NEW FILE BEGINS

Doc #103

Dr Pate/Mr Chamb

E001745

NATIONAL ADVISORY COUNCIL

TRANSCRIPT

June 13, 1974

WHD-152

Parker/Chamberlain

NATIONAL ADVISORY COUNCIL ON

REGIONAL MEDICAL PROGRAMS

BOARD MEETING

9:00 A. M.
Conference Room G-H
Parklawn Building
Rockville, Maryland

Thursday
June 13, 1974

C O N T E N T S

WD/em

P R O C E E D I N G S

DR. PAHL: Good morning. I would like to call the meeting of the National Advisory Council in Regional Medical Programs to order, and I would first like to welcome to the council table the new members of the council.

Since we started a few minutes late and there has some socializing, I have a suspicion that most of the new members at least recognize and have perhaps said Hello to the current members of the council. Since we will be here for two days, why, we will make every opportunity to get you acquainted with each other, but we do welcome the new members and we are very happy to see the standbys here with us.

In that connection I would like to say that we are particularly happy to have three members on the council who represent reappointments. We feel very fortunate in having Dr. Kamerof, who cannot be with us at this meeting but who did attend the orientation meeting last month, Mr. Sewell Milliken and Dr. Ben Watkins are back with us, and we are very pleased with that.

I would like to comment, for everyone in the room, that this session of the council meeting is the open session. We are delighted to see a number of visitors with us. We won't take the opportunity to identify you, although we do know who some of you are; and I would expect that, at the appropriate time, before we go into our closed session,

possibly very late morning or early afternoon, we will make an opportunity for any member here of the public to make whatever statement or comment he feels to be appropriate. And if that does occur, I would ask the individual who wishes to make a statement to please identify himself for the record. And if he is representing an organization, if he would please identify that organization or unit.

I would like to introduce to you the people here at the head table.

I must say this is a pleasure. We have been known to use smaller and smaller tables over the past years. So it's very nice to see a full complement down this end and also up here.

I think that most of you, or a good many of you of course, know Dr. Harold Margulies in the center here, who is the Deputy Director of the Health Resources Administration, and will be making a presentation to you very shortly. Again, most of you are familiar with the fact that Dr. Margulies was a director of a program for several years before moving into this position as Deputy Administrator.

On my immediate left is Dr. John Greene, who is the Director of the Bureau of Health Resources Development in which bureau we are located; and Dr. Greene has taken some time this morning out of a very busy health manpower legislation activity that is going on currently to comment, and I think

we will have some comments along those lines that will be interesting to you.

On Dr. Margulies' left is Mr. Gene Rubel, who not only is the Acting Director of a comprehensive health planning program but also has the responsibility for coordinating internally and in conjunction with what we believe to be the new legislative directions, the Health Resources Planning activity of the Bureau, and is Associate Director for Health Resources Planning in Dr. Greene's Bureau of Health Resources Development.

Mr. Chambliss, on the far end of the table here, I am sure you all have met. I know that, as the Deputy Director of the Division of Regional Medical Programs. And Mr. Ken Baum, on my right, through whose good offices , and Mrs. Eva Handel at the entry table, this meeting has been made possible, for all of the mechanics and materials that have been coming to you.

Now, with those introductions out of the way, I would just indicate that we have a very heavy schedule for this particular council meeting, and in order not to unduly delay the other activities that these gentlemen have before them today, I will hold off my report to you and first ask if Dr. Margulies would give us some perspective from the point of view of the agency on matters that I know will be of interest to you.

Harold.

DR. MARGULIES: There are two or three general subjects I would like to raise with you, without taking up too much of your time, but all I think relevant to the deliberations of this council, and I think to the general level of interest which you have in the health affairs of the nation.

When this council last met, a number of you were not present, so let me briefly sketch once more the organization of the Health Resources Administration, so you know what is in it, and what it represents in terms of federal health activities.

In fact, it's probably useful to those of you who were here before, because there has been enough reorganization to be confusing even to those who are very close to it.

The Health Resources Administration was created with the belief, which I think is basically valid, that there is a need to address the issues of resources and the use of those resources in the delivery of health resources in a rather special and unified way.

This council and the activities which it supports are very pertinent to those concepts. It is noticeable, in fact, as you look at the introduction of major legislation and particularly as you follow the introduction of legislation national health insurance and the debates on it, that

they tend to divide into two major portions: one of them representing the processes of reimbursement; and the other representing the processes by which reimbursement leads to effective and acceptable services.

And, in fact, one of the legislative proposals, the Kennedy-Mills bill, goes far enough as to identify these as separate responsibilities, placing the payment mechanisms in one type or form of structure, and the health resources in another.

So that I think the philosophy and the dynamics are fairly convincing, that if one is to set about paying for services as a general national responsibility, one must also set about the business of finding out whether those payments lead to effective services available to all of a reasonable quality in a manner which is economical, efficient, and able to contain costs.

That is -- the latter part is where HRA is.

Now, it would be exaggerating things to suggest that HRA represents all of the capacity in the country to deal with health resources. On the contrary, the capacity for meeting health needs in this country remains essentially overwhelmingly a private function of the private delivery system, and there is every intent that it remain there for whatever period of time is necessary to have the job done, hopefully forever.

There is, however, in HRA, Health Resources Administra-

tion a collection of activities which is sensitive, critical, and, in the course of events, could make most of the difference between a different and an excellent result as we continue with our efforts to utilize federal resources for general benefit.

If you look at the structure, you will find that the three bureaus contained in any particular order you wish to take, the resources or the capacities necessary to develop data statistics or, in a broad sense, the intelligence required to understand what is going on and what needs to be done in the health delivery system, and this is largely in the National Center for Health Statistics. It contains a significant part of the federal effort and in some ways the leading edge of health services research which will assist the country in understanding how better to do what it is attempting to do in the delivery of medical care.

This includes economic analyses questions, the quality of medical care, the development of new kinds of systems, better types of communication and recording, et cetera.

And in the third bureau, which is represented by the other people at the table here, those activities which have to do with the supportive institutions which produce the health manpower and with other aspects of effective uses of health manpower.

Those activities which have to do with the federal interest in developing health care facilities, hospitals, nursing homes, and so forth, and the planning elements which are probably, along with the intelligence elements, the two key contributions which HRA can make to a better understanding and a better delivery of health services, now, and even more so in the future, with national health insurance.

We have been trying to integrate these activities so they represent a common kind of a function. It is not difficult for me as an individual having coming from the RMP to move strongly in the direction of an effective planning activity and to recognize the relationship between what this council does and effective planning.

I was pleased not long ago, because this kind of recognition comes rarely, when someone gave me a certificate which is based upon the contributions I had made to comprehensive health planning. I have been trying to do that since I came to RMP.

The first statement I made when I came to Regional Medical Programs was that this program, RMP, must be dependent upon an effective planning process which, at that time and at the present time, is comprehensive health planning.

That confused people initially, but I think in the course of time most people became dedicated to the concept that there is an interrelationship between the two; but that

a planless system is an undesirable system, and that therefore effective planning was critical to effective use of always limited resources.

So HRA is moving along, but still facing some real problems. Its problems are those which are familiar and which seem agonizing to visitors to Washington, they seem agonizing to those of us who live here as well, when we get to mid-June and we have no legislation which authorizes us to stay in business and no appropriations to pay for us if we did stay in business.

That's not really too remarkable. It merely has to do with the pressures of other events in Congress and in the Administration. And there will be legislation which will extend those in a variety of ways, and there will be appropriations which will probably come in varying periods of time, some of them soon enough, some later than they ought to.

Of most interest to us here is what may appear in the form of new legislation which extends the activities of RMP, CHP, Hill-Burton, and so forth -- and I will comment on that in just a moment.

We will almost certainly have, without much difficulty, an extension of the legislation for what was the National Center for Health Services Research and Development, now it's the Bureau of Health Service Research. That will,

I think, pass without much difficulty or delay.

The same thing is true for the National Center for Health Statistics.

My own personal concern, and I think the concern of the agency in this particular context is to give very high priority to the development of an enhanced and growing capacity in the National Center for Health Statistics, to develop an intelligent base, a source of knowledge and information, and analytical capacity which we do not have in this country anywhere at any level, and to do it in such a way that it's useful at the national level, at the State level, at the urban, the inter-urban level.

So that when people attempt to get something done, they know what their base is that they begin from, where they are going and what needs to be done. This is clearly top-level priority in this agency, along with an effective companion planning activity, to make sense.

The passage of the legislation, therefore, for those two activities is important, but the sense of Congress which goes into whatever they propose is even more important. Health manpower legislation is highly uncertain at the present time. The bills which have been introduced are variable. The Administration's bill moves in one direction, the House bill in another, and the Senate bill in a third.

There are points of agreement, and many points of

great disagreement. What will happen with what has been known as the Hill-Burton legislation is also uncertain, because the Administration does not propose to extend the traditional Hill-Burton program. The Senate and the House have other versions, and that will make a considerable amount of difference.

As I am sure you know, a planning bill which is to extend, as I indicated a moment ago, CHP, Hill-Burton, RMP and some specific activities like area health education centers, has not yet been reported out; but it has gone far enough so that one has reason to feel secure in what it will produce, what kind of a bill we will have. And I think there is reasonable optimism now about the passage of new legislation in the fairly near future.

In any case, Mr. Rubel and his staff and the staffs of HRA have been working assiduously and I think rather remarkably to anticipate the passage of new legislation; have actually been looking at multiple possibilities and so are prepared to move in whatever direction Congress and the succeeding regulations require they move.

I think the transition will be much less difficult because of that kind of effort, than it might have been had we merely waited for the events to catch up with us.

I think what we shall probably see in the new planning legislation is a combination of the Administration's

bill and the Rogers bill -- and rather than using those names, let me tell you essentially what would be contained in the activities.

There will be legislation to support within States a planning activity which is essentially designed around a combination of public and private interests which act together, the planning agents will be private, non-profit in character, and they will depend heavily upon an interrelationship between what needs to be done and the capacity of the market and the professional and public leadership to respond to sensible planning activities.

There will, in all likelihood, be an associated agency established at the State level to coordinate, review, approve those kinds of plans and to make sure that there is a balance in those kinds of authorities.

There will, in all likelihood, be a separation between planning functions and regulatory functions, but they will be -- certainly the regulatory functions will remain the State's responsibility, like those that are associated with Section 1122 of the Social Security Act, which is concerned with the construction of new facilities, the addition of new beds, et cetera; the kind of certificate-of-need legislation.

That kind of planning authority would be an improvement on an extension of comprehensive health planning. It would contain a modest amount, I suspect, of developmental

funds in order to make things happen which might not otherwise happen, but primarily as a kind of stimulating or coordinating or catalyzing activity, rather than having a large outflow of funds to do what appears to be desirable at the local level.

If this is done so that the legislation makes good sense and is manageable, and if it represents, as many of us suspect it does, a modification in planning understanding at a time when people have begun to appreciate more fully the importance of planning, in fact the essential character of it, and with the high likelihood that we will have national health insurance in the fairly near future, we will have a combination of better legislation, strong federal support, better State understanding, and a new zeal, I believe, to put some rationality into the system.

I can imagine no way in which any kind of legislation will prove effective if the decision makers of the country have not reached the conclusion that it is better to do it sensibly than by guess and by chance; and I think we probably have reached that point, although not consistently throughout the country.

Where it has been inconsistent, I am sure that Mr. Rubel will help to make it more consistent. That will be an interesting activity.

This council now, in reference to that kind of legislation, has a heavy kind of concern, and I would like

to make a particular point in reminding you of what this council is and does and should do. It's a rather remarkable arrangement.

The National Advisory Council was created by Congress, saying to the nation and to you members of this council that you are to be depended upon to carry out the will of Congress in ways which combine your understanding of the legislation, your concern of the public welfare, and your various kinds of professional skills.

This council is unusual in that it is given more authority for the approval of grant awards than are councils generally in this government.

You are told that you will be given some applications which have been carefully reviewed and which have been put in a form of presentation which you can understand, and understand quite readily.

And that you will make recommendations to the Administration, without which grant awards cannot be made, but which do not necessarily represent the amount of the award that will be made. In other words, you have a veto power and you have an approval power. If, however, the approvals which you provide exceed the funds that are available, quite clearly there are adjustments which have to be made.

