ORIGINAL

# Transcript of Proceedings

## DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HSMHA

REGIONAL MEDICAL PROGRAM SERVICE COUNCIL MTG.

Rockville, Maryland

Monday, 16 October 1972

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REGIONAL MEDICAL PROGRAM SERVICE COUNCIL MTG.

Conference Room G-H
Parklawn Building
Rockville, Maryland

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P R O C E E D I N G S

DR. MARGULIES: The meeting will please come to order.

I have just one or two announcements before we get to the more specific business of the meeting.

First, I would like to have the members of the Council again read the confidentiality of meeting and conflict of interest statement, which is in the front of the council agenda book. This would apply only to the portion of the meeting in which we are involved with review of applications, because the first portion of the meeting in which we are now involved is an open meeting, which is pursuant to Executive Order 11671, which establishes open meetings, open to the public, with adequate information to the public prior to, during and subsequent to the meeting, on all issues in which the advisory body as a public body is providing assistance to the government in its decision-making processes.

This does allow for attendance of the public. It requires that the meeting be announced early in the Federal Register, which has been done, that there be an agenda published at that time. This has been done, and as a consequence, there has been a wide national circulation of information regarding the fact that the meeting is to be held and what the agenda will be.

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We will arrange for whatever is necessary in the way of appropriate public contributions to the meeting.

There has been a microphone set up at the back so that it can be used as necessary. However, to provide for an effective management of the discussion, it will be advisable for any member of the public who wishes to speak to any portion of the agenda to give his name, title, whatever institution-interest group he may represent, so that it may be a matter of public record.

We do need to have anyone who is here register at the door and wear a name tag so that we can give proper recognition to those who are representing public interests in the course of this discussion.

We would like to have members of the council refrain from discussing any individual applications outside of the hearing at the time the applications are being appropriately considered during the other portions of the meeting.

For those members of the public who have a special interest, there are special agenda books available at the back part of the room. You can see Mrs. Handel or Mrs. Seevers, and we will have available for everyone, including those who requested from public attendance, highlights of the meeting within a period of about three days after the meeting has been completed.

The other requirements of the Executive Order

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included the maintenance of minutes, the establishment of a regular secretary for the council activities and as members of the council know, that has been the dustom, so it produces no change in our usual method of management.

The arrangement today for coffee breaks are 10:15 and 2:15. There will be coffee and doughnuts, which will be in the cafeteria, in the Charcoal Room, which is identified by the fact that it is called "Charcoal Room," on a sign outside the room.

We will try to stay on schedule as much as possible.

This morning, Dr. Wilson is at a meeting with the officials of management and budget, and of course, we are delighted to have him there, because he will, among other things, be discussing during the course of the day the Regional Medical Programs, and we have as an alternate, and a very welcome one, Dr. Fred Stone, who is interim deputy to Dr. Wilson.

You have all met him before on previous occasions, and I would like to have him speak to the council, respond to any questions, or raise any issues with you, and you with him, that seem appropriate at this time.

Fred?

DR. STONE: Thank you very much, Dr. Margulies.

I would like to say a few words, a very few words,

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now, and I will ask Dr. Margulies at a later time, after I have had a chance to have some conference with him, to say a few words specifically for Dr. Wilson.

Needless to say, I am very glad to be back with Councils again. I am particularly happy to be with this Council, because there are some of us still on the staff who remember how the legislation leading to this program got started.

It always gives someone some feeling of reassurance when you are not faced with a totally new program, as it has been my lot to be sinc e I have been here.

As you all know, my background is one -- some of you may not know -- that my background is one which comes over with me from the NIH, and I have had four years of outside experience with universities.

All this means is that I have sort of bounced around a lot. It clearly doesn't make me an expert on anything in particular.

Harold, if it is all right with you, I will shut off at this point and later on, after you have had a chance to see this text, you and Mr. Riso, then I may be given even time for a few more words.

DR. MARGULIES: Okay.

We will proceed, then, with a few items that I do want to bring up for your attention in any discussion

which you may want to make.

I was going to say something specific at this time about the fact that Dr. Milliken and Dr. DeBakey are ending their maximum feasible term on the Council.

As long as you are here, Clark, and Mike isn't, I will warn you in advance that if you want to make valedictory statement somewhere during the course of the morning, you are free to do so. It can be either official or unofficial, depending on whether you consider yourself a member of the council or free public during the course of the discussion. But you may indeed want to have something to say before we are all through.

I will wait until a later point to comment further on that.

We discussed last time the fact that we were planning to develop a conference to address the issue of quality assessment and assurance in the delivery of health care. That converence has been set for St. Louis in January, January 22 and 24, I believe, are the correct dates.

It appears to be developing in a very appropriate and rewarding manner at this time. It is being designed around the total interest of the Health Service and Mental Health Administration, which is involved in this question extensively.

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The purpose of the meeting really is designed around a professional look at all of the issues involved in quality assessment and quality assurance, ranging from descriptions of what we mean by quality to considerations of community interests, to looks at the present status of medical records systems, to the development of criteria, audit issues, and so on.

In order to be sure that the conference covers such a very difficult area as effectively as possible, we will, unless there is some abrupt change in our plans, make it pretty much a theater kind of conference rather than a workshop kind.

This is done very deliberately, because there is more need for a kind of updating of understanding on this subject than there is a free discussion between equally qualified individuals.

What I am saying is that not everyone is equally qualified in this subject, and we are hoping to move to the point where there is a base of understanding upon which a number of activities can rest, and perhaps not rest, and move ahead. This will involve not only RMP's interests, but all those in the Health Services Administration.

Attendance will be kept at a very limited level so that we can move through the agenda effectively, and you

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will get more information about it in the course of time.

In your agenda book, and I would like to bring it up for your attention at the present time, is, under Tab B, the covering memorandum which has to do with the Redional Advisory group grantee policy statement.

The council went through this very carefully last time, endorsed the policy, and it has as a consequence been sent out to all regional advisory groups, all coordinators, and has been made available to all grantees.

It addresses an issue which has troubled this Council for as long as I can remember, and certainly before I appeared here, and that is the appropriate relationship between the grantee, the regional advisory group, the coordinator and the staff. It has been accepted as a reasonable statement by the Regional Medical Program.

It has created some commotion, because in some instances, the grantee has not fully appreciated the extent and limitation on its responsiblities. It has sharpened some differences between Regional Advisory Groups and coordinators on the one hand and grantees on the other, where the grantee had interpreted the program as one over which it had total responsibility, despite the fact that the Council had advised it otherwise for a good, long time.

But in the main, the reaction has been appropriate, and it has caused no major difficulties.

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In order to give all regional programs the opportunity to consider it carefully, and reach the kinds of conclusions necessary to put their own systems in order, we have provided time until March 1 of 1973 for them to adjust their working mechanisms, their bylaws and their internal processes to be in conformity with this particular statement.

We are not going to, as you would assume we would not, tell them how to write their bylaws or give them specific wording for how they manage.

We will provide any kind of advice at checkpoints in the development of any changes which they may have to establish. But for the most part, we will be there when they need us, but we will expect them to be in conformity by that date.

Perhaps some of you have some discussion on this or some comments on the statement as it exists.

It very clearly says that the council has said, so far as I know, from the very earliest days, that the responsible party for the development of policy and program is the Regional Advisory Group.

DR. CANNON: It should have been done three or four years ago.

end 1

DR. MARGULIES: All right. If there is no discussion on that, there is an appropriated associated document under tab C which has to do with the discretionary funding policy.

This is going to become increasingly important, to establish a good understanding of how the Council, the Regional Medical Program Service and the Regional Medical Programs are to function in the future, and it is based upon a clear appreciation, a clearer one than we were able to establish in earlier years, about the freedoms with which RMPs can develop new activities without a formalized review, and at the same time restrictions on what they can do under other circumstances.

It also has been circulated, and I should add at this point that each of these documents is discussed early with the Steering Committee which the coordinators have established through their own voting processes.

We do discuss it with them. We get their input, and in fact a very wide input from other groups of individuals before we bring these to the Council, so that we can present to you any comments from outside of our program and outside the Council which might be appropriate.

It is always difficult to establish policy in which you describe how to be discreet. Discretion is something

very hard to regulate or pin down.

I think we have a good understanding. I think the document is well stated, and any changes which have occurred since what you saw are primarily in the form of editorial improvements or tightening up of the language.

But it applies very clearly to the concept that a regional medical program, having set out what it proposes to do and received endorsement of what it proposes to do, and having given proof that it knows how to go about it, should have a degree of flexibility during the course of the year and during the course of the triennium to pursue those interests without having to stop at every stage of the process and go back to review activity which would endorse, in essence, what they have already had endorsed by a previous review.

This does involve a transfer of responsibility and of judgment which is consistent with the decentralization of the RMP function, and if there is any doubt about it, or any question about it now or in the future, it does merit full discussion by the Council.

MRS. MARS: You don't think there ought to be some sort of a financial, well, quota set as to how much of the funds could be rebudgeted?

In other words, say they at their own discretion rebudget 10,000 or up to 20,000, or 50,000? This seems to me a little dangerous that they can rebudget without any

brake whatsoever.

DR. MARGULIES: I think if you look at the language carefully, I would be willing to consider that possibility. The degree to which they can rebudget is pretty much restricted to what they have already said they would do.

In fact, all of the kind of new activities which they have initiated under the discretionary pattern have been modifications of what they have set out to do.

The primary purpose is to allow a regional medical program which has, we will say, decided to concentrate on ambulatory health care as a major objective, to move into a new area, or to initiate another program aimed at the same purpose so long as it has consistency with what they have otherwise been doing, and the restrictions are great enough so that rebudgeting is more a matter of expansion or sharpening of what they are already doing.

If they try to move or wish to move into a totally new area which has not been presented to the Council, that is clearly out of, or beyond the limits of what they can do.

MRS. MARS: Yes, I understand that.

DR. MARGULIES: It is worth considering, but it would be extremely difficult to place a level on what that amount should be.

DR. KOMAROFF: This would be reported to staff if it looked as if it were being rebudgeted inappropriately; that would be brought to the Council's attention?

DR. MARGULIES: Yes. The document provides us adequate control over what occurs. We will know what is happening. Rather than telling you that program X decided to move to the southwest part of the state with the same activity, and do you want to go through a review of the whole thing, we would inform you, but if the move appeared to be at all doubtful on the basis of previous Council activities, then we would bring it back into Council.

It is really two levels of discretion, their discretion and the discretion of the RMPs in keeping the Council well informed and not burdening it with what turns out to be frequently a pro forma kind of action.

I think in answer to your question, Mrs. Mars, it would be a good idea for us to come back in at the next meeting of the Council with some descriptions of how this discretionary policy is being carried out, so that you can decide whether it represents shifts in budgeting beyond which you would think are reasonable.

I do think we have to watch it carefully and bring in regular kinds of summaries of what happens as a consequence of the discretionary action.

MRS. WYCKOFF: The developmental fund, too.

mea-5

DR. MARGULIES: Mrs. Wyckoff is referring to the fact that the developmental funds have a ceiling of ten percent. This brings it up prematurely, but I think we will discuss this whole issue of developmental funds, because in the context of discretion on the part of regional medical programs which we have described, there is all of the freedom and more freedom than they would have with the use of the developmental funding. And we need to have a discussion of that which we hope to have with the Council, because it begins to introduce a -- well, it has introduced -- a kind of fiscal fiction to have developmental funding to do something which the RMP in any case can do, so long as it has the funds available, and it has led to some misinterpretation of the meaning of developmental funding.

But we hope to raise that question later on with reference to the application review, but it is a good point.

At the time of the last meeting, we brought to your attention the kidney guidelines which had been developed for the management of applications for dialysis and transplant activities, and there was some concern at that time about some of the language in those guidelines, specifically what was meant by a full-time transplant surgeon.

The Council directed the regional medical program service to clarify the point to make sure that what we were talking about is a kind of commitment on the part of

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transplant surgeons rather than something very tightly defined as "full time."

That was done; it has been sent out; it has been made available for your own review, and it appears to have satisfied the questions that were raised at that time.

There also has been an orientation for kidney technical consultants, because this has become a very critical part of the review processes.

You may recall that at the time the Council met last, there was concern over how the kidney consultants were to be made available.

The Review Committee had some doubts about the use of a national panel, and the Council felt comfortable with it, but felt there should be a very ample resource for kidney consultants for dialysis and transplant activities, and that there should be a good level of understanding among them as to how they were going to carry out their review functions, because it is not simply a technical review, but rather one that has to follow the overall principles of the network of dialysis and transplant centers to which RMP and the Council are committed.

There has been a two-day meeting held earlier this month to acquaint a panel of kidney specialists with their activities. Both Dr. Schreiner and Dr. Merrill -- Dr. Merrill won't be able to be here until tomorrow -- were

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present at that meeting, and from all accounts it appeared to cover a great deal of ground and establish a good base for their activity.

George, you may want to comment on that meeting, if you would like, or not, if you don't want to.

DR. SCHREINER: Just briefly, the turnout was excellent. It was held attached to the end of the week of transplant meetings in San Francisco, and this enabled us to pick up a very significant group of people who were at the transplant meetings.

We put them with a blend of the dialyzers, so there was a pretty good admixture of people, and I was very impressed by the number of people who attended and the kind of people who attended, and I think it gave a large exposure to the opportunity to kick around guidelines and see that everybody sort of was listening to the same thing at the same time and not getting a little piece here and a piece there.

I thought it worked out very well.

DR. MARGULIES: Good. The purpose of it was to get all differences addressed, all general concepts of the consultant role established, and to provide us with a large backlog of consultants who were acting alike and thinking alike as much as specialists in any one field can do.

I think that the move was a very auspicious one.

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I don't suppose it is inappropriate, because it is not exactly a private subject at this point, to tell you that the National Kidney Foundation has acted to present their annual award for contributions to medicine to the regional medical programs for what they have been doing and are doing in the kidney field. That will get formalized at a meeting next month, but since I saw a copy of the letter announcing it, I guess I can tell the Council they ought to know before they read about it in the newspaper.

I think there are a great many people who feel comfortable and pleased with that particular action on the part of the Kidney Foundation. I hope that that will be a source of encouragement for us to do more and better in the same areas of interest.

XXXXX

You have under tab E a summary which is primarily for your interest, but which allows us to discuss with you for just a moment the reason for pulling together a statement of what the review process relationships are.

For the last several months, we have had at each meeting of the National Review Committee extensive discussions about what the function of the Review Committee is, vis a vis Council, the staff and Advisory Review Panel, and so on.

This happens periodically with all review groups, as there is a change in membership and a change in the

pattern of the program. They became curious as to just what it is they are supposed to be doing.

In order to clarify this, we did have not only discussions, but put together a basic description of what each step in the process is, what the relationship is of one step in the process to the other, the special authority of this Council, which often has to be redescribed, because it does not function like all other councils. It has a higher kind of responsibility and authority than do others.

This was discussed by the Review Committee. They found it perfectly acceptable. The only alteration was from one member of the Council, Dr. Hess, who felt there should be a kind of chart to the RMP's proposals which should be added, which is a mechanical feature rather, and comment on what the function of the Review Committee is.

But I am sure you all appreciate that the Review Committee does analyze applications in great depth, spends a considerable amount of time on them at site visits, subsequent to site visits, and during the discussion.

We have, I think, done some things to make them feel more secure in what they do by feeding back actions of the Council to the Review Committee, and providing an opportunity for them to understand why there are differences, why the differences occurred, and why the

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Council may have acted rather than as was recommended by the Review Committee.

When this has not been done in prior years, it has created a sense of frustration on their part, not because they think they are impeccably right, but they like to know when they are impeccably wrong and why.

I think this level of communication has improved the whole tone of the Review Committee. There are some changes in the makeup of the Committee which we will bring to your attention in a short period of time.

Now, just two or three things very quickly. These are as a matter of status reports. We have reported to you in the past that the new policy manual is being prepared; it is now completed in draft. It consists of a compilation of all established policies and a draft of new policies where they have been needed.

It is the latter which has been particularly difficult. This is going to be a looseleaf cross-indexed policy manual which will be made fully available. It can be duplicated and circulated to coordinators, chairman grantees, members of the Council and of the Review Committee, and will be made available to those who request it after having it announced in the Federal Register.

Obviously the whole manual, which is a pretty thick document, will not be in the Federal Register, but

there will be an opportunity to review it and to have the 60-day period of comment after it is in the Federal Register.

If there are any specific questions about it, which would be difficult at this point, not having seen it, Ken Baum or Roger Miller, who are here, can be responsive to it.

The regulations which are associated with the program are under discussion. They will be redrafted, but they have been held back until the policy manual could be completed.

The same thing applies to section 9-10, for which a policy has been drafted.

For some new members of the Council, let me explain what sections 9-10 and 907 are, and for further clarification, they are easy enough language to read in our legislation.

Section 9-10 was established to provide certain kinds of opportunities in the regional medical programs to do what could not otherwise be done.

One portion of the effort is to allow regional programs to combine on a sectional basis, a national basis, whatever is necessary, to do something together so it can be done better together rather than separately.

It also covers a different kind of grant mechanism when a regional medical program is doing something

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which has national interest rather than regional interest, so that it can request funds under section 9-10.

Section 9-10 also has some portions in it which have broadened the scope of regional medical programs and has had heavy influence on the direction of RMP, because it provides freedom for RMP to be dealing with problems of health manpower, in education to improve the output of the medical delivery system, and in improving health care delivery per se.

So that some of the activities which have been carried out in the past are carried under section 9-10.

We have always had a problem in putting out a policy statement, because the policy statement on a section which has not been activated produces a trigger mechanism. The trigger mechanism is that whoever reads it says there is more money available for something than there was before.

Now, since whatever we do with 9-10 comes out of the same pot, that is an illusion, an understandable one, but we always put out a new directive of that kind with great reluctance, but we will be doing it. In fact, 9-10 has been utilized already.

We are going to have to use it in the future, but we would like to have a clear policy statement on what it invites and what it awards.

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MRS. WYCKOFF: How do you allocate money to 910?

DR. MARGULIES: The question that Mrs. Wyckoff asks is how we allocate money to 910. It really depends upon in what category it falls, but if there is a Section 910 application which the council should act on, the only way in which we could determine whether it will receive an award or not is by looking at the totality of funds that we have available, looking at the programmatic priority recommendations in trying to make an equitable decision, which means we are, as we always are, in the uncomfortable situation of balancing budget against total programmatic demands and against requests for specific funds.

If it were used, for example, as part of the kidney activity, we do our best, whenever we know how much money is available in RMP, to make a commitment to dialysis and transplant activities which represents a certain funding level in any one year, and we adjust it around that.

But it was the Section 910 activity representing something new, or a priority which has not been addressed, and then it needs all the attention of this council as well as the grant administration process to reach a conclusion.

So, when this comes up, we will be reminding you once more that anything which is under Section 910

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is competitive with other kinds of resources, and that fact has to be borne in mind. At the same time, it should be judged, as we hope all applications are, on its merit without regard to budget, but with some statement of what priorities the council gives it so that the grant award process can be carried out as a reflection of council interest.

The Section 907 activities are those which refer to that part of our legislation present since the beginning of the legislation which asks us originally -- it was to be the Surgeon General and now the Secretary -- which requires the Secretary, in fact, to prepare a list of those hospitals which have the most advanced capacity for dealing with heart disease, cancer, stroke, and now, kidney disease.

In the earlier years, and this is very familiar to some members of the council, and not, I assume, to other members, in the early years of RMP, what was done in preparation for that was the establishment of a series of contracts which produced some guidelines for the diagnosis and management, prevention, diagnosis, rehabilitation of cancer, of cardiovascular disease, and more recently, kidney disease.

In order to be more explicit now, about this, and to develop a list of hospitals which do represent the

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kinds of capacities which have been addressed, we have entered into a contract which was reported to you earlier, with the joing commission on the accreditation of hospitals. That contract utilized the kinds of criteria which were available for the major categories of diseases in this program to develop a set of questions to be included in a questionnaire.

The questionnaire attempts to elicit a response from every hospital in the country. It has been circulated now, and the responses are coming in, providing information on a timely basis is regarding equipment, personnel, teaching programs, patient loads, all of the issues which a set of experts looking at criteria felt were important to determine levels of qualifications for doing what we know how to do for heart disease, cancer, stroke, and kidney disease.

Up to the present time, there has been no decision made about how extensively that list will be used, whether the final list will be limited to those hospitals which appear to have the most advanced kinds of techniques available, whether it will be a broader list in which there are available ranges of skills placed against the criteria which have been established, and what the circulation will be.

It is very likely, however, to be a most

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important undertaking, because it will, to my knowledge, be the first effort to establish a list which does not depend upon minimum requirements for what are qualifications. It will be an effort to establish levels of quality regarding major diseases, those diseases with which RMPS is by legislation concerned.

Therefore, the manner in which it is done to the contract, the way in which these lists are developed and the final decisions on the circulation, which in this arrangement will be made by the Secretary, or in collaboration with the Secretary, will be most important.

We anticipate in the questionnaire, in the compilation of the data, the kinds of information about facilities, individuals or groups of institutions, which we have never had before, and which in a period of planning and resource allocation and attempts for regionalization, could be of great value.

It also suggests very strongly that such a list, if put together, must be maintained in an effective, timely way, and must be subject to modofication as conditions warrant, and must be made broadly available as it has been in the initiation of the activity.

Now, since this is a contract activity, it is primarily brought to your attention for you to realize that this is going on, and as there is a greater feedback

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and a greater understanding of how it is to be used, I think you will have a high interest in that kind of information.

MR. OGDEN: Is this contract a kind of a one - shot thing, or has it been set up so that there can be continuous monitoring of the information?

DR. MARGULIES: If we are going to continue with it, it would require the development of further contract activity. This one is designed around completing the present task, but that is the way things are done. We have to have a contract for a purpose. But we do need to raise that question promptly if it is to be continued.

MRS. WYCKOFF: Are you getting good cooperation on answering the questionnaire so far?

DR. MARGULIES: Florence, if you don't use the microphone, I am going to have to tell everybody how you are each time.

It is really too early to tell, in answer to your question, because the questionnaire was sent around to the hospitals quite recently, and for the most part, though, we expect a good response, because the hospital has everything to gain by responding and a great deal to loose by not responding. I think there may be some impatient people who won't want to.

DR. BRENNAN: Why didn't we work through the

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regional advisory groups and try to get this done on the basis of a logical emaluation by people who are on the site?

DR. MARGULIES: Primarily because it was an extensive data gathering activity for which the regional advisory groups really have very little money. What we depended upon was a close collaboration between the joint commission and the American Hospital Association which allows us to use their survey techniques, which everybody is familiar with, and to time it appropriately with the other survey which the AHA carries out.

It appeared to be the most workmanlike way of going about it, a nationwide survey, for an extensive questionnaire. If any of you would like to see it, it is available, but it is very demanding.

DR. SCHREINER: How do we avoid getting too much cooperation?

DR. MARGULIES: You mean a little exaggeration?

DR. SCHREINER: From the hospitals? Most hospital administrators will tell you they have everything.

DR. MARGULIES: Of course, that is kind of a risky run, but it is tabulated in such a way that unless they are flagrant, we will have to depend upon it being valid. It is a good point, though, George, because in this kind of an activity, we do not have the freedom

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to do the kind of spot checks and on-site misits and so forth which, under ideal circumstances, would be done.

But if you are familiar with verification of data in these circumstances, that kind of on-site visiting and verification is a fairly remote dream in institutions. It is a real handicap, though.

Dr. Stone?

DR. STONE: I might add that this is tied in to the regular accrediting visits of the joint commission on accreditation of hospitals, and through their help and through a certain amount of visiting, we expect to be able to check on a good many of the returns. There are also internal checks in the questionnaire.

DR. MARGULIES: Dr. Brennan?

DR. BRENNAN: I don't want to hold the meeting up on this, but I would like to point out that no amount of hospital accreditation information is of any use whatsoever in my deciding as an internist where to refer a patient for care for a specific problem.

In other words, I don't care what the laundry and the basement and the laboratory and all the rest of it are like. We make up our minds on the basis of known performance at a comparative level within that community, and I think the regional advisory groups and their professional advisory committees are in a far better position

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to give you realistic information as to the quality than the joint hospital accredication people are, or ever can be. I don't care how many they say so.

DR. MARGULIES: Mr. Ogden?

MR. OGDEN: A comment has just been made that makes sense to me, and that is before the Secretary promulgates his findings, perhaps it would be useful to have the regional advisory groups in that area go over the hospitals within their region which might be on the list in order to be sure that all of these things are really there, and that the quality within the community is acceptable.

