years hunting pheasants there, and now there aren't any pheasants left, and I left lead scattered all over the State.

DR. KRALEWSKI: Do you have a lead poisoning problem there?

MR. O'FLAHERTY: Dr. Schmidt, at their recent April 13 meeting of the Regional Advisory Group they revamped the by-laws governing the program. They have specifically delineated groups from which consumers would come. They have established a nominating committee which would be comprised of a majority of consumers. The same nominating committee will now appoint providers or recommend to the Regional Advisory Group that providers be appointed in that manner. They were sensitive to our recommendation that this be taken out of the realm of the speculative and put in the realm of performance to meet these kinds of specifications.

DR. SCHMIDT: All right, are there any other comments, questions?

MR. HILTON: This is not with respect to the motion, but I wanted to mention, before I forget: Lorraine, do we have any guidelines, or anything asked for in any of the forms, to give us any idea what percentage of time is given to

RMP? I know on some of the sheets, in the kind of situation that was discussed earlier, the possibility of there being some confusion of the affiliations of the granting organization.

DR. SCHMIDT: Yes, the budget sheets list the people and their percent of time.

MR. HILTON: And the other concern I just want to kind of amplify -- and I notice it has come up with other regions -- the definition of consumer. I think what many of us feel a real need for is to have representative consumership, that is economic cross-section of each area, and a tendency to elect as chairman of the board -- and in not all instance is it just the guy who can read and write. In the larger urban settings it becomes a guy who is very far removed from the populations that are supposedly being served in some indirect way through all this. And I wondered if there were any guidelines, through CHP or RMPS, that specifically designates -- I don't know how you would go about it, by annual income or what have you -- that there be a cross-section in the consumer body.

DR. SCHMIDT: There have been guidelines promulgated for choosing RAG members. I think probably historically people who were chosen were non-physicians with clout. And we have been moving away from that in many of the programs. But the criticism is a very valid one. It's the same thing that is being faced all over the country by hospital boards of trustees that generally have corporation presidents on them and

nobody from the community on them. This is changing, and I think this will change, too.

All right. Are there other comments?

I would interpret most of the things that have been said as being advisory to the region and concerns. I would ask before putting the question to the vote whether anyone was concerned with the level of funding or giving them this amount of money. It's a moderate amount.

Unless there's strenuous objection, I'll call the question.

All in favor please say "aye."

(Chorus of "ayes.")

Opposed, "no."

(No response.)

That concludes the formal part of the actions of this committee. It is now 12:30, and I think we should decide what we want to do at this point. There are two or three things that we ought to do, I think. Bill Mayer left us with a list of two or three things. One we have talked about during the morning. It's the emasculation issue that I think probably may not be as vital an issue as before. There were questions that Mr. Parks had relating to council feedback, and there was the issue of a chairman for this committee.

If the committee wished, Mr. Dick Clanton could make a report to us concerning civil rights. This could be left to

the next meeting. So we could go for a little while and then break up. We could have lunch and come back for a little while. We could stop now.

What is the desire of the committee?

DR. SCHERLIS: I would suggest we remain here and finish. I don't think that there is that prolonged a discussion required unless it is the view of the chairman otherwise.

Is Dr. Margulies free?

DR. PAHL: I think he had to leave for an NIH meeting.

DR. SCHMIDT: Harold told me earlier he would be here until about noon, and then I missed him when he got up and left. So that I can't answer that.

DR. PAHL: Let's call upstairs and find out.

DR. SCHERLIS: I would suggest maybe we could stay and finish. Is this an open session or executive session or what?

DR. HESS: Before staff leaves, there is an issue, a question I would like to raise, apart from these three issues.

DR. SCHMIDT: The floor is yours. Would you talk into the mike, please.