The forms in which you make your actions, the comments

which you make represent the distillation of public interest representing Congressional action and your final move in the direction of public welfare.

It is a heavy responsibility, and one which requires your greatest possible attention. It becomes especially difficult now, because you are encumbered by a rather chaotic history of RMP's, certainly in the last eighteen months.

You enter into it in what are administratively and ethically perilous times, so that you need to pay close attention to what you consider to be right and wrong. And you are also looking at a set of activities determined by a court order which at the same time move in the direction, we are certain, of new legislation before many of these activities are well launched.

You will therefore have to express some judgment about how these activities need best be carried out.

It seems highly likely that before the funds which you are going to be looking have been provided for RMP's, and certainly before they have been formally expended, there will have been new legislation, new considerations, and new activities facing those organizations which receive these grant awards.

As a consequence, you must keep open the likelihood that there will be a new set of pressures on institutions here

and elsewhere throughout the country which may determine the best possible use of these funds.

I think these ideas need to be set well aside from your basic concern, from the fact that you are operating under a congressional Act, which has not been changed, under court orders which are quite clear, and under a public purpose which you are the best individuals available to determine.

Now, finally, let me say in that regard, and as a special note again, taking advantage of an opportunity to be personalized, that those of you who have served on the council before, and many who have not, are fully aware of the tremendous workload which is involved in bringing to you grant applications which have been reviewed, given the best possible consideration to be put in form for you to act upon.

In past years this was done by a large staff, and it was hard work. This time it was done by a much smaller staff over a shorter period of time under extraordinary difficulties.

It is customary to give thanks to a staff which has operated in these circumstances. This is no customary comment. This has been an unbelievable undertaking by those who are dedicated and who care and who have done what they have done because they believe it needs to be done.

They have done it in circumstances where their existence is threatened, where their jobs are unsure, where

their future is unknown, and where they have been given damn little encouragement from any source at any level.

And this goes, certainly, probably several times over for Dr. Pahl, and down on through the entire organization. It has been remarkable. There is no kind of award, there is no kind of statement, there is no measure that I know of that can fully recognize what difficult times these have been.

I remain astonished that people will work that hard, with that much vigor and that much honesty, in the circumstances in which they have been placed. And I am very, very grateful to them, and I am sure you will be before you are through with this council.

Now, if there are any questions that I can answer, after what has been about as long as I expected to talk, I will be glad to respond.

DR. PAHL: On behalf of the staff and myself, Harold, thank you very much for those comments. I think we do indeed appreciate that commendation.

Are there any points -- I believe you can stay a few minutes longer, but perhaps you had better nab Dr. Margulies while you have him.

If you need anything else from that agency point of view on the tenth floor.

I should add here I am glad Dr. Margulies charged Mr. Rubel with bringing consistency into government, and we

will be working toward that end, too.

Well, perhaps we might move on to the next speaker, and I am particularly delighted to bring to you Dr. Greene, to discuss again matters of importance to the council from the Bureau of Health Resources Development.

RMP has been located now in three agencies since its history. It started off with the National Institutes of Health as a home; it was then moved to the Health Services and Mental Health Administration, and when that was organized last July 1, we moved him to the Health Resources Administration. Since last July we have been in two bureaus of the three bureaus of that agency, and I am particularly delighted to state that we are presently under formal consideration for inclusion in only one bureau, and it is Dr. Greene's Bureau of Health Resources Development.

DR. GREENE: Thank you very much, Herb.

I do appreciate the opportunity to meet with the council. It's my first opportunity to do so.

In looking at the agenda, I have just noticed that it's a morning filled with remarks, and I guess that's kind of a remarkable morning -- if you turn it around the other way.

I will keep mine very brief, so you can get on with the rather full agenda that you have.

And I know, since it is scheduled on here, that you

might be working on Saturday, I am sure that you are anxious to keep things short at this end so you can maybe get out of here, so you don't have to work through the weekend. So I will try to help you in that regard.

It is a pleasure to follow Dr. Margulies, and to echo some of the comments that he made very briefly about the adverse situation under which the staff has been working here in relation to the Regional Medical Programs and in relation to all of Health Resources planning. And the outstanding dedication and work they have done, as I am sure you will recognize as you work through this council session.

But I will let it go at that and add an "amen" to what Dr. Margulies has said; and I am very grateful to them, as I am sure you will be, too.

I would also like to congratulate you as the council and the Regional Medical Programs in general, for the work that has been done and the work that you are doing, and the perseverence of the people who have been dedicated to Regional Medical Programs through some rather adverse and difficult times.

The fact that you're continuing to carry out the purposes that Dr. Margulies outlined on Regional Medical Programs in the interest of the public and public concern, and congratulate you for it, and I want to express my

appreciation to you and to the Regional Medical Programs in general for that effort.

Dr. Pahl mentioned that the Regional Medical Programs now scheduled to formally move into the Bureau of Health Resources Development, and there is a formal request to make that formal, although we have been operating this way since last February; that there is a request now to make this a formal transfer.

We have not a formal, official reply to that, making it official, but it is expected to come at an early date.

Now, Dr. Margulies indicated that the Bureau of Health Resources Development, into which Regional Medical Programs is moving, included the comprehensive health planning, Hill-Burton program, as well as the old Bureau of Health Manpower Education, which has, as its legislative base, four pieces of manpower legislation: the Comprehensive Health Manpower Training Act of 1971; the Nurse Training Act; the Allied Health Act; and the Act that covers Public Health.

Now, all of these pieces of legislation affecting manpower expire at the end of this month, and we have been quite busy on the Hill and within the Department, trying to help fashion a new piece of manpower legislation.

I thought I might just comment on that for a few minutes, because I know Regional Medical Programs have been quite busy and active in the manpower area, and I thought you

would be interested a little bit as to what the current scene is and what might come out of it; and I will try to make this brief.

But, as you probably know, the Congress is -- the Congress and the Department and the general area of manpower and education are more concerned now about the type and location and utilization of manpower than the total numbers of manpower as had occupied the scene most since the Health Professions Educational Assistance Act started in 1973.

The focus up until this time has been largely on shortages and trying to increase output, of number of health professions of all types.

As we move into considering what is needed over the next three years or the next legislative cycle, the emphasis has shifted away from a focus on continuing massive increases in output and has shifted to greater focus on other problems, problems more of location of people, geographic location of people to deliver services; the types of people; the specialty distribution question; the problem within medicine.

The greater emphasis on trying to increase productivity of health workers of all types, with great concern about the continuing qualifications of people after they are out in the marketplace, and out delivering services.

Now, as to how this all will come out is anyone's guess at the moment, but let me just run down some of the

provisions, some of the kinds of things that are being given attention, a little more specificity than what I've just mentioned.

While there is less emphasis on continuing to stimulate increased output, there is general interest and concern about the stability of the institutions that do provide manpower. This interest and concern is expressed in different ways, in different pieces of legislation: those of the Administration, those of Members of Congress. As you are probably aware, the Institute of Medicine study which recommended a certain level of capitation.. The Congress has been quite interested in that study, and the recommendations made by it, and are likely to latch onto those recommendations in their committees. That is, in my estimation.

However, the Department is recommending lower levels of capitation to maintain stability of the institutions than was recommended by the Institute of Medicine study. But in all likelihood there will be continued levels of support for the health professions' institutions.

Now, it also -- there also is a lot of interest in exacting something in return for that front-end money or basic support. As a minimum it seems that there will come out of this a requirement that the institutions at least maintain the current output or current enrollment of numbers

of people within their school. I think that's a minimum.

Now, it goes on from there in some of the proposals in Congress to require such things as having to be eligible for such capitation support that all students within the school would either agree to serve in the National Health Center service corps or serve in some shortage area or shortage profession within the country. This is in the Kennedy bill, and this is an extreme at one end as to the kinds of requirements that may be placed or could be placed on capitation support.

It is, I think, unlikely that what will come out of Congress will be to that extreme. I do think the Congress will ask for more assurance, that the institutions will be addressing the problems of geographic distribution and the problems of specialty distribution than they have in the past.

The question of specialty distribution, the major concern is the growing shortage of persons to deliver primary-care services, and I think we can expect out of the legislation much more emphasis on getting involved and the whole area of graduate medical education to assure that there is a turnaround and a drift towards an increased output of persons prepared, specially prepared to deliver primary care.

And, again, the proposals to Congress vary in the strength of the leverage that they would apply to accomplish this. Some are quite direct, and others are more indirect.

I think it's very likely that we would have something fairly strong in this area, because of the general concern.

I mention again the question of geographic distribution and what is likely to come out there.

We have been, I think, essentially unsuccessful so far in materially affecting the geographic distribution of health resources -- of manpower resources, and because of the very general and serious concern over this issue, I think we may see fairly strong language and fairly strong provisions in here on this issue. And this becomes an area of particular concern to you, because you've been trying to do something about this in the past. It becomes an area of concern to the whole Health Resources Planning, because this is an area that must be addressed to the development and distribution of manpower to serve the country in the future.

There will be greater emphasis on productivity and greater emphasis on the development of health professionals who can work together and, in a team concept, utilizing paraprofessionals to their maximum to deliver the most quality services at the least cost.

The committee in the House is now in the process of marking up a committee bill this week. There will be Senate hearings, or they are scheduled now to be held on June 24th. Because hearings have not been held in the House

to this date, it's highly unlikely that we will have anything to work with, a new bill to work with by the end of this fiscal year. It will probably be a few months yet, in my estimation, before we're ready to implement the new manpower, the new piece of manpower legislation.

One other element in the new legislation is likely to be, instead of having the four pieces of authority, we are likely to end up with two instead of four. And one would be for nursing, preparation of nurses; and the other would cover all of the other health professions, most likely it will come out this way.

I will stop here now.

DR. PAHL: Thank you, John.

Perhaps you'd be responsive to questions.

Dr. Haber?

DR. HABER: Dr. Greene, in the move towards greater provision of primary care it seems to me there are a couple of options on a national basis, and I wonder if you could enlighten us as to what congressional thinking, as to which option seems to be most in their thinking, or are they equally concerned with all of them?

I am talking now about the move to increase the scope and number of allied health professionals, particularly surrogates for primary care, in the nurse clinicians, physician assistants, or are they more likely to try to remake medical

education so that more physicians go into primary care? Or are all of these options equally significant?

DR. GREENE: The primary attention in the discussion so far in the Congress has been more towards redirecting graduate medical education.

However, there is interest on the other option that you talked about as well, and likely the legislation will provide authority to pursue both.

And in my opinion both need to be pursued, and I think there will be legislative authority that will enable us to do that.

But most of the discussion has centered around attempts to shift graduate medical education or primary-care specialists.

DR. PAHL: Are there other questions or comments by the council?

Dr. Janeway?

DR. JANEWAY: Do you think, Dr. Greene, that two bills will come out of the House Subcommittee on Health, or just one?

DR. GREENE: When it first started, I thought there would be only one. The reason I say it now, and I had not said it at first, I think there might be two is because the Roy provisions have now been picked up in the Kennedy bill and will have to be taken seriously now, I think.

And Mr. Rogers may hold out and not want that in his bill that he participates in, and other members of the committee may decide that they want to follow more down the line of the Roy provision, and may come out with two bills. It's hard to tell yet, since they are just starting.

They may come out with two instead of one.

DR. PAHL: Dr. Janeway, would you care to give your assessment?

DR. JANEWAY: No.

DR. GREENE: I'm just reaching out for that one at the moment. They are going to make -- they are making an attempt right now, they are in session today to try to compromise and try to come to one bill.

But I do think the Roy provisions have to be taken seriously, more so than a lot of people thought earlier, at the beginning.

DR. PAHL: Are there further comments or discussions?

If not, I thank you, John, and hope you can stay as long as possible, or drop in if your schedule permits.

I would like now -- we have not forgotten coffee, for those of you who didn't find a cafeteria earlier this morning; but I think we might wait for that until we have had the remarks by Mr. Rubel, because I really do feel that this package of presentations will give you a perspective

that's most important to have at this particular time.