DR. MARGULIES: Yes, I think it would be unwise to limit the potential use of this kind of a list to the manner in which practitioners find it valuable. Other people have made the same point you have, Mike, and it may very well be valid. Although there are some questions about which people decide what hospital they want to send their patients to on a sound basis, or whether it is on a sentimental basis or an old school tie basis, and I don't know that anyone has ever identified carefully how people do that, but the utilization of a valid set of data which describes in a current fashion what the hospitals potentialities or actualities are, has much wider usage than just for referral of patients.

That kind of information is not available at the

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present time for those who have to deal with certificate of need legislation, for example, or who have to develop plans over a longer period of time, or who find that in a community there are half a dozen centers for doing open heart surgery and only one of them is busy.

There has to be a basis for that kind of information, which will be included, such things as patient load.

DR. BRENNAN: We have spent years in building a national organization which is supposed to recommend at the local level as good as grass roots for representing medicine there and seeing what the possibilities are as we can see in any other agency or source.

Now, I don't believe that we come around to fulfilling this contract that the kind of factual data you are talking about, that the hospital commission can get for you, should be the only thing we rely on.

I think that if RMP is going to make this recommendation to the Congress, I think that in each region the regional advisory group should endorse the ranking, or the designations which are given to hospitals with respect to these capabilities.

DR. MARGULIES: There is certainly nothing in what we are planning that would rule that out at all.

Dr. Clark?

dh10

DR. CLARK: Harold, has any decision ever been made about how long to make the list? By that, I am referring to this ultimately very important question of whether we list just a few places which may have all of the facilities necessary, or the most advanced kind of diagnosis and treatment, or whether we list facilities which do a good job in the setting which they find themselves.

We discussed this on a number of occasions, and the policy issue here is a big one. How are you going to go about deciding the policy issue as to how long to make the list?

DR. MARGULIES: That question, which is the critical one, is currently under heavy discussion. There are several options which one could pursue. One of them would be to restrict the list to an extremely elite group, which you could have picked out without going through a questionnaire, because you pretty much know which they are. That would probably cause commotion, only because one of those that you would normally have picked out wouldn't manage to get on the list, and that would be interesting.

The other alternative would be to have a larger listing which covers a range of activities which you would generally associate with those kinds of professional requirements that are the reason for referral, which is much bigger than just an elite list.

dh11

Another alternative would be to make the information available against the criteria with relatively little designation of what institution meets what requirement, but with the kind of data which those who plan or those who refer or those who want to develop their institutions can utilize effectively, without actually listing by any kind of layering of quality.

I doubt that we could justify being that non-specific, as in the third instance, but I think we could easily justify a fairly wide list, but particularly if it could be utilized to make sure that there is no assumption that because a hospital is somewhere near the top of the sophisticated list, that the ordinary problems have to go there.

If there is a great risk that every one will assume, or many people will assume that because a hospital is on the list that it is the only place to go if you have an uncomplicated mild cardio infarction, or have to have bowel resection for annular carsinoma, or something of that kind.

How that can be handled without creating some confusion, I don't know. I doubt if we can avoid the confusion. I personally would like to see these kinds of data used as effectively as possible for all kinds of regionalization, planning, and an appropriate investment

dh12

in the new services.

Dr. Cannon?

DR. CANNON: When we originally discussed this, we thought there were a lot of potential dangers in any kind of list we put out, and I know we did agree to utilize the commission.

I wondered, and wonder now, if it wouldn't be wise, after hearing this discussion, to have a motion that after the list is received by this council that it be distributed to the local regional advisory groups for review and comment and modification and then return to this council before the final list is passed on to the Secretary, and feeling that the council has that in mind, I so move.

VOICE: I second it.

DR. MARGULIES: It has been moved and seconded that the information collected under Section 907 activites which provides data about hospitals regarding the diagnostic management and rehabilitation of heart disease, cancer, stroke and kidney disease be distributed to the regional member programs for their review and comment after the information has been collected and prior to any further utilization of the data.



end 3

DR. CANNON: It is the list that each regional advisory group would have a privilege of commenting on for their area, and then return to us so that we can see the whole list and then make a judgment about it before it is submitted to the Secretary.

Since it is going to be an effort of the regional medical program, I mean that is our job, the 907.

DR. BRENNAN: We are going to be tagged with it.

DR. KOMAROFF: What would you expect the advisory groups to do? Would they be limited to pointing out fraudulent claims or would they, for instance, be asked to make comparative judgments about sophistication among hospitals that on paper appear to be similar with respect to hardware?

DR. CANNON: Harold left out review and comment. By this I meantthey could appropriately readjust the list if they felt it was wise, in their judgment. Then we would have to decide which would be best, the joint committee's representation or the recommendation of the regional advisory commission.

DR. KOMAROFF: So in a sense they would be able to rate the variety of institutions?

DR. CANNON: Just as the joint commission would be doing, yes.

DR. SCHREINER: My understanding is that this

isn't really a rating. In other words, if you set up a certain descriptive criteria, if you have a pump oxygenator, and if you have five hospitals that have those that do more than ten patients, you are not going to rate them all one to five.

DR. MARGULIES: I think it would be easier for the Council to make a decision about this particular action if it knew what the nature of the list would be and since we don't know what that list will be you are about to vote on something which is still uncertain.

I would be happy to make sure that this Council is made acquainted with the final decisions on the list, and can then act on what they think is the appropriate use for it before we do anything with them, but there are several options still open as to how those lists will be used.

Their list is, incidentally, a steering committee representing the major health organizations in the country which is guiding the joint commission in the development and the utilization of the list, but in the absence of a decision about how it should be made up you are voting on something which is a little hazy, but which will do no harm.

Sewell?

DR. MILLIKAN: I am not against lists, but I don't know whether this is going to end the confusion. Some

have been told in kidney "Don't submit grants for institutions that serve less than 3,500,000."

There are a lot of planning going on now based on this criteria.

Secondly, well, you brought up, Dr. Margulies, a moment ago, an important thing, and this is the certificate of need legislation going on in many states, and there has to be some communication between RMP and the state authorities that are carrying out certificate of need activities.

We are going to have tremendous confusion, I am afraid.

DR. MARGULIES: Dr. Brennan?

DR. BRENNAN: I think a serious effort to describe the capabilities in a region and to define the means for a more rational medical care program that facilitiates proper referral practices and centralizes certain types of different professional work, I think we need to face up to that, that that exists in every regional advisory group, every regional medical program, if it is to fulfill its mission.

Now, we are all dodging away from the clear intent of the instruction given to us about these things, I think, by the Congress, which was that we provide some guidance for medical consumers as to the right places to go for certain problems.

It is a sticky problem. It is a very sticky

problem. But it is still something which is laid on, and I think we are inevitably going to have to take part in some sort of rating of these things.

But if I consider what organ within a state, the state medical society, the hospital association, the university, what organ within a state is better prepared to achieve a reasonable grading of this kind than the regional advisory groups, I can't think of one because those regional advisory groups include consumer representation, they include all of these various component elements, and if we can work this out anywhere we should be able to work it out in the regional advisory groups. We certainly don't want to leave it in comprehensive health.

Now, for this reason I would like to see the mechanism include a plan for operation of the regional advisory group and I don't see where we need a list in order to know, in principal, that this is the right position to take, unless RMP is simply a paper tiger in the first place.

MRS. WYCKOFF: I think the question is that we have no idea of what it is.

DR. MARGULIES: We can get copies of the questionnaire. Mrs. Wyckoff would rather look at the questionnaire before she takes any kind of action. If you would like, we can delay consideration of this until we have it. There are copies available, I believe.

MRS. WYCKOFF: Is it a New York telephone book?

DR. MARGULIES: It is pretty thick.

DR. STONE: It is the intention to compile the results of the questionnaire as an inventory of resources available for the diagnoses and treatment of these four disease areas in the United States and it is intended to give wide publication and wide distribution to the inventory which can then be used for planning purposes by each regional medical program and health planning group in every state in the country, every region in the country.

Pending decision by the Secretary as to the exact kind of list which should be produced, the advisory committee incorporated under JCAH contract have been developing sets of criteria, and not having yet firm guidance about the classifications which should be developed, they are developing sets of criteria which will describe primarily, intermediate and tertiary facilities in the United States.

We can certainly make these criteria available.

DR. MARGULIES: Dr. Cannon?

DR. CANNON: Harold, I really don't see that the motion that has been made in any way interferes with the process of going ahead and getting it done. What it does is just to ensure ahead of time that the mechanism won't leave out the opinion of the regional advisory groups, especially when it comes to local affiars, which they will have to be

faced with after this list comes out, and I am afraid that there are a lot of bad things that are going to come along with the good things with this list.

So I would request that the council go ahead and take action on this measure and move ahead and then when we get the questionnaires we can see how it appropriately fits.

DR. MARGULIES: I see no problem with that.

DR. CANNON: I would like to call for the question.

DR. MARGULIES: All those in favor say aye.

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No response.)

DR. MARGULIES: Then what I said earlier must be amended when I was summarizing it. You were referring to the list rather than all of the data.

Is there any public comment at this point?

(No response.)

I would like to turn next and ask Dr. Pahl to discuss two issues of significance in our development of policy with the council. One of them has to do with the RMPS evaluation committee and the other has to do with the management information steering committee.

DR. PAHL: Just to briefly bring you up to date on two developments internally, Dr. Margulies has recently

established an internal management information steering committee composed of senior staff of RMPS, and also a RMPS evaluation committee likewise composed of senior staff of RMPS.

The documents establishing these two internal committees are included under Tabs H and I of your agenda books and perhaps you would be interested in perusing them at your leisure.

What I would like to merely indicate is that in each of these actions I believe we have demonstrated our very real interestin setting as a high priority the better employment of our management information system, and also to take a closer look at our evaluation activities.

In terms of the management information system, this is a tool which serves both the staff, the review committee, site visitors, and council in various ways.

We have for the past year and a half or two years gone through much technical development of this system and now I believe we are at the point where we must as a staff, in order to serve the needs of the groups that I have just mentioned, look very closely at what data we are collecting and what data we are not collecting, the usefulness of these data, and in terms of making this information available to the site visitors review committee and council, just how can we best emloy this new technical tool that we have.

Consequently we have in establishing the committee made it a requirement upon ourselves to pull together approximately ten or eleven senior staff once a month to discuss what the problems are, technically, and from a larger informational point of view, and to advise the director as to the best way to use this information system.

In terms of the evaluation activities, I believe the council is very aware of the fact that this has up until, I believe recently, been a somewhat hazy area. We know that there are evaluation monies available and every once in a while the information is brought to you in terms of contracts that have been let or contracts that we propose to let, and then months go by and eventually a brief report is given to you about the findings.

There has been generally an unsatisfactory situation both for you and for us, and again it is more and more important as the program becomes mature and we now are just over seven years old, it is more and more important that we have a better understanding of what it is that we are accomplishing as a headquarters staff and, more importantly, what we are accomplishing within the individual regional medical programs.

Evaluation as a primary management function is assuming greater importance at all levels within government and we firmly believe that it is useful to us to understand

better where we are going, what we are getting. Therefore, in establishing the RMPS evaluation committee Dr. Margulies has indicated to all of the units within RMPS and the RMPs that the evaluation function is to assume a higher priority in the future than it has in the past.

What we shall attempt to do is to bring to you on a more direct basis brief reports of what actually is going on and what it is that we propose to do and try to include both the review committee and the council in some of the formulation of the plans so that over a period of time all of us will be able to find out those things which we deem important about our own activities.

I think that it is hard to stress evaluation -- it is hard to overstress -- the importance of evaluation because in the end result that is what people want to know from us, what is it that is happening in our programs.

There are many dollars afforded to us for this and much staff time, both internally and within the regional medical programs is devoted to evaluation. It is that kind of information we need in order to provide understanding within the department and the agency and, also, of course, to the general public about our activities.

With the establishment of these two committees and tying them together with appropriate cross liaison personnel, we believe that as the months go on we will be in

a better position to inform you about some of the substantive matters we have been involved with and that we propose to go into.

In addition to informing you, we will be looking for your advise and consideration about items and specifications before we proceed. In this way we believe that our evaluation function will be carried out much more effectively and that it will have your interest and support.

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DR. MARGULIES: The consideration of the management information system and the evaluation activities together is of obvious importance because with the information system we now have available to us a range of data not previously usable, or identifiable. I don't believe the Council has yet had the opportunity to fully appreciate how effectively that information system can be utilized in a variety of ways.

We can use more and more of that information in the review process, and you will see more of it as you get into that part of it. But the system is now open to specific kinds of queries, if the questions are appropriately framed and if they refer to the kinds of activities which are either localized or generalized within the RMPs.

We worked for a long time to devise the information system around the kinds of questions which we would need to respond to with a variety of questioners, ranging from members of the Council to people outside the system entirely.

We have occasionally tested it and found it of more and more value to us. Asking such questions as how many RMPs are spending how much money on nursing homes where they are upgrading the skills of staff, for example. That kind of information can now be derived from the management information system, or specifics on dialysis or specifics on types of efforts to improve quality assessment,

or specifics on medical record systems and so on.

With that kind of generalized information and with some idea of what the RMPs are doing on a broad and limited scale, we have mobility in planning and evaluation which we haven't had before.

I would invite any of you to inquire further into what is in the MIS and in the related systems within the regional medical programs which are under development.

Now, I would like to have Dr. Pahl pick up again on the status of the Review Committee.

DR. PAHL: Under Tab F, you will find a new listing of the committee members, and I am happy to report to the Council that we have three new appointments, Dr. William Lugen Buell, and Mrs. Maria Flood, and Dr. Grace James. These three new committee members met with us at the last meeting of the Review Committee, and I believe that we believe that we all found that to be both a stimulating experience and a very rewarding one.

We have, because we have new people on the committee, also some resignations, and I would inform you that we have resignations from Mr. Janus Parks and Sister Ann Josephine, and Dr. Edmund Lewis.

So I believe that the listing that you have under Tab F now is a correct membership of the Review Committee.

Under Tab G, we have prcvided for your information some of the key personnel changes in the regional medical programs which have occurred in recent weeks, and rather than take the time of the Council now, I would merely call to your attention that this includes the appointment of new coordinators and the change of certain key people in the regional medical programs with the 56 programs.

There continues to be a rather dynamic picture, and we will try to make it a practice to bring to you routinely such listings so that you can keep fully informed rather than just through the review of the individual applications.

DR. BRENNAN: I ncommenting on the Review Committee, I realize on inspecting the list that we have passed into, or through, I think, an area of marked decategorization of regional medical programs, but on going down the list here, with the exception of the field of cardiology, I fail to find represented central disciplines with respect to our primary program missions.

I don't see anyone here strongly qualified in neoplastic diseases. I can't say that any one name here strikes me as particularly distinguished in neurology and stroke, and kidney disease is perhaps represented, but that is an obscure branch, and I am not really up on that.

(Laughter.)

I am quite serious, however, in calling to mind

that we still have a primary responsibility to push ahead the kind of thing, the insertion of better methods of a special technical sort and so on in the regional medical programs. They still visualize themselves as having a substantial categorical mission, and I think that in the past we have had on the Review Committee resource people who could have been of greater help with respect to some of these technical questions, categorical disease questions.

Is the Review Committee limited in number, to this particular number, or would it be possible to obtain that sort of expertise on it?

DR. MARGULIES: The makeup of the Review Committee as we have been doing program review rather than technical project review has been deliberately designed in this direction. It has shifted from a review of individual projects in which some specialized technical knowledge was needed to full program review. It has on the other hand required through action of Council and RMPs the presence of technical skills in the local review process, which are much more demanding and much sharper than they were in the past.

You are quite right, Dr. Brennan, we have tried to rest heavily on the decentralized function in the regional medical programs, and have in the development of review criteria and in the verification of review criteria made

sure that the technical input was greater than it had been in the past, but when we are not reviewing projects, as we are not at the present time, and rather reviewing program, our concern was more with the institutional processes with the ways in which they affect social needs than it was with the technical aspects.

Of course, we do have on the Council the kinds of technical skills which we will maintain, which can add that particulare feature to the review process.

MRS. WYCKOFF: It changes the role of the Council versus the Review Committee a little, doesn't it?

DR. MARGULIES: Well, it does, but I think if you will consider the point raised by Dr. Brennan during the portion of the meeting where you review applications, you will find that the utilization of techn ical expertise included in the Council is less important than the utilization of the breadth of the members of the Council in looking at programmatic efforts. It is the way the Review Committee was designed.

I am perfectly wiling to have the issues raised as to whether that is what RMP ought to be doing, whether it should continue with program review, or return to some kind of technical project review. But we seem to have passed that watershed some time ago.

DR. BRENNAN: Some group and its functions of

review then supplemented by ad hoc expertise? Is that the plan?

DR. MARGULIES: I think the kidney program is the one example of that in which it is done, because we are doing technical review, but only on dialysis and transplant activity. Otherwise, we are doing progrmmatic review.

DR. BRENNAN: WE don't have anything against educational people and administrative people, or people with a reasonable concern for public health in medicine, but RMP is a great deal different than CHP, I think, and it does have these special categorical jobs to come back and report progress on, and I think that since the Council is strongly influenced by the kinds of reports and liberations that come out from the Review Committee, that a voice to insure, I think, proper evaluation on program content in these categorical areas, which are our primary mission, should be preserved in any commission.

DR. MARGULIES: Mr. Millikan?

DR. MILLIKAN: I would like to add a comment on this particular subject. The issue is a bit broader than the issue of whether there is someone who has an interest in stroke or heart disease or cancer. I think probably a good many of us would agree that a look at some of those things by a person knowledgeable in the area may produce a qulaity judgment which can be extrapolated to large portions of

program content.

In other words, a look at some of the so-called technical or medical aspects of something which may have an administrative focus may actually be a way to find out whether the whole thing is any good or not, rather than just looking at it purely and simply from the standpoint of whether it is good stroke work or good cancer work, or whatever, because the quality content may pervade the entire mix of administrative, socioeconomic, social and medical.

So there is more to this than just the business of having a disciplinary purview involved.

DR. CANNON: Harold, I tend to support this.

DR. MARGULIES: Are there other comments?

DR. BRENNAN: I think one of the difficulties is that it is conceivable that the thing could be administratively very sound, you know, in terms of the arrangements that are made, and it could be very noble in its social purposes, and it still could be founded on an unrealistic assumption about what is achievable in a particular field, because in addition to wanting to do good, we must always recognize the restrictions on our capabilities, and many things that we would want to do in one field or another, it is known that scouters and students in the field, for example, may be quite impossible.

I think that as Clark said, it is important that

at some point a skillful, realistic quality judgment on the entire plan be provided, and I don't think that can be done except when particular items are picked up and looked at in comparison to the reality, and I think, also, that this other element of the preservation of a relationship, of intention to feasibility, has to be all of the time paid attention to in the kind of work we are in.

So I should strongly like to see in these areas toward which we are directed toward the Congress, that we have on this committee experts, but not merely experts, but hopefully men who are experts and have sympathy for the social purposes of the program as well.

DR. ROTH: I would like to support the philosophy that has been expressed here. I want to say some of the things in a slightly different context.

If my concept of the value of the Review Committee up to this point in history has been correct, then the new direction which it is taking must be incorrect.

It seems to me that our entire regional structure with an RHP, the more recent requirement for running these programs through CHP, our eternal criticisms of -- constructive criticisms -- of the structures of regional advisory groups to get all sorts of community input, consumer input and so on, is an attempt to guarantee that these factors are thoroughly considered in the regional level.

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We also have the restructuring of this Council in order to get these broader, less narrowly scientific concerns. But somehwere in the process, you need to have quality control and evaluation, not necessarily categorical, but just by technically educated people who are in touch with what is going on in these developments across the country, who can spot duplications, gaps. overlaps, unnecessary expenditures of money, and I strongly support the fact that somewhere in a program which is designed to improve medical care for the people, we must give the highest degree of expertise to the program that we can, and I think the Review Committee is the place for it.

DR. CANNON: We went through the battle of deciding who was going to be responsible for the assessment of the quality, we probably should have said more about building into the system the necessary personnel that would be required to maintain quality.

MR. HIROTO: I would like to agree with the medical people on that. I recently went on a site visit, and I found that all of us who were site visitors tended to look toward the experts to give us the answers and give us a point of view, and I think it is important to have on this Review Committee the expertise that is necessary, be it categorical or otherwise.

DR. MARGULIES: I think in response to this that

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what we had best do, and I will do it promptly, is to circulate to you the further information about the kinds of people who are on the committee and the kinds of interests they represent.

I am not sure they lack many of the skills which you are seeking, and I am confident that they represent in some ways the kind of input which the Council can very well utilize.

We have a wider range of selection with the two. They serve not a carbon copy function, but a broader role than that. Our thinking has been that the Review Committee should have within its structure the capacity to address some issues which were brought to the attention of the Council, which would at the same time have a high level of competence.

I think it is quite a competent group, but certainly would yield to your opinion on this.

Dr. Roth?

DR. ROTH: A question.

Harold, how are the selections made, and who is the appointing authority?

DR. MARGULIES: The appointing authority is the administrator HSMHA.

MRS. MARS: Is this committee up to its full quota, or could you add members to it?

DR. MARGULIES: There are some vacancies coming up.

Dr. Brennan?

DR. BRENNAN: I should like to make a motion to the effect that the Council expresses through the administrator its conviction that authoritative scholars, qualified in neurology, ontology, cardiology be included on the Review Committee.

DR. CANNON: I second the motion.

DR. MILLIKAN: I second the motion.

DR. MARGULIES: Is there disucssion?

MRS. MARS: I would like to add to the motion that the vacant places be filled according to this concern.

MR. OGDEN: I take it it is the concern of the Council that these types of fields be continuously represented on the committee.

DR. MARGULIES: Dr. Millikan?

DR. MILLIKAN: I have a concern, that some other specialty would want to be added at the next meeting, and two at the meeting after that. My concern expresses itself in whether or not this Council should advise or in some way make possible for the director himself to provide on the spot technical assistance as it is needed, whether it is a member or whether it is a consultant for that meeting, because if we are only going to do it one way, then we are

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going to be spending a lot of time on this Council, adding people. I don't think that is the function of this Council.

DR. MARGULIES: If you take a look at the makeup of the Review Committee, and of course the choice is yours, you may recognize the fact that it allows for an input greater than the Council has from minorities, women, people in the allied health field, and those who represent community interests of a different kind from those who represent them on the Council, and it is for that kind of an input which we have moved in the direction that the Review Committee as it is now made up?

DR. MARGULIES: Mrs. Morgan?

MRS. MORGAN: Do we not have on the Review Committee in some of these gentlemen listed such as dean of the Abraham Lincoln School of Medicine, maybe these fields are represented and not in. They may have a direct interest in neurology, for example, although their official title may not be chairman of that particular department.

DR. MARGULIES: But they were not selected for that reason. It is quite true that if someone is representing a position of deanship that he is there for that reason, just as a practicing physician represents the broad field of practice rather than a specialty. I think the motion is directed more at a different kind of selection process, quite clearly.

Dr. Brennan?

DR. BRENNAN: My whole concern here is that this is a program directed toward heart disease, cancer and stroke. I don't mean to be restrictive in mentioning what disciplines might be appropriate to place on the committee -- in my motion -- because I have no objection to seeing good pediatricians there.

But I do believe in terms of the enabling legislation that we are in a weak position if we don't have active, recognized scholars and leaders in these fields on this program, and on the Review Committee as well.

DR. MILLIKAN: In response, I would only point out that the phrase "be included in the membership of the Review Committee" was part of the motion, and there was no restrictiveness about this, and only those items were included by name which are a part of the legislative language.

DR. ROTH: I accept that.

DR. SCHREINER: I think it would be helpful to have more background people.

MRS. WYCKOFF: I don't think it matters at what level you have it.

DR. MARGULIES: Would you like to vote on this motion now?

All in favor, say aye.

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(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No response.)

DR. MARGULIES: It is coffee break time. It is 105:15. We will return at 10:30.

End #5

(Recess.)

Note on BC membership motion

XXXXX

DR. MARGULIES: The meeting will please come to order.

One matter of business I would like to bring up before I ask Dr. Stone to reappear on the program, and that has to do with future meeting dates. They are before you February 7 and 8, 1973, June 5 and 6. We have October 16 and 17 down, but that was without having available to us the calendar of meeting for next year. Our calendar stopped at September 30. Mrs. Mars pointed out to me that the American Cancer Society meets on those days and that would be one conflict.