DR. HESS: We have for a number of years now been placing emphasis on the gathering of evaluative data that would assist in decision making. And one of the problems which I find in looking at the applications and progress reports, and so on,

is that that data is almost uniformly missing. We see descriptions of the process, and summary statements that evaluation is being carried out, but very little of the results of that evaluation. And I am wondering if staff might give some attention to seeing that that data appears in the applications and that selected parts of it might appear in the summaries we get so we can begin to get a little better feel of some of the outcomes of the results of all the money we are putting in. I realize I am asking a difficult question. It's a difficult request. But I think that all the years we have been talking about, we ought to begin to see some results surfacing here.

DR. SCHMIDT: Dr. Margulies is coming down and will be available until 1:10, is the answer to that question.

Does the staff or anyone have a comment, or is there supplementary comment to what Joe said?

Pete.

MR. PETERSON: I think staff has been concerned with this same problem. It is a long-standing problem. It doesn't even get around to what I think you're talking about in the way of evaluation. So for example, recently we have been looking, just as an activity which is an intermediate step, and we find that these are often lacking in and of themselves.

It is a concern at the regional level, too -- at least in some of the regions they feel that some of the evaluation activities that have been undertaken don't allow themselves

to be reflected adequately in the present application. On the other hand, a number of regions have begun as a course of submitting some of that as a supplemental to the application.

I think from looking at it, Dr. Hess, some of it, at least some of the more recent ones, I think it's a problem that has to be worked at and is one -- and I know you and I have talked about this a little -- that particularly in relation to triennial review in connection with site visits -- and I go back to, for example, the site visit you and I participated in, the Greater Delaware Valley -- if you really highlight it in those instances, I think often we are faced with a lack rather than the presence of it.

DR. HESS: My point is that if we continue to be content to just having the process described and not seeing the results, that it means that we continue to have shoddy evaluations. On the other hand, I think perhaps there is some data which is available which may be worth seeing, but we never asked for it. It is not required. And I am just suggesting we begin to require the inclusion of outcome type evaluation in fact on health care in the applications.

MR. PETERSON: One of the things we have discussed in connection with the present application form is the possibility for some other additional information. One specific, and it is only one of several things, is perhaps the desirability of seeing, on activities that have been constantly completed, at

least with the RMP supported and placed out, something in the nature of a termination report some time after the activity has really been completed that would provide some of the information I think you are talking about, as well as information which I think is critical in terms of the sustaining of an activity once RMP support has been phased out.

That is one of the few areas in which I think we can present some fairly hard data. That doesn't tell you anything about the impact of the activity, but at least it begins to speak to the success, whether it is a categorical activity or something quite comprehensive, success with which a region can initiate efforts and can see them carried on within the regular health care planning.

So I think there are points with which we can begin to present some valid data, and I think this has been an area in which the committee has begun to make gross judgments, the inability to get out from underneath activities. It doesn't say anything about how meritorious they are.

DR.HESS: Well, I just feel we don't --

DR. SCHMIDT: Joe, the stenotypist simply cannot hear you. Would you speak into a mike, please?

DR.HESS: I just want to reemphasize that if we don't start insisting on seeing it, I don't think we are ever going to get it. I just feel that we've got to take a much firmer stand on this than we have in the past.

DR. SCHMIDT: All right. Other comments?

I would guess that the committee would agree with you in those comments.

All right. Does anyone wish to pursue the issue of the charge to the committee or the actions of the committee, the constraints on them? Are we agreed, Harold, that there will be some clarification of these issues coming from your office or staff?

DR. MARGULIES: Yes.

DR. SCHMIDT: Mr. Parks, you had some queries.

MR. PARKS: I had a request for answers. At the last meeting of the committee, we formulated several questions which were supposed to have been put to the council. And I have not been informed that the council either entertained them or acted on them. I do not have the specific articulation of them, but the one that I'm particularly concerned about did have to do with civil rights.

And my questions are, first of all, did the council receive it, did they act on it and, if so, what action? What was the result.