And I am very pleased to have Mr. Rubel be able to come this morning, again it's a very busy schedule, so the fact that he's here today is somewhat fortunate for us because Mr. Rubel is intimately involved in the development of the Administration's point of view of the new legislation; and, as Dr. Greene indicated, since about January or February of this year the RMP program has been working closely with Mr. Rubel, who does have responsibilities for coordinating internally our several activities under CHP, RMP and the Health Facilities Program.

So, without further comment, Gene, will you take whatever time you feel you need to bring all the information to us.

MR. RUBEL: I will try not to be too "remark-able".

First of all, in the context of manpower debate, I would suggest to you an article appearing in this week's National Journal Reports on Manpower Legislation. I think it is remarkably put, the presentation of the problems as well as the politics, and there are a lot of politics.

I will try to be a little more down to dealing with the nitty-gritty things.

I met with some of you back in February, and I am not sure I knew then what I was getting into; but we did discuss at that time what the Department's plans were for

spending RMP funds. This was almost immediately after the court had entered its order on February 7, Dr. Pahl, in his letter to you did summarize the situation as it existed early last week. It keeps changing.

You may remember that back in February we discussed the possibility or, as we saw it, the fact that Section 910 of the Public Health Service Act was in the law and still is in the law, and I believe I indicated that the Department was very much interested in utilizing some part of the money that had been appropriated under Section 910, which is an authority we can use to do some things outside the scope of the individual regional medical programs.

The Department, through its representatives in the Justice Department, did propose an amendment to the court order, and we have gone through several months of motions and counter-motions, and all kinds of gyrations, including a lot of time spent answering questions and the like.

We have reached a settlement with the plaintiffs in the case, the National Association of Regional Medical Programs, under which we would be able to use up to five million dollars of Fiscal '73 funds under Section 910. We have made it clear that those funds will not be used to support any kind of State activities in attempting to plan for future regulatory rules.

Some of you have been very much involved in this, and

I won't take a lot of time to go through this.

One thing is very clear, that the Department wants to put this litigation behind us. We are interested in administering the laws that we have today as well as anticipating what is coming in the future, and we don't see any great benefit in continuing to litigate here.

As I understand it, the judge signed an order on Friday, in which he requested each of several Regional Medical Programs to comment on the settlement, and each of the RMP's has, I believe, thirty days to do that, to the extent that there is no comment, the final order will be entered; to the extent that there are, he has indicated that he will deal with them very expeditiously.

So that I would hope sometime in the middle of July this litigation will finally be concluded.

In terms of legislation, you have heard a summary of what's happening. The House Subcommittee did spend Monday, Tuesday, and yesterday morning debating the questions of health planning, as they call it. They are kind of following an unusual pattern. The purpose of those two and a half days of discussion was to provide guidance to the staff in order for them to produce a clean bill, a new bill.

The Subcommittee then intends to take that bill and actually mark it up, go through it page by page and line by line. But I think, after the two and a half days, the

Subcommittee did give pretty much of an idea, understanding of what it wants; and I don't think the mark-up that is going to have to come next will take a great deal of time.

It is remarkable that we had so many members of the Subcommittee spend so much time. It is obvious that they are concerned and interested; both sides, from both political parties, young and old alike.

I would have to say in very general terms that the kind of thing you're talking -- we are talking about, is best embodied in H. R. 13995, which was introduced by most of the members of the Subcommittee in general, to look at all the pieces of legislation. They are very similar, and I don't believe we heard a great deal in those two and a half days that is different from what was in those bills, with perhaps one exception.

It appears to me, and I never said it explicitly, that the Subcommittee is interested in including a large -- relatively large -- pot of money at the State level for the State government to somehow continue on, or with some kind of variation -- it's very difficult to know exactly what -- of the facility construction program, the Hill-Burton program. That was not in any of the bills recently proposed in any case. Exactly what it's going to say and how it's going to work, I don't know.

It beats me how that staff is going to write some-

thing; but they always manage.

In general terms, we have what we call a health systems agency at the local level, non-profit, private organizations, and the committee was very firm on that, with, by and large, a larger geographic area or population base than we have in CHP agencies today. They came down firmly on a minimum figure of 500,000 people, but which could be waived by the Secretary down to 200,000 if he found it to be necessary or desirable.

This agency would be responsible for doing the planning for its area. It would also have some relatively small pot of money available for developmental activities.

There would be at the State level a State planning council whose members would largely come from representatives of the local health systems agencies, with additional members appointed by the Governor, and it would be that council that would approve the individual plans proposed by the local agencies, as well as using State governmental support, filling in the chunks and making sure that a highway doesn't stop on this county line and here and start on the next one two miles away.

The State would be responsible for whatever kind of regulatory features are going to be in the bill, and there was an awful lot of discussion of what anybody means by regulation. As you may or may not know, there are some

members of the subcommittee that are very adamantly against regulation, although everybody agrees that something like 1122's view of capital expenditure, certification of need is important and desirable.

The staff was instructed to draft provisions that would allow, that would provide federal support on an optional basis with -- for any State that wanted to get into rate review activities, and that was further than a lot of people anticipated they would go.

You may know that Mr. Roy is very much in favor of a mandatory review kind of role, but he was very happy with an option, which of course is what the Administration proposed also.

I would be delighted to respond to any questions either here or privately about features of the bill.

The House Committee has prepared a very, very exhaustive analysis of the various proposals that are pending. Unfortunately, it's either in -- being printed right now or on its way some place or other. I am trying to get copies for you, either today or tomorrow. I am not sure that I am going to be successful.

In any case, if you want copies, you can write to the Committee on Interstate and Foreign Commerce, and I am sure that they will supply one for you.

Unfortunately, it does not have a number, except a

little thing on the side here, and I don't know what that means, but, for what it's worth, 32-84. This is an analysis of all the bills that are currently pending before the Congress.

The Senate has not taken any formal action yet, although it's my understanding that this is a Committee Print about to descend from some place.

In terms of a timetable, much like the manpower legislation, some optimists hope we will have legislation enacted in August.

Of course, there are a lot of other things going on on the Hill. There is an election to be run in November. And we just don't know.

A week ago I was a lot more pessimistic than I am today. I think the action that the Subcommittee has taken has moved a very, very long way down the road, and the staff is talking about working on Saturdays and Sundays; so that's the kind of pressure they're under from the members.

Enough about the status of legislation.

Let me turn to problems of transition -- to what, we know not yet.

We made a decision back in January, that we talked about in February -- we have three separate divisions operating here: one for comprehensive health planning; one for Hill-Burton; and one for RMP, and that is going to

continue until Congress enacts new legislation.

That has caused some problems, but I think, by and large, we have been able to continue operating as well as trying to work together anticipating what is coming in the future.

We have had a series of groups working together, trying to plan for the future. We have had a group working on possible organizations and another group trying to plan on how we go about the area designation process; how do you take into account sub State planning districts, PSRO areas, current CHP patterns, standard metropolitan statistical areas and the like.

We are in the process of producing a series of maps for every State in the country, and you see lots of lines intersecting.

How you make some kind of rational health planning areas out of them is a major challenge. I think we have come a long way toward understanding how that process might work. And many other groups, as we anticipate what is coming.

Just as soon as legislation is enacted, we intend to involve in our planning process representatives from all sorts of organizations, professional organizations at the national level, representatives from each of the components that are going to be into this scene.

We don't feel, however, that now is really the time

to do that, with all the uncertainties as to what may come.

I would like to make one plea. We have had a fair amount of quibbling, fighting, figuring out whose turf is whose, over the years. I think that is one of the key problems that the Congress is attempting to deal with.

We have had a difficult process even during this review cycle in how CHP agencies relate to RMP's. Frankly, from my point of view, I am surprised how well things are going and how much cooperation and coordination there really is.

I don't believe it is to anybody's advantage to continue and perpetuate those kinds of arguments and discussions at this point. We've tried to get along as best we can.

It's obvious that if progress were to continue both programs as they currently exist, I think we would have to do a lot of work, because I'm not satisfied with the relationships we have today.

But I don't believe that Congress is going to continue the current law, so let's devote our energies to how we can improve things in the future, rather than arguing about how poorly they've been done in the past.

In terms of a transition, we have worked very hard to insure that the agencies, organizations that are funded now will be funded through some transition period. We don't

believe it's to anybody's benefit to stop everything now and then try to start it all over again next year.

Most RMP's will be funded through Fiscal '75. The 314(b) agencies, the local agencies, will be funded through April of Fiscal '75. We have a very real and big problem with the State agencies.

Mr. Milliken works for one, where, as it was described in a hearing, "we fall off a cliff on July 1." I think we can figure out a way to handle that with some help in the Congress, as part of the continuing resolution.

In any case, we have tried very hard to find -- to insure that there be some kind of orderly transition. I think that's something that everybody agrees is very necessary. The question has come up, and you are going to have to face, during these next few days, to what extent there are organizations that perhaps should not be continued during that transition. And that's something you are going to have to deal with on a case-by-case basis.

I would just like to give you my observation. That I think you have to decide is something marginal, you know, is it doubtful. We've been carrying something along for a long time in a certain kind of situation, and if that's the conclusion you come to, my recommendation would be to let's keep going.

Why do we want to change things now when a year from

now we are going to have a very natural kind of resolution.

On the other hand, to the extent of organizations that have no capacity, that are not doing things useful in their communities, I think we have an obligation and you have an obligation to conclude that federal funds will be wasted on that kind of situation, and to act accordingly.

Finally, I have tried to make a plea for many months, and that is that we don't want to see major organizational changes made at this point in time. I have told -- perhaps some of you have heard this story, but last October Congressman Roy spoke before the American Association of Comprehensive Health Planners and talked about his concept of a Regional Health Authority, and that evening someone came over to me and said, "Where do I submit my application?"

And I tried to say, Well, that's just one Congressman's idea.

We had people at that point that were prepared to make all kinds of changes in order to accommodate an idea that someone had proposed.

Well, if that had happened, they would be in very sad shape today because all of the concepts and ideas that Congressman Roy advanced have not been accepted, and I think the same thing is true today. We still don't know how this is going to work out.

And I don't believe it's in anybody's interest to

actually make changes.

On the other hand, all of us are planning and trying to come up with contingency plans; and that is very proper.

But let's wait until the Congress acts before we make any kind of permanent changes, because we may have to make them all over again.

Finally, I would like to echo Dr. Margulies' point, you are going to have some very difficult decisions to make here.

I think we have to hit the hard issues hard. There is no point in trying to gloss over things. I think the staff has done a very good job, and the review committees have done a very good job of raising the problems. And they are going to be difficult to deal with in some cases.

I suggest that we try to make difficult decisions. This is a time that many people are questioning whether the government can function at all, let alone function effectively. Let's see if we can demonstrate that as servants of the people, really, that we can do the job effectively.

DR. PAHL: Thank you very much, Mr. Rubel.

Are there questions or comments by the council on any of the matters touched upon, or just perhaps glossed over, in view of the vast amount of activity that's going on at

this time that you would like a little further clarification or amplifaction?

Dr. Merrill?

DR. MERRILL: I have realized, from what you and previous speakers have said, that no one has the answer; but what I would like is perhaps an educated guess, so that I can respond to people who ask me such questions.

One which I hear most frequently is the following: Let's assume the transition period works and all the contingency plans are fine.

If funding for RMP is continued, in what form, under what authority will that be?

MR. RUBEL: I can see about a 99.5 percent probability that funding for RMP, as such, will not be continued. I spent two and a half days before the Subcommittee and I did not hear a single member even once raise that as an option. It is conceivable that it will be done on the Floor of either House, or yet within the Subcommittee or Committees; but they clearly are looking to set up a new kind of arrangement.

Now, on the other hand, it is also very clear that they intend to build on the structures and the people that we have working in the CHP agencies and in the RMP agencies. I can see many RMP's, as we know them today, with or without changes, becoming very much a part, becoming health systems

agencies in many places, and that kind of thing.

I don't know if that answers it.

DR. MARGULIES: John, can I pick up that five-tenths percent, because you and I are physicians and understand about that.

There is, up to the present time, no planning bill which has even reached the House, and we have seen many misfalls in legislation. On that five-tenths percent basis, what could happen is a matter of technical process.