I think what we will do is to delay taking action on the October meeting until we see what kind of problems we have and ask you to accept or not accept the dates of February and June.

MRS. MARS: The American Cancer Society changed its date. They were supposed to meet at the beginning of June, and they have changed it.

DR. MARGULIES: Are there any other conflicts for people here?

DR. OCHSNER: The 16th and 17th of October is difficult.

DR. MARGULIES: I think we will have to alter that date when we get all the calendars up. But let us tentatively set February and June. I realize there will be conflicts with

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some people. That is almost unavoidable with this large a group. We will re-assay the October meeting.

MR. OGDEN: Dr. Margulies, I ask whether there has been thought given to those meetings on Mondays and Tuesdays rather than mid-week. I know February 7 and 8, 1973, if my calendar is correct, are Wednesday and Thursday. June 5 and 6 are Tuesday and Wednesday. I rather like having these on Mondays and Tuesdays, because I can travel back here on Sunday and get back Tuesday night.

DR. MARGULIES: There really isn't any special reason why they should not be on Monday and Tuesday rather than later in the week. About the only thing that ever comes up, Mr. Ogden, is that we have sometimes orientation for new members, but, you know, that we can work around.

In fact, we can use Sunday for that purpose.

MR. OGDEN: Rather than pin down these dates as being definite now, let's say Tuesday and Wednesday or Thursday and Friday, are you going to circulate some new dates before we vote on this?

DR. MARGULIES: I think we had better, because there are doubts about it.

MR. OGDEN: I would suggest we hold this point until sometime later on.

DR. MARGULIES: All right. There is no need for us to do this rapidly. We can reconfirm at a later date.

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Now, if we may, I would like to turn back to Dr. Stone to pick up the discussion that began this morning.

DR. STONE: I wish I were more cognizant of the modus operandi of regional medical programs so that when technical questions came up that appear herein, how they would be worked into your standard operating procedures. I would be able personally to answer them then.

Therefore, I will have to rely on Dr. Margulies, which I am pleased to do, but the deficiency which will appear obvious to you is one which I hope will not be severe.

In matters of certain kinds of definitions should they be requested, I will immediately fall back on Dr. Margaret Sloan. With those two somewhat mild disclaimers, I will go ahead.

Dr. Wilson has asked me to express his sincere regret that he is unable to meet with you this morning. This is his day to defend the budget before the OMB, and I am sure you will understand, as Dr. Margulies has said, and that you will wish him well in his travel.

Before we get into the body of this address, there are four items that Dr. Wilson wanted particularly to have me bring to your attention because they represent milestones in your operation.

It views your procedure as one of the final de-centralized decision-maker programs. Decentralization, as you

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know, is one of the basic principles of our department, and in this you have gone along in an admirable fashion. As Dr. Margulies is wont sometimes to tell us, you and he together have decentralized far beyond the regions in many cases.

Dr. Wilson also feels that in a special sense you have provided revenue sharing at its very best. Further, he feels that these programs have evolved into the only reliable working tool to relate to the professionals, and that in the regoinal medical programs we have the largest pool of talent addressed in the professional sense to health care.

Those are four items that he wrote this morning. There are several things he has asked me to discuss with you, and the first is the matter of priorities. We are well aware of the many pressures which have buffeted regional medical programs since they became a part of HMSHA in 1968, and never has the strain been greater than in the last two years. Under guidance, they have made the best of very difficult situations and their contribution to solving the problems of excess to primary comprehensive health care has been remarkable.

Their flexibility, imagination and resourcefulness have been most impressive. They have found it possible to adjust to new priorities identified by HMSHA when these came along. Item: The medically underserved, Indians, migrant

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workers, urban and rural poor, young children and the elderly. They have been able to place emphasis on ambulatory care facilities and the more effective use of allied health personnel.

Their ability to enlist cooperation of the providers and all concerned groups in the regions was most notably displayed in the recent program set up some urgency of emergency medical services, and we believe no other organizatio in the country could possibly have done this so rapidly and so well.

However, our priorities are also set by the Congress which in general reflects the will of the people, and it has been inescapably clear that many members of Congress are just as interested today in improving the care of patients with heart disease, cancer, stroke and kidney disease as they were when the RMP legislation passed in 1965.

As a matter of fact, the National Cancer Act of 1971 was passed in part because the RMPs had not fulfilled the expectation of those who plead for the RMP legislation in 1965 and those members of Congress who overwhelmingly supported it, so they decided to try again.

Those members of the health professions concerned with heart disease were not quite so frustrated because they had been deeply involved in the RMP efforts to develop guidelines for optimal care through the Inter-Society Commission

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for Heart Disease Resources, which was discussed previously.

Nevertheless, they were also deeply distressed as HMPs appeared to withdraw sharply from support in the field of heart disease, and they urged equal time with cancer on the Hill, with a capital H.

Congress expressed its continuing commitment to care for a lot of people with cardiovascular, respiratory and blood diseases by passing the National Heart, Respiratory and Blood Disease Bill of 1972. It is no accident that increasing amounts of 20,30 and 40 million were authorized in both bills for control activities in cooperation with other government agencies.

When appropriations came around last spring, members of the Congress were hearing bitter complaints from their constituents. Doctors and patients concerned about heart disease, cancer and stroke, who found that many RMP programs in these disease areas were being terminated or were in danger of being terminated.

They have pointed out that the legislation on the books still makes heart disease, cancer, stroke and kidney disease the major responsibility of the RMP. They are right.

At one point, the impact of these complaints even lead one Congressman to state that if RMPs didn't pay attention to the Congressional directives, he would attempt to see to it that the legislation would not be renewed. I

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would like to say insofar as one can speak now off the record, this is the exact truth.

Of course, it is perfectly true that if people do not have access to health care at all, they will not have access to care for heart disease, cancer, stroke and kidney disease either. Therefore, the recent emphasis on access to primary care is completely justified and easy in fact to justify. What the RMPs have been able to accomplish in that direction has served admirably to strengthen the base of all medical care across the country.

Now, however, Congress has made it crystal clear that it wants the national effort in the control of heart disease, cancer, stroke and kidney disease greatly intensified and that it will no longer be happy with diversions of funds appropriated for those purposes.

At this time, it has authorized special funding for control efforts in the budgets of NCI, NHLI and in both cases it has directed that these activities be carried out in the closest possible cooperation with other government agencies. The emphasis is underlined.

The appropriation committees have been generous with the control portion of NCI and NHLI budgets, but at this point we cannot tell what funds will eventually be released, if any.

Partly as a result of Congressional pressure, partly

kar 8 because of the need to achieve better coordination between the various parts of NHEW, and because of the crushing magnitude of the problems of heart disease, cancer, stroke and kidney disease which constitutes at least 70 percent of the content of comprehensive health care, the secretary has agreed that HSMHA , and this is the total agency, will work closely with the institutes in the area of disease control and specifically in the field of heart disease, cancer, stroke and kidney disease.

I would like to say again in a less formal manner that the secretary has made this known rather widely through Dr. Duvall, both in testimony in a formal fashion and more informally.

As a forerunner of the kind of intense cooperative effort which will henceforth be coordinated by the institutes which will henceforth be coordinated by the institutes, I repeat, the secretary launched the National Hypertension Program of July 25 of this year, aimed initially at professional education in the field of hypertension, and it will later move on to public education and to the preparation of health services delivery systems to respond to an increased demand for screening, diagnosis, treatment and follow-up.

This activity is being served by a National Advisory Committee, by an inter-agency working group through four task forces made up of members of the National Advisory

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Committee, representatives of NHLI, the VA, Mr. Musser is one, FDA, Dr. Richard Kraut, I believe, and HMSHA has several representatives, Dr. Margulies being one.

The first will determine the content of the educational program to find the level above which treatment is indicated and recommended with that program should be. These recommendations will be made to the secretary, and what formal presentment will come out, we do not know. But the secretary is officially committed to make some presentment, and it is a program in which he has taken personal interest, and we feel plenty of steam under this one.

The secretary will plan the professional education program, and the third will plan the public education program, and the fourth, chaired by HMSHA, will evaluate the impact upon health services delivery systems and determine the resources needed to respond to the professional and education programs.

This was a point which was forcibly brought to the attention of the Committee in an admirable fashion by Dr. Margulies himself. Dr. William Smith, regional health director for Region 9, San Francisco, is serving as chairman of Task Force 4. On Wednesday, two days from now, Dr. Wilson himself will make the presentation of the findings of Task Force 4 before the secretary or whoever fills in for the secretary on Wednesday morning over at NIH.

kar 10 This has been very intensive effort since July and has engaged a lart amount of time of Dr. Margulies, Dr. ~~Shulman,~~ Dr. Sloan, and Dr. Greenfield. Eventually, it must engage the time and attention of this Council and of all regional medical programs.

I would like to say again, and somewhat informally, that it will also engage the time and attention of the 15 other programs in HMSHA.

Dr. Wilson has made a firm commitment that every HMSHA program which can increase its attention to the measures affecting control of heart disease, cancer and stroke, within the limits of present funding and personnel will do so. Depending upon the level of funds eventually released, additional contributions will be made by HMSHA programs for the control of these diseases in cooperation with NCI, NHLI, NINDS.

The area of hypertension will take precedence over this cooperative effort, but the others will not be far behind.

What does this mean for the RMPs? This is why, ladies and gentlemen, I wish I personally were more technically aware of your program and how it operates.

Somehow, they will have to be encouraged to put a larger part of their programs back into the fields of heart disease, cancer and stroke, but to do this as an integral

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part of comprehensive health care.

We wish to protect the gains that have been made in the last two years and to reintroduce some of the categorical disease activities in a very special way which will not adversely affect the noncategorical program current efforts. We wish to seek you reaction to the following proposals.

That the RMPs be encouraged to retain or redirect a part of their regular grant program to support these activities which seem most important at the logical level in relation to the heart disease, cancer and stroke.

That a special fund be designated for control activities. The exact amount must later then be determined by the level of funds finally released by the RHP service, RMPS, by the OMB and DHEW.

I would like to digress just a moment and say it is unfortunate that we do not know what funds will in fact be available during the remainder of this fiscal year, thus this discussion would have greater point, and your advice to us would be more timely, but that isn't what is happening, and I don't like to predict things, and I will not predict, but I will say it would not be surprising to me but what an executive committee of the council might be called together into a special session.

Now, this is entirely gratuitous, and I have been proven wrong many times in my gratuitous observations. I am

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prepared to be proven wrong on this one, but I think it shows the seriousness of the allocation of these funds, and I am assuming that some additional funds will be allocated by OMB in relation to this very important effort.

Emphasis would remain on getting this advice and funds to the RAGs as rapidly as possible, but with more specific guidelines than has held for some of our past programs.

I don't know, frankly, and I am not technically aware of the specificity with which your guidelines have been framed, but the two species of law that govern these programs, heart disease and hypertension, and in cancer, are very specific concerning the promulgation nationally, and that is, centrally, have program policies if not specific guidelines. The extent to which this central distribution will be, or will come about depends upon the leadership in the two institutes concerned. It is clear and specific under the law that these programs are under their control from the point of view of policy, and from the point of view of the establishment of a control program.

In other words, the National Heart Institute will have more than a little to say about what constitutes control programs recognized by them. This is the law. The Cancer Act is even more specific.

We are cooperating in every possible way with the two institutes across the road, and as a total agency we will

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continue to do so. As a group which has the greatest professional contact in the field, Dr. Wilson feels much of the leadership and practically all of it, will probably be exerted through RMPs, through this Council, and through the staff of the RMPS.

Once again, I am adding a little gratuity on this statement, but I don't think I will be proved wrong on it.

Some part of these central funds may, in my understanding, may be awarded to the regions by contract after review by appropriate committees of expert consultants for activities which will follow guidelines developed by RMP in close cooperation with NCI, NHLI and NINDS. The NINDS, they have a control program and I think, Margaret, that legislation is not yet through, that is correct?

DR. SLOAN: It is really included in the National Heart and Lung legislation. The circulatory part of stroke remains within HLI and the neurological part with NINDS.



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DR. STONE: Thank you.

This has been discussed with this council before, but the issue has never been more urgent.

Some of these central funds also will be used to support contracts, A, with national professional organizations for the development of criteria for quality assurance.

It is a bit reminiscent of our previous discussion. In relation to heart disease, cancer and stroke, that is, and,

B, with institutions or groups of institutions which deomonstrate various alternatives for the delivery of high quality services to patients with these diseases, and

C, with reasonable national medical programs for national professional organizations who promote the regionalization of specialized facilities and services.

Review mechanisms will have to be worked out. The staff will have to be assigned as ~~many~~ additional positions as possible. Methods of communications of these changes to the regions will have to be developed.

In short, RMPs have some new priorities which are really some of the ones they started with from which now should be integrated new comprehensive health care as much as possible, and represent a partnership of effort with NHLI, NCI, and NINDS, now a policy which the council has had in effect for some time.

The other subjects we wanted to discuss with you

concern your council policy of decremental funding and the phase out of projects at the end of three years.

We all know and appreciate the dangers of getting trapped in demonstration projects for which it appears impossible to find other sources of support. Obviously, if these are allowed to become fixed charges and continue to proliferate, the situation would resemble Medicare and Medicaid, soaking up an ever increasing share of the RMP budget.

The program would then cease to be a developmental one and would lose the marvelous innovative catalytic role it has played so well and which is so widely recognized.

But it was this three-year termination policy, also, that gave us special trouble in the Congress last spring. Programs were being terminated rigidly, because they had had a three-year funding.

I might say in a somewhat informal way again, many of the local RAGs won't even entertain applications for further funding than the three years, at least by common report.

In some cases little effort was made to help the project directors find other sources of financial support. In some, allegedly promising projects were terminated in a catastrophic way where one or two more years at reduced funding might have enabled them to become self-supporting.

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Some of these were successful programs. Some of these had received national recognition. Some of these were just beginning to be successful, and to fulfill their promise, and it appeared that the reward for such success was financial annihilation.

What I should like to have you consider are some modifications of your policy which would put emphasis on the following:

1) Continue, as I know you do now, requiring new applicants to indicate how funding will be covered from other sources in three to five years;

2) Make awards with decremental funding when possible;

3) Ask the RMPs to take greater responsibility in helping applicants find other sources of funds;

4) Apply the policy with flexibility. Not all of our innovations in heath care will be acceptable to the funding organizations. There may indeed be some service projects of such value that RMPS should continue funding them for more than three years. If no other alternative funding can be located then decremental funding should be applied gradually with a maximum of technical assistance to the local program so that we are not in the position of abandoning patients abruptly;

5) Particularly in programs involving children

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or the elderly, it would be better not to get started on them at all if there is no hope of other funding at the end. But the RMPs will surely lay up credit in Heaven if they can start programs which bring help to these groups and eventually make them self-supporting.

That is the end of the text.

I assume, Dr. Margulies, that it is open for questioning.

DR. CANNON: I gather much of the information was in text form, and I would like to request that copies be made of those immediately, so that we could have it to study.

I would also like to say that this is the finest presentation that the administrator has made before this council, although he has given fine presentations b efore, and that I sincerely hope it is not his swan song.

DR. STONE: Shall I answer that?

(Laughter.)

DR. STONE: As his deputy pro tem, I heartily agree with your sentiments. I know no reason to believe that he won't be here for a long time.

DR. ROTH: I am just a little bit confused by trying to relate back, at least in my own experience over the past few years, the problem with respect to decremental funding as related to the relatively new policy change

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which gives so much authority to the local RAGs, and I am wondering if there are specific examples that might allow me to get a better grasp of programs which indeed did get chopped off and amputated before they had matured or shown what they were supposed to show. It seemed to me that we had somehow or other in giving the local authority considerable flexibility in the dedication of funds, the possibility for use of unexpended core funds, in switching from programmatic funds, and so on, would pretty well take care of the problem that I though the last half of the remarks was directed to. Did I misunderstand something?

DR. MARGULIES: The limitation on funding had to do with the pediatric centers, I believe.

DR. STONE: And there have been rather sharp complaints from other programs, or certainly other specific programs which have come about. The administrator feels that the Council will do well to consider this policy and how it has been enforced in the past, and I think Dr. Margulies could, over time, because he just saw it this morning, he could provide you with the kind of data you need.

I would like to say that I think again, and in a somewhat informal vein, much of the criticism, which seems to be fairly intensive, has come to us through Congressional sources on an informal basis, of course, but it does represent some of their thinking as some of their constituents

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must have talked to them about it.

Now, the executive branch works as a co-equal branch, but it clearly does work in cooperation with the Congress when we get what appear to be fairly well founded comments, and the administrator would be foolish to ignore them. What he has said in these carefully chosen words is to use the policy with flexibility, and that is underlined. He didn't say abrogate the policy, he didn't say modify it, he said use it, or see to it that it is used through the RAGs and other groups with flexibility.

The policy is not a law. Policy is a general body of opinion to which exceptions can be taken for good cause.

DR. MARGULIES: Dr. Brennan?

DR. BRENNAN: I think it would only be fair to remind the administrator, although these comments are obviously ones with which in a general way I agree very strongly, to remind the administrator that the funding stages of these programs have all been so minimal compared to what would have been necessary to continue to finance on an ongoing way the various initiatives that were begun, that the real cause for our having to have been rather firm about the three-year mothod was really a budgetary cause, and I don't think it was ever a choice of the National Advisory Council of the RMP.

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Finally, I think it should be stated, at least on the basis of our experience in Michigan, that there has always been a lack of follow-through on extending valid initiatives, proven programs, out wildly into the region.

We have had programs that have been very successful and with help from our central office, and local work, many of these programs have individually been able to keep on going.

But we have never had a systematic way of going to advisors, going to the Medicare and Medicaid and to Blue Cross and developing an expertise for the presentation of arguments in support of the financial validity of an initiative to such bodies in such a way as to bring them -- to make it possible for them to begin in other areas that would also have wanted to start them up.

I think that has been a fault in RMP, and I think as we look at our program directors and our program staffs that we should really be thinking about the development of a wing in those staffs which has the particular purpose of doing economic planning, argument and presentation to funding bodies in the localities that might make improvement extendible throughout the region.

Certainly RMP funding is never going to be sufficient to allow for that. These were demonstration programs, initiative programs, but of course demonstrations are

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useless a way is found to carry them through, and I am afraid we have to consider as part of the demonstration business the need to have this sort of economic wing? Our regional group.

DR. MARGULIES: Dr. Schreiner?

DR. SCHREINER: Although it is a bit premature, I wonder if I could take a few minutes to amplify the priorities. As you probably know, the House passed the conference version of the Social Security amendments which redefined disability for kidney patients. We expect that to pass the Senate today, since they originally passed it the first time. There is no reason to believe they would change their minds.

This would, I think, simply amplify the remarks of Dr. Stone, to put kidney disease in that same basket, and it would mean that many of the RMPs who have feared getting into kidney programs because they assumed they would be open ended and because they assumed they would be stuck, and who had reservations, as Mike said, for budgetary reasons, rather than philosophical reasons, I think ought to be reassured now, and ought to provide the leadership to go ahead once the legislation is nailed down, as it appears there would be. There will be no possibility of open endedness, decremental funding will be built in the government structure, and we ought to be able to start up projects with a greater peace of mind.

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DR. KOMAROFF: To raise a question, with respect to categorical diseases do we know how much, or what percentage of the RMP budget now is directed toward identifiable categorical disease projects? It used to be, two years ago it was well over 60 or 70 percent. I am wondering if there has really been a slide, although we have a feeling that things are getting noncategorical, it may not be as dramatic as we feel.

Then the second point is to raise the point that regardless of the merit of emphasizing categorical diseases again, the mechanism used to do that, the earmarking in particular of funds and the raising of the specter of a considerate mechanism to do it bothers me, because for all of the virtue of the activity, I have reviewed a couple of regions this time where a major block of money was given for EMS, for instance, so major that relative to the total budget for the rest of the regional program, it created a sudden imbalance.

In fact, in one case the project director for EMS. His own political force within the region vis-a-vis the coordinator was suddenly enhanced in a way that might have been detrimental. It is just the mechanism for earmarking beautiful ornaments on to this Christmas tree for RMP produces problems, and I raise it only to point out what may be obvious to everybody.

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DR. MARGULIES: I will ask Pete to give you a response on the percentage of effort with his going into categorical activities, but before he does, I would like to re-emphasize what you have been hearing from Dr. Stone, and that is that these reference are to control programs, which is significantly different from scattered, specialized individual units which we have dealt with.

So when you hear the data, it will obscure what has emerged in categorical areas.

Pete, would you like to comment on those figures.

DR. PETERSON: We do have some data that probably could be very readily made available to the Council today or tomorrow in the form of the draft reports to Congress, where a number of these issues, decremental funding, categorical emphasis and the like, are summarized. To take the two issues that have been mentioned, categorical initially, I think there is no question, and I don't have the exact percentage at my fingertips, that we did see from 1971 to 1972 a marked decrease in single categorical disease activities.

Part of this decrease was recommended by virtue of the fact that there was a marked increase in all RMP funds. There was actually a small absolute increase in the dollars, but percentage wise it was less. What that fails in our analysis to do is such that I can give you a great deal of particulars.

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Again, going back to the management information system, we do have data subsumed under a broad category, multi-categorical comprehensive activity. That tends to mask a great deal of categorical activity that is not single disease centered, so that a frozen blood program in New Jersey which would meet needs of cancer, kidney disease, et cetera, gets into the second rather than the first category.

So that is the brief outline. There has been a decrease in percentages. There has been a small increase in dollars. It doesn't provide the kind of analysis that would permit one to say "Well, how much of this multi-categorical activity, how much is changes in that part as opposed to comprehensive."

As far as decremental funding is concerned, our data are fairly recent. We have seen over the last year that roughly two-thirds of the project activities that are being phased out for whatever reason are being picked up from the other sources.

Now, we find that the level at which they are being picked up is one the whole somewhat reduced, about 80 percent. What this means in simple arithmetic is that in the last year of funding, if there are two RMP dollars, we tend to find them replaced by one other dollar. Now, there are a number of activities, and again the analysis we have done doesn't permit the highlighting of this specifically, but

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there are a number of RMP activities which are terminated and not continued for what I presume are valid reasons. One, the activity was unsuccessful. Two, it was an activity that was time limited in its nature, so the termination -- I mean it wasn't envisaged as an ongoing activity.

Finally, a number of the activities, and this has certainly been true in the past, are being continued, but the initial needs having been met at a far reduced level.

So I think depending on yours and other wishes, the draft reported to Congress, or at least some sections of it, relating to categorical emphasis and decremental funding might be on information of help to the Council.

DR. MARGULIES: We can certainly make it available as a draft for your information.

I think the reference to contract activities, and perhaps you would like to speak up on this, Fred, really addresses the issue of trying to maintain by collaboration from the National Institute, with NHLI, as a specific example, the consistent kind of control program. It would be difficult, if not impossible, to envisage a national effort in which each of the regional medical programs decided for itself what that recommended in the way of control.

At the same time, we want to maintain the kind of decentralized decision-making activity which is essential if we are to get the continued cooperation and support of

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many people who are part of RMP.

So it is aimed at having a reasonable level of discretion combined with a reasonable level of consistency, and that obviously is not an easy thing to get done. But if definitions are clearly stated, and if what we are after is plainly described, then I think we can approach the balance of those two interests with some optimism.

Fred, maybe you would like to comment on that.

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DR. STONE: I think the explanation given by Dr. Margulies is a classic one, and it would be fatuous for me to expand on it.

Harold, would you like to try, "What is the definition of control?"

DR. MARGULIES: One part of the question is easy to answer, and that is, is there a professional definition? The answer is no.

The other part of it is a little more difficult, because we have had wide experience in control activities, but not all of it has been successful. We have prepared at one time in the past several months a paper which attempted to define what we mean by disease control, but it could be best represented by at least one example.

Let's expand a little on the idea of a hypertension control program and perhaps the chief difference, if one is to address that problem, can be discovered by dissecting the problem a little bit.

Just placing the highlights of the issue before you, there are estimated to be about 23 million people in the United States who have hypertension, and it appears to be a well-established fact that it is more common among blacks than among nonblacks, and it appears to be a much larger cause of disability and premature death in some population groups than in others.

If one went about the management of hypertension at one extreme by making available everything we know about the diagnosis and treatment of hypertension, it would have at a minimum widespread physical examinations, kidney X-rays, and so on.

At the other extreme is something which is based upon an epidimiologic approach to the disease, which says of the 23 million, some seven million are at present known to have hypertension and are under some kind of management.