DR. SPELLMAN: I wasn't at the last meeting. What was the question, more specifically?

MR. PARKS: There should be a stenotype report of the last proceedings, and it might be well and helpful, I would think, if the proposition was stated as it was put to council.

DR. SCHMIDT: I'm afraid I can't be helpful because I was not at the last meeting myself.

DR. MARGULIES: We had intended to bring this up on the agenda yesterday, but Mr. Clanton couldn't be here. We have asked him to be here today, and I think he can be responsive.

MR. CLANTON: Let me just say at the outset that since assuming the position of EEO officer for RMPS, I share the concerns that I've heard in the past few minutes of some of the committee members. As I look at the ethnic profile of many of our RMP's across the country, as I look at the profile of our program staffs, of our Regional Advisory Groups, and of our local advisory groups as well as committees, I certainly share the concerns that I've heard in the past few minutes.

Since you last met, the RMPS EEO office has been reorganized. We have broadened the scope of activities to include addressing the issue of civil rights in the RMP's. We are still in the process of recruiting staff, and we are hoping that in the not too far distant future we will have our full complement of staff.

We did get involved -- I got involved -- at the point when I was asked to make a presentation to the National Advisory Council to reflect the committee recommendation at your last meeting. I talked to the council in terms of civil rights compliance of grantee institutions, the requirement to

complete the Form 441, which guarantees in so many words that a grantee will bein compliance with the Civil Rights Act of 1964.

In addition, I pointed out to them some of the activities which we would be proposing in the coming year.

I also presented them with your recommendations, and I now read that to you.

"The review committee recommends to council that council establish a policy in which they instruct those participating in the review process, whether that be site visit or this review activity, that a special interest be given to and attention to the issue of compliance of the individual regions with the Civil Rights Act. And that as a part of the review, that documentation occur in each and every instance that has in fact occurred in the review process. And if in fact the reviewers felt that there was some question of compliance, that they would have the right and responsibility to request that appropriate review of that issue occur."

This was presented to the National Advisory Council. The council endorsed this recommendation and approved it, which I feel gives us the leverage that we need to go about the business at hand.

In addition, I would call to your attention the RMPS affirmative action plan which, incidentally, is considered in many circles as the best affirmative action plan in this

agency. And incidentally, I will be mailing copies of the plan to each of you. I call to your attention page 40 of the plan which deals and addresses the issue of civil rights in the Regional Medical Programs, and I read to you some of the action steps:

"1. The Director, RMPS, will appoint a study group composed of, but not limited to, representatives from the Operations Division, the Youth Advisory Council, RMPS Minority Caucus, RMPS Women's Group, Office of Communications and Public Information, the EEO Council, and resource people from outside of RMPS, to define the responsibilities for implementing and monitoring an EEO program in the 56 RMP's."

This is one of the activities which we will be about in the very near future.

"2. Site visit teams will be constructed in such a manner that the objectives listed above are dealt with on all site visits.

"3. Site visit reports will include a comprehensive section regarding progress toward effective implementation of RMPS EEO goals and objectives.

"4. The Director, Operations Division, will review the EEO Section of the site visit report, and quarterly report to the Council on the EEO progress in the 56 RMP's."

Again, I say the Director, Operations Division.

"5. After the completion of the study group's

report, an abridged version of the RMPS affirmative action plan will be distributed to the RMP's.

"6. The Office of Communication and Public Information will regularly distribute EEO information to the RMP's."

Now, this plan has the endorsement of top management at the agency level, and has been endorsed by the program director. And we feel this, in addition to the council approval of your recommendation, gives us the leverage that we need to go about the business of EEO within the RMP's.

I would close by saying that we solicit your support, we solicit your suggestions and your recommendations in improving our efforts here in helping us in these efforts. We will need your help, certainly. We are in room 11A16. If you want to write to us individually, feel free to do so. Call us. We need your help in the effort.