It is a continuing resolution and an extension of legislation in its present form. We will certainly enter the next fiscal year in some of our programs on that kind of a basis, and you realize -- well, I'm not so sure you realize, a lot of people don't seem to realize, even at high levels in government -- that when there is a continuing resolution, which says that the appropriations will continue into the next fiscal year, that also extends the authorizations to which those appropriations are attached.

So that possibility could exist. That would immediately be negated with the passage of legislation which would replace the RMP, CHP, Hill-Burton, et cetera, with a new kind of planning legislation.

MR. RUBEL: Or by passage of an appropriations Act.

Now, to be very candid, Dr. Margulies and I were at

an Appropriations Subcommittee hearing not long ago, where we were told by -- we were asked, the Administration was asked: You're proposing to eliminate the RMP program -- and then we were told not to hold our breath.

So, you know, there are a lot of things that are possible, but I can report to you that in two and a half days before, you know, eight of the eleven members of the House Subcommittee there was not one mention made of continuing any of the current programs in their current form.

DR. MERRILL: I think the thing that's been confusing to many people, including myself, is the kind of thing that you state, and what I've heard repeatedly, and that is: Let's keep things going the way they are.

And, on the other hand, the statement that there's 99.5 percent chance that things will not be kept going the way they are.

I realize there's probably no other alternative, and I certainly don't have one. But -- I think you have defined those difficulties.

DR. GREENE: With the council's permission and because of the importance of the topic, I would like to recognize Dr. Donald Sparkman in the audience, who is the chairman of the national steering committee of RMP Coordinators, who would like to make a statement on this point.

DR. SPARKMAN: Clearly, Doctor, Mr. Rubel is much closer to the legislative situation, and Dr. Margulies, than I am; but from other sources from which I learn information about this, it is not quite 99.5 percent sure that there will be no RMP.

There is a consideration of this, and I would remind you that as of a year ago the Administration said there is going to be no RMP as of June 1973, and the Administration officials, Mr. Rubel and others, clearly said that. And beyond that time RMP probably will not survive, and the Secretary and others took steps to make it as difficult as possible to survive.

We are still in business. I think there is at least a reasonable possibility that some modification of the existing RMP concept and function will continue, and I find it difficult to accept his statement.

DR. MARGULIES: John, may I pick up on that, because I think your point is an important one.

Partly because it provides us the opportunity to separate the rather restricted federal view of affairs from the much more mobile and flexible view at State and local levels.

Let me go back to what I said earlier to this council. You are operating under existing legislation, and there is not much reason for you to speculate about what new

legislation will do. You are also operating under a court order, and it's quite clear what Congress intended, and Congress has not changed its mind.

In fact, this RMP will continue, as does any other program, unless Congress specifically rescinds Title 9, which is the basis for the legislation.

But beyond that these comments are, in a sense, specious or irrelevant, at least; because if there is to be, with or without legislation, an effective amalgamation of the programs we have under discussion, it will be because of the efforts of people at State and local levels.

The wisest thing that we could do with this council activity is to encourage and support the RMP's to function in the most material manner possible, and the wisest thing they could do is to combine with their CHP colleagues and other appropriate agencies in the State to talk with one another now about how better to function at the State level, regardless of what happens.

I don't think there is the slightest doubt about the need for that to occur, whether the legislation is passed or whether it stays the same.

In fact, if the States could deal effectively with the elements within their boundaries, which we are dealing with at a distance, they could do whatever is proposed in upcoming legislation without any new legislation being passed.

The fact that they have found that difficult to do has encouraged Congress and the Administration to alter the forms in which they function; but the best thing we could hope for is for people to act together in a common interest within the State, knowing more about what's going on than anyone else does.

And I would add to that, Don, and I know you would agree, because we talked about this before, that the time has passed for us to concentrate too heavily on two programs which happen to have been passed about the same time and have somewhat similar interests. When we are talking about planning for a State in the field of health that involves a wide range of institutions and activities in which the CHP represents the major, and from the federal point of view, the critical planning force; but it has to deal with maternal and child health services, mental health services, hospitals, nursing homes, payment mechanisms, the whole gamut, not just two programs. And if we can get a little further toward that understanding, I think, regardless of the legislation, we are going to be better off.

DR. GREENE: Thank you.

Are there other comments?

DR. WAMMOCK: I would like to echo that feeling, because of being involved in that situation of getting the States involved, to accept what's going on as a cooperative

effort, and I think that some effort has been made in that direction in some areas to do that very thing. Because you have got six different roads or detours going off doing different things.

And I heartily echo that situation, regardless of what happens to RMP, because there are things in here that are salvagable and worthwhile to be used in the future. And if we can combine these with the efforts that the State level is trying to do, I think we are going to be better off.

MR. MILLIKEN: To this end, I think there is a need right now. A good demonstration of the need for pulling this together, to have an effective activity.

I don't know about the rest of the country, but Region 5 and Region 3, HEW regional offices, are in a kind of a problem of working with States who are tending to pull back everything to within their State boundaries.

Now, between Indiana, Kentucky and Ohio, there has been, for a long time, a very significant cooperative program where both RMP and CHP are in interstate health trade regional activities. And there is an urgent meeting called next week in Louisville to bring regional offices, States and local areas together to see what can be done to continue this kind of cooperation.

Now, the HUD program and other kinds of government planning are not unrelated to this, and it does begin to put

us into, you know, if we can't have a strong front here, in view of the need for keeping these kind of trade area voluntary coordinated kinds of programs, then I think we face a very serious problem.

DR. MARGULIES: I think one of the reasons that there was and is a heavy commitment to the private, non-profit approach to thing is because it does lessen the likelihood that the artifacts of political boundaries will be too constricting.

On the other hand, you've been on this council long enough to know that at the State level that artifact is a very powerful one. After all, funds flow into States on a geo-political basis around those boundaries. But I feel reasonably heartened, as I would think you would, over the very successes that you pointed to, like that tri-State arrangement with both RMP and CHP that you've had down there, that people have managed. And I think it's much more likely from our experience that that could be worked out between the people there than for us to do anything certainly dictatorial at this end. It just won't come out that way at all well.

MR. RUBEL: I can report to you that the Subcommittee very firmly stated it is in favor of interstate areas, and for that reason decided not to allow the Governors to make the final decisions on area designations.

Certainly the Administration bill would advocate

interstate areas. It's a very complicated kind of problem, we tried to get into it, there are some 17 interstate CHP areas today, but there are 37 interstate Standard Metropolitan Statistical areas.

Now, some of them we have interstate, some of them we don't. The political processes are quite apart from any kind of knowledge about the medical trade area and what service patterns are, are very difficult to deal with. But it was something that the Subcommittee did deal with very explicitly, and you may know that Senator Kennedy's bill provides for areas wholly within the boundaries of States.

So we will see how it comes out.

DR. MILLIKEN: One more quick question.

The new legislation on the relation of PSRO, was that left in?

MR. RUBEL: It was brought up before the Subcommittee. The question was asked: Well, should there be the same boundaries or not, and I think there was pretty general feeling that some of the PSRO boundaries don't make much sense. And the Subcommittee finally decided to tell the staff to use some vague language about the need to coordinate with various kinds of things, like PSRO boundaries, sub-State planning districts, and the like, without any mandate that you must follow.

DR. PAHL: Thank you, Gene.

Are there any other comments or points to be made by the council?

If not, I would like to thank you for the remarks and say that Mr. Rubel has indicated he will be here for the better part of the day, and there will be various points, I am sure, you may wish to interact with him as we come to other topics.

Now, looking at the clock, I would like to ask your indulgence for one more thing, because I see that Dr. Goodman has come into the room, and I know from earlier conversation that his schedule is very tight today, and therefore I would like, before we break for coffee, to have his few remarks to you, because he will have to leave for another meeting.

I would like to go to Item 6 on our agenda and introduce to you Dr. Alvin I. Goodman, who is the Program Coordinator for the End Stage Renal Disease Program for the Bureau of Quality Assurance of our sister agency, the Self Health Services Administration. They too are located in the Parklawn Building with us.

We are, as you know, as an RMP program, heavily involved in a kidney program, and those of you who have been on the council have witnessed the development and establishment of dialysis and transplantation centers as a result of the activities of RMP's.

Because of the Social Security amendments of 1972 and the payments that are now possible to patients under those amendments for treatment with dialysis and transplantation, the End Stage Renal Disease Program has been established. Dr. Goodman is the director and has asked, over recent months, for the assistance of Regional Medical Programs in helping to implement in the initial stages the activities which he is required to establish and administer.

So I would like to have him address you and stay for whatever length of time is possible; but I know it will be brief, because he has, as I say, another meeting.

I think it's important that you hear the message from Dr. Goodman.

DR. GOODMAN: Thank you, Dr. Pahl.

Members of the council, as most of you, I am sure, are well aware, in October 1972 as part of Public Law 92-603, Section 299(i) addressing chronic renal disease as considered to constitute a disability, was passed by the Congress.

This legislation went into effect as of July 1st, 1973; as part of the mandate of the legislation, there were various requirements, including a specific one for medical review boards. As yet these medical review boards have not been constituted nor established in the field.

During the interim period, an interim policy was enunciated in June of 1973. Since then, in April of this year,

1974, final policies for the End Stage Renal Disease Program of Medicare were announced by the Secretary.

For those who do not have copies of those final policies, I am leaving some on the desk here.

These final policies reflect the input of many professional organizations associated with delivery of End Stage Renal Disease Care, including professional input from the RMP office.

The major aspects and issues to address at this moment is the fact that there will be finally what RMP's have been working on for years, a development of a network approach for End Stage Renal Disease Programs, in that the broad array of professional skills and facilities required for the treatment of such patients requires such a coordination of effort and that facilities will be organized in regions on such a network approach.

And perhaps at the apex of the network will rest a medical review board to screen appropriateness of care, to screen quality of care, and to assist with other organizations in facility planning.

We are in and in-between phase. This was quite discerniblewhen I arrived. On the one hand, those local bodies, RMP's who have had expertise in these areas and plans which, to a lessor or greater degree, were being implemented -- often, unfortunately, to a lesser degree -- their existence

was threatened, as was discussed this morning.

On the other hand, the PSRO groups were quite, and still are, in their infancy, so it became a question of how does one, as rapidly as possible, establish these networks, establish these medical review boards without going through the long,laborious history that established RMP's, that are establishing PSRO's.

In discussions with members of RMP here, it became clear that it might be possible, with the willingness and cooperative approach of various RMP offices across the country that we can initiate the program and implement the program through these RMP offices, and see what develops in terms of what their future history is, and what the PSRO history is in trying to phase in appropriately this program and then phase in eventually, perhaps, with PSRO.

This program will be administered through the Regional Health Administrator's office. It is readily recognize that the RHA's andtheir offices neither have the experience nor the on-board expertise from the professional point of view and from the planning point of view to easily implement this program, yet virtually every community across the country, every region across the country still has an existing RMP office in which there resides such expertise and much planning in terms of renal disease.

So what is hoped for, in essence, is that various

government agencies and authorities in the given regions will be able to associate themselves together, some lending forth the organizational structure, the federal structure, the regional health offices and others giving their expertise in regional [illegible] planning toward the rapid implementation of the network concept, the affiliation of institutions in a given region, and a development of local medical review boards appropriately to work out in the initial difficult phases this type of planning and this type of logistical and administrative support.

This is sort of quite compatible with the statement made within the program of trying to use that type of programming and expertise still inherent in RMP in facilitating new programs and new plans as they come about. We hope that we are able to develop this cooperative approach.

I still have plenty of time for questions here.

DR. PAHL: Okay, thank you.

I think we are interested in bringing this message to you at this time, because this is one of the instances in which the existing organizations known as RMP's are finding themselves to be of great importance to another administration's program, in fact another agency's program, and we are delighted to be cooperative and helpful with Dr. Goodman. And there will be official materials developed and sent out to all RMP's shortly about this. But there has been a lot of

behind-the-scenes work between these two agencies and two programs, in order to try to use our resources to help establish and initiate a program that otherwise would not be able to be started for many, many months to come.

I would like to have any questions or comments that you have directed to Dr. Goodman.

Dr. Schreiner?