If you are going to go from the seven million to the 23 million level, you have to approach it as a community issue, and utilize the existing delivery system by increasing its effectiveness so that the problem can be approached and managed within a reasonable period of time.

That would require a simplification of the screening process, a simplification of the treatment process, a simplification of the management of large groups of patients in a new kind of structure that utilizes the existing delivery system, so that it has as its goal a broad management which keeps within the bounds of reason and resource the kind of things which need to be done.

If you were to set up a program on the other hand which is going to eradicate an extremely expensive and complicated form of disease, then the cost would go up in association with it.

This means the development of the control program, in that you have to ask yourself some very basic questions: What is it that we know to do that can be done? Who is available to do it? For whom will it be done? And if you can do it in that kind of a ratio, and I must say I picked up those concepts as I was talking, you may get somewhere near an idea of what a control program is.

It would be foolish in a control program to set up a mechanism for treating hypertension for those people who already have good treatment. What we try to do is try to identify those who do not, including those who never get near a doctor, and I think in this kind of illustration, the RMPs are particularly well situated, because they understand their own resources and problems and communities.

That is a rather loose definition, but I hope it is of some help.

DR. BRENNAN: In regard to the categorical dimensions being talked about here, I would like to say in the Airlie House Conference, I was assigned to a subcommittee at one point that had to do with control programs for cancer, and we were supposed to put out something, you know, that big bunch of blue books that came out.

We have a few words in there about cancer control.

During those meetings, I tried to remind the group that the regional medical programs provided they have an implement, they have an organizational base, and have the

communication that is required in order to mount, if you don't want to call it a control program, at least an early detection program, with respect to a few things about which we can do something.

And I think that we didn't get a lot of applause for that proposal, but on the other hand, it does seem to me that it would be a great tragedy if, as these control programs are developed in the National Cancer Institute, people lose the sight of the fact that they are not merely a technical problem at all, and that if they don't work along with the RMP structure, there will be no choice for, say, a statewide control program in, let us say, cervical cancer, other than to pay for the assembly of another organization and its staffing that will be just like the RMP.

You can't go at these things with anything less than that.

So, I think it is absolutely critical for real hope of accomplishment at any reasonable funding level in the future, that the Institute cancer control programs understand the aims they are trying to serve can't be reached without the help of agencies like the regional advisory groups and the regional medical programs.

DR. MARGULIES: Dr. Engall?

DR. ENGALL: For the record, my name is Jack

Ingall, and I am from Western New York.

I would like to make just one or two comments, Mr. Chairman, to endorse Dr. Brennan's last comment. I think that is an absolute obligation on my part. I think what he said is perfectly true.

Relative to Dr. Stone's comment, I am quite happy that we should lay out credit in heaven for pediatric programs, but it doesn't necessarily imply that this is the best sequel to these programs.

Now, the other thing is termination of a project. I think this is a very difficult term to use. Projects are terminated because they have reached their goal, and I think this has got to be very carefully separated, Mr. Chairman, from those projects that have been terminated because they are not doing their job.

This is a very important factor, because your figures can certainly get messed up on this.

The other question about contracts and where they come from has been a considerable problem for the coordinators across the country, especially when they are not aware of those contracts, and these contracts are in fact financial inducements to do something.

What is the difference between an inducement and a bribe is a very fine line, but I think what we really want to do is to be very clear where these contracts are

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going, and see that those coordinators certainly across this nation know that they are being set out, and we would certainly like input into Dr. Wilson's office on this matter.

The practice of the RMPs to incrementally ~~increase~~ de their support, or go into self-support is very strongly part of the review process at the ~~logical~~ local level, and there are many very good and very successful measures that have been taken in this matter, and I think it would be very important for you, Dr. Stone, to take this back to the Administrator, because I think we can certainly give you some stupendous examples of this, not only of small projects being taken up by other agencies, but in fact those agencies that are mandated to deliver what we are helping them to do have been forced into a position by society, if you will, to take this up.

I think the RMP is the only mechanism available to the Administrator for doing this.

Now, there is one other comment that I would like to make, and that is the categorical measure. Now, I realize there are differing opinions about this, and one feels one's strength relative to these categorical opinions depending on one's background.

There are important things, however, that I think the Council should realize. That is that one of the major

problems, sometimes, not always a problem, but a major asset is that the regional advisory groups themselves already have very strong categorical protection built within their format, and their operation.

It is not so difficult for me to say here, because I believe that many of our regional advisory groups have such strong categorical protection that some of the time the subsuming of those categories into the general delivery of health care is the problem, and not the converse.

That, I think, is all the comment I would make, except that I would reendorse Dr. Brannan's comment that the RMP in my view is the best, in fact the only way, that the Administrator has got to implement what he has in mind.

DR. STONE: Dr. Margulies has convinced me to make a few summarizing comments.

I very much appreciate and shall take immediately to the Administrator the comments made by Dr. Ingall and others.

Dr. Roth, I will see to it that you get a copy, and all others on the Council, get copies of the piece of paper as soon as I can, and I will include the personal comments that Dr. Wilson has put on the side of it, so that you have a running text.

Dr. Brennan, I am happy indeed to emphasize the efficacy and efficiency of the network that RMP constitutes.

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Dr. Rosher of the Cancer Institute has been very clear in his statement that it would be folly for the Cancer Institute to attempt to build or to administer or to try to stimulate another set of networks.

The fourth thing I will say before I leave is the fact that this -- this has three sections. A, this council has some real work cut out for it, not that you have not already had it, but you will have it much more.

B, this is a HMSHA - wide program in which RMP and the Council will take the load. You will not have the sole activity, but you clearly will take the load.

C, under four, being a HMSHA - wide program, there is the health service delivery grouping or cluster of 6 agencies, 6 programs, that have had a certain amount of experience, some painful and some pleasant, in dealing with the third party payment problem. These people would be made available wherever they can be spared from the point of view of technical consultation with the RMP, or with others, who might need this kind of expertise that they can bring to bear.

This expertise includes not only the Federal agencies, but it would include expertise in the financial aspects of the continued support of projects which was mentioned by one of the gentlemen over here on my left. It might have been Dr. Brennan, or one of the trio that

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is sitting there.

If I may be excused, I will go upstairs and clean this copy up, and I will see to it that you have before you close out the day enough copies for everyone, and should you wish to discuss this this evening, Dr. Wilson's plans are that he will be there. If he is not there, it is because his plans have been supervened by soem other requirement, and he and I shuttle in and out, and it was not sure in a sense that I would be here rather than OMB, and I would much rather face the council than I would the OMB.

I feel that he has definitely lost the toss today, but on Wednesday, he meets the hypertension group and I meet a secretarial review group, and he wins the toss on Wednesday.

DR. MARGULIES: Fred, before you levitate to the 17th floor, I think Dr. Millikan has a point.

DR. MILLIKAN: I think it is only appropriate, Fred, that you carry a message to Vernon that some of us around here feel it is better to be slow in being loved than never to be loved at all.

(Laughter.)

DR. STONE: I think you and I can understand the undertones of that better than some of the younger members.

END STONE

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DR. MARGULIES: I would like to pick up for a moment on something that was proposed in the discussion which requires a little explanation, and that is the report to Congress which was referred to.

Those of you who look at the legislation very carefully may recall that 91-515, under which we operate, requires that the Secretary make an annual report to Congress which reviews a number of elements in the legislation. That is under preparation, and the report has to address the combination of programs which were covered by the legislation, not only regional medical programs, but comprehensive health planning and the National Center for Health Services, and the National Center for Health Statistics.

The draft, I see no reason for not circulating it. It does contain summary information, a review of data which are relevant to the discussion which we have just had, and if you see no reason for not producing it, Pete, I think we can get it around.

DR. PETERSON: I have asked to have 25 copies before the end of the day, so that we can make them available to the council.

DR. MARGULIES: Okay.

Now, if there is no further discussion on the last presentation, with the understanding that if you wish

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to, you can return to it, ultimately, we would like to turn to a series of special reports and at least get a portion of that presentation completed before the lunch break.

The first of them is one in which we have asked Mr. Gilmer to present to you, which has to do with RMP relationships with health care institutions. We have asked ~~Stan~~ SAM Gilmer to spend a large portion of his time addressing those kinds of relationships which he is doing in his function in the office of the director, and what he has to present to you is in the nature of a preliminary or progress report.

end 8

Right.

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MR. GILMER: That is right.

RMPS enabling legislation emphasizes the importance of the hospital role in the RMP effort. The more generic term "health care institution" also appears prominently, along with "facilities."

All share what might be termed "equal billing" with medical schools, medical centers, research institutions and the physician elements of the health care provider group.

However, while hospitals, institutions and facilities are listed in several places in the legislation, I'm sure we have all encountered (and perhaps I a bit more than some others associated with RMP) those in the hospital world who feel, even if they don't really believe or know for a fact, that hospitals and those most concerned with their administration and governance have no very real ties with RMP. Many in RMP, as well as those in hospitals, would say that our health care facilities have not always participated optimally in the planning and in the continued welfare of the Regional Medical Programs.

This does not mean that there is an unawareness that the Programs have operational projects in a majority of the hospitals in the country. To be a bit more specific, the hospital people I have principally in mind are found within the ranks of administrators, trustees, and the boards and staffs of the hospital associations, the latter

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catering to the professional, educational and legislative needs of the hospitals.

Of course, I'm referring neither to all hospitals nor to all hospital administrators, trustees and association executives. But it would appear that there is little evidence to indicate that hospitals are institutionally committed to RMP to any significant degree at this time or in the past.

Nor is there much evidence that the RMPs, as a whole, (or the RMPS for that matter), have displayed a commitment to hospitals proportionate to that displayed with other elements of the provider group.

I am speaking of the hospital's commitment as an institution which comes from the hospital's governing body having taken a positive stand vis-a-vis RMP to the extent that it has adopted an official policy concerning hospital-RMP relationships. Before such a commitment can be made, though, the hospital administrator must wholeheartedly support the RMP concept and want to have the hospital he represents become intimately associated with the goals and objectives of the RMP.

I doubt, for example, if very many hospital governing bodies would go on record as supporting RMP unless they are first convinced by the administrator of its soundness.

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While I'm sure that there are examples where such commitment exists, I cannot cite any specific examples at this moment.

We want to make it possible for hospitals and other health care institutions to play more active roles in RMP than they have in the past.

As I earlier and somewhat pessimistically indicated, I am convinced that hospitals have felt "left out" where RMP is concerned. Perhaps we in RMPS should have taken more positive steps to do something about this a long time ago, for we have indications for some time that too large a number of hospital administrators believe that RMP exists largely for the benefit of medical schools and their associated teaching hospitals.

Perhaps this feeling is less strong today than in 1968 when the American Hospital Association and the then Division of Regional Medical Programs cosponsored an invitational conference on hospital involvement in Regional Medical Programs.

While several participants in the Conference presented evidence of fruitful RMP-hospital interrelationships, a perusal of the conference report brings out the interesting point that the almost inevitable choice of the medical school as the primary participant in the RMP planning process produced, at the onset, a sense of nonparticipation

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on the part of the community hospital.

It was also noted that while state hospital associations were involved in the planning stages of all RMPs, the degree of that participation varied widely.

True, it was said, many RMPs recognized the hospital as the primary organizational level at which members of the medical staff start to relate in some meaningful organizational way.

True, also, it was said, RMPs could offer the hospital and its medical staff an organizational structure which could assist in the identity of community needs. Concurrently, hospitals would be offered unique opportunities to tap the resources of the great medical centers of the country.

Why, then, did they fail to respond with enthusiasm? Could it have been a lack of interest? Perhaps a lack of understanding? Whatever the answer, it was stated that hospital involvement varied widely at both planning and operational levels from RMP to RMP.

The conference report states that perhaps responsible, and to a degree unknown, could have been the customs and traditions of some hospitals which often led them to isolationism, provincialism, pride, and nearsighted concentration on self-interest.

Almost, inevitably, of course, the conferees

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observed that hospital administrators, trustees and physicians are often prejudiced against Federal participation in health care planning and practice.

Yet, since regionalization would maximize hospital potential through continuing education programs and improved communications, it was thought that hospitals would recognize and respond to their responsibilities in the planning and conduct of RMP supported projects.

Since an ultimate objective of RMP was to be the creation of an environment conducive to continued education and research in hospitals, the university center, the RMP and the community hospital would work together to develop teaching facilities and toward the creation of better interrelationships.

The end result could be none other than an improvement in diagnostic facilities and the training of a broad spectrum of health professionals. The conference participants recognized then, and of course, it is still true today, that some RMPs are successful in their relationships with community hospitals.

It was recognized that some RMPs were engaged in dialogue with hospitals and hospital associations around the concept that the hospital is truly an integral component of any comprehensive health care system.

That was in 1968.

jr 6

What of today?

Remarkably, smaller but more recent conferences with hospital oriented people indicate that neither the majority of RMPs nor the RMPS have shown much real progress vis-a-vis hospitals to the extent all of us would like.

What are we doing about it?

Several things:

Hospital involvement is accorded a high priority in RMPS. Studies and future action programs to enhance hospital participation in RMP are centered in the immediate Office of the Director, RMPS.

A survey of hospital administrative competence within the several Programs is being conducted. Returns indicate that about two-thirds of all RMPs have designated a staff person to look after their interests in hospitals.

About half of the RMPs have hospital administrative personnel on their central office staffs. To establish a common terminology, let's call these people hospital administrative consultants.

Some, but by no means all of them, hold graduate degrees in hospital administration; have had real experience in the actual administration of hospitals and are assigned primarily to liaison with hospitals.

Two of the conferences we have held recently (Atlanta in June; St. Louis in July) were limited in

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attendance to selected RMP staff who had demonstrated their competence in hospital administration; who held graduate degrees in hospital administration, and whose principal duties lay in the area of hospital-RMP liaison.

Additionally, numerous conferences have been held with individual hospital administrators not in the employ of any Regional Medical Program. Similar conferences will continue in the future and a full report will be made to the National Advisory Council at a later date.

Some interesting observations have come out of these conferences:

It is important that any RMP recognize the delicacy of becoming involved with hospitals in pursuits which others, for example, a state hospital association, might believe to be their legitimate area of interest and responsibility.

A rather classic example of this would be in the area of continuing education for the administrators of rural hospitals, a generally recognized need. But it would be unwise for any RMP to undertake such an activity without the total support and collaboration of the concerned state hospital association.

It must be remembered that some state hospital associations may resent any effort of RMP to "invade their territory," even though they may have no active programs in

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the proposed activity.

Seldom, indeed, do hospital administrators applaud one another, but such was the case when one administrator observed,"RMP represents one of our last grand chances to develop control over our own destinies."

Without exception, it was agreed that the hospital administrator needs to be brought into project planning while the project is still in its conceptual stage. This is especially true when any of the parties concerned expect the project to be continued with local support after Federal support is concluded.

It was pointed out that more projects should be institutionally based rather than individually based. What happens when the principal investigator moves or what are the ramifications of project salaries which differ substantially from those in effect for the institution as a whole?

Introspectively, perhaps subjectively, many administrators feel that they could play fruitful roles in an RMP if they could be called upon to make available their considerable administrative and managerial talents.

Other administrators point out that would be beneficial to all concerned if RMPs would pay more attention to the governing bodies of hospitals, a matter noted briefly at an earlier point in this presentation.

Even if we admit that control and administration

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of community general hospitals has undergone change during the past few years, it must be conceded that the governing board of the hospital still contains a goodly portion of the power structure of the community.

We wonder to what extent some RMPs appreciate this fact and if they appreciate that they, too, could benefit from the services of these trustees.

The potential for cooperation and assistance certainly exists, as it does for the utilization of hospital administrative personnel on the various committees and task forces of the RMPs.

With continuing reference to the governing body of the hospital, perhaps RMPs might further the TAP program of the Joint Commission on Accreditation of Hospitals.

This program, with seven sessions scheduled prior to May 14, 1973, is directed toward the responsibilities of trustees in the assurance of the quality of care rendered by the institutions for which they are ultimately responsible. Invited, also, are administrators and physicians.

A few RMPs have looked into the conduct of special programs for trustees. However, they have quickly found that this is a sensitive area as far as both the hospital administrator and the state hospital association are concerned.

And added complication is the procurement of rosters of trustee membership.

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Of course, the only wise course is cosponsorship with the state hospital association. On the other hand, I believe that it is reasonable for an RMP to express an interest in the quality of institutional care. There is plenty of room in the field.

At this point I'd like to list a potpourri of other areas of interest:

How can successful urban outpatient programs be extended into rural areas?

Working always with the state hospital association, could not RMP assist in bringing the expertise of the trained hospital administrator to the aid of his rural counterpart without pain to either?

Could not RMP assist in bringing the benefits of management engineering to more hospitals, especially the smaller and the rural?

While RMP has done much to expand the ranks and increase the technical skills of many classifications of hospital personnel, does it not have a responsibility to serve as a resource and assist in the skills maintenance of those who work in our hospitals?

This would be especially true of dietary, medical record, x-ray and laboratory personnel, not forgetting, of course, the vast needs for the continuing education of plant and equipment maintenance personnel.

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Why shouldn't RMP hold more conferences to bring together the principal officers of the various health oriented groups and agencies within a given State or service area?

Many hospital administrators in the smaller hospitals have good ideas about what would make a fine RMP project. However, they are not experienced in grantsmanship.

Why not provide assistance in how to develop an idea from its conception through to submission of an application?

What could/should RMPs do in relation to home health care programs, with especial reference, of course, to the role of the hospital inclusive of such items as the medical record?

What can RMP do in conjunction with hospitals to reduce the waste and the hazards of the practice of "shopping around" for medical care by patients?

How can RMPs work with state hospital associations to promote better interhospital communication?

In the matter of quality assurance, what is the role of institutional administration? What can RMp do about this facet of the problem?

Is there an RMP role in promoting better communication between hospitals and other institutions offering special care?

What can RMPs do in cooperation with hospitals

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to attack the problem of transportation for the rural sick. Everybody seems to be interested in the transport of the injured!

In summary, beyond the foregoing, there are two additional areas which should be mentioned:

1. Fundamentally appreciated by all with whom I have spoken is the fact that little increase in service should be envisioned in the primary (including emergency) health care field unless there is a more realistic consideration of the sources of financial support . . . continued financial support.

It simply is not enough for an RMP to call for greater hospital involvement without offering some idea as to where the money's coming from! The tax base must be considered.

2. Hospitals must be approached in terms of their institutional totality, not merely on a basis of the competence, interest and availability of some departmental facet of its operation. The administration and the governance must be fully informed and fully supportive of any RMP project which is to have lasting effect.

Finally, I would note that we expect to be able to present a comprehensive and more factual report to the Council in one of its coming meetings.

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DR. MARGULIES: Thank you very much. It is a good report.

Are there any comments or questions of Mr. Gilmer?

Well, we will pursue these and bring them back to you.

DR. BRENNAN: I would like to thank him for what I think is a very fine report, a very truthful one.

DR. MARGULIES: I will transmit that information to him.

DR. BRENNAN: Right.

DR. MARGULIES: I think we might, if you don't mind staying on for just a little bit longer, be able to finish the open part of this meeting with two brief reports, one of which may engender some special discussion, and perhaps not. I don't know.

But Mr. Gardell, would you come up here, please?

I think it might be better to summarize the management assessment activities first -- well, either way.

MR. GARDELL: All right. My name appears on the agenda for these two items, and I am going to ask the concerned staff members in our grants management branch to make the presentation to you, if I may.

From the presentation on the third party reimbursement, I think you will be able to learn quite quickly that we hadn't been informed previously of Dr. Stone's

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presentation this morning, but suffice it to say that the policy we are talking about now and informing you about, and it is informational in nature, is in its second draft form and it is presently being discussed within HSMHA, so that it is not finalized, and I think that we can probably expect some changes coming down the pike.

Mr. Roger Miller in our branch leads up the policies and procedures function, and he will make the presentation to you this morning.

MR. ROGER MILLER: This is Roger Miller.

During July 1972 the Office of the Administrator, HSHMA, approved an operation planning system process to develop and implement by June 30, 1973, in all HSMHA programs and supported Health Service Delivery Projects, a fiscal management policy which would lead to augmenting and ultimately replacing Federal Grant Support with increased third party reimbursement and other cost reimbursable devices.

As a result of this directive, an interim policy statement on Health Service Funding relating to third party reimbursement was developed during August, 1972, to give effect to the concept that grants awarded under the auspices of the Health Services and Mental Health Administration are considered to have as an objective, community assumption of the operations of programs involving personal health services which have been planned and developed with the assistance of

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HSMHA Funding.

The Administrator decided that this position is supported by legislative language such as "Demonstration Purposes," and for "Initial Period" which is contained in most legislative authority for HSMHA Programs.

This interim policy requires that HSMHA support of all continuing grants and contracts and new projects subsequent to the effective date of this policy will be planned on a diminishing basis and that additional support to maintain the planned level of operation must be obtained from Federal or Non-Federal Third Party Payment or other funding sources.

To the maximum degree possible all projects are to become basically self-sustaining community based operations within a period of time which will be determined for each Health Services Program.

In this regard, the decisions reached by the National Advisory Council on November 9-10, 1970, predate this concept, as it was decided that (1) Regional Medical Programs do not have authority to use funds for support of services, (2) Each RMP's Operational projects are to be designed to be integrated into the Health Care System of its region, and (3) Each operational project is to be disengaged from Regional Medical Program funding at the end of its support period of three years or less.

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Projects in operation that are failing to become disengaged from Regional Medical Program support by the end of their third year may be allowed a reasonable period in which to become self-supporting or be terminated.

The Council recommended at that time that no more than 18 to 24 months be considered a reasonable period but refrained from setting a maximum which might tend to become a customary period.

A second draft of this HSMHA funding policy statement was reviewed by us in late September, at which time it was indicated that the policy was still an "interim statement."

It is now being discussed with the Regional Health Directors throughout the Country. Many changes are still being made to the interim policy and the complete applicability of all conditions contained therein to RMPS has not yet been resolved.

Once the final policy is promulgated, RMPS shall take action to develop specific requirements to which RMP's grantees shall be required to adhere to give effect to this policy.

Other salient points of this policy are:

(1) Specific program policies are to designed to promote an orderly phase-out from grants to community assumption.

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(2) Grant support for future funding periods will represent the difference between the approved budgeted costs of operation and the amount of income anticipated to be generated from non-grant sources.

(3) The determination of each project's third party financing and reimbursement potential shall be outlined in a required financial plan to be submitted by the applicant or grantee at the time of new or continuation funding.

(4) Funds received from Third Party Reimbursement may not be used for new construction or renovation or for major equipment purchases or activities related to "Program Expansion," and,

(5) Regional Medical Programs shall be required to comment on the effectiveness of implementation of these requirements by all grantees and prospective grantees for Health Services Funding, in the area served by the Regional Medical Program.

The proposed policy also enumerates selective criteria regarding (1) the basic review of the application and the financial plan, (2) the grantee responsibilities in connection with implementation of this policy, and, (3) the treatment of grant related income in connection with HSMHA supported activities.

Any questions you may have in this regard, I shall try to answer.

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DR. MARGULIES: Thank you, Mr. Miller.

Dr. Brennan?

DR. BRENNAN: I think that is directly contrary to the message we got from the first speaker this morning in terms of disease control activity.

I know it won't be directly contrary, but there is some kind of a coalition here.

The fact is that when a program is begun, there is no reasonable or honest way to say that it is going to merit support unless the demonstration it sets out to perform is a successful one.

Now, it is precisely because we are after innovative changes, and we don't know how they are going to come out, that we have to make a gamble.

Writing out financing plans that inform everyone that you are going to get Blue Cross to pay for this after you get through showing how good it is is not going to gain anything for anybody, and I think it is very unrealistic for us to think that a regulation like this can change our fundamental position.

About the only thing it seems to me, we can practically do in this regard is to build into the regional staffs a technical capability for pursuing with presentations and with appropriate legal means a policy of informed advocacy for changes which we have shown and have

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evidence are good.

This, I think, is a very, very unrealistic position to take at the present time.

DR. MARGULIES: Let me just expand on that for a moment.

In the first place, I think it is equally unrealistic for us to try to compete with Medicaid and Medicare.

Secondly, there is a presumption that every activity that was initiated has to be in an area where there are no service payments available.

You can innovate where there is a method as you can where there is not a method for paying for it.

Finally, your point is still a good one, because at my insistence, when this policy was being reviewed, we developed a beginning glossary of what we mean by demonstratings.

There are all kinds of demonstrations, so that if you are demonstrating an established kind of procedure with the understanding that it is acceptable for reimbursement, that is one thing.