DR. SCHMIDT: I would like to request that copies of the plan be sent to review committee members. I think it would be imperative we be familiar with this.

MR. HILTON: May I ask what is the expected size of your staff?

MR. CLANTON: The staff will be three people, as it currently stands. Of course, we are hoping for more.

DR. SCHMIDT: All right. Are there questions?

Mr. Parks.

MR. PARKS: Mr. Clanton, you have just announced

something to us. It would be helpful to me if you could get the exact wording of the action of the council. That would be very helpful to me.

The other thing that I would ask, beyond the announcement you have just made here today, has this been brought to the attention of the staff that is involved with these particular programs? That is the first question.

Secondly, will it be in the immediate future communicated to the various RMP's so they would be on notice.

Third, could you provide us with the information pertaining to the various civil rights acts and the provisions which HEW has published in the Federal Register with respect to programs funded by HEW which are found not to be in compliance with the several civil rights acts and regulations.

MR. CLANTON: Gladly.

MR. PARKS: Thank you, sir.

MR. CLANTON: In answer to your second question, which had to do with communication to the staffs of RMP's, we have begun to interact with several of the RMP's, not all, to date, several who have indicated an interest in recruiting individuals for their program staffs. We did distribute to the council members, as well as a number of consultants to the program, copies of the affirmative action plan. A number of the RMP's now have the affirmative action plan. As a matter of fact, as the representatives from the program staffs come

in to visit us, we provide them on the spot with a copy of the plan. So there has been some communication to some of the RMP's, not all.

DR. SCHMIDT: Bill.

MR. HILTON: I was simply going to suggest, Mr. Chairman, that as a national commitment, and as the opportunity now presents itself with the unfortunate departure of four of our members, we possibly ought to consider those areas that are served by RMP where we have large Spanish-speaking populations in the country that are served by RMP's, I would hope whoever it is that replaces those of us who retire or pass on or something would consider having Spanish-speaking representation on the review committee in the future.

MR. CLANTON: It might be interesting for you to know your request has gone forward for Spanish-speaking representation on this committee at this point. I believe for some reason or another it has been tabled. But the request has come from the program to include Spanish-speaking representation on this committee.

It would seem to me a statement from the committee would certainly help us in this effort, some kind of a statement to the agency.

DR. SPELLMAN: I submitted a name this morning of a Spanish-speaking representative from the University of Puerto Rico who I think would make an excellent addition.

DR. MARGULIES: I think the word "tabled" is probably a little misleading, Dick. What we havedone is to provide names of people who we thought would very well serve the interests of Spanish-speaking people, which is not just a single interest. If you have someone from the Southwest United States, that's not the same as a Puerto Rican from New York, or not the same as a Mexican-American from California.

We have run into a conflict of priorities for the time being which we simply have to sort out, because we also have to meet geographic needs, we have to meet the legitimate and very pressing needs of representation by women, and there is a requirement we have representation by people under the age of 30. We also have a requirement to try to find some people who have certain kinds of professional skills and educational skills and educational interest to balance the whole committee structure.

So it's a matter of trying to maneuver through that and still come up with what we need. I recently had a rather acid discussion on a related subject coming out of a Chicano conference -- and incidentally, we are in the process of sponsoring another one -- in which there was an insistence that people dealing with Chicano affairs on committees be competent to deal with them, and that there should be representation from the Chicanos on all their councils.

Some bright person in HSMHA said that's fine but we

must have evidence of competence.

And I said, "Well, that's all right, we'll have the same evidence of competence we require for all of our committees, and what is that?"

Well, there wasn't any answer because we don't require that kind of thing in migrant health councils, and so forth.

I suggested that one of the better qualifications for sitting on a committee to deal with Chicanos was to be a Chicano, and I continue to believe that's a pretty good idea. Interestingly enough, I met an argument on that one as well. I really did. I had a very severe argument over that.