DR. SCHREINER: Well, we heard about the problems of integrating trade areas with State boundaries, and this legislation, when they started out orienting payment out of the Social Security regions, which are different than the health regions.

I would like to get your idea, when you're talking about regional review boards, are you talking about the nine Social Security Regions? Are you talking about the six regions of the RMP's? Or are you talking about an entirely different set of regions?

DR. GOODMAN: At the most local level, at the network level, the network level which is completely flexible, since it is contingent upon facilities that bear the care. One can even see in certain sections of our country, if you were to talk about the Dakotas, Montana, and so forth, that you may have a network which is based on a large extensive area that may cover two or three States, in terms of the most local levels.

In other areas of the country, the large metropolitan centers, you may have several networks or several review boards, similar to the PSRO system, within a given metropolitan area. So that is at that lower level.

At the secondary level, the regional representation, that would stem out of the ten health regions, the ten health regional offices, because there must be some way to administer this from central headquarters, if you will, out into the regions. And that would be based on the health regions.

However, we are keenly aware of the fact that there are artificial boundaries in so far as facilities are concerned, and as far as the patterns of referral of patients, and that you can have a region -- well, as a classic example, you might be having a Philadelphia-Camden situation, which are specifically separate States, specifically separate health regions, and yet one health area in terms of planning, certainly for this particular problem.

And it is certainly an issue which has to be addressed, and which we are leaving all flexibility to be addressed, and we hope that perhaps we can even be a little iconoclastic about such issues.

DR. HABER: Exemplary of possible metamorphises of relationships between various federal agencies is the VA's interest in the renal dialysis with which we have been talking to Dr. Goodman and others about.

We estimate that twenty percent of all renal dialysis currently performed in this country is performed by the Veterans Administration. We have an effective arrangement under which a small but growing number of non-veterans can be dialyzed in our facility through sharing arrangements.

The rationale for this being that we will dialyze non-veterans in exchange for comparable services for veterans by whatever hospital or medical school we have such a sharing agreement with.

This is entirely consonant with our basic mission of providing care for veterans.

This effective arrangement of limiting unnecessary duplication of scarce resources is threatened by a legalistic argument as to whether or not the Social Security Administration can reimburse third-party payers, who in turn reimburse the medical schools with which we have these sharing arrangements.

Two issues are at stake. One is the legalistic argument I mentioned, which I hope can be resolved; I feel fairly confident it can be.

The other, which I am almost certain can be resolved, is the question of medical standardization. And we are in entire sympathy and support with Dr. Goodman's contention that one standard for renal dialysis should prevail throughout

the country, since most of the people in the VA -- I'm talking about physician providers now -- who are involved in this are people who are employed on a part-time basis with the VA and they are also employed at the schools of medicine and so forth.

So we feel reasonably sure that this will be consonant with our mission. Sweetness and light will prevail.

DR. PAHL: Thank you very much, Dr. Haber.

Dr. Merrill, did you have any questions or comments?

Anyone on the council?

Mr. Milliken.

MR. MILLIKEN: Well, I think I have spent more time in the last month on the renal thing, the renal problems than I have time for, or intended to.

Because of the lack of coordinated concept at the present time, of who is already in the act and who is getting into it, and what the process, indeed, is.

It's my understanding in our region, for example, that the Social Security office in Chicago receives applications for renal programs. They then forward these applications to the A agencies, who then submits it to the B agencies for review and comment.

Now, at the present time, in Ohio there was a very good active program initiated through RMP, which sort of extended itself into a Statewide renal advisory committee,

and there was some unfortunate lack of communications between that committee and applicants, and the confusion on what the process is for submitting applications and getting clearance.

We had one case in Columbus where a New Jersey firm has come in and set up a dialysis program, and at the present time they have been unable to get back-up arrangement from the medical center at the university.

So the whole thing is stymied and bogged down right now because of the fact that the Social Security office in Chicago is not able to get the kinds of clearance from the B agency and the A agency necessary to recommend and approve that program operating in that city.

It's being straightened out, and it will be. It's well on the way, and we're having good cooperation. But the man-hours lost and running down these leads and problems and getting the right people together and finding out who is doing what is absolutely amazing.

DR. PAHL: Dr. Merrill?

DR. MERRILL: I might, perhaps, in view of Mr. Milliken's comment, ask Dr. Goodman a question.

As I understand it, what Mr. Milliken said is that there are problems with new facilities. Do you see this as more of a major problem that coordination of existing facilities, or are both equally important?

DR. GOODMAN: Well, there is a very clear mechanism.

There is an allocation of responsibility between the respective agencies, Social Security agency, and we are at the stage now, we have the professional input into the program and implementing professional aspects of the program.

The Social Security office for administrative purposes and ease of administration receives the application. CHP, which could not and should not be ignored, is supposed to ascertain need on a local basis and on a State basis, to the extent that they are capable of doing so and do a good job. This facilitates the flow of the applications and it facilitates the movement and their final adjudication.

Dr. Rubel and I are aware of the problem that certain areas have. The CHP's, in some areas they do a beautiful job, they come out with beautiful plans, as have RMP's in some areas. And in some areas, as have some RMP's, they have not, and many more CHP's have not addressed these issues.

To the extent that they don't, that means the regional office then receives the application, the health officer attempts to -- to the extent that they do not have the expertise within that office, we do here. We pretend we do have the expertise, and we make decisions.

Now, we have received about a hundred applications, we have approved about fifty to date, since the program was on. We have referred others.

The major problem, indeed, is not so much the flow, it is the competition, the competing forces out there to establish these units, and ascertaining of need. Quality becomes somewhat easy to ascertain. You can develop standards easy enough to do that.

But it is really truly ascertaining need. We are absolutely in whole segments in the country where we feel people are not literally dying in the street because of lack of our facility. It's kicking them back and forcing the agency to make determinations, which is a club I think we can use.

Certainly the potential providers are warned that in no way are they starting an operation that binds this government to pay for it until such time as they meet the qualifications, and meet the question of need.

What we are hoping is that by the formal development of networks, by the development of a medical review board composed of professionals, delivering the care and allied health professionals and health planners -- we may call it a medical review board, but it has a number of functions beyond straight-forward medical review -- that it will serve as a spearhead and a stimulus to the CHP's and others to develop appropriate local planners, and to overcome the problems that you alluded to.

DR. PAHL: Thank you.

Any other comments?

If not, I would just indicate that I guess last month, early last month, Dr. Goodman did meet with a number of coordinators with the steering committee, and we talked about the details of how the RMP's could be of practical help in initiating this thrust. And, as I say, materials will be coming forth to the council, our review committee, and also RMP's in the near future.

I would like to call a break at this point, and thank Dr. Goodman for bringing the comments. And may I suggest that we reconvene at as close to 11:15 as possible.

Perhaps you would care for some coffee, soft drinks, and so forth; and the staff and others can guide the new members to our cafeteria for some refreshment.

[Short recess.]

11:20am

DR. PAHL: Will the council please come to order.

As we reconvene, I find myself being bumped to lower and lower on the agenda, and about this time I have decided you won't need a report from me. But I am delighted to yield to the gentleman from the Health Services Administration, who is sitting on my left, who is Mr. John Reardon, Acting Deputy Director of the Division of Emergency Medical Services in the Bureau of Medical Services, Health Services Administration -- and that long title will be found under Item 7 on your agenda.

The reason I have asked John to come and speak for a few minutes with you and again be responsive to questions and inquiries, is because he is in charge of the Emergency medical Services over-all program and is responsible for coordinating our activities in the EMS area with those of the Department of Transportation, Health Services, and others.

I have asked him to please give you a perspective of the total EMS activity, with special emphasis on how the Regional Medical Program activities fit in, and the kind of cooperation which we have been experiencing together over these many months, and particularly this last week when there was a meeting, which he will summarize for you, and in which all of the projects from our regions which will be appearing before you today and tomorrow were discussed and put into a total framework.

John, would you care to give whatever comments, and then be responsive to questions, please.

MR. REARDON: Thank you.

Members of the council:

I think this council has been involved for a number of years in Emergency Medical Service type problems, and you have funded a number of activities which, in the past two or three years, I personally have followed with interest, and many of which I have been out to see, have been involved in, and am very happy to report that they have

developed into the magnitude of systems effort which now can be accommodated within our new law.

In terms of programs, the Emergency Medical Service program, which I am involved in, this began about two years ago when we awarded demonstration contracts. These are now in their second year of three. We have had successes and failures, but I think that's part of demonstrations.

I think we have demonstrated that the systems approach to the delivery of emergency medical services is not only feasible but is a practical and economic approach to solving the problem.

We have full Emergency Medical Service systems on the street, taking care of people on a regional basis, and these systems are approaching self-support levels.

With that much of introduction and passage, if you will, of our demonstration activities, as you recall, last November the Emergency Medical Service System Act of 1973, Public Law 93-154, was passed by the Congress, signed by the President, and we had funds in the amount of $27 million provided under the First Supplemental to the FY74 budget.

The funds basically are three and a third million dollars. This year it has gone, been appropriated for research which is being handled by the Bureau of Health Services Research in Health Resources Administration. The training

aspect for not only professionals but allied health professional personnel is six and two-thirds million dollars. That is a decentralized, completely decentralized program being handled in the ten federal regions, and the applications have been received. Those applications are currently under review.

That program is being administered by the Health Resources Administration, Bureau of Health Resources Development. Seventeen million dollars is concerned with a feasibility study, planning, initial operations, implementation, if you will, and expansion of existing systems of emergency services.

That is the portion of the budget which I am particularly involved in.

Our regulations were developed immediately after the passage of the Act. We went through the clearance procedure. They were published on the 29th of March, an extremely short period of time was provided, essentially thirty days, to communities to submit applications and have them back in essentially by May 1st.

This was an absurd period of time to put together a meaningful application for a total system. We recognize that. However, in order to get rid of the moneys by June 30th, which we were faced with, that was the only way we could approach it.

We did receive $54 million worth of applications, and for $17 million worth of money.

Some of those we have not been through. Some of them were atrocious. We received a few good ones, and those that were good have a high probability of success. We will fund.

As part of this, I think it's important that we come back to your interest in the Regional Medical Programs. We are concerned with a total system which, in my definition, contains three major components. The professional services, of surgical, medical and mental health services. It contains all the functional components of transportation, communication, training, consumer education, information type programs. These are the kinds of things that people routinely associate with emergency services.

We also have to pay particular attention to how these services and the components are amalgamated in the rural and the urban setting. How you put them together in the total systems approach is significantly different in the two types of environmental settings.

We are concerned, though, that we develop total systems. That is the charter of our law. And the number of applications we did receive were for categorical requests. They wanted to buy an ambulance. We turned them down, because that is not permitted by our law; and other funds are

available.

In the report both from the House and Senate, the language of the report very clearly sets forth the intent of Congress, and this particular Act was to support total systems. The communities that seek categorical funds should go to other programs for those types of funds.

Now, as far as our working with other programs, I think we have perhaps set the ground rules way back when we were working with demonstrations. We just finished this week a national review of the regional recommendations. We had representatives there from CHP, RMP, the Department of Transportation.

I understand 11, as you recall, has been very active in training, communications, transportation.

We brought in Health Service, we brought in other people like this who were spending money on categorical components of a total system. We worked very diligently with these people over the months, to be sure that we were not only concerned about the funds but also that we use their technical expertise to make it available to the community in terms of technical assistance outreach programs, so they can be part of the total system.

We have cross-exchanged financial information in terms of potential grant award programs, where money is being spent, where it's being recommended to be spent, to be sure

that there is no duplication of funds, to make sure that our funds are complementary.

I am also happy to report that within the two or three regional medical programs that are fairly large, that you have been involved in over the last couple of years, those programs have made application and they have progressed in their development to a point where they are now ready. There are others approaching the level of beginning full system implementation, and we are very receptive to those.

I should mention, if you don't already recognize it, that within our law there is one part, Section 1207, which says, in effect, that other funds of the PHS Act, other than the EMS funds, cannot be used to support full EMS systems; and that is a restriction which the Congress has placed upon your deliberations.

However, Dr. Pahl, our general counsel and myself in the EMS program have worked on this, and we have no problem with the recommendations that will be presented to you in your current meeting.