If you are demonstrating a new idea innovating and altering directions, then it may in fact call for the kind of flexibility we talked about this morning. It depends on how you use it.

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DR. SCHREINER: I think that is an important point, because there are projects that deal with an all accepted service entity, where it is quite reasonable to ask the individual to outline what proportion will be peeled off to service care fees and how these will be applied in the program as a whole.

The problem, I think, is that what we would like to see start more often in RMP is what I would describe as venture capital, where you are really being innovative, and if you start out with a sign on the front door saying that everything has got to be taken over, then you are saying that we are going into the venture capital business only in businesses that are guaranteed to succeed, and once you do that, you eliminate about 80 percent of venture capital business, and you just can't get ventures in those situations.

So the more inflexible you are in demanding that, the less imaginative your projects are going to be, because the only projects that are going to come are the ones in which the people already know they have a peel off.

DR. MARGULIES: Just to put this in perspective, and without pursuing it too much, let me say that the policy which has just been read to you is primarily aimed at programs other than Regional Medical Programs.

The chief deficit that is being addressed is a

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very real one, and the major share of the concern is there, and that is the development of activities in areas where there is clearly available third party reimbursement which is not pursued, and we have all kinds of evidence of that going on all through the health services, mental health administration activities.

If there could be more force put behind that, we would be putting less money in competition with funds that we can't compete with and more in the development of new activities.

I think the impact for RMP is much less significant than it is for other programs, but this policy is not in final form, and I think it requires some further attention before we know what it means for RMP.

DR. MERRILL: Have you had any success in obtaining reimbursement for RMP?

DR. MARGULIES: That is the kind of thing Dr. Engall was talking about. A number of projects we have been able to develop and for which we have been able to attract Federal program support, Title 18 and Title 19, is significant.

Now, I can't breakdown the exact number, but it is not an easy thing to do. It is easier under Title 18, than under Title 19. In many states, the State laws are rigid, the amount of money limited, and it gets to be a difficult thing to add to the burden of Title 19 when the State is already

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having difficulty meeting the financing placed on it.

Of course, that carries on up to the national budget, where the uncontrollables are somewhere in excess of 82 percent or 83 percent of the HEW budget.

If there is to be a reduction in budget, it will not effect the uncontrollals. It will close in sharper on HMSHA and NIH, and anymore money we lose reduces our effectiveness.

We have one other report which I think would be useful to place before you before the lunch hour. If any of the people here representing the public would like to comment before the final lunch break at the end of this open meeting, they will be free to do so.

MR. GARDELL: Either you present on, or some member of your staff, with whom I assume you are acquainted.

(Laughter.)

MR. GARDELL: I just spilled my joke. I was just going to say that Mr. Thomas Simonds, who leads up the function for grants management surveys in our branch, I don't think he is associated with any hotel, is a graduate of the VA's internal audit program, and is well versed in this subject.

Back in late 1970, this function was assigned to the grants management branch, and the completion of the surveys has changed to some extent.

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It has now become an integral part of the entire review process, and as a matter of fact, has gotten considerable recognition by the administrator's office and the secretary's office.

Our reports are now utilized by the department auditors and they are also utilized by the staff of the Office of Grants Administration policy, and their review of improving the management of the grantees, quality of management of the grantees, so we all work together.

We are bringing you today what we are doing, and how he is doing that.

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MR. SIMONDS: For some time we have been conducting management surveys, and several of you have come in contact either with the survey directly or programs through reports.

We thought it was appropriate to now tell you something about how we conduct these and how they are arranged.

There has been quite an evolution in the management survey program since it was first begun in September of 1969.

The Management Survey Program was first organized in September 1969. At this time a survey was conducted only at the request of the Coordinator or with his agreement.

At that time it was considered only to be a service and advice to local management to help them strengthen their administrative procedures.

Teams were composed of myself and two people selected from other RMPs who had particular ability in conducting management reviews. Approximately two years ago, Dr. Margulies relocated the program in the Grants Management Branch and changed the manner in which Management Surveys would be scheduled, conducted, and used.

With this change, the Coordinator was no longer the only criterion for a survey and the team composition was changed to be made up entirely of HSMHa employees without utilizing consultants.

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As will be seen at the end of this presentation the use made of survey findings and recommendations has been changed dramatically.

The purpose of a survey is essentially the same as it was in the beginning in that it is a review of the administrative procedures of both the RMP and its grantee. The team makes no judgment upon the quality of projects or the professional aspects of the program.

SCHEDULING:

By the end of November we will have reviewed thirty-five regional medical programs. We will schedule approximately eighteen surveys during calendar year 1973. (Six "A" rated, nineteen "B" rated, and ten "C" rated.) (We have not done Susquehanna Valley, Central New York and Missouri.)

A survey schedule is developed during November of each year for the ensuing calendar year. Various factors are taken into consideration in setting the priorities of regions to be surveyed.

1. Whether the region ever had a survey.

2. Regions identified by the Operations Desks.

3. Preceding a site visit; particularly when the region is applying for triennial status.

4. Questions raised by the SARP.

5. Actions taken, questions raised, or interest

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expressed by the Review Committee or National Advisory Council.

6. Non-Profit organizations (California, Maine, New Jersey, Tri-State, or Wisconsin).

TEAM SELECTION:

The management survey function is now staffed by two full-time people. These two peole serve as the team leaders. In addition to the team leader there are two other people selected from either RMPS or the appropriate DHEW Regional Office.

Ordinarily, we would include the Operations Officer responsible for the region being surveyed, or if he is not available, another person from that desk. We also attempt to include a Grants Management Officer or a Regional Grants Management Officer to examine that aspect of the RMP.

PRE-SURVEY PREPARATION:

In preparing for a survey the team gathers as much information as is possible on the region while we are here in RMPS. This involves discussions with the Operations Officer, the Regional Program Director, and a review of the files in RMPS.

Of particular value in our preparation is the report on the verification of the region's review process if this is been conducted.

To assist the team members there is a survey guide we routinely use to lead the team members into areas of

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of interest to the survey. These questions have been developed by the HEW audit agency, which they use in their review of non-profit organizations.

SURVEY:

Surveys normally are conducted for three full days, beginning with a meeting with the Coordinator and Program Staff and ending with an exit conference on the fourth day. During the initial meeting the Coordinator gives the team a very broad overview of the RMP.

The team leader also explains to the Coordinator and his staff how the survey will be conducted and what each team member will be responsible for.

Following the meeting each team member goes his own way to begin his part of the survey. Interviews are normally held with employees at their desks rather than having employees come into a team room and appear before the entire team.

We feel that this way works better since the employee is more at ease sitting at his own desk. Also any files and records or exhibits which we may need to see are more readily available at his desk than if he were to come into the team room.

One team memeber, normally the operations officer, is assigned to review Program Planning, Development, and Evaluation.

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In this process he interviews members of the Regional Advisory Group and its committees as well as the individual on the grantee who is most closely associated with the RMP.

He must of course spend a good bit of time with Program Staff members who are involved in these aspects of the program. Since the intent of this review is to determine how decisions are made and how the program is managed and coordinated at that level. A great amount of time must be spent in the review of committee minutes, by-laws, affiliation agreements, and any written memoranda of understanding between the various organizational elements.

With the recent policy on the relations between the Regional Advisory Group -- Grantee and Executive Director, we must delve rather deeply into matters which would give us a clear understanding as to whether this policy being met in intent.

All of the Management Systems are also examined. In order to do this we first review the written policies of the region and of the grantee agency as they apply to the RMP.

We, then, through a series of questions and review of documents determine how the regional medical program is living within those policies and to what extent they are meeting them.

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If the policies themselves are inadequate or if they are too extreme we would make recommendations for change. A review of the timekeeping and leave system is conducted, by first examining the policy to see what is permitted and then reviewing the timecards and leave records.

For example, we frequently find that there is no way whatsoever that the employee or coordinator can determine the leave balances of employees.

The payroll procedure is examined to assure that the same person does not keep the timecards, prepare the checks and then distribute them. We also are interested in what sort of documentation the payroll office requires before preparing a check.

The entire financial management function is closely examined by the Grants Management Specialist on the team. This is not a deep financial audit but rather one which determines the adequacy of the recordkeeping, how well the reports are prepared and where they are sent, and what use may be made of the financial reports as far as rebudgeting of funds is concerned.

We also compare rather carefully the records maintained by the Program Staff with those that are available in the fiscal agent's office.

RMPS contends that the grantee is responsible for maintenance of this type of record and if there is a

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duplication in the Program Staff office we would recommend reducing it only to that part which is essential for day-to-day operation.

The Procurement System is reviewed to assure that prudent business practices are used in the purchase of equipment and that quality items are obtained at the least possible cost by accepted bid procedures or blanket purchase agreements.

The identification, control, and inventory of equipment purchased with grant funds is also a matter of interest to the team. The records concerning this are carefully reviewed and again it is of interest to us to determine if there is a duplication between the grantee and Program Staff records.

Throughout the total review of management systems the team members must each be aware of and alert to other signals which they may receive since we also are reviewing the internal communication within the office and the manner in which the office is directed and controlled and coordinated.

These are areas which in many cases, the team members must exert a fair amount of intuition and then through careful questioning develop the item to its fullest extent.

For example, in reviewing the personnel system, we sometimes find that there is some problem with the type

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of supervision administered and that there may be an underlying morale problem. In determining the cause and extent of this we are frequently able to a good fix on manner in which the program is directed.

PRELIMINARY REPORT:

Each day throughout the survey the team meets and discusses its findinds, conclusions, and potential recommendations. On the last morning the team meets with the coordinator and representatives of the Regional Advisory Group and the Grantee Institution.

At this time an oral report is given to that group. Nothing appears in the final written report that has not been discussed at this meeting and which they have had an opportunity to rebut.

SURVEY REPORT:

Upon returning to RMPS, each team member contributes a written report on his area of responsibility during the survey, and the team leader edits, rewrites, and combines the parts into a single survey report.

Copies of the written report are distributed to:

Director, RMPS

Director, DOD

Chief of Responsible Operations Branch

Office of Planning and Evaluation

Coordinator

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Chairman of Regional Advisory Group

Grantee Institution

Office of Grants Management

Office of Grants Administration Policy

HEW Audit Agency.

Recommendations made in the report are used:

(1) To correct the deficiencies identified,

(2) To assist the Operations Desk in working with the Region,

(3) To be used by the Director in making management decisions concerning the Region,

(4) Part of the total review process, and

(5) As information to be included in the site visit package.

We also expect to compile significant findings from all surveys without identifying the region and make this listing available to all RMPS for their review.

The findings may also result in developing new RMPS policy and may be the basis for special studies by either the Grants Management Branch or some other office in RMPS.

The Office Of Grants Administration Policy has used the reports as basis for reconsideration of indirect cost rates for grantees.

The DHEW Audit Agency Director has stated that

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the Management Survey reports provide them with information and are a major consideration in their determination of audit needs at RMPS and that by relying on these surveys they have been able to limit their own reviews.

Approximately six months after the report has been given to the RMP and grantee and after their written response to the report has been received either the Operations officer or the Regional Program Director conducts a follow-up visit to determine the adequacy of the region's implementation of recommendations.

DR. MARGULIES: Are there any questions you would like to ask?

Obviously, the sharpening of the management along with the verification and review process has given it a far better level of understanding and management capacity with the Regional Medical Program.

I think it has contributed greatly to their strength.

Dr. Brennan?

DR. BRENNAN: I think that it is certainly good to review the administrative and fiscal policies of the groups, but I see a certain hazard here.

The grantee corporation and the Reginal Advisory Group has a primary duty of judging whether or not the program director is doing a good job and whether he has

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a good administrative setup and doesn't morale in his staff and so on.

I can see very clearly that management review like this, when it is consultative and assistive is one thing. I am a little jumpy about having people coming in from somewhere else and picking up gossip about how people feel about each other in the office and making that some part of a report that gets written down.

It is impossible to find anyplace where we have got more than 5 people where they are all happy, and I am a little fearful here about the kind of an insertion of our monitoring function into a relationship of directions that belongs rightly to the local region and a corporation.

Now, with respect to honesty and integrity of the bookkeeping, et cetera, rules can be given, and those can be followed.

But I am a little jumpy about administrative review from hearing these things being carried in this detail, because I think responsibility belongs at home for those things.

DR. MARGULIES: Is there any other comment?

MR. OGDEN: The only comment I would make is that I have to take a little exception to Dr. Brennan's remark in that we do site visits, all of us have participated in them, and while they may not be involved directly with this

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type of management survey, we still are assessing the relationships within the staff, the Regional Advisory Groups relationships to its coordinator and a variety of other things.

So I simpathize with your reaction, but I think this is the kind of thing that we also need to do.

DR. MARGULIES: Mr. Engall?

MR. ENGALL: Mr. Chairman, having participated in earlier site visit, it has been rumored or suggested to me that where we had regional medical programs, people from other regional programs directly, that this practice is now being discontinued. Is that correct?

DR. MARGULIES: Yes.

MR. ENGALL: Is there a specific reason for that?

MR. SIMONDS: I am not sure I can answer it exactly. I will try.

One reason was the feeling that RMPS people, the operations officer in particular, should be present, that the grants management people should also be present, since they are working each day with the regions, that people from other regions, programs, would not be quite as objective, maybe, or would not have the RMPS understanding from this end as to what RMPS was like.

Dr. Margulies has changed this philosophy in moving it into grants management, having participated in an

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earlier visits where there were other members of RMP staffs from other regions present, and many site visits where coordinators have been present, I think their presence is invaluable.

The simpathy they have with reality of the day-to-day operations, whether you are looking at overall program philosophy or management issues, is, I think, something that we shouldn't shut out on a policy basis.

DR. MARGULIES: I think the question, there is no question about their value in site visits and other activities involving regional medical programs.

I think what we are trying to do here is to protect the management activities of the regional medical program against a great many possibilities of variance from regulation and from what you described very clearly by the Federal Government as their responsibilities.

The more one decentralizes, the more one is obligated to verify at regular intervals that the decentralized activity is doing business the way it ought to do business.

This is a matter of attesting to their activities. For the most part, the management assessment visits have proven to be of tremendous value to the individual programs.

These are not site visits. This is strictly addressed to management assessment, the way in which the

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program manages its affairs.

It is more concerned with the kind of issues that Mr. Simonds has outlined here. In fact, I think that we would be highly irresponsible with the individual regional medical programs if we did not give them this kind of support.

I think it has obviated audit exceptions and a great range of difficulties to which they would be otherwise subject.

It has been strongly endorced by the regional medical programs who have had the benefit of it.

DR. BRENNAN: I don't think it ever hurts anyone to have a detailed review with good advisers about all of these regulations and the rest, and these interoffice procedures and personnel records and all the rest, but what is bothering me is that the grantee corporation is the one that we say has the responsibility for seeing that these things are rightly done, and it is going to obviously judge us whether they are right when it proceeds with a particular staff and coordinator in office, and I think that we ought to limit -- I don't want to see this go over into an evaluation, so much as I want it to be a consultative assistive service to the grantee corporation in which the legal responsibility is fixed for that program.

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But I think what is bothering me is that the whole lot of independent reports coming back to all that tremendous list over there, and one of them happens to fly over to the grantee corporation, too, but an awful lot of harm can be done with the misunderstanding on the part of a management survey team that I don't think would be just, and would make a bad conflict.

If these were viewed more as tutorial or assistive consultative things which in part in large part they have been, because the men have been reasonable who have been doing them, that is one thing, and I think that the first duty of this management survey team is to report back to that head of the grantee corporation, and I think nothing should be communicated until the survey teams reports has been reviewed and considered with the grantee corporation and then the whole thing should go on.

DR. MARGULIES: Are there any other comments?

Are there any other comments from the public visitors?

Well, we will hereby adjourn the open part of the meeting for lunch, and reassemble at 1:46 for review of applications.

It will be a closed meeting.

(Whereupon, at 12:45 p.m., the hearing was recessed to reconvene at 1:46 p.m., this same day.)

CR7534
End #11

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AFTERNOON SESSION

1:50 p.m.

DR. MARGULIES: Will the meeting please come to order? This is the portion of the meeting of the Council which operates under rules of confidentiality which are in your agenda book, covered under the requirements associated with application review and confidentiality of applications and those who submit the applications.

The first order of business, if you are prepared to look at it, is the minutes of the meeting of the June 5th and 6th Council. Because that was a very active council discussion, we have distributed the minutes to you for your review.

If there is any hesitation whatsoever about the form in which they appear, we can delay consideration of the minutes until you have a better opportunity to look them over.

DR. BRENNAN: I move approval of the minutes as written.

DR. MCPHEDRAN: Seconded.

DR. MARGULIES: It has been moved and seconded that the minutes be approved as written.

Is there discussion? All in favor say aye.

(Chorus of ayes)

DR. MARGULIES: Opposed?

(No response)

DR. MARGULIES: Very good.

I did want to make just one or two comments about such issues as RMP legislation and appropriations. This can be brief, because I don't have much to tell you that you don't already know. I am sure you are aware of the fact that the appropriations act was passed and vetoed, and that there has been another effort for further appropriations, and also pending in Congress as of last night and certainly during the current week is the legislation which would affect the manner in which spending controls are to be managed in government.

This depends on whether or not Congress will give to the President a control over spending based upon a specific set of delegated responsibilities.

As far as I know, that has not been settled, and it would clearly have some influence on this year's available money as well as next year's.

So until there is a final action on our appropriations and a final decision on spending control, we do not know at what level we are operating the RMP for the current year, and since there has been no formal submission of the budget to Congress, we do not know what the proposed budgetary levels will be for the next fiscal year.

There is very persuasive evidence that in an effort to limit the spending in the Federal budget, restriction will be placed wherever possible on expenditures, and that

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our RMP budget will be under review with a good possibility that the level available during this fiscal year, the coming fiscal year, will be reduced.

But that is a kind of a general statement without any specific information as to what it will be. That also does not deal with the fact that Congress has yet to finish its appropriations act for fiscal 1973, and is not considering any appropriations as yet for fiscal 1974. It is a completely unanswerable kind of issue.

The evidence that we will have less money available during this and the succeeding year is quite good, unless something extraordinary happens.

During this year, also, as you well know, there will be a need for the RMP legislation to be extended, because it expires July 1st of 1973 -- well, really on June 30, and during the current year, there have been a number of organizations which have been developing their ideas about what RMP legislation could be, or should be.

There has not been to my knowledge any final position taken in the Administration regarding the form of the RMP legislation, and there have been no hearings in Congress on RMP, Hill-Burton and other programs which have to be restored during the coming year to remain in business.

So it is going to be an active season with an uncertain state of future legislation and an uncertain status

on the current and projected budget. Aside from that, I can shed no light on the situation. That means we will have to do what we did in the past, that is, carry out a review process and base decisions on what appears to be a reasonable response to a reasonable application and worry subsequently about how close we can come to meeting the kind of level which the Council believes is appropriate for each individual program.

Now if anybody knows more about the appropriations status as of this moment than I do, and there could be many, he can be heard without delay.

I think you have to bear in mind as you consider the kind of priorities which were discussed during the morning that a significant reduction in the available budget for RMP would require some choices between the various kinds of things which the RMP's have been doing, and that, of course, depends entirely on what level it is we are talking about, and until we get there, I think it is almost impossible to make any kind of a decision.

I would like at this time, as we prepare for specific action on applications for a review of the processes which have been utilized to ask Judith Silsbee to present to you some of the ways in which we have developed altered format for the committee as it goes over programming.

This was at the request of the review committee

Silsbee re visuals



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and on the instigation of staff, hoping that we can improve the display of information and sharpen the attention of the committee to critical issues on their own recommendations.

MS. SILSBEE: I have some examples of the types of visuals -- I will repeat that. I have some examples of some of the types of visuals that were used before the review committee, but before we show them to you, I thought we would give you background.

The review committee membership changes such as council membership changes, and the early information that was available within the group about where the regions were located, what their geographic terrain was, their past history, has been less evident to the committee as a whole than it was earlier on.

We have a lot of this information in our management information system and in the minds of the people who have served the regions, and so the attempt this time was to try to bring some of this background information to the review committee in a way that they could grasp it quickly without it interfering with the process of review.

Three regional programs were selected for this purpose, all of which had been site visited, and the site visit chairmen were there to report to the committee. In December we had a case study showing the history of a review of a region from its early days and showing the effect that

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the review process had had on the region's progress.

There were a variety of visuals, maps, with overlays showing where projects were located and where programs were being proposed. Also, changes in the types of sponsoring institutions and changes in the request data and how it was allocated versus the allocations of the funds in the past.

The committee felt these presentations were helpful, primarily the background information. They thought it would be particularly helpful to have this kind of information in some form at the time the team meets, the evening before the site visit begins.

They also felt that canned visuals could be very misleading to a region, and to the presentation of the region, and asked that these visuals, any visuals that were presented would be kind of tailored to the situation.

They suggested a judicious use of visuals, and the point was made in some instances the information presented in such a capsulated form could be very misleading. They also suggested that at the time of the site visit the team itself could take a look at this situation and see what would be helpful to the review committee at the time it was deliberating on the site visit teams recommendations.

Now I will show you three examples of what we used. We have three of the regional programs from New York under review, and there was a way of bringing to the review

committee's attention the locations within New York State.

This is a very dramatic portrayal of the differences in project sponsorship in a region which is under review, probably the most pure example of this type that we have.

Finally, here is an example of the way in which a region allocated its funds during the first 3 years of its operational program, and what its request is. This was the kind of a visual that the committee felt could be misleading, because if you will note, they are asking for about twice as much money as they have now, so the request information and where they might allocate it might be very different from where the money actually goes.

DR. MARGULIES: All we hoped to do was to give you an idea of the altered methods we use. One reason for presenting the Rochester program is because it had been one that was a source of anxiety over a long time. It had appeared initially to be a program which was naturally destined to be a good RMP, but which never made it for a variety of reasons, and in the process of review and by using a number of illustrative slides, we could demonstrate the alteration of the program, but only as a consequence of actions of the review committee, council, staff, and efforts on their part and so on.

You could not say anyone specific event was responsible for it.

As we develop these materials more regularly, and

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that will depend on the RMP's who use them, we will be applying them to the review process that you are involved in, including site visits.

Are there any questions or comments on this?

DR. SCHREINER: I have a question. When you analyze something, is this done purely on the dollar routing? Because it is a danger, it seems to me, of penalizing the very thing that you are trying to accomplish. If a university in fact is successful in, let's say, sending a half time man out to a hospital, it is conceivable that it could end up in a visual at the university of Rochester, and it is conceivable by disassociating it as having it as a disembodied hospital fund, it may make the figures look good, but the reality very, very bad.

I wonder, you know, if you are making this distinction, or if you are doing it by the way the dollars go. I would much rather see the university involved in the community project than to simply take pride in the fact that you cut off so many funds from the university and got the money out into the community hospital.

That may be more desirable than an intramural university program, but less desirable than a combined approach.

DR. MARGULIES: This particular one we picked to look at is a good example, George, because it was a university

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sponsored activity, and their understanding of what the rest of the region needed is what they decided they needed, and if they decided they wanted someone to go out to the community hospital, they did that.

That would be a university-sponsored activity. If it represented some kind of understanding between the rest of the region deciding what was desired and what the university was willing to cooperate with them on, that is a different kind of a category.

Of course, you could never be quite adequate with any diagram of this kind. That is one of the advantages with a quick look. One of the disadvantages is that it hides a number of things. But as they reviewed their own activities, if you look at that chart, they themselves discriminated between what was purely university and what the university was involved in.

There happens to be at Rochester a program that belonged to the university for it to design, manage and conduct, and I think we illustrate that. When you get into some other areas, it is not so certain.

We should have spent more time on that chart, because what that demonstrated is the difference between where they have been, and where they are supposed to be, and you are actually looking at the application as it is outcoming, which does move away from the kind of thing which

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we are demonstrating in the first part of the chart. I think that becomes more obvious as we go to the review of that program. The differences between the existing and the projected programming input is what I am referring to.

DR. DEBAKEY: It does not make any difference if it is the present or the future. The fact remains that as far as the chart is concerned, it does not provide you with the information you need to assess where the money goes. That is the point I am trying to make.

From the Council's standpoint, from the standpoint of our accounting for the funds, when you leave a large segment of the funds being used for purposes which are not clear in terms of their relationship to the objective of the program.

DR. MARGULIES: It is not intended as a substitute for the review of the program. It is merely a matter of brief overview illustration. We will carry out the complete presentation of the program.

DR. DEBAKEY: Harold, you don't seem to get my point.

DR. MARGULIES: No, I don't.