But that's what we are trying to get done. I think we will succeed in getting that kind of representation on the committee. I cannot speak for the council. That gets into another area.

DR. SCHERLIS: How are you progressing as far as replacements of this committee are concerned?

DR. MARGULIES: That's a part of the whole thing. What we'd like to do, of course, is maintain the high level of competence that the committee has. And when you have people like Bill Mayer leaving, you would like to have a replacement somewhere near his qualifications. And then when you try at the same time to meet the other requirements, the choices get constricted and it becomes a matter of priorities. So far as

I am concerned, representation of women and of Spanish-speaking or Spanish surname people is the top priority, regardless of other factors, but we have to deal with all of them. I think we can manage all of them, but it requires a very careful kind of analysis.

MR. HILTON: Is it your judgment, Harold, that we need to make a motion officially on this matter, or could it be left at a suggestion?

DR. MARGULIES: I think we understand the committee's desires in this. As a matter of fact, it is a part of the official policy of HEW, and as I'm sure Mr. Parks can tell you, it also represents civil rights legislation, so that I think we can pursue it along those lines. It is really more a matter of sticky process than anything else.

On this subject, if you would like any further comment, Joe de la Puente -- I don't know whether Jessie is here or not -- but the two of them have been dealing with this particular issue, and we have set up a number of activities outside of review committee and outside of RMP to foster our involvement with the Spanish surname group.

MR. DE LA PUENTE: I must say our activity has been very intense since the recent Southwest conference for Chicanos in San Antonio, which was sponsored by Dr. Du Val's office and paid by RMP, partly.

As a result of this conference and a positive resonse

for this conference, several activities took place.

First and foremost, we are going to have a conference north of Albuquerque run by the Cultural Awareness Center of the University of New Mexico. In this conference we will have all the coordinators of the seven Southwest States, the nine coordinators of the different areas in California and appropriate staff, and pertinent staff here in RMP. We are looking forward to this conference. I think it's very timely.

From then on, there will be several activities that will take place concerning the effective participation of Chicano consumers in the decision-making and program planning throughout those regions. We are looking forward to this activity, and we are working very closely with Mr. Chambliss in these efforts, because that division concerns itself not only with the minorities in the Southwest, the Spanish-speaking people in the Southwest, but also the Spanish-speaking people throughout. And we are also working very closely with an urban group that we will have some urban health conferences in which these issues are going to be arranged. As a matter of fact, Mr. Wood from the New Jersey RMP is going to be at the conference in New Mexico as the liaison with the urban group. So things are starting to percolate and we are looking forward to it.

DR. SCHMIDT: Thank you.

Jerry, did you have a comment?

DR. BESSON: Yes, and I hope my comments are misunderstood. I've been a critic so often of the way things are done, it is delightful to see the alacrity with which there is a response to this comment made at the last meeting, and I must say, since I'm not going to be here again, that although at this end of the table I have appeared to be critical of RMPS and its seeming lack of responsiveness, I would like to say that that is certainly more than balanced by the sense of responsiveness that I have felt emerging at this meeting. And it was probably there right along.

DR. SCHMIDT: All right. Thank you. Are there other questions or reports? I have an uneasy feeling that this was one of a number of questions that were posed, Mr. Parks, is that correct?

MR. PARKS: I don't recall specifically what they were, but as I recall, there may have been another question. It wasn't on this particular issue, but as I recall there was at least one other question that I think was referred to. I don't recall what it was.

DR. SCHMIDT: Can staff help here? The discussion at the last meeting.

DR. MARGULES: I think what happened is there was a very good discussion about it, and unless I am confused in my memory, Mr. Parks, there was a movement in one direction which was then altered to produce the statement which went from here

to council, and you may be thinking about both. But I am really not sure, but that is what our record shows.