We feel that these are not in opposition to the intent of Congress, and that they complement our program and they do not conflict with our program.

We have also reviewed these against the applications that we have been reviewing in the past few days, and we have no problems with this.

Somebody was talking here this morning about the Social Security Administration and renal dialysis. I think one of the things that we are perhaps most aware of in the topic of emergency medicine is that we are dealing with a conglomerate of federal agencies, local agencies, State agencies. This is one reason that we have before the Congress, and Congress did provide under our law an inter-agency committee. That committee will be composed of approximately 22 federal agencies, departments and offices concerned, and it does involve the Social Security Administration, SRS, and people like that who are involved with Medicare and Medicaid.

Because if we are going to develop emergency medical service systems, we have to be sure that the reimbursement mechanisms covered by those agencies are adequate and are equitable in terms of reimbursement for the quality of service that's provided.

Our intent is to develop self-sustaining systems and not systems that depend on continuing federal aid. We are working on those kinds of problems. We are starting now and not looking back, five years from now, and saying that's a problem that should have been discussed.

We are working with people in the Department of Agriculture, the Rural Extension Service, in some of our educational programs.

We are working with the Veterans Administration, the Department of Labor, in terms of inclusion of the returning veterans in training programs, getting them involved in some of the paramedic type activities.

I think we have a very exciting program, and it's a program that has in effect been in being for a couple of years, but has now new legislation, and we are on the threshold.

Next year the Administration has requested a budget for FY75 of $27 million. Again we look forward to our '76 plan, we have already prepared the papers requesting somewhere on the order of the full authorization of 75 million. So we are looking toward building the program.

We will stress funding of quality projects. I will say that the one efficient thing we have found in many applications, and I think it is not due to the applicant's fault, it's more due to the federal government's fault, this year is that we had many local communities, county, city, metropolitan community apply. This is fine. It fulfills the letter of the law.

However, what we're trying to do is to develop regional comprehensive systems which pull together and make best use of the investment and resource that the community has.

I think we will see, through our technical assistance

program and through the funds we have spent in the coming year that there is a growing interest in this regional approach.

We know it can work.

I will be very happy to answer any questions that anyone may have about this program, or anything that might be related to your discussions today.

DR. PAHL: Thank you.

Dr. Janeway?

DR. JANEWAY: Mr. Reardon, I can understand your rationale for this short timeframe perhaps, because I happen to know of one area that did not submit a request because it thought it could not develop one of high enough quality.

On the other hand, the EMS research, I find, have a four times application cycle, and the EMS training, I guess, will have one.

Is it your guess that with an appropriation for FY75 that you will have four cycles for applications, or just one as you had this time?

MR. REARDON: That's an issue which we are currently -- currently have our grips on. I doubt very much there will ever be four cycles. If we're looking at cycles at all, we will be looking,probably, at one or two cycles.

I would like to have a continuous cycle. I think any time a community has developed a meaningful application

and has it ready, it should come into our consideration so that we can immediately review it and start to critique it.

DR. JANEWAY: What is your guess as to the probability of having continuous applications?

MR. REARDON: [illegible] by the appropriations cycle, I think that's the governing mechanism in terms of a continuous cycle.

For example, we could be able to receive applications in July, August or September, but we won't know what our appropriation is until probably October, November or December. And it will be very difficult to make the best investment with those moneys in July or August, although I think we can review those, and we would hope to work with the communities to -- to work with them to approve a good application, to the point where it should be funded when the funds become available.

I think there is a backlash, of course, on the continuous cycle, and I think communities tend to respond to a stimulation. If we say it's got to be due by a certain date, they tend to get things ready. If they are provided an adequate period of time, sixty to ninety days' notice, we say it's continuous, continuous in our reinforcement that we are receiving applications, that committees will go back to sleep and they won't submit them. And they lose a good opportunity. It is a dilemma.

DR. PAHL: Dr. Watkins.

DR. WATKINS: Did I misunderstand you on funding, when you said you'd avoid Medicaid and Medicare, and obviously NHI. Are you then going to depend on RMP and one other source?

I wasn't sure about that.

MR. REARDON: What I said was that as we begin to develop and implement, the local communities develop and implement and put on the street total emergency medical systems, service systems which are defined in our law, we are going to have to look for improved coverage and reimbursement in the area of Medicaid and Medicare to reimburse the provider of that service at the local community level for the services that are provided.

Right now, as an example, it's not unusual for Social Security Administration to be paying ten dollars for an ambulance call. Well, that's all right if you have the vertical or the horizontal taxi delivery, that covers the cost of the transportation and oxygen; but in terms of the quality service, which is supported with central communication, well-trained people on board who can do EKG, telemetry, treat trauma, stabilize trauma, ten dollars is a ridiculous fee to be paying for this type of service. And we must obtain an equitable reimbursement.

We are working with SSA and SRS to improve their

coverage and reimbursement mechanisms in this area.

This has to go along with our national health insurance proposals and PSRO and HMO and some of the other mechanisms that are also being developed.

DR. WAMMOCK: Are these people going to be classified as physician's assistants and EKD's, or what, if you're talking about on-board assistants and physician's assistants and so forth?

MR. REARDON: I can't really answer that because one of the things we were chartered to do and reported to the Congress this year is a legal barrier study. There is a great controversy and in some cases absence of legal coverage, if you will, were whether it's permissive or restrictive in the States.

DR. WAMMOCK: I am just asking for information to clarify it in my own mind.

MR. REARDON: I think what we're finding right now is that a few States do have permissive legislation that allows these people to perform these services, and I would say more communities are operating under the remote direction of the attending physician.

DR. PAHL: Is there further discussion on any of these points, or others that have not been sufficiently covered?

If not, thank you very much, John. We appreciate

that, and we will let you escape.

We will now get to the important part of the meeting.

The advantage of having so many speakers precede you gets it whittled down to where I think it won't take so very long, which I think is good, because one of the more important aspects we have coming up this morning is Dr. John Gramlich, who will be reporting to you about matters which are of importance on the review of arthritis applications.

So, as a preliminary to that, I would just like to make a few comments on a point or two, to make sure that we try to keep all of you up to date with some of the activities that have been going on.

As you know, the council met last on February 12. Much has transpired, and that has been reviewed pretty well by the preceding speakers.

However, we did develop a letter to you just last week which tried to bring you up to date on matters, and I believe, Ken, that that has been handed out at the table, in case you did not receive it in the mail.

If you have been following the Washington Post stories about the U. S. Postal Service, we felt it best to Xerox another copy and give it to you at the table also.

In that report I believe that we have covered most

of the matters. You know that the Secretary did authorize the full strength of the council, and sent invitations to individuals so that, had all accepted, we would be fully augmented at this point.

There were a couple of non-acceptances, for very valid reasons, and we regret that; but we are very pleased with the fact we have so many new members here.

In order to make this initial experience for the new members of the council perhaps more meaningful and rewarding, both to them and to the work that has to be done here, we held an orientation meeting for the new members of the council and any other past members who felt they would like to attend on May 31, and this was a very busy day. I will just briefly indicate that we tried to bring this group of people into full knowledge of something concerning the history of their program, the major areas of activity over the early years, the various earmarked programmatice activities of 910, kidney, EMS, HMO instruction, arthritis activities, and so forth.

We tried to indicate something about the review mechanism that we had established and followed earlier concerning the review criteria ratings, the development of our mission statement, how this had been developed and applied.

We spent some time on the phase-out and extension of the program and what staff had done, what obligations and

responsibilities had been placed upon local regions, how these local regions had indeed responded and survived over this last year.

And we got into the class action lawsuit and gave them the current status background, and what seemed to be the direction we were heading with that. And you have heard from Mr. Rubel this morning the latest on that item.

We dealt with what we saw to be the transition period that we are now in, and went into the current advisory structure apparatus that we now have with the ad hoc RMP review committee and the ad hoc arthritis review committee, what they had done just the week before, and what this council, at both this meeting and its next meeting in August, will be called upon to do.

We went into what regions are expected to accomplish through their local review processes, our management assessment visits and so forth. We talked about available funds.

We discussed our organizational and staffing position and posture, what it had been, how it had undergone changes, and what the current status is. And we went into such matters of interest as the Federal Advisory Committee Act on confidentiality, conflict of interest, open and closed sessions of the council.

At least from staff's point of view, I would like

to thank those who took this extra time to come to Washington. We found it very rewarding. We know we provided too much material in too short a time, but we hope that maybe some of it will make this meeting a little bit more helpful; and indeed we felt it to be a very worthwhile thing if we would have that opportunity prior to coming together in a large group.

With respect to our review activities, of course the major part of this meeting will deal with the results of those activities, and Mrs. Silsbee, at an appropriate point, will discuss some details.

But I would like to say that we did feel pleased that the Secretary of HEW did establish, permit to be established two ad hoc review committees for the work that we had t carry out. The first of these was the ad hoc RMP review committee, and I believe you have at your table a membership listing for both that committee and the ad hoc arthritis review committee, which was also established under the Secretary's authority.

These two committees each met for three days. The one on May 22, 23 and 24 to review the RMP applications from all 53 regions. Mr. Petersen and Mr. Chambliss chaired the individual sessions where the review of the applications occurred; I chaired the opening session and the closing session, where the full committee met, in the latter instance,

to review the recommendations of the two separate panels under Mr. Petersen's and Mr. Chambliss' guidance.

I think I should just take one moment and express, as the Acting Director of the program, my appreciation to Mrs. Silsbee for the vast amount of work that she and her total staff did prior to this meeting, and again there is no point in belaboring it, but it was a tremendous amount of work under the most stringent conditions of personnel, time deadlines, and so forth.

I think that again you will get an impression out of this when you see the applications on the front table and note we are down in our staffing to one-third of what we used to be.

In this connection I would like to also thank Dr. Endicott, who is not here, but who did support his commitment made before this council in February, when he said he would try to make available to our program the agency's resources to help carry out the workload that we had. And in fact we were able to call upon, I believe it was finally seven former RMPS staff members who were very experienced with the review process to return from their jobs in other parts of this agency, during the month of May, to give us assistance. And some of them are here, but all of them are not; I thank both them and their supervisors, because this did help us materially in getting the materials for the

review committees.

The second review committee, the ad hoc arthritis committee, met on May 23, 24, and 25. Dr. Gramlich served as our ex officio liaison council member to that committee and sat in on the discussions, and shortly will be giving a report to you.

Mr. Spear, our staff person for this activity, has worked long hours and, as with Mrs. Silsbee, deserves a special note of commendation for the tremendous amount of work well done in, again, a short time period from the inception of this program, when we first brought it to your attention at the February council, to this point where you have recommendations on a number of applications.

That committee was chaired by Dr. Roger Mason of the Nebraska RMP, who did an outstanding job as chairman, and we had hoped to have him also here to present a report to you, but a prior commitment made that impossible. But I do want to note that for the record, our appreciation to him.

Turning to another point, our own organization and staffing, to just merely state that you have heard from Dr. Greene that we still functionally are within the Bureau of Health Resources Development, and that there has been submitted to the agency a formal request that we be in that Bureau organizationally, whereas as of the moment we still officially are in the Bureau of Health Services Research.

Our personnel now number about one-third of what we had before. I believe you will see from the work that is coming to you that there are still many people who are committed and dedicated to this activity, and have done excellent work, but, nonetheless, we have lost many good people; and, nonetheless, I believe we are managing reasonably well.

Attrition continues of our staff, and this hurts particularly in the office of, or Division of Operations that Mrs. Silsbee heads, and as people depart from that office, why, we particularly feel the attrition.

We did meet with the national steering committee of RMP coordinators in May and had a very fruitful day. Part of that discussion was related to the cooperation with Dr. Goodman and the End Stage Renal Disease Program.

We also had a presentation from Mrs. Bernice Harper, who is the Acting Director of the Division of Long-Term Care, because there are program interests between that division and this agency and the RMP program, where perhaps cooperation between the two areas can further enhance the responsibilities of both.

I would like to make two announcements to the council. I am both pleased and regret to announce that two of our senior people will be away for short periods of time. I regret that announcement because this is our busy season,

but I am pleased to announce it because I think that the opportunities that each will have in the next few weeks will be very nice for them, and will certainly make their own growth and development -- will advance their growth and development and also will bring back to the agency a broadened outlook on matters which are of interest not only to RMP but to the agency.