DR. DEBAKEY: Maybe it is because I am not making it clear. I don't expect it to be a substitute for the review of the project, but I expect on the basis of the chart to be able to tell where the money goes. That is the point I am trying to make.

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I don't think the chart tells you where the money goes. Put up the last chart and I will show you what I am talking about.

Now there you see that all of the red part shows one thing, and the rest another. Either that chart is misleading, or that is one of the things I have been critical of the program about.

DR. MARGULIES: The chart is not misleading.

DR. DEBAKEY: If you are helping heart transplants and other areas which are multi-categorical, then you could easily divide that program up, and out of that 47 percent you could put a red overlay and an orange overlay and you could express that categorically, and that it is in fact helping those areas.

DR. MARGULIES: Fair enough.

DR. DEBAKEY: I think it will be very difficult to go to Congress with that kind of thing. It is misleading.

DR. MILLIKAN: We have funded some audio visual laboratory phenomena out at UCLA and in Washington. Those were large amounts of Washington, or if they were, that would have been in yellow, wouldn't it?

DR. MARGULIES: Yes.

end

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DR. MILLIKAN: This is the point, because those large quantities of money were contributing significant educational aids, audiovisual aids of all kinds, TV tapes, et cetera, to heart, to cancer and to stroke. Yet, if you were making a Congressional display and an appearance, the figures in your program, the heart portion of that would have been lost.

That is what Mike is talking about.

MR. OGDEN: I would have to second what Dr. Millikan is saying. We have a great deal of money devoted to staff, and yet that money is hiring people who are directly responsible for heart programs, for cancer programs, or stroke programs; to be used in production of television shows.

We are seizing that now, but it has been used specifically for continuing education directly in these programs, and yet we call this program standards.

I think many times we should break it out categorically or in some other way, and yet these people also become involved in multiple things. So I recognize the difficulty of creating a chart of this nature, and I sympathize with Dr. DeBakey's comments.

I think it is very difficult to visualize something of this nature, what Staff does, and be accurate with it.

DR. DE BAKEY: Dr. Brennan?

DR. BRENNAN: I think there is another thing to

note here, too, and that is that the regional medical programs are a coordinative element, and just as the state medical society has substantial staff budget, vis-a-vis project budgets, I think when you get into the area where one of your main purposes is to achieve a communication and organization of medical efforts, that you are bound to have a pretty large staff element that can't be categorized into these other things with any real honesty.

MS. SILSBEE: I was going to say that some of the regions you just mentioned is why the committee was anxious this be used as background information rather than focus on the program as it is under review; and we are doing that at this time, and I think the very fact that you have asked these questions shows that some of the data that has formerly been in the printouts may be needed to be displayed in a different way, and because the data has been there -- and now we are trying to bring it up for discussion.

And the review committee, as I mentioned before, was very anxious that this not be canned data, but that it be presented in such a way that it reflects particular situations in that regional medical program at that time.

They were skeptical about this, too.

MRS. MARS: How does this compare with other programs?

MS. SILSBEE: In this particular program, the fact

that it has been -- I think the fact that the program staff was being built up was a result of previous review by committee and council, that showed that they needed to have more staff in the developmental area. The actual staff people that are represented by the 41 percent earlier in this program were nearly all categorical in nature.

DR. DE BAKEY: Back to changes in the program staff component.

They were as a consequence of the recommendation of the council that they get stronger staff activities in that program, because they were not dealing with comprehensive health planning; they were not developing cooperative arrangements; they were not getting programs initiated in an effective fashion.

The actual amount of the programmatic activities which require time for what is called administration do not exceed about 15 percent, and the rest of it is professional activity which is essential as we have been developing regional medical programs.

The council has an opportunity today and tomorrow and on every review to take a look at that aspect of each regional medical program and to act on it as it deems appropriate.

MS. SILSBEE: The program staff category list include feasibility studies, central resources and developmental

type activities.

MR. OGDEN: Don't forget evaluation.

DR. DE BAKEY: I don't think the point I have made has been made clear enough.

All I am saying is that I think it is very important that you reflect in a chart of this kind the programming activities rather than taking it down in such a way that the reviewer is aware where the money is going; and that is what I am saying.

MS. SILSBEE: Dr. DeBakey, the committee would agree with you completely on that point, and this was an attempt to try something. We are going to have to be experimenting. It is very easy, as you know, to mislead with this data.

DR. DE BAKEY: Sure.

Dr. Millikan, are you prepared to make a report on the visit to the Mountain States and so forth?

DR. MILLIKAN: Yes.

DR. DE BAKEY: Let me introduce this by saying we have had the question of territorial overlap which has been a chronic issue in recent programs, and one that received special attention. This involves the Mountain States, Intermountain and the Colorado and Wyoming RMP's. And Dr. Millikan is a part of a group that went out there to address this problem.

DR. MILLIKAN: The question was with respect

to overlap, particularly between the group centered in Salt Lake City, which had moved into Montana, Wyoming, Idaho and Nevada, as well as being in Utah and Western Colorado.

The hope was that there could be some resolution of their communications system and network, or in re-identification of the boundary outlines, or at least the areas of overlap of those three, Colorado, Mountain States, and Intermountain, so that there would be less friction than apparently had developed.

Well, to make a long story short, they have gotten together and have drafted -- which is actually available -- a document which summarized the situation as it was at that time and presented a series of alternatives as possible solutions, and they themselves decided to create an inter-regional executive council designed to reach joint decisions regarding programming in overlap areas, and it assumes that the existing RMP structures would be maintained.

Overlap is desirable so that programming can thoroughly be coordinated, and that duplicate programming in communities could be avoided, together with the idea that there were some communities in which the very aggressive group at Salt Lake City would withdraw from.

So with that idea in mind, they have drafted a series of what one might call "guidelines" or "procedural rules" called "Policy and Procedures for Coordinating the

Activities of Regional Medical Programs in Overlapping Areas in the States of Colorado, Idaho, Montana, Nevada, Utah and Wyoming."

There are minutia in this that I suppose one could take apart, but what it is, is ongoing methodology for communication and decision-making about any possible questions of differences accumulating around different geographies or different activities.

I presume that your staff has probably had an opportunity to review these and see whether they think they are feasible and reasonable. It seems to me that these suggestions that they are now getting ready to implement, and I believe have working at the moment, are entirely in order; and if carried out would basically solve the crisis or solve the development or prevent the development of the criticism that we have leveled at them.

Do you have any comment?

DR. DE BAKEY: Just one or two.

We felt when this problem was to be addressed that it was most important that the regions themselves reach an understanding of how they would manage, and so it was planned and was carried out with that kind of arrangement.

The meeting which Dr. Millikan attended included members of the regional advisory group from all three areas, of the grantee agencies, and coordinators; and they were able

to decide what they wanted to do.

Our instructions primarily were for them to reach a workable decision and to try to deal with two issues:

One of them is the kind of activities which do require geo-political boundaries, like some agencies where there has to be a way of addressing what is intrastate, and at the same time those things which require the kind of flexibility which RMP allows in allowing institutions which are naturally related to one another, regardless of state boundaries, to continue those kinds of relationships.

So where there are areas of uncertainty, they had set up a mechanism, as Clark had said, for making a decision for a policy process, and we will follow it closely and report to you regularly on how close it works.

The only other thing I would like to say is that I doubt very much that the experience in those three regions is directly applicable to any other regions, because their circumstances are quite different.

In that case, we had programs which involved multiple state regions, which is not quite the same as some of the other overlap areas, which I think we will come to, and which will come to our attention from time to time; and which we would like to resolve by a level of understanding by the people there, rather than impose upon them some arbitrary boundary which might not suit the facts of life.

Pahl re developmental component



I don't believe this requires any action. It is more of an information report.

DR. PAHL: Before we turn over to the review of applications, there is one other area, and that has to do with developmental components and the role that it has played and is playing in the regional medical programs.

The staff review committee, and I think the Council over a period of time, have observed the changing character of this developmental policy, and we have as a staff looked into the matter more fully.

Subsequent to the last meeting, that is, and Ms. Silbee is serving as spokesman for the staff, and she will indicate to you what some of our considerations are, and what we would like to propose, and in order to just steal her thunder, we are not asking for action at this time.

This is a matter of information to you, and we will be coming back at the next meeting of the council with a specific plan and request for action by you on this matter.

So at this time we are trying to get to the topic and to give you some idea of the complexities involved, and the directions we are going.

MS. SILSBEE: The developmental procurement has been difficult. The idea was a long time aborning, and it actually got announced in the spring of 1970. It seems like a long time ago, but actually it wasn't so long.

The notion of a developmental component at the time that it was developed was to allow regions an opportunity to initiate activities without getting bogged down in long-term support. It was to give them an idea to try out this.

At that time, the project review was in ascendency, both locally and nationally, and theis seems to be, because regions were allowed to come in four times a year with supplements for more projects, it was very difficult from both the regional medical program standpoint and the national review standpoint to see where all this was going, looking at things out of context as a whole.

So the developmental component was initiated at the same time the requirement was announced that regions would submit applications once a year, and at this point in time, the emphasis went back on program review rather than review of individual projects.

Since that time, it is interesting to see the process, because in the initial review of requests for developmental components, the idea of a region getting out from under this project stagnation, really, and the desire to get regions turned around, and the requirement for a region being eligible for developmental components were really in conflict.

Regions that needed the developmental money were thos that did not meet the standards for receiving the funds.

At this point in time we have regions -- 13 of the 14 presently rated "A" regions, with approved developmental funds. All but two of these "A" regions received funds in their initial request time.

Of the 26 "B" rated regions, six do not have developmental components yet. One of those regions has never requested one.

Of the 13 "C" rated regions, only one has an approved developmental component. Eight of these "C" regions have been applied, and been disapproved at least twice for developmental funds.

Three of the 56 RMP's have not yet been rated.

Since the developmental component was announced, a number of significant events have taken place. Project review has been decentralized, the RMP review procedures have been studied, a trennial system has been inaugurated, ~~bidding~~ rating by review criteria has been initiated and discretionary funding policies have been announced.

The developmental ~~compliance~~ component has been useful as an instrument. It focuses attention on such things as forward planning, budget control, the key role of the regional advisory group, the importance of developed programs, and program staff activities in the development of the program.

In summary, the initial staff review feels the developmental component may have helped the regions to

develop faster.

It may have helped the other regions focus on the deficiencies that were needed to get their decision-making in order and to strengthen regional advisory groups and to monitor expenditures and so forth.

At the same time, it may have had a detrimental effect on those regions which have been denied ~~governmental~~ developmental component status.

Some regions, we have found, have interpreted the disapproval of the development component as a disapproval of the activity proposed, rather than a consideration of their own processes, and so forth.

At this point in time, we feel that there are several factors that anyone may think it timely to consider, looking at this developmental component as a way of developing the program. We have new techniques for analyzing weaknesses and encouraging the "C" regions to change their processes and improve the review criteria.

The discretionary funding policy has been implemented which gives regions considerable flexibility within a triennium, and the activities and funds can be generated through various means.

Regions can curtail or terminate projects, they can initiate requests for a higher level of funding; they can re-budget as expenditures lag in certain areas.

There are at least ten different ways that regions have now to free up funds for activities that the developmental component was designed to help, and, in addition, we are in the process of developing new instructions for the RMP applications, and there are ways of phasing out the developmental component and keeping those aspects of it which are important and putting them in a different place.

Before we had this meeting, I talked with a member of the review committee about this particular situation just to see how he felt the review committee might look at it, and he said, "Great".

He thought it was an idea whose time had come, and perhaps would go on at this point.

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DR. PAHL: I think what we would like to have is perhaps a briefer period for any questions or discussion by the council. Again we are not trying to take action at this point. As a matter of fact, applications before you today have requests in and should be acted upon with respect to the developmental component.

We will be bringing to you at the next meeting a grand policy statement together with a further analysis of this developmental component situation, and at that time we would request action looking toward moving out of the developmental component in the best interests of the program which at this time we believe it will be, and giving to the regions those kinds of flexibilities which were alluded to already on discretionary funding authority and other policies that we now have.

Is there any discussion at this time, however, by the Council?

DR. KOMAROFF: I had a question on the discretionary funding policy that we approved last meeting. As I read it, Tab C, number 3(b), in talking about those regions that are not approved for tri-annual status, it seems to me to imply that one of these regions can, if it has funds available to rebudget, can start up a whole new operational activity that falls roughly within the states and approved objectives of the program, but the specifics of which have

not been looked at by any Federal reviewing body.

I am not saying that is bad, but the fact that that flexibility seems to exist even for a region which does not have triennial approval adds more urgency, I think, to your statement that the uniqueness of the developmental component has been over shadowed by the other devices that have become available in the last couple of years.

DR. PAHL: Yes. The groups have the real authority for deciding priority, and we have in a sense eroded other authority.

DR. KOMAROFF: I was wondering. It appears that the programs which have not received triennial approval have almost as much flexibility as those which have, and what we regard are we really giving a region which we give it triennial approval other than a certain amount of security and a little bit of padding in the form of developmental components?

DR. PAHL: I think basically you have indicated there is only a slight difference with respect to ability and stability and planning over a long period of time. As you know, we are working with as much speed as possible to get our programs going in that regard.

The difference has diminished as we have come in with these kinds of authority. You have to suffer the good with the bad under this type of policy.

DR. MARGULIES: Some of us are not so sure, Tony, that the one year approach to programs is in itself such a good idea. We can carry out a careful review process on programs which require annual review and still give them a greater continuity of support so that they can make some plans which will allow them to grow where they otherwise could not.

At least it should be possible for institutions on a regional medical program to plan for more than one year ahead. It makes it very difficult for us on operations, and some of us have been talking about at least the advisability of trying to set up budgeting processes, or at least book-keeping processes which are more on a 3-year than on an annual basis.

That is something we would also like to bring up for your consideration at a later date.

MS. SILSBEE: Dr. Komaroff, there is one other point, under the review responsibilities under the triennial system, and a region not under triennial wants to come in for counselling every time.

DR. DEBAKEY: There is a concern I have, and that is the ability to give some direction to the development of control measures. There has already been criticism, and I think we will continue to develop further criticism. I think if you read the record, you will realize from the

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testimony that part of the basis for the assertions made was that that was never assumed properly, and I think this is a matter of continuing concern to this council, because I think that the future of the regional medical program is going to depend upon its ability to demonstrate that it can do this, and I don't think it has demonstrated it up to this point.

DR. MARGULIES: This was the subject of the morning's discussion, Dr. DeBakey, and I think the council indicated agreement with the statement you just made.

DR. PAHL: If there is no further discussion on those matters, perhaps we should turn to the review of specific applications, but I am reminded by Mr. Baum that the cafeteria dictates the time schedule of the council if we wish to have coffee, and we will have to break in ten minutes in order to find the cafeteria open.

We had a late lunch, and so perhaps it is not necessary.

DR. MARGULIES: Let's eliminate the coffee.

DR. PAHL: We will eliminate the coffee and go to the first application.

DR. OCHSNER: There are six other physicians called associate coordinators and who are supervisors of various regions. (Inaudible)

The ARMP seemed to us to be too heavily weighted

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with physicians. Albany Medical College is the grantee organization and receives a 52 percent for administration. We felt this was too high.

Although it did cover the fringe benefits, this seemed a great deal higher than necessary. A very fine plus of the ARMP is the fact that Dr. Borghley, who is chairman of the RAG, is also chairman of the Executive Committee. Dr. Broghley spends a great deal of time with the ARMP, a day a week, and they have had two meetings a month of the Executive Committee which is apparently a very fine, dedicated committee.

This is a unique activity because prior to this apparently the RAG was not very active. Dr. Borghley was asked whether the Executive Committee ever went into executive session. He said they did not because the discussion was so frank that they felt it was not necessary. It was the feeling of Dr. Kraft that the greatest need they had was that the grants management organization was considered and gone over carefully.

It was the feeling of the site committee that many of these were hastily conceived, and not all of them should be approved. There seems to be a very good rapport among the members of the organization. Apparently a good deal of progress has been made since the last site visit and the team is expecting to do good work.

The Executive Committee of the RAG is very

dedicated, having things pretty much under control. We were concerned about the way the coordinator was chosen, and the fact that the RAG -- in the way the RAG was chosen -- and we made specific recommendations that they change their constitution and bylaws, which I understand has been done.

It was disturbing to us that the grantee organization receives the percentage it does, which seemed far too high. The director holds a tenure appointment in the Medical School. Since then I have been told that they have implemented some of the recommendations.

There is a letter under date of September 15th. They have made a number of changes, implementing some of the recommendations that the site visit team made.

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DR. PAHL: Thank you, Dr. Ochsner.

Dr. Ogden?

DR. OGDEN: Well, I would like certainly to second everything that Alton said. This program is one that has gone through a tremendous metamorphosis in the last 18 months, and as a site visitor I came away really quite impressed with the extent of the change and its rapidity and the thought and the effort of all of those who had gone into it, both the staff and the RAG, and there is genuine potential for success.

They still have some problems, and I think that is inevitable, and that some new problems have appeared is a happening which I think they are prepared to meet. I think triennial funding is warranted here, and certainly I would recommend it to this body.

I would propose that we keep a rather close touch, the operations branch, keep a close touch with this program over the next year at least, because relationships with the Albany Medical College, I think, need to be formalized carefully, and indeed even rearranged in some cases.

The bylaw changes apparently have been made. I have not seen this as yet. There needs to be a formal document of affiliation in my opinion with Albany Medical College, the housing of the RMP itself is an issue.

They need job descriptions which need to be

formalized. The fiscal management techniques ought to be better developed, they need better in-house personnel management and continuous program evaluation.

But despite all that the program is off and running with a much broader scope and depth than it had before. They have an excellent staff. They have good leadership, and while their problems aren't over, I think our concern for the success of the program is now considerably less, and our assurance that the public's dollars are being well spent is greatly enhanced.

DR. PAHL: Thank you, Dr. Ogden. The Chair understands that you moved to accept the committee's recommendations, and it was seconded by Dr. Ogden. Is there further discussion by members of the council?

Does the staff have any comment to make regarding this obligation? Yes, Mr. Klein?

MR. KLEIN: I happened to be up at Albany this past Thursday for a review process verification visit. I would like to indicate that the fiscal man who was recommended is now on board as of the, I believe, the 15th of September or the 1st of October.

I can't remember which. Secondarily, as of 1 January, the concern over housing of staff in one location will be resolved, the entire staff will be under one roof and under one location as of 1 January.

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The agreement has been drawn up between the Medical School and the program. The bylaws have been revised, and nearly all of the recommendations including the revisions or the modifications suggested for the revisions of the review processes have been instrumented and there is now a concerted effort to bring together the projects into a more concerted programmatic thrust. This is somewhat recent, some of the things I happened to experience just the other day.

DR. MARGULIES: Mrs. Wyckoff?

MRS. WYCKOFF: I would like to ask if there was any discussion with the regional boundary with respect to its relationship with Northern New England? I understand there are two counties that use Albany as a service center, and also use the Northern New England center.

There was a sort of an overlap, and I wondered whether that was discussed.

MR. OGDEN: We were aware of this. There are, as I recall, two counties. I don't recall that there were any turf problems.

MRS. WYCKOFF: I just wondered if you had representations from those two counties, or how you handled them.

end

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MR. KLEIN: Possibly I could comment on that. There is representation from the CHP B agncy which is located in Berkshire, Massachusetts, on the Albany program.

MR. OGDEN: I stand corrected.

DR. MARGULIES: Is there further discussion?

MR. OGDEN: Florence has been up to Northern New England, you see, and she has run into the same thing.

DR. PAHL: A motion has been made and seconded to accept the review committee's recommendations on the Albany application. All those in favor please say aye.

(Chorus of ayes)

DR. PAHL: Opposed?

(No response)

DR. PAHL: The motion is carried.

I would like to call the council's attention that on the center of the table there are two volumes in the black loose-leaf binders of the various printouts that give to you the specific information on the funding history requests, and the recommended amounts and so forth.

Please feel free to use these during the course of the meeting. We would like now to turn to the Bi-State Regional Medical Program with Dr. McPhedran as the primary reviewer.

MRS. MARS: May I ask what happened to the Missouri-Texas?

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DR. PAHL: At the request of Dr. Frick, we have deferred this discussion until tomorrow, and we will present at then at that time.

MRS. MARS: Thank you. I apologize for interrupting.

DR. PAHL: Not at all. We skimmed over it on the agenda.

DR. MCPHEDRAN: The program was site visited on 29 and 30 August, and the recommendations of the site visiting team were accepted by the review committee, and I am recommending your acceptance of those recommendations. They are that this region which includes St. Louis, greater St. Louis, and includes Southern Illinois and which applied for triennial status a year ago and was turned down at that time, that it now be awarded triennial status, but no developmental component, and that another site visit be made after this coming year, which would be the operational year, another site visit to encourage the region, we hope, to carry out some of the recommendations that were made, recommendations with organization of staff, about the regional advisory group, and also to take up some problems which are continuing problems, things that don't necessarily have to do with organization.

The money here is as follows in their current 03 years. They received funds of about $924,000. They had requested $1,398,000 for the 04 year with increases by the 06

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to $1 million 568,000. The site visit team and review committee concurred on recommendations of $150,000 for the 04 year with 7 percent increases for the 05 and 06.

As I said, that does not include a developmental component. The site visit report which I think that you have is complete and detailed, like a problem oriented record, but it does not really summarize very easily what we thought, and the best summary can be found in the conclusion and funding recommendations on the last two pages, 34 and 35 of the site visit report.

The organizational problems that you have referred to are as follows: First of all, the regional advisory group is very large, unwieldy, may be not effective in planning very often, and it has seemed to RMP's and others in the past that it may very simply be a rubberstamp for programs that were for projects that were university sponsored within this program.

On closer inspection, we were not sure that that was the case. A rubberstamp it may have been at times, but it was difficult sometimes to see the hands of the university -- there are several universities -- in hatching these projects.

I think we came away with less of a feeling than we had had when we got there that there was university domination of this regional medical program.

The universities in question are the grantee institutions which is Washington University, and the two others that cooperate in an agreement which is formally drawn up, this group of 3 is called the consortia. It includes Washington University, the grantee, St. Louis University and Southern Illinois University.

At any rate, it seemed that no matter whether the universities had dominated activities in this program in the past or not, that the regional advisory group was too large, unwieldy and not really an effective instrument for carrying forward a regional program, and we recommended that the numbers in this group be reduced and that it be charged with more of the responsibilities that should belong to it according to our policies.

The organizational problems and the program staff are another thing that we took up. The program staff is under the direction of the man who seems a very able coordinator but it was the feeling that all of us had that he required too much direct supervision over individual members of the program staff, that he delegated nothing to anybody much of the time, and that he needed help, perhaps he needed, we thought he certainly needed a good deputy coordinator.

We hope that this will solve the problems. We thought him a very able person, and we hope that with this addition in staff that this might solve many of the internal

organizational problems.

He was very frank with us in private discussions and talked about particular people on the staff that he thought needed changing, and we agreed with him about that, so we do feel that the direction is adequate to bring about the kind of changes that will strengthen the staff.

I should mention that we had other criticisms of regional advisory groups, that it again was not recommended. That not enough consumer groups were represented by our lights, and those were the organizational problems that we saw.

This Regional Medical Program has a real conflict with -- well, a possible conflict -- with the Illinois Regional Medical Program, over who was going to represent the southern part of the state. It appears that the Illinois Regional Medical Program wants a boundary definition and the direction of the bi-state program does not feel that that is necessary or desirable.

I gather that this difference of opinion is going to have to be resolved, and perhaps that a boundary will have to be drawn. We, fortunately, did not have to do that. That was not our responsibility, but I gather that somebody is going to have to do that, or else satisfy the Illinois Regional Medical Program that it does not have to be done somehow.

Now the last thing that I have to say is that in this funding recommendation we made, we perhaps anticipated some of the things that were said this afternoon about the developmental component, because while we denied it as such, we included in our funding recommendation some money that we feel would make it possible for the coordinator to hire a deputy coordinator and do the things that are going to be necessary to change the internal organization of the program staff, so that that -- so that the amount of money we have listed here is $50,000 in discretionary funds for Dr. Stone.

So we have completed that. While it is not a developmental component identified as such, we did thing this money would be suitably used. That is all I have to say about it.

I recommend that we accept the review committee's view, which is the triennial status be awarded, no developmental component as such, and in the amounts I have described.

DR. PAHL: Thank you. Mrs. Curry?

MRS. CURRY: I second what the Doctor has said. I recommend we discuss this region further. I think it is important to relate it by state region.