Maybe I should comment to you about what our hopes are for continuation of chairmanship and of vice chairmanship of this committee. What I would like to do, as long as we are able to keep him active on the council, is have Mack Schmidt continue as chairman, and John Kralewski as the vice chairman with the understanding he will assume the role at the time Dr. Schmidt finds he also succumbs to time in the rules and regulations of the committee membership.

DR. KRALEWSKI: That calls for comment. In keeping with our institution here, I would say that in that statement there is some good news and bad news.

(Laughter.)

I'm not sure which is which.

DR. SCHMIDT: All right. My leading instinct is that we are coming to closure here.

John.

DR. KRALEWSKI: If we are off of that topic, I have one other question I wanted to raise. Maybe you talked about this yesterday morning when I wasn't here, and if you did, please forgive me. But since you are going to be reviewing some substantial applications separate from this review committee, such as the emergency health service programs, et cetera, what mechanisms have you developed so that this committee will

be on top of the results of those reviews when we look at regions and look at their total program and try to come to grips with a total funding package.

DR. MARGULIES: Very briefly, we did discuss this at length yesterday. What I explained was that we had to set up a special review mechanism for both of these activities. In other to meet that requirement, we established a review committee for each of them made up of a combination of members of this committee and members of council, and these will be processed in time to go through the council. The results will immediately come back to you so you know what action took place and it will become part of the record of what is going on in each Regional Medical Program.

DR. SCHMIDT: All right. Sister Ann.

SISTER ANN JOSEPHINE: I would like to follow through on a comment that Dr. Hess made earlier, and that is on the material that is provided us for review.

The reason I feel that if we could develop a more meaningful format of information we would possibly be able to make better judgments and ask more correct questions is because recently at the hospital I am affiliated with we developed a patient drug profile, and it is interesting now that the doctors look at the drug profile. It is making an impact on the ordering of drugs for the patient.

So I feel if we could develop -- and maybe staff

needs to brainstorm this, and we have capable people on the staff who have expertise in this area-- the kinds of profiles that will be meaningless at this point in time when we are not only identifying the programs as A, B and C level, but we are having an interesting opportunity where South Dakota, of course, doesn't have the problem of large programs, where there are conflicts between universities and schools of medicine, such as we find, for instance, in Ohio where the conflict is between Western and Ohio State. But we have a program that is still in the planning stage that has some of these obscuring areas removed from the picture, and whereas Mr. Parks indicated we can begin to concentrate and not keep on repeating the problems that we see are emerging in other programs and have caused problems. And I think we are fortunate to have a staff, Harold, who has expertise in evaluation, and with this expertise will be able to give them the kinds of help that a program in a planning stage in moving toward an operational stage needs.

So I think that we are coming into a time when there are many very basic things we can begin to identify, maybe regroup and provide a kind of new viability to programs as we begin to look at a new direction, which is to insure the viability of the total program.

DR. MARGULIES: I would just like to make one comment about that which is in support but which also carries with it some very frank expressions of concern for our present

problems and problems that will persist. And these are in violation of my basic principle which is that there is no point in sharing my problems with you if you can't do anything about it; they're my problems.

Nevertheless, the pillaging of staff in all of the programs in HSMHA has been tremendous. We just put together a list of people who have been taken away from us. Of course, when someone takes someone away to do something else, he always wants the best possible person. So we have lost people on detail after detail. We have tried to remodel the system of review for the Operations Division so that their time is not totally consumed with the review process because the other thing we most want them to do is to serve as technical assistants and deal with the kinds of issues particularly which we just discussed, those which have to do with the interests of minorities, and those who are deprived.

So there is an extremely heavy demand on staff, and at some points in the game, as a management principle, we have to do some things better and some things less well.

I would be misleading you if I were to suggest that we are going to amplify very rapidly or in great depth some of the kinds of information which we would like to have in everyone of the programs. Instead, what we will have to do is manage this so we can concentrate as much as feasible on problem areas in the Regional Medical Programs with all the risks that that

entails, and I don't see any alternative. To suggest that we can do it all is to send this staff, which is sitting around here and some who aren't here, into a state of collapse because they work extremely hard.