Mr. Roland Petersen will be gone for the next two weeks to attend a health executive development program at Cornell, at Ithaca; and I guess will be leaving this weekend.

The other item is that Mr. Chambliss will be gone for six weeks attending a program for health systems management at Harvard University Graduate School of Business Administration, and will be returning the end of July.

I think we will certainly be looking forward to the return of both he and Bob.

We have been operating, back to our general staff picture, under a postulated decentralization of Regional Medical Program functions to HEW regional offices. I am happy to say that after a reasonable amount of discussion internally that that decentralization plan has not been implemented as of now, and in fact I think, through the offices of Mr. Rubel and others, it has become possible for the Under Secretary of HEW to state that no determination has been made about such decentralization, and no determination on

this point will be made at least until after legislation is passed.

Nonetheless, having said that, you will appreciate the comment that Dr. Margulies made earlier, that job uncertainty continues to face our staff, hence the attrition; yet we are happy when we can place our employees in perhaps more viable jobs, although we are sorry to see them depart the program, particularly when they have had several years of experience.

I think, for the most part, they still enjoy what they are attempting to accomplish.

Our current funding situation I think will become clear as we go through it today, but in general it's something on the order of 110 to 115 million dollars to provide support for the Regional Medical Programs out of both this council and the August council.

During our closed session, you will be reviewing the recommendations of individual applications, and I am certain that by the time the council meets in August we will have an exact figure for you, as a result of the timetable, with the conclusion of this much extended litigation. But at this time, the best I can do is to give you a $5 million range under which we're operating, and I think that's pretty good, from the point that we've been at some time in recent months.

Mr. Rubel and others have gone over in some detail the legislation, the status of that, and I feel that I don't want to comment further and take your time on that.

With respect to the over-all program for the council today and tomorrow, I would like to say that we will have a report by Dr. Gramlich, which I believe is of general interest to the open session, about the arthritis activity. And we have the other items shown on the agenda.

And one or two items of business, which will come up both at the time when the public comments are in order and under Other Business.

Then we will go into a closed session of the council, at which time we will treat in detail the review of the applications, and staff will be present to add comments, and there are a number of people from the regional offices and other federal agencies, and they are invited to attend. Members of the public may not attend.

The closed portion of the meeting is under the restrictions of confidentiality and conflict of interest, and I believe we brought that to your attention routinely in certainly the orientation meeting and I believe the statements in the package of materials given to you.

During this open session of the meeting, however, the information is open to everyone, and I therefore caution speakers or others not to get into specifics of applications,

technical review committee approach when it met on the 23rd to the 25th of May.

All the members were present.

The funding there was, as I am sure you know, in the neighborhood of $4,275,000 available for which the committee had the problem of properly approaching on an over-all view something over $15 million in grant requests. There were 43 applications involved in these grant requests.

Interestingly, ten regions had not submitted requests for a variety of reasons.

It was immediately apparent that this was a unique RMP function, on a pilot basis, one-time-only, and some of the aspects of the uniqueness of thia particularproblem were well exposed by Dr. Pahl and by others, in that these were funds that would be supervised by individual RMP's, that there were no specific legislative constraints.

This funding operationg in toto had been somewhat interesting in its inception, but at the same time this was a truly pilot type program, the development of which, and the philosophy, might well have profound influehce on programmatic thrusts and such even more remote aspects as the effects on future legislative action.

One of the committee members promptly pointed out that the RMP had frequently led the way in such critical matters, and used the example of the kidney dialysis and

transplant program with pilot studies and establishing policy and networks leading to the ultimate adequate legislative funding, and he hoped that such a situation might well develop with arthritis; and it might.

And to quote this particular committee member, he said that this arthritis program may be a unique opportunity to make a major impact.

Now, the committee had the benefit of staff review, and although Dr. Margulies and Dr. Pahl have very properly lauded Mr. Spear and members of his supporting team, I think the highest compliment that I could pay them as an observer at this committee meeting was that the staff work was good.

The requests were noted to have several common characteristics;in the patient care area, there were many elements aimed at the development or enhancement of inpatient or other central facility care, leading in turn to satellite clinics for arthritis care.

Many of the requests had strong patient education components and public education components, and here an interesting linkage with the arthritis foundation developed, which was that the Arthritis Foundation was involved in many other grant requests.

There were some specialized programs to develop, for instance, juvenile arthritis programs, arthritis care programs, gout was in a lot of the grant requests, and there

were program elements that were quite common to most of the requests also, such as major equipment acquisition, purchase of vans, development of specialized laboratories, enhancement of existing equipment, audio-visual. Some grant requests had considerable funds hoped for in terms of research, including epidemiology and tonography as well as patient care and basic research.

Some grant requests were looking towards specialized units in hospitals, arthritis and rheumatism units somewhat similar to intensive care or coronary care units.

After the assessment of the over-all view of the many requests, Dr. Pahl very kindly discussed some of the committee's policy charges, and this was an enormous asset to the committee in its functioning and future thinking.

He first noted that it was important that this was to be a national program, not a series of small isolated projects, but that its impact would be significant if the committee succeeded in putting it all together, and that this aspect should be seriously kept in mind during its deliberations.

The essential elements of the one-year program were outlined and in this regard there was some effort made to devise the appropriate direction of appropriations or of activities in the areas of the more sophisticated arthritis units already in existence, or in those with minimal or

widely spread capabilities.

The pilot aspect was emphasized as was the necessity for some measurement of the one-year outcomes for the benefit of the ongoing legislation program.

The appropriate role of a local arthritis chapter was discussed at some length, as was the feasibility of proposals that came through the arthritis chapters.

There was considerable direction toward the desirability of giving additional weight to program elements such as outreach in response to special population needs.

Patient-focusing rather than general public-focusing programs, and the basis for the continuing deliberations of the committee was clearly established.

After the summary of the staff review, the public comments were called for, and then the committee went into full session.

Now, this signaled the beginning of a full day's deliberation in closed session as to the guidelines, the appropriate guidelines for assessing equally and in-depth and impartially all of the grant applications. And the committee did give a great deal of thought and effort to establishing the appropriate guides by which the evaluation and recommendations for funding could be made for each individual application that was being processed.

The first plan that was worked out is a brief

summary which discussed about nine or ten areas of policy significance. The comprehensive health care for patient groups, that is the elements of coordinated care, was discussed at some length. The matter of professional education of people providing care, including the outreach area, the concept of "train the team" and including techniques of reaching or training the patient, was a major consideration.

Quedstions as to what might be the best module for delivering care, the kinds of provider roles, the different kinds of patients, coordination of communication took the attention of the committee for a considerable period of time.

The matter of the delivery team, how best it could be managed, facilitated, what the range of its functions might be was considered as an element important in the assessment. Research and evaluation was an obvious need which was considered by the committee, as were the problems of needs, assessment and quality control.

Then the matter of funding ongoing existing programs, as opposed to new start-ups, was considered at length by the committee, and finally the matter of needs for future funding after the expiration of the one-year RMP grant was a major concern.

These were just broad guidelines that were then

distilled into the resolutions and guides which you have in front of you in the minutes, and which I won't need to detail particularly.

I would emphasize that throughout all its deliberations the committee kept in mind the need for a degree of cohesiveness on a national basis, and at the same time maintaining an objectivity in the assessment of each of the individual grants.

The guidelines that you have in front of you emphasize the importance of outreach, and this was a major consideration as the main thrust of the programs to be approved and funded in the opinion of the technical review committee.

There were some negative aspects, and the committee felt strongly that data banks and registries, per se, should not be funded. At the same time it felt that these were not appropriate funds to spend on expensive hardware, particularly complex audio-visual, television, film making ventures that would have very short-term, if any, payoff.

The committee did feel, however, that if there were demonstrated needs and usefulness for audio-visual materials, using video tapes as an example, there were certain areas in the country of expertise where , on a loan basis, widespread distribution might be obtained of materials on a somewhat more centralized basis than if each unit went about establishing

its own.

In the matter of public education, the problem came up several times of public programs aimed at fund raising, and of course it was immediately apparent that this is prohibited by federal regulations.

Vehicles were mentioned several times in particular grant requests, and it was felt again in general by the review committee that it was important that large amounts of funds not be spent individually on equipment that might have very little long-range use, and might be unsupportable by future funding.

So that there was definite concern about large amounts of funding for hardware.

The final negative guideline was in relationship to professional training, since a number of applications had requests for funding residency programs and degree granting directions for personnel.

The RMP policy was such that the residency programs in general could not be approved.

Now, this sounds a little negative. It is not, actually, because you will find when you start going through the applications that the matter of positive effect in terms of outreach, and the various principles involved in the solution to the problems of the pilot program were carefully dealt with and the discussion went on in depth and was not

pressured at all.

In the evaluation of the applications, each application was reviewed in depth by the entire committee and the over-all national viewpoint was kept strongly in mind in the assessment of each application.

The individual application was assessed. It was sometimes modified. It was given a ranking score. And after this the committee discussed program coordination and outcome.

And this, I think, merits a quote. The notion that communication and evaluation of this program pervaded the entire technical review committee's deliberation.

The committee felt strongly that the development of experiences and innovative activities -- and I am quoting now -- "conducted under the pilot arthritis program should be widely publicized, that a periodic newsletter or similar communication about development of supportive programs should be supported by BHRD, to increase shared experiences and to avoid duplication of effort."

The committee suggested, if possible programs should make quarterly reports, and that there should be enough action on the part of the individual recipients that staff be well underway at the end of three months and that personnel and organization be completed and in operation at the end of six months.

In terms of evaluation, the committee requested, if

possible, that there should be conference in six months, or some reasonable period, at which time they would see -- they or the committee would see what was going on in the funding program, to maintain continuity.

It was recommended [illegible] it was respectfully requested by the technical review committee that the actions of this council, the advisory council, be made reasonably available then, so they could appreciate and evaluate the benefits of their work.

This committee was a distinguished committee, as Dr. Pahl has mentioned it was chaired by Dr. Mason from Nebraska, and I will briefly tell you who was on the committee -- not for subjective reasons, but because it will perhaps help in future deliberations this afternoon on the grants themselves, about the membership of the committee which included a Mrs. Annette from California, a nurse; Dr. Baily, an arthrologist from Georgia; Dr. Donaldson, an orthopedist from Pittsburgh; Dr. Engleman, a rheumatologist from San Francisco; Dr. Pfeiffer, an orthopedist from Washington, D. C.; Dr. Hastings, a podiatrist from Washington; John Poleski; Dr. Larsen, an orthopedist from Iowa City; Frank Schmidt, an arthrologist from Chicago; Dr. Schulman, arthrologist from Johns Hopkins; Mrs. Silverstein, occupational therapist from Baltimore; Mrs. Wilson, a social worker from California; Mrs. Yarborough, who is a physical therapist from

Georgia.

I served as a swaying bridge from the technical review committee on one side to the national advisory council on the other, over the stream of action that the review committee was floating down.

The committee worked long and hard. In fact, after a day and a half of establishing guidelines for fair assessments of the applications, they took another day and a half to review individually and collectively each application.

This was not the easiest occupation, since, I believe, there was a little trouble getting the Parklawn Building to keep the air-conditioning working Saturday; but they persevered and adjourned in the afternoon on the third day with a self-laudatory comment which Matt Spear had included in the minutes presented to you. They said that the efforts of this committee have been exemplary, as far as acting to the best interests adhering tc the guidelines proposed.

We consider this to be a very meager effort toward a tremendous problem, and it in no way begins to provide a solution of any definitive kind.

Now, they also made one very important point. The additional funding to include many of the projects that were rejected, as well as the bulk of other projects

which should have been submitted but were not submitted because the guidelines provided by the legislation or by the constraints of time should be considered when such moneys would become available.

In other words, the committee really looked upon itself as a waystation in a truly pilot program that has national implications and should have a long-term payoff.

I think that there is one other comment that is worth making, and that is that it is typical of RMP flexibility and viability in that this program could be thrust upon on a crisis oriented basis and that the staff could come up with a proper administration to effectively get the program to the state it now is, in a very short period of time.

A great deal of credit is due Mr. Spear, Dr. Pahl, and the entire staff.