DR. PAHL: The Missouri site visit discussion will be a report to the Council. There is not formal action being requested of the council at this time on Missouri, so we are

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asking the council to take a formal action on the application of bi-state as presented. In that case, would you care to second Dr. McPhedran's motion?

MRS. CURRY: Yes, I second his motion.

DR. PAHL: The motion has been made and seconded to accept the committee recommendations for the bi-state medical application. Is there discussion by the council?

All in favor of the motion please say aye.

(Chorus of ayes)

DR. PAHL: Opposed?

(No response)

DR. PAHL: The motion is carried.

At the request of Dr. Milliken, I would like to go out of order a bit and ask we take up the Wisconsin program next on which he is primary reviewer, with Mr. Millikan the back-up reviewer, and following this application with the indulgence of Dr. Cannon, we would like to take up the West Virginia application.

So we will now turn our attention to the Wisconsin application with Dr. Millikan.

DR. MILLIKAN: The Wisconsin application is one which has received staff anniversary review. The summary of this is in the record on the pink sheet. A good many of you have followed with interest the history of this program and some of its many achievements.

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It would be belaboring that to review them at length. The staff after their careful analysis of the activities related to the amount of funds requested have recommended that the commission be funded for its sixth operational year, including $312,881 for ~~regional~~ rural activities.

This amount represented an increase over the current national advisory council group level. The staff has also recommended that the developmental components be funded at 10 percent of the current analysis level, and that would make it $177,907, rather than the $200,000, approximately, requested.

This is, as you may recall, a staff anniversary review. Wisconsin already has triennial status. I move we accept the recommendations of the staff.

DR. PAHL: Thank you, Dr. Millikan.

Mr. Milliken?

Well, is there discussion by the council on the recommendations?

Will someone please second? Mrs. Wyckoff has seconded the motion. Is there discussion by the council?

DR. ROTH: I would like to ask a question, having participated in the site review of this once. One of the graver problems that we saw at that time, and made recommendati for its correction, was a lack of depth at the top, for the top notch coordinator, but just about no place for it to go

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if something happened to him. Have they done anything about that?

DR. MILLIKAN: This has been corrected.

DR. PAHL: There further discussion?

If not, all in favor of the motion say aye.

(Chorus of ayes)

DR. PAHL: Opposed?

(No response)

DR. PAHL: The motion is carried.

Dr. Cannon, if we may, we would like to turn to the West Virginia application.

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DR. CANNON: I was quite interested when I was asked to participate in the site visit for two reasons.

One, I noted the non-M.D. coordinator, and I was aware of the dangers inherent in such an arrangement, having been sent prior to the one in the Susquehanna Valley some few years ago by this Council.

The second reason was that the application has essentially no mention of the categorical diseases of heart disease, cancer and stroke.

So, for those two reasons, I was interested in participating in this site review, and also requested that Dr. Margulies present this application and the site visit report to Dr. Millikan and Dr. Roth so they would have an opportunity to comment on it.

There are some facts about the region I think you should be aware of. The total population is 1.75 million of which 61 percent is rural; that West Virginia ranks 46th in U.S. per capita income, and it is a good 40 percent below the average.

In other words, per capita income in West Virginia is 2.6 -- I mean 2600 while the average in the United States is somewhere around 3600 or 3900.

It is also of interest that the geography of West Virginia and the transportation difficulties should have merited the attention of the Department of Transportation,

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because many of the difficulties in the health care system probably could be alleviated by an adequate transportation system.

They have lost 30 percent of their physicians in the rural areas; their economy has been in pretty rough shape. There are 40 to 50 percent of their patients that come from rural counties, and are indigent, with this pay. They have about a thousand physicians practicing in the state, 400 of which are nonlicensed M.D.s practicing in coal mining clinics and so forth.

These, of course, are foreign medical graduates. It is of interest that the term "categorical diseases" of heart disease, cancer and stroke really has no significant meaning in such a setup.

Now, concerning the coordinator, the program lost its M.D. coordinator by untimely death. The associate coordinator was a Mr. Holland; Mr. Holland's background was in hospital administration. They sought to find an M.D. coordinator, but eventually decided to make Mr. Holland the coordinator.

This proved to be a wise decision in the opinion of the site team after its visit. One should not lose sight of the one person who is the primary mover of the RMP for the State of Virginia, and that is Dr. Charles Andrews, who is Vice President of Health Affairs at the

University of West Virginia.

Dr. Charles Andrews came to West Virginia because he was primarily interested in lung disease, and wished to participate in the study and work of those who were afflicted with such. This would indicate the dedication of a man to medical problems.

Likewise, he has a certain expertise in administration which he has been well recognized for, and it is Dr. Andrews who is really standing behind the whole movement of the RMP in West Virginia, and I dare say that his presence is the essential reason that the program has proceeded in the manner in which it has.

It is noteworthy that the state medical association is heavily involved and gives strong support to the RMP program. This is in the home state of the present President of the American Medical Association.

In fact, the state medical association introduced legislation through its appropriate representatives for $300,000 from the state to be applied toward residency training programs which were in sad need of financial support, and this bill was passed.

So far as categorical diseases are concerned, the need was so great and the health machinery so immature or undeveloped that it was necessary to establish some mechanism that could eventually be utilized for the

categorical support.

I interjected that myself. I don't think you will find that in the site team's report, but it is my feeling that once you have the mechanism, we should again stress the categorical approach.

The utilization of other programs in coordination with RMP is stressed in the report. The examples would be such as the university extension program where they have many workers that are connected with the university extension program who are now being educated in health care.

These people are being assembled in the homes in these small Virginia towns, and I dare say that you don't walk into a small West Virginia town as a stranger and expect a reception.

You might expect something else. So, the utilization of that program should be stressed.

I think it is significant that the RMP there has invested a small amount of money for matching funds with one of the local foundations, and I have forgotten that figure, but it seemed like for about 10 or 20 thousand dollars they got about one million and a half. Somewhere that is mentioned in here.

That would indicate that they have been perceptive in seeking other resources.

Their main investigator is in health care delivery and health manpower and emergency medical systems. As long as the university has as its objective orientation to the specific needs of the State of West Virginia, as long as the university has a man of Dr. Andrew's stature and interests, and as long as the RMP remains close to the university and has the support of the medical association, I see no reason why it shouldn't succeed in its present undertaking, and why it couldn't reorient itself gradually toward the categorical aspect when and if the machinery are established to do so.

So we recommended, and I support the recommendation, funding at 1.5 million the first year, 1.6 the second year and 1.7 the third year.

DR. PAHL: Thank you, Dr. Cannon.

Dr. Roth?

DR. CANNON: By the way, I want you to know that I did not speak to Dr. Roth or Dr. Millikan concerning this application, so there is no collusion here.

DR. ROTH: I can make my statement concisely, I believe. I have concluded that West Virginia is a state generally acknowledged to be short in medical resources, long on problems related to medical needs, and endowed with a region's specific peculiarness shaped by geographical and occupational factors.

If it is the role of RMP to strive for the understanding of the several elements of the overall medical problem and to address itself to the solution of these problems through the proper use of existing resources and the development of appropriate supplemental resources, it would seem that the West Virginia RMP is functioning well.

At first blush there would appear to be a preoccupation with studies characterized as planning studies, feasibility studies, and the like.

On balance, however, it seems clear that piecemeal uncoordinated unplanned approaches to the problem areas have not been effectively productive in the past, nor would they be in the future.

It becomes reasonable to assume as one looks at RMP involvement that it is playing a catalytic role in stimulating a multitude of concerned organizations to coordinate their activities and to dedicate available funds and resources and manpower facilities to plan productive ends.

I find cogency in the site team's recommendations for the request of the developmental component requests, and that was to stimulate the residency programs, graduate educational programs, which will attract medical personnel to the state and hopefully keep them there for future care of the people in the state.

I would second the recommended approval for

triennial status with operating funding as listed in the site visit's report.

DR. PAHL: Thank you, Dr. Roth.

The motion has been made and seconded to discuss the Committee's recommendations. Is there discussion by the Council?

Dr. Millikan, did you have anything specific in mind?

DR. MILLIKAN: I was only going to discuss it if there was opposition.

DR. PAHL: I see.

Hearing no opposition, I will ask the question: All in favor of the motion, say aye.

(Chorus of ayes.)

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The motion is carried.

I would like to turn to the Central New York application with Dr. Schreiner as the primary reviewer and Dr. Musser as back-up reviewer.

DR. SCHREINER: Thank you. I was tempted to ask for a show of hands as to how many people thought West Virginia was more or less rural than Central New York, but rather than embarrass you, I will tell you that it has the same population in 15 counties with 2000 more square miles,

which comes out to 68, whereas West Virginia has 72 per square mile.

DR. ROTH: West Virginia is lumpier.

DR. SCHREINER: The other interesting thing about the region is that there are 5000 Indians in the St. Regis Reservation without a doctor or a nurse, and who have never been visited by the United States Public Health Service and they have never been visited by a Bureau of Indian Affairs, because they never signed a treaty with the United States, but only with New York State, and one of the workers who went there in preparation for our site visit found a completely equipped dental clinic which had never had the plastic wrappers taken off because there was nothing to operate it.

So, they have transportation problems in their 15 counties.

We were very much helped by the site visitor -- the composition of the site visit team, rather -- which took place on August 9 and 10, 1972.

Dorothy Anderson was the Chair person, and I think the visit in my mind accentuated the point that Tony made this morning, because she is Associate Coordinator and Dr. Simmons Patterson is Executive Director, and I find them both helpful in quickly getting to the staff problems which would have taken me a lot longer to get at without their

expertise.

There are a number of interesting problems which bring up a point that Bland made, and that is I find some difficulty coming to grips with this problem of a non-medical executive director.

Mr. Murray was the Medical Director after the departure of Dr. Lyon, and then just before our site visit was made the Executive Director of the region on the basis of a great deal of energy and commitment and tremendous amount of work.

However, everyone felt that there was a great need for physicians to be employed in the program, and one wonders just how an energetic layman like this is going to find a topnotch medical administrator to work under him and I think this poses a very significant philosophical problem, because he is undoubtedly a good man.

There were some management problems in that he had not yet significantly delegated things and that he had a lot of people on his staff who were in fact intimately then involved with the programs; and I think that it was the most constructive site visit I have ever been on in the sense that people who were on the visit were sufficiently management-oriented that they took right off giving suggestions right at the end, and one had the impression that a lot of good ideas were exchanged in addition to the

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overview of the program.

I was very humbled to find out that although there are a large number of excellent nephrologists in this area, they had no concept of what regional medicine was all about, and we had a meeting with them and persuaded them to withdraw their application, because they simply didn't address themselves to the regional aspects of the needs.

There were little bits and pieces of projects which had been inserted, and I felt that they really did not get guidance from the Executive Director or from the RMP in how to prepare their application.

We had a very frank exchange, and they were a little embarrassed, actually. They had never had the program really explained to them.

So, they went out and promised to come back with a more coordinated effort. This was the only basis for our report suggesting that money not be increased, because the training program as they envisioned it would have been a very static thing, confined to the Syracuse area, which is obviously the least needy part of the whole region.

So that I felt from that point alone that it was a very successful site visit.

The dealing with the cooperative organization and bank was not approved, because again it did not follow the kidney guidelines, and they needed some more time to

improve that particular application.

There was some difference of opinion among the site visitors on the many contract proposals. Mr. Murphy, since he had very few programs actually in the pot suggested, or contrived a rather original approach, and he sent out some really -- he littered the whole area with some 5000 solicitations for minicontracts, and got back 124, and then had a very elaborate system for deciding priorities in which a rating system was put in by almost everybody, including all the health agencies, all of the members of the RAG, all the members of the institutions; everyone, almost, got a chance to vote for the ratings on priorities, and they came up with the most democratically-oriented set of priorities.

This did involve a lot of work, and one comment was that never have so many labored so long over so little, but I felt that it was almost an instant way of regionalizing, because he got so much interest from around the region, places that they didn't know were in existence.

At least from a public relations standpoint, it was a superb maneuver, and I think they got out of it a few original ideas.

So, we were kind of split, and commended them for the effort, but encouraged them not to continue to go that route as far as minicontracts, which are rather expensive

mea-12

in staff time.

So, all in all, I would agree with the review, and move that it may be approved in a reduced amount of $889,000, down from the requested amount of 1.4 million, realizing that they will probably come back in with some guidance, I think, with a pretty good kidney program. They have a potential.

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End 16

DR. MARGULIES: Thank you, Dr. Schreiner.

Dr. Musser?

DR. MUSSER: I second the motion.

DR. MARGULIES: Is there council discussion?

The motion has been made and seconded.

MRS. MARS: Isn't a drastic reduction going to be discouraging to them? Surely it seems to me they need a little more encouragement.

DR. SCHREINER: The problem as we saw it, Mrs. Mars, was that they really didn't have the staff to cope with very much larger amounts at this time. I think we made specific recommendations as to how to increase their staff, and I think that eventually they should come up with very substantial plans, but we had reservations whether they could handle it at this time. I think the people have to come first.

DR. MARGULIES: I would like to point out this is below what they requested, but above where they have been. In fact, they were a little too ambitious during the immediate fiscal year and were not able to utilize all the funds available, so I think by the time they get themselves well organized, this will not hamper them.

MRS. MARS: They do have funds left?

DR. SCHREINER: Yes. They were careful with the expenditures. Even the $5,000 minicontracts, very few of

dh2

them had actually expended the $5,000. They were parceling it out frugally.

MRS. MARS: Do they get lower salaries, or what?

DR. SCHREINER: The director, you think, is too personally involved. He keeps close track of the progress in each individual area of the program.

MRS. MARS: So really they are not as progressive as West Virginia?

DR. SCHREINER: Sometimes we ought to have a philosophical discussion on whether we are not really locking the door in bringing in a non medical administrator. I wonder if you can ever get out of that once you have set that pattern.

MRS. WYCKOFF: By non medical, you mean --

DR. SCHREINER: Certainly at least a non-M.D. I don't really know, or remember, all the background.

Do you remember Mr. Murry's background?

MR. STOLOV: His background is in business administration, and one of his jobs was directing an OEO poverty program.

DR. SCHREINER: He showed very, very careful control of the business aspect, but I think he would have some difficulty, or is certainly going to need some help in relating to some of the medical - political problems in the area where there is a fair amount of rivalry, particularly

dh3

a large clinic down in Pennsylvania, and there is a Pennsylvania - New York kind of business, and there are a lot of medical problems in the area. He is going to have a little trouble keeping with it.

DR. CANNON: I am sorry I missed some of that with a phone call. But did you come to a method of solving how you are going to get M.D.s on the staff if you have a non- M.D. coordinator?

DR. SHREINER: I asked the question.

DR. CANNON: I thought maybe you answered the question while I was out of the room.

DR. SHREINER: I have some reservations that he could recruit a reasonably talented medical person on a staff basis. He did have consulting help, which was quite dedicated, but they have a lot of trouble moving around, particularly in the winter time, because they only have two seasons, winter and July.

DR. PAHL: Is there further discussion?

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

(Chorus of ayes.)

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The motion is carried.

If we may still continue out of line with the

dh4

agenda, would you like to take up the Michigan application with Dr. DeBakey as the primary reviewer, and Dr. Frederick as our backup reviewer. The record will show that Dr. Brennan is out of the room.

DR. DE BAKEY: I would like to recommend that we follow the recommendation in approving the amount recommended, which is two and a quarter million dollars, rather than the $2,097,479 requested.

The reasons for this are given in the report, with which I would agree. I think we can hope that with the new administrator that some of these problems will be resolved. They have been through them largely because of the lack of a coordinator for that period of time.

DR. PAHL: Thank you, Dr. DeBakey.

Dr. McPhedran?

DR. MC PHEDRAN: I don't know how the figure of $2.5 million was arrived at. The council approved level is $2.1 million. I think it is a strong regional medical program and a very good one. I am sure the staff and advisory review panel had reasons for increasing the increase above the council approved level, and I don't doubt they are good reasons.

I just couldn't find them in the material that I had. The problems in this region have been that they haven't been able to get a new coordinator, apparently,

dh5

until just recently, and while they had some able people on the staff who were temporary coordinators, they did have difficulties during these changing times, but I thought one of the good indicators was the use of developmental funds, that projects are well described, and they actually developed focus in serveral of the developmental projects, in sickle cell disease, as a matter of fact, and it seems as though they have gotten what I gather to be a very good state wide program in the identification of sickle cell trait, and this seems certainly to fit in with their goals and objectives.

I thought it was a good program when I site visited it over a year ago, and I think it undoubtedly still is. I just want to know what was the reason for increasing the council-approved level.

MS. SILSBEE: Perhaps Mr. Van Winkel could help us on that?

MR. VAN WINKEL: I think it was to help the coordinator expand his staff.

DR. MC PHEDRAN: I agree with the recommendation and second the motion.

DR. PAHL: The motion has been made and seconded to accept the committee's recommendation on the Michigan application.

DR. ROTH: I would like to ask an unhelpful

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question which stems from just having come here from attending the part of the sessions of the American Academy of Pediatrics in New York. I am not a pediatrician, nor am I a hematologist, but I listened with interest as there were some impassioned pleas made that to the effect that screening for genetic defects among which sickle cell and sickle cell trait is one, can be carried out with a rather small increase in funds, equipment and so on, to cover some -- I have forgotten whether it is 17 or 18 kinds of inherited genetic defects, not limited racially -- I mean, in whites as well as in blacks and Chicanos and so on, and the pleas were directed as a deemphasis on zeroing in on sickle cell disease, and I don't know whether this has any implications for this council or not, but if I as a non hematologist and non pediatrician got the message, it seems to me that with a relatively small increase in input, a substantially larger impact could be made on the control of genetic defects, and this would take somebody more expert in the area than I to evaluate.

But at least the pediatricians almost unanimously approved this point of view.

DR. PAHL: All right. Thank you.

Is there further discussion by the council?

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

dh7

(Chorus of ayes.)

Much vote

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The motion is carried.

Before we turn to the application from Hawaii, I would just like to ask for a show of hands of those council members who perhaps need transportation for this evening's get together at the Ramada Inn after the council meeting, and we will then make arrangements.

May we now turn to the Hawaii recommendation?

MR. HIROTO: This is my first site visit, and my first report, and I guess the staff will have to bail me out.

The site visit was made August 7 and 8, it is a triennial application, the second triennial application in two years. Last year's was turned down, and for obvious reasons.

If you will look at the yellow sheet, the first page of it, you will note that there have been a number of staff visits to the area, and that a management assessment visit and a review verification visit was made on May 15 and 18.

Unfortunately, the reaction of the Hawaii regional medical program was only verbalized in a letter form, and they hadn't had time to implement any plan that

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they may really have had, and so the review team's recommendation and reactions are really just basically gut reactions, caused by the enthusiasm of the members of the RAG and members of the staff.

The organizational problems still remain, the difficulty that the coordinator was having in not hanging on to all of the work and dividing up among the staf still remains, apparently, and the review process and evaluation process still has not been defined to the satisfaction of RMPS.

Despite that, there was a recommendation of the site visitors and of the survey review committee that the 05 funding will be at $1,185,480, which is $15,000 less than the site visitors recommended, because of some difficulties in the kidney project.

No developmental component was recommended for this year, but it was the feeling of the site visitors and agreed to by the review committee that in as much as this was a second application for a triennial standing, that until the developmental component or some dollar figures were based in there, that the RAG and the staff would be discouraged and wouldn't move ahead as they seemed to be moving ahead at this time.

That completes the report about developmental components. But I recommended that the funding level be

dh9

end17

approved for 05, 06, and 07 years as indicated by the review committee.

DR. PAHL: That also includes the earmarked fund for the basin area?

MR. HIROTO: Yes.

DR. PAHL: Mr. Komaroff?

DR. KOMAROFF: I was wondering how unsatisfactory these are and what the implications of that might be.

DR. PAHL: Mr. Russell will respond to that.

MR. RUSSELL: I would rather not speak into a microphone so I can be heard. We received the bylaws which at the time of receipt had not been approved by the Regional Advisory Group. They are being presented to the Regional Advisory Group just this past week.

One key difference is found in the RAG grantee relationship. The Hawaiian Regional Medical Program chooses that the coordinator is hired and fired by the RAG, not by the grantee as is implicit in our policy. That is one of the key things.

DR. PAHL: Thank you. Tony, any other comments?

DR. KOMAROFF: No, I second the recommendation. This has been the third year in a row we have given them the recommendations, with respect to having a deputy on the core staff and the other responsibility.

I hope next year we don't tide them along in the same way, but make some firm decisions one way or the other.

DR. PAHL: All right. The motion has been made

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Reba 2

and seconded to accept the review committee's recommendations. Is there discussion or further comment by the council?

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

(Chorus of ayes)

DR. PAHL: Opposed?

(No response.)

Hawaii Vote

DR. PAHL: The motion is carried. Dr. Komaroff, if we may move to the New Mexico application and have you start off as primary reviewer, with Dr. Watkins as the back up reviewer, that would be the next order of business.

The record will show that Mrs. Morgan is not in the room during this discussion.

DR. KOMAROFF: On the 17th and 18th of August we made a site visit to New Mexico. Let me briefly review the characteristics of the region for those members of the council, and the region is the State of New Mexico which has about a million people.

The grantee is the medical school, and the special aspects of the region is that it is largely rural, sparsely populated areas. It is poverty, and it is below average medical manpower and facilities.

The history of this program is interesting and characterized most predominantly, I think, by its relationship to the coordinator who, when it began in 1967, was the dean

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Reba 3

of the new medical school and chairman of the advisory group and director of the hospital as well as the dean of the medical school.

For the first two years when the coordinator was the dean, the program was criticized as being too closely tied to the medical school, and after the coordinator resigned his post as dean, it was then criticized as being estranged from the resources of the medical school.

In the last summer, in June of 1971, a site visit which Dr. Schreiner and I participated in demonstrated, I think, for the first time that there was some basis for enthusiasm about the real development of this region, although at that time it was thought ill advised to award triennial status.

Shortly after that site visit, the coordinator for the first four years resigned as coordinator and left the state, and the new coordinator was hired, and the progress since that time has been substantial.

At least that was our perception that August here when we visited. The main improvement has been that the advisory group has been significantly expanded and the recommendation is much more broad and none of these appear to be token recommendations.

The new members are among the most active and vocal in the leadership of that advisory body. Particularly

active in the role of the project evaluation, and they have made some hard decisions about dollars.

The new coordinator, Dr. James Day, who is a neurosurgeon, and has a long history of ties with the community and with the medical school -- where he is associate dean -- has generated a tremendous amount of new enthusiasm both with the staff who for the first time have been fairly stable and have not had a high turnover rate, and also he has given the program great visibility in New Mexico.

There are several excellent management tools, one of which is a computerized program for giving a monthly expenditure report by line item, by project, for each activity in the program, which obviously allows for a lot of flexibility in decision making and the directions of the program.

The other outstanding feature is a health data base which is really inparallelled in any other agency in New Mexico, in fact which is used by almost every health planning agency in New Mexico. There were some concerns and criticisms, however, that I would just briefly mention.

One is the absence still of short term measurable objectives, and what are called objectives are broadly stated goals and good intentions, and the absence of any priorities by any rank, order or sense, by which the program can make its funding decisions and its decisions on committing staff time.

# 18

Reba 5

In fact the staff did seem threatened in a sense by being pulled now in too many directions from the many inquiries from around the region for help. And for money, too.

Another area of concern was the phasing out of RMP support. This bears obviously on the issue that Dr.Stone raised this morning. Six projects have in fact been discontinued this year after four years of funding, but 7 are being continued for a fifth year of funding, and this is a particularly difficult region to be run in, because the options for other funding resources are so few that the site visitors found it hard to be -- hard to recommend discontinuing any program which was going into its fifth year of funding, but with regard to the tumor registry, they did state fairly categorically that only a further year of support would be envisioned, and that over and above that certain changes in the shape of the registry should be made.

A third area of criticism was with regard to minority representation on the staff. The region has already responded by hiring 3 minorities. Minorities in New Mexico are largely Chicano, which represent almost 40 percent of the population, and that criticism appears ameliorated to some extent.

The recommendation of the site visit was for even closer working relationships, particularly with CHP, the

# 18 Reba 6

Loveless Clinic, and Presbyterian Medical Services. We detailed that in the site report.

Also there were a group of individual recommendations on projects that are explicit in site visit reports that I won't bother to highlight here.