I have to go over and negotiate with the National Heart and Lung Institute right now, and I see my companion is waiting for me to go, but before I do I would like to say again without overstating it in any sense, that the people who are leaving this committee are leaving the committee with some holes that just can't be filled no matter how well we do. They are remarkably good contributors. It is going to change things permanently. I know that you have said things to them already, but whatever was said that was nice I support, and if you thought anything bad I don't support it. They go with my very deep thanks and with my blessings. And again my affirmation of what I said yesterday, we aren't really going to let them get away entirely.

DR. SCHMIDT: Thank you very much, Harold. We appreciate your time that you've spent with us these last two days.

Any closing comments? Jerry.

DR. BESSON: I'm sorry Harold left, and I really should not usurp his last word, but I did want to follow up on the comment Sister made and he responded to, because this is one subject that we have skirted around but haven't really

discussed, and I don't think it's appropriate at this time to get into a long discussion of it, but I would like to raise it for the review committee's consideration at a future time.

The sense of what I gathered that Sister has said on more than one occasion at this meeting is that we are sometimes not asking the right questions, and that sometimes we become so involved in the trees that we are not looking at the forest. And this is something that has disturbed me a great deal about the way the RMPS seems to be operating currently.

About a year ago the National Center asked me if I would serve on a committee to evaluate the Center. And I was privileged to do so and it was an outside look by people who are not involved at all with the National Center. I know that the Arthur D. Little Corporation did such a study for RMPS about a year-and-a-half or two ago, and that was a remarkable document in many ways and probably formed some of the basis for the shift in direction of RMPS. It served a useful function but in many ways it was too ponderous to be helpful to the rank and file. The summary was very helpful. But I think that that kind of ongoing outside evaluation of RMPS is probably going to be continually necessary if RMPS can maintain its viable and responsive posture. I sense in many of the applications that we've discussed over the past two days, Northeast Ohio, Oklahoma, and I know even though we haven't talked about California that a recent action in the California Committee for Regional

Medical programs has for the first time created a breach between the practicing physician, as represented by California Medical Association, and the entire Regional Medical Programs, in that California Medical Association Council, reaffirmed by House of Delegates, indicated to California Regional Medical Programs that they would only continue to cooperate with Regional Medical Programs if Regional Medical Programs stuck to its original charge, which was continuing education and categorical interests, and did not begin to meddle in delivery.

Now, that may be symptomatic of what we're seeing in the statements of Dale Groom, perhaps, and in the statements of Charlie Hudson in Northeast Ohio and various places, which may not be quite articulated. But I think that it does represent a potential problem for RMP and should be surfaced, this committee should be aware of its extent and the extent of the breach that may be developing, or maybe there was never really close communication with the practicing physician, as I sometimes suspect, and this kind of information should be brought back to review committee so that in dealing with the individual regions and in dealing with the individual decisions that we have to make about the nitty-gritty, we can do it in the context of viewing the entire program as serving a national purpose. Is it on target? And if not, what are the impediments?

Unless we can do that, I think we can very often be wide of the mark and spend much of our time fruitlessly in

discussing details that may be totally irrelevant.

So I would suggest that this review committee, perhaps at later deliberations somewhere along the line, or perhaps they might consider presenting to council the notion of doing this on an ongoing basis for review committee and council's advice, to have an outside group -- maybe not as ponderous as Arthur D. Little -- but to have some outside group put itself in a position of continually evaluating philosophy, purpose, meeting of goals of the program nationally, rather than any individual area.

DR. SCHMIDT: I suppose this is akin to a lot of the universities that have visitors' committees, the same type of function.

All right. Other comments?

(No response.)

Are we ready to adjourn then?

All right. With great thanks, we will stand adjourned.

(Whereupon, at 1:15 p.m., the meeting was adjourned.)