The overall recommendation, then, of the team was to approve triennial status because of the strength of the advisory group and the staff, and also to approve the developmental component as a slightly reduced level. We regard specifically the issue of the RMP support, a mini-site visit -- a review for next year was recommended, and there was a stipulation that no dollars be spent for basic training in established allied health professions and there are several of those in the region's proposals.

The dollar levels that I am proposing here, I have xeroxed them up separately, because it is hard to extract them from the printed material you would have available.

Basically, the region is operating now at a level of about $1 million 36,000. This site visit did not consider two projects which were earmarked money, one per EMS and the other for community health education services, which were approved by the last council, and those two projects, as you see, represent a substantial amount of money.

What we did was approve dollar levels as you see them for core staff, operational projects and developmental

#18 Reba 7

components. Actually, there is some shifting here summarized below.

The region requested about $1.7 million excluding another $500,000 for the two earmarked projects. The site visitors recommended $1.3 million and the review committee cut back on that by $150,000 by not recommending that we boost up slightly the review committee recommendation to 1.2 million, largely because they are boxed in with the earmarking of those operational dollars for EMS, which they won't be able to rebudget easily.

In short, the recommendation is for approval for $1.2 million in the 05 year, $1 million 3 in the 06 and so forth, excluding those monies already awarded by the council.

end #18

DR. PAHL: All right.

We have an initial motion, I believe, on the floor to accept the Review Committee's recommendations.

DR. KOMAROFF: No. Accepting the recommendations, but altering the dollar levels.

DR. PAHL: Yes, by increasing them $50,000 for each of the three years.

DR. KOMAROFF: Yes.

DR. PAHL: All right. Thank you.

Dr. Watkins?

DR. WATKINS: I second the report of Dr. Komaroff.

DR. PAHL: All right.

The motion has been made and seconded as just stated.

Is there discussion by the Council on this motion?

MRS. MARS: What is going to suffer by the reduced funding?

DR. KOMAROFF: Administration, you will know that really the region is expanding considerably even at this reduced level recommendation over their current level. They will be almost $700,000 richer in the next year. The money that was looked at was for nonspecified areas of project interest, that is, they wanted to do something with satellites in health education, but there was no specific project or plan worked out for that, or for any other similar areas.

We felt it was appropriate to give them essentially planning money for those areas, but we couldn't approve the expenditure of about $400,000 for a project that had not been worked out in enough detail.

MRS. MARS: You don't feel this is going to dampen the enthusiasm, because according to this, the director has done a most commendable job.

DR. KOMAROFF: I shouldn't think it would. They are expanding their budget by almost 70 percent, and the realities of recruiting staff in New Mexico are such that it would surprise me if they could in fact even spend the money for expanding the staff which has been allocated.

DR. PAHL: Mrs. Wyckoff?

MRS. WYCKOFF: I understand satellites are important in that area. How much money would the RMP use for satellites?

DR. KOMAROFF: If my memory is correct, something on the order of $20,000, but the venture is -- well, the satellite won't be up until four years from now, and there is no guarantee whatsoever that any time will become available on that satellite for the public health education broadcasts in the Southwest. It was a very, very tentative opportunity for Project Involvement.

DR. PAHL: Is there further discussion?

DR. CANNON: The only thing I would like to say

is that after hearing the presentation by Dr. Stone this morning, and the idea that RMP is really going to move ahead, I think we ought to be careful about restricting the budget, particularly after a site team visit, you know. I mean it would seem to me that we should have some faith in the ability of the new coordinator, and the enhancement of the program. We are talking about a relatively small amount of money. I think the difference is $50,000.

DR. KOMAROFF: Between this proposed recommendation and the site visit recommendation?

DR. CANNON: No, between the site visit and yours.

DR. KOMAROFF: It is $100,000 difference. The Review Committee cut that back by 150,000, and really did that with the rationale of forcing the region to find alternative sources of support. I guess your point is that we needn't be so stringent, especially considering Dr. Stone?

DR. CANNON: Yes.

DR. KOMAROFF: You are so flattering to a coordinator who is a neurosurgeon.

DR. CANNON: That wasn't my reason. I do know him, and I know his ability and dedication, and this makes a difference. I know he can do the job. I felt the same way about Mr. Charles Holland.

DR. KOMAROFF: Would you recommend the higher level of $1,250,000?

DR. CANNON: I would go for the 1.3

DR. PAHL: Mrs. Silsbee was trying to make a point.

MS. SILSBEE: No, I am asking for some clarification, because I have to report back to the Review Committee the reasons for the changes in their recomendations, and I am just not clear at this point.

DR. KOMAROFF: Well, originally, I felt they have been too stringent with their cutback in terms of trying to cut, or force alternative funding options within this first year, particularly since the $500,000 that we have already approved is earmarked money that won't easily be budgeted. That would be the rationale for raising it to 1.2. Bland is simply carrying the same rationale.

DR. PAHL: There is a motion on the floor and seconded for an increase up to the 1.2 level, and increases of $50,000 above the committee's recommendations for each of the subsequent years.

Before proceeding further, I would like to ask for the question on that motion.

All those in favor of that motion, please signify by saying aye.

DR. KOMAROFF: Wait. I would like to retract that motion if there is any substantial body of opinion that we should be more charitable.

DR. CANNON: Let's split the difference.

DR. KOMAROFF: 1.25. I recommended 1.25 and

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50,000 more in the 06 year and another 50,000 in the 07.

DR. CANNON: Second.

DR. PAHL: All right. We have split the difference and the motion now is for 1.25 million in the first year and a proportionate amount in each of the next two years.

MR. OGDEN: Might I ask what the money would be used for?

DR. KOMAROFF: The extra 100?

Yes, it would be used to increase the core staff from the level of 610,000 to the level of 800,000 plus, and to continue support of operational projects which currently are at the level of 350,000, which we would have reduced.

MR. OGDEN: Are you suggesting a particular split between the two?

DR. KOMAROFF: I did on paper here, and I think we shouldn't be more directive to the region than that. They have the opportunity to rebudget anyway.

MR. OGDEN: What particular need do you see would be added here?

DR. KOMAROFF: Well, to plan in the various program areas that I can go into detail about.

MR. OGDEN: I am trying to get toward Mrs. Wyckoff's question as to whether this particular satellite program is something that needs assistance, whether there is some particular reason for devoting time to that.

DR. KOMAROFF: The person now devoting time to it is devoting time to about six other things, too. On page 30 of the site visit report, some of these proposed developmental activities -- 10 of them in fact -- are highlighted, including the requests for the region for each activity.

MR. OGDEN: Since this would be a triennial grant, the regional medical program would have the opportunity to budget this money however they chose provided we don't say so much of it is for people and so much is for projects.

DR. KOMAROFF: Yes.

MR. OGDEN: So let's make it a lump sum then. It would be in the nature of a developmental bonus.

DR. KOMAROFF: It would. This breakout was only for our conceptualizing is what it boiled down to.

MR. OGDEN: Does that help, Mrs. Silsbee?

MS. SILSBEE: I will have to cogitate after I read the deliberations of this group as to what I will say to the Review Committee.

DR. BRENNAN: I think the substance of it is that we don't want to come down as hard on them about getting other sources for ongoing projects as the Review Committee did with them only a year into it.

So, in other words, we didn't want to, within one year, make them staff as many things as they would have other-

wise have had to staff.

DR. KOMAROFF: The fact is that they did stop and found alternative funding for 6 of the 13 projects. The fact is that in New Mexico, it is hard to find other support, and particularly in the direction of the administrator that the Council urged and the Review Committee didn't. We felt we should pinch less hard in this respect.

MR. OGDEN: Yes.

DR. PAHL: All in favor of the motion, say aye.

(Chorus of ayes.)

New Mex Vote

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The motion is passed.

Now, if we may turn our attention to the application from Northern New England, with Mrs. Wyckoff as primary reviewer, and I see Dr. Millikan has left the room.

MRS. WYCKOFF: There is a request for triennial status for the Northern New England RMP in the amount of 1.2 million for the fourth year, 1.2 million for the fifth year and 1 million for the sixth year.

There was included a continuation request of 78,740, for project No. 6 in kidney disease for a second year and 70,000 for a third year.

The Review Committee agreed that the Northern New England RMP be denied triennial status but that its

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program be awarded $850,000 a year for the 04 and the 05 years, and that within this amount a developmental component be awarded a 10 percent of the program's annual direction cost level which would be 72,500.

DR. PAHL: Thank you, Mrs. Wyckoff.

MRS. WYCKOFF: They both recommended the kidney disease project funding remain at 37,500 and 25,400 for the second and third year.

Northern New England RMP covers the State of Vermont and three counties of New York where it interfaces with Albany RMP and in the Connecticut Valley where it faces New Hampshire.

The total population covered is only 444,732 people, and it is 67 percent rural. Large variations exist in characteristics of its population county by county in income, education and health problems. It has a considerably higher mortality rate in heart disease, mortality and stroke than the rest of the United States.

The Vermont RMP developed differently from other RMPs in the United States, partly because of its long time interest in rural health, going back to 1932.

They invited the National Committee on the Cost of Medical Care to do an in-depth study in 1932. In 1944 the Vermont World Policy Committee published "Rural Health" after the war, which led to a proposed statewide health plan.

In 1967, the Northern New England medical needs compact was signed by Vermont, New Hampshire, and Maine in an effort to plan for rural health services where needed. The compact also recognized the overhang of medical market areas in those two states.

Finally in 1964, the states' Central Planning Office issued a report on general health, mental health and welfare facilities, calling for much greater cooperation between agencies and meeting health needs in rural areas.

The long standing interest in statewide rural health planning made Vermont more than ready for regional medical and comprehensive health planning programs.

The Northern New England RMP is just now beginning to get back on the track after a series of unfortunate derailment. The first was spending 2-1/2 years before becoming operational, and the second detour was when the program plan so bogged down this data gathering that the original plan for democratic participation never materialized. The third time they got off the track was when they formally united with CHP with a joint governing policy board called the State Health Advisory Council, and this occurred with the approval of Secretary Robert Finch.

When this policy was reversed and the Northern New England RMP was instructed to separate the board from the comprehensive self-planning, this has been a great set-

back.

Another setback occurred in the spring of 1971 when HMSHA invited the State Health Planning Council, this joint board, to make a contract offer for the development of an experimental health services planning and delivery program. It was agreed the organization were not ready for this responsibility, and it was agreed they apply for $1 to keep the option open. This was not acceptable to HSMHA, and the final outcome of negotiation was for $932,000 for two years.

The impact of this large amount of money to RMP's small staff caused RMP to drop everything to work on this contract.

The director of the Northern New England RMP, Dr. Weinberg and Mr. Miller of the RMP resigned to take positions in an organization called HSI Health Corporation. RMP was further drained of staff. The net result was neglected management of RMP.

Now, a new coordinator has been appointed and has shown real capability in turning RMP around and to get it moving again in the right direction. The amazing thing is that Northern New England RMP has been able to achieve very real accomplishment in spite of these obstacles.

First, they have developed a regional disease management system in which they are improving the quality

of patient care throughout the region.

The regional disease management system is very much in line with what we were asked about this morning.

They have developed a good data base for health planning, and they have published useful reports on heart, cancer, kidney and respiratory disease.

Both reviewers feel this program is almost all new since March 1972 when the new coordinator took over. We have agreed on a list of detailed suggestions for improvement, which you can read. The coordinator with the help of the administrator is now trying to balance his staff and fill in important vacancy, including that of an associate director, hopefully from the medical profession. He already has a doctor working for him, and has one staff member which Dr. Schreiner was concerned about.

He was able, however, to get another doctor to work for him.

Resources are limited. I mean the manpower resources from which he can draw, and after observing what happened when one part of the health planning field suddenly became overfunded, we felt the modest recommendation was appropriate in that situation.

We also feel that close attention should be paid to this program for the moment, and that it is not yet ready for triennum status. But if, after another site

visit at the end of the 04 year it seems ready to apply for triennum status, it should be permitted to do so.

The amount selected would permit Northern New England to fund all their top priority project, amounting to $299,000, and a few more.

I move approval of the recommendations and of the Site Visiting Committee and the Review Committee.

DR. PAHL: Thank you, Mrs. Wyckoff.

Is there a second to Mrs. Wyckoff's motion?

DR. MC PHEDRAN: Seconded.

DR. PAHL: It has been moved and seconded.

Is there discussion by the Council?

All in favor of the motion, please say aye.

(Chorus of ayes.)

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The motion is carried.

I think we would like to turn to the Virginia application with Dr. Watkins as our primary reviewer and Dr. DeBakey as our backup reviewer and the record will show that Mrs. Mars is not in the room.

End #19

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Tape #20

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MR. WATKINS: The Virginia visit was conducted in the light of television, newspaper and congressmen, so that I think that this will have to be one of the more intellectual time conducted site visits.

Sister Ann Josephine, who had seen this area before, was much impressed by what she saw now. Dr. Perez, with his backup general, E.C. Hanake, apparently had converted this program into a good program.

One of his lack, however, was the absence of a deputy coordinator, and in fact, General Harnake apparently pinch hit as a business representative, as an administrator, and also as a deputy coordinator. There was a program staff turnover, since the last review, as noted by Sister Josephine, and this was for the better.

Some of the principal accomplishments included the location of the nursing coordinators in five educational institutions, the establishment of the Virginia Medical Information System. There were efforts to improve the patient program and the major medical programs, and so forth. The site team felt the program had achieved a maturity and a competency in the way it was moving and the way it was anticipated it was going. It was felt it was eligible for triennial status.

Some of the conclusions felt were that the progress of the Virginia Regional Medical Program had shown that they had indoctrinated their fairly new Rag group and that it had

improved a policy making process, that regionalization had been improved, and in general one of their new programs, the establishment of subregional coordinator officers in five subdivisions in the region, forming a local advisory group, the LAG, to more positively determine local needs and priorities. That should provide a firmer foundation. They have many RAG's, many coordinators in five segments of Virgina. This would relate directly to Dr. Perez.

We felt that this proliferation of energies could in some way be negative because the staff was new and the staff, even though they were doing a good job, could not as easily handle it as if they were continued on the same basis.

However, this was good for the regionalization and extension of the program; because of this, the recommendations were that this was an ambitious undertaking, and even though it might overburden some of the qualified staff, that the triennial status at 1 million 8 hundred ~~thousand~~ direct cross level should be accepted on the developmental component and the requested amount should be ~~funded~~ within the total $1.8 ~~billion~~ million. In other words, that no extra funds should be granted for the developmental component.

They were requesting 2.7 or rather 2.9 million for the first year, 2.7 for the second, and 2.4 for the third. We recommended they get 1.8 for the first, second and third, and this should include the developmental component. So, we are

recommending this to the council.

DR. PAHL: Thank you. Dr. DeBakey?

DR. DeBAKEY: I second the motion.

DR. PAHL: The motion has been made and seconded to accept the recommendations for the Virginia application. Is there further council discussion? If not, all in favor of the motion please say aye.

(Chorus of ayes.)

Opposed?

(No response)

The motion is carried.

We will leave the Mississippi and Texas applications until tomorrow, because of abseentism of some of the primary backup reviewers, and we will turn now to the Indiana application with Dr. Brennan as primary reviewer and Dr. Ochsner as backup reviewer.

DR. BRENNAN: I was going to start this review with a remark that I hope won't be taken amiss. It is a pun. I think programs we have all, and particularly the staff has been ragging the RMP a little bit heavily in Indiana. I started this about two or three years ago when I made a site visit there and criticized the program along with my fellow site visitors for its lack of any clearcut state plan or any use of the vast amount of data that it has collected, and it was an ingrown program at that time, and there wasn't evaluation of

things underway, and there were expensive things underway that were yielding very little, very expensive technological things that were yielding little in the way of improvements.

Well, there were several proposals offered for improving the status of this region. One of them was certainly an enlargment of the RMP RAG group, so that it would be more representative of medical interests and provider interests outside the particular university setting, the University of Indiana. It happened that the coordinator was a professor of cardiology at the University of Indiana, and was continuing to work there while he was running the program. And, also, in order that there might be more representation of community people, allied health people, et cetera.

But one thing was clear, and that was that Indiana was trying to develop a sub-regionalization structure, and I thought that had a fair degree of promise.

If you look at what you have in your books, you will find that we are continuing to chastise this outfit for lack of many of the things which were absent when that visit was made, I think in December of 1971. In the meantime, the coordinator has resigned, and a new acting coordinator has been found. The RAG has been somewhat more widely based.

But I think if there is any region that needs some encouragement it would be this one. This region had wanted to go triennial some time back. We dissuaded it. It has been

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vigorously criticized by two site visits, and by a strong letter to the former coordinator by Dr. Margulies, all of which I think were certainly justified.

But I think it is about time we let up on them a little bit, and I would like, therefore, to recommend that their five years request, which was for $1,526,000, and which it has been recommended should be cut to $1,200,000, that we explore the possibility of raising these funds to some degree, the funds available to them.

Now, as far as program staff is concerned, it is recognized that they are still rather thin on that, and they need expansion of that. The contracts which they had wanted to put out came to a larger amount of money than the three hundred thousand recommended by the review committee. I AM trying to find exactly what that sum was. Perhaps a staff person here can help me with that.

The continuation projects were at $200,000. They certainly have to be able to carry on, I think, in order to maintain any morale in the district at all.

So, I am in the position of wanting to recommend to these people a little larger amount of money than has been recommended by the review committee, with two purposes in mind. One is to increase the freedom and room for activity of a new coordinator, and two, to encourage the region and those associated with it to feel that a brighter day is dawning for

Indiana in this program.

Now, the amount of money that we would be recommending if we went beyond the review committee recommendations, the differences would come largely in the area of the contracts that they want to put out. They wanted to put out five hundred five thousand in contracts, most of which would obtain information and assistance for the kind of generalized planning for the state that we have always been so strongly recommending to them. They have been cut to three hundred thousand for that.

So far as continuation projects are concerned, it is hard for me to tell if what I have available to me, how that two hundred thousand will fit in when there is going to be a requirement to cut out several on-going projects or find other support for it if we go to that figure. I would like advice from the staff about that.

MR. TORBERT: I think they would be a little hard pressed with no coordinator at the moment. The doctor there is a holding coordinator until they find a new one. There is a search committee looking for a new coordinator. They don't have the coordinator or expertise on staff to really manage that increase.

DR. BRENNAN: Very good. I will fall back on the recommendations of the review committee.

MR. OGDEN: Isn't there an increase for contracts in here anyway? Currently they are at one-hundred, and they wanted five-hundred-five, and the staff recommended three-hundred

anyway.

DR. BRENNAN: There is an increase.

MR. OGDEN: And where they were at thirty-seven for program staff, the staff is recommending five-hundred, and it doesn't look to me like $1.2 million is an unreasonable figure here for this program at this time. That doesn't mean they couldn't come back in for a supplemental. I really think that if they turn up a coordinator and he begins to see the opportunity for real progress, that this council would recommend coming in for a supplemental request for things he sees medically necessary in order to put himself in position to apply for that.

DR. BRENNAN: I think potentially it is a very good regional medical program.

MR. OGDEN: It is obviously an area where we want ont.

DR. BRENNAN: Indiana is very strong in its own way. I think we should really now try to remedy a reputation of perhaps some hostility which has developed in that region and encourage them as much as possible.

DR. PAHL: Before we open this up, perhaps we might hear from Dr. Ochsner.

DR. OCHSNER: I second Dr. Brennan's motion.

DR. PAHL: Thank you. Mrs. Wyckoff? Parkon?

DR. MARGULIES: Mrs. Wyckoff is asking why the coordinator resigned. I think it was by mutual agreement

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between the regional advisory group and the coordinator. Primarily, the mutuality was on the part of the regional advisory group.

DR. BRENNAN: Actually, I think there was a terrible fight, and he resigned.

DR. PAHL: A motion is being made and seconded for a recommendation for the Indiana program. Is there further discussion by the council?

All in favor of the motion please say aye.

(Chorus of ayes.)

Opposed?

(No response).

The motion is carried.



end #20

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DR. PAHL: Now, if we may return to the application, the last one this afternoon is the Rochester application with Mr. Milliken as our primary reviewer.

MR. MILLIKEN: I wanted to say a special thanks to Staff for a great job of getting this ready and following up on this site visit.

To just give you a little background, that you can use in looking at some of the problems, this is primarily a rural region. There are ten counties in midwestern New York. The area is contiguous with the CHP, and there are only two cities of any size; Rochester and Elmira.

The ten counties have a population of approximately 1.2 million. Five and a half percent of it is not white. In the City of Rochester, the nonwhite figure is about 18 percent.

There are 27 community hospitals. Most of them are located throughout the area, and each county has at least one. Some of them, as you might guess, are rather small, and need development.

The importance of this is that, as some of you may know, Rochester, for many years has been the Mecca of health planning. As long ago as 30 years, Rochester was pointed out to be a self-propelled community, with a nonunion industry of large size, with much community attention to health needs and resources.

As a result of this, the RMP was sort of lost from the confusion that went on within Rochester, itself, and I personally believe that it had something to do with its default up until recently.

As we conducted our site visit, we found the plans are now in focus for the RMP to really take hold of the need for doing regional planning throughout that rural area, by pulling the resources together for heart, cancer, and stroke, and related kinds of activities that badly need to be regionalized; and to get the focus off just Rochester.

Up until the last few months, this RMP was plagued by no leadership. They did primarily project funding with no program focus, and the RAG, itself, was very weak and took very little responsibility as evidenced by a nine to a eleven month hiatus in meetings at one point.

They did not meet.

The sight visit team committee and the council last year took a "get tough" stance, and as you recall reduced the funding for one year only for the sight visit, which we had in this August, and we were very pleased in the sight visit to see some very dramatic changes.

One of these is that the old coordinator resigned, and a new coordinator has been found in a young physician, Dr. Mark, who has had considerable experience in working with communities.

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A by-product of this is that Dr. Mark's brother, a well-trained hospital administrator and also with community experience, has been brought in as the second man, Assistant Director for the CHP, so if we can do this within the kinfolks, and get cooperation, then I guess all is not lost.

The whole program is now, as you can see in reading the blue-green sheet, sixteen projects have been dropped new goals have been established for the coming year, and the new RAG is very active with some new blood and with some responsibility for their own purpose.

The ongoing, down-the-road, immediate situation is, the Staff tells me today, that communications with them as recently as the last few days shows that they have obtained already, their assistant director for program director, Mr. Chuck Adair, formerly of a Kansas RMP.

Former program specialist slots have been filled, and they are working. Plans are final for the RMP move into space in the new University off-campus building, a block up the road, and up till now, the university has never been able to provide space for the Staff to be all together in one place.

The bylaws are proceeding. They are expected to be submitted within a few weeks, maybe less, including the new review process, which is being streamlined.

I was very impressed while at the Staff visit, to

see how they are getting down to brass tacks and details between CHP and RMP, and they actually have joint committees. They meet and take a blackboard; they look at the needs of the communities, they are sharing one of the better health planning data systems that I have seen, with some very excellent data available.

They are putting this on a blackboard and then they are lining up and the RMP is taking primary responsibility for certain items that seem to be secondary, and vice versa.

So they are actually proving, with a lot of community interest and support, the fact that they are not duplicating, but they are supplementing what each other are doing, and if there is -- and there is an order and reason for the kinds of money spent next year, and what it will buy.

It is my recommendation that they be funded in lthe amount that is recommended, and that is 535 thousand. They agree, and Dr. Mark, himself, seemed satisfied, if not happy, over the reduction from the requested $1,035,000.

It is evident that while they have done a great deal in a very few weeks, they still have a long ways to go, and the site visit team felt that in order to take a reasonable amount, which is more than they have had in the past, in the last year, and do a good job with that, and

show that they are reliable, and that they really do this, and get them revisited within six to nine months; and at that time, consideration for really letting them go on their own and exercise their own ability.

So, with that, Mr. Chairman, I move the adoption of all this.

DR. PAHL: Thank you. I understand the recommendation to accept the committee's recommendation include the contingency provision that the bylaws be completed.

MR. MILLIKEN: Yes.

DR. PAHL: Dr. Brennan?

DR. BRENNAN: I second the motion.

DR. PAHL: The motion has been made and seconded. All in favor, say "Aye."

(All Ayes.)

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The motion is carried.

That ended our reviews this morning. And, tomorrow morning, we will reconvene at 8:30, and we will have the applications from Texas, Mississippi, Memphis, the Missouri Site Visit Report, and the 910 Applications.

The reception is at 6:30 p.m.

(Whereupon at 4:40 p.m., Monday, October 16, 1972; the meeting was adjourned to reconvene at 8:30 a.m., Tuesday, October 17, 1972.)