DR. PAHL: Thank you very much, Dr. Gramlich.

Are there questions for Dr. Gramlich on this rather brief survey of what was intensive effort of the arthritis center program?

The minutes of that meeting, that have been distributed to you, as Dr. Gramlich stated, are quite important because they contain the resolutions and guides, that is, the premises upon which the committee later evaluates the application; and also there is in that document recommendations for follow-up by the Division of Regional Medical Programs,

so as to try to make it an effective national program, even though it be a one-year effort, as John has stated. And I think it would either be appropriate now or at a later point in the meeting, if you have not had time to read those minutes, to have a formal council adoption or endorsement of those resolutions and guidelines, as well as the recommendations to our agency in program for an appropriate kind of program involvement following the awards for the approved programs.

And if it is the council's wish, this could be done at a later stage. But I think it would be well for us to have that formal endorsement of the committee's processes and basic underlying premises, because this is an initial thrust, and we believe the committee not only did an outstanding job, but they set for themselves certain rules and procedures so as to try to carry out, to the best of their understanding, the mandate that was given to us.

I dont know to what extent you have had an opportunity to read these materials that Matt has. These materials are at the desk today?

MR. SPEAR: The minutes aren't here, unless they have been distributed. They were mailed out.

DR. PAHL: Okay, they were mailed out to you. If you have had an opportunity, perhaps you would care to discuss that point, or, if not, that could be left -- we need

some extra copies, which indicates to me that this is not the appropriate time, then, to take any action.

I would suggest that we get some extra copies and give them to you, and perhaps later today, or at such a time as we take up the arthritis applications, these could be gone over and that action instituted.

Are there any points of discussion for either Dr. Gramlich or Mr. Spear at this time on the arthritis activity?

Well, thank you, John, very much for your report, and we will be getting into the detail matters early this afternoon.

I would like now to take up one or two items of usual business before the council, and that is to ask for a consideration of the minutes of the last meeting of the council, the February 12th minutes.

If there are any changes or amendments?

If not, the Chair would entertain a motion for adoption of the minutes.

MRS. MARS: I so move.

MRS. MORGAN: I second.

DR. PAHL: It has been moved and seconded.

All in favor say "aye".

[Chorus of "ayes".]

DR. PAHL: Opposed?

[No response.]

DR. PAHL: So moved.

I would also like to call to your attention that the next meeting dates for the council are August 8th and 9th, and I would hope that this two-day scheduled meeting is still appropriate for you. It has been very difficult to arrange a meeting in August, and we do urge all of you, and those who are not present this morning, of course, to make that meeting, because at that time there will be applications from 43 regions or so, requesting something in the neighborhood of $42 millions.

So there is a reasonable set of responsibilities involved in that statement, so we would hope that all of you would try to make that August 8th and 9th meeting.

At this time we are not attempting to establish a meeting date beyond that, because, very frankly, we would not know what date to suggest or what the needs and responsibilities are, so if you will bear with us until August 8th and 9th we will bring in a large calendar and see what we need to do at that time.

Before we get into the last item of business, I would ask for any public comments or comments by members of the public on any of the matters that have been brought up today by us or other matters relevant to the council consideration that you care to make.

If there are individuals who care to make statements or comments, I would ask you to identify yourself for the record, and if you are representing an organization, that is, someone other than yourself, please identify whom you are representing.

So the floor is open at the moment for anyone who feels so inclined to make any general statement or comment upon what has transpired so far.

MR. POPPER: My name is Robert Popper, and I have been on the New York Regional Medical Program almost since its beginning. And for the past three years, or something like that, I have been chairman of the RMP.

Now, I have watched RMP as a concerned, interested citizen, because I am a volunteer. Nobody pays me anything any more. And also as a taxpayer.

Now, I take that responsibility very seriously. Considering the alternatives, I would rather pay taxes than not, but I do want to get my money's worth.

I have watched RMP over these years and have watched some of the things it does, particularly in our city, that I have never seen done before. It has managed to convene some people who never before could have believed that today was Thursday, and I have managed to get these people, to sit them down in a room, to establish priorities and implement programs; and it has been really quite a

remarkable thing.

A lot of these people have nothing to gain from RMP, they are not people who submit grants, they are just people who think that RMP is worth something.

I think this is good, and I think it's important.

Now, I come to you particularly with an unusual problem with New York. I hate to bore you with statistics, but the fact is that I memorized them on the plane coming down, and I'll be damned if they're going to go to waste.

We have ten million people, nine counties, twenty-one congressional districts, two hundred hospitals, and, so help me, seven medical schools.

Now, if you think that that's an easy group to get going on anything -- you are quite right; it is extremely difficult.

In December of 1972, when we had our site visit, our director had just resigned, our grantee was asking permission to withdraw, the RHE was acting under wraps because we never knew from day to day what our powers were, and I can assure you when I cross Fifth Avenue the cops didn't stop traffic for me.

Today this is all different. We have a grantee who is responsible, respectable, and who cooperates, but does not interfere.

We have relationships with our comprehensive health

planning agencies and other planning agencies in town that have never been better, with a good deal of cross-federalization and a great deal of conversation, particularly with CHP, we are in good shape.

We have a staff that's absolutely devoted and competent, and works just as hard as the staff down here, and we have a strong and vigorous RHE which attends meetings, and which deliberates and which does everything it has to.

Now, I'm not going to go into all the projects. You have them here. I merely want to say that if you think all urban areas have problems, we, with our ten million people and seven medical schools, have ever so many more problems than anybody.

But we have the solutions to solve those problems, and all we ask from you is consideration of money. We are five percent of the population of the country, we are putting in an application for roughly five percent of the impounded funds. Anything you give us will be deeply gratifying, and if you give us more, that's even better.

Thank you very much.

DR. PAHL: Thank you, Mr. Popper. I am glad we received those statistics also into the record.

Are there other members of the public, or are there comments by the council at this time relative to this statement?

If not, are there other general statements to be made before we go into the last item of business I have in the open session?

I would like to have you turn your attention, then, if you would -- I am not sure in what form this was given to them, Ken, is it in the agenda package?

In the material which contains your agenda, the last two sheets, there are two staements there which the ad hoc review committee for the RMP applications formulated and addressed to the council for their consideration, and I would like to, at this point, have you consider them in this open meeting because they are not related to any individual application or the review of any individual application, but rather are matters of general interest to the review committee and to this council.

The first statement I have is the CHP review and comment. Do you all have that statement in front of you?

MRS. MARS: Who drew this up, Dr. Pahl? What is it?

DR. PAHL: This statement was drafted by Dr. Teshan, who was sitting on the review committee, but I believe that there were several. He's the one who presented it to the full review committee.

The full review committee considered this statement and passed favorably upon it for submission to an action by

this council. So this is a proposal to you to consider and adopt it, amend it, or not act upon it at all, but it is brought to you from the review committee, and we are serving in that capacity.

In introducing to you this statement, you should be aware of the fact, and this is particularly addressed to new members of the council, that there is a procedure within the RMP guidelines and policies whereby applications from the local RMP are submitted to the local CHP agency for review and comment, and that these comments by the CHP agency are returned to the local RMP, where the comments are to be considered by the regional advisory group and the RMP, and some kind of positive response made.

That does not mean that the advice by the CHP agency has to be adopted in all cases, but the comments have to be seriously considered and an appropriate kind of action taken following the RAG consideration of the comments.

In some areas I think it is fair to say that there has been very good close working relationships, and I think we just heard a statement from Metropolitan New York RMP, where such activities seem to be working out very well.

In other areas of the country I am afraid things perhaps have not always been as smooth.

Consequently, there has been a spectrum of both the kinds of advice given RMP's from the CHP B agencies as

well as the kinds of responses that RMP agencies have made to such review and comments from the CHP B agencies.

As Dr. Margulies and Mr. Rubel have already stated this morning, much of this is past history, because we are moving into a new direction, and I believe that the sources of friction are much less widespread than rumor would have it.

In many places things are proceeding very well. Many of you who have sat on the council know that the local RMP's have done much in the past to staff and help establish the local CHP B agencies.

They are sitting on the RAG's and on the CHP B agency councils and boards, people from the other agencies; so there is good collaboration and cooperation in many quarters, but it is not uniform.

As a result of still this divergency of interest and activities,this statement was drafted by the review committee for your consideration, and I would like to read it into the record, and then you may take whatever action, following discussion, that you care to.

Mr. Rubel is here, and I think this is appropriate, because he has these two sets of responsibilities, and that is not only as Acting Director of the CHP Program, he is interested in such activities, but in his more major role, and that is the Associate Director for the Health Resources

Planning. It is his reponsibility to try to make a more effective program both internally and externally, between the CHP and RMP functions.

So I would like to read this review committee recommendation for your consideration into the record.

"CHP Review and Comment.

"Recommenation for Council Policy and Request to Health Resources Administration:

"While recognizing legislative mandate and Division of Regional Medical Program regulations regarding RMP-CHP relationships, Council requests that the national CHP leadership transmit to Areawide CHP(b) agencies nationally the mandate for fully reciprocal relationships with RMPs, especially in calling upon RMP assistance for professional and technical input into ongoing CHP plans development; and in the interests of fairness and full reciprocity Council furthermore agrees and instructs ad hoc RMP Review Committee and Staff to set aside any influence of negative CHP comments upon an RMP application unless the commenting CHP(b) agency has provided the RMP with (1) the criteria and a description of the b-agency review-and-comment process and (2) a list of the b-agency objectives and priorities upon which at least a part of the RMP response should be focused."

Perhaps it might be appropriate, since Mr. Rubel is here and has already treated this, in a sense, in his

earlier statement, to first make a comment or two which I think may be helpful and then ask for council discussion.

Gene.

MR. RUBEL: As I tried to say before, it seems to me this statement is an attempt at raising issues that have been very bothersome and troublesome in the past, and, very frankly, I don't see it as providing any positive effect for the future.

There is no question that there has been an awful lot of each agency trying to further its own means within the RMP world. There has been the question of "who sent you out to be our master" kind of a feeling, and it is certainly evident in the discussion of the review council, that that was a major one of the problems.

"We don't respect you, anyway; we know what we're doing, and who the hell are you to tell us what we should do?"

That has been the attitude in many places.

On the other hand, there has been an attitude on the part of many CHP people, one of, in many cases, jealousy, envy, "you have all the bucks and we're struggling; and we're going to sabotage what you're doing." A lot of that has occurred as well.

I think the Congress is in the process now of trying to reconcile the problems that we've had in the past. We certainly, I would say, over the last three months, four

months, have tried to do it here as well.

When the applications went out to the RMP's back in February, we sent copies of them to the CHP agencies as well. The first time that had ever been done.

We tried to explain what the rules are, where we also try to lay out some priorities, as we saw them, where they could be working together.

As I travel around the country, I have found an amazing amount of interaction that people are trying to work together. I think perhaps some people feel the problem we have as bigger than what really is there.

There is no question in the context -- the first part of the statement, I am not sure I know what it means; but in terms of reciprocity I think that is happening, people are talking to each other. And I am not sure what making that statement really means.

Well, let me stop there, and I will certainly be glad to respond to any comments you have.

MRS. MARS: Personally I don't think this is a responsibility of the council, and I don't think it comes under our prerogative to try to settle internal politics, so to speak, in that this is more or less a political issue. And I would be very much against recommending it.

DR. PAHL: Dr. Merrill.

DR. MERRILL: I agree with both those comments.

Since I have read this thing, I wondered where the other eight commandments were.

I think it's calculated to raise the hackles of the people who receive this. It's extremely high-handed, and I think the issues which are involved, which are much dealt with by a soft sell rather than an extremely hard and irritating sell such as this one.

DR. JANEWAY: John, on those two commandments hang all the Laws and Prophets.

DR. PAHL: Mrs. Flood?

MRS. FLOOD: I would inquire as to the interpretation of the CHP(b) agency by the wording of this comment. Would this encompass also the areawide planning agencies that are unfunded, that are strictly voluntary and functioning in areawide health planning without any federal or State support, but who fill the role of review and comment for these levels?

MR. RUBEL: Under current Department policy, there is only a requirement to get review and comment from those agencies that are funded by the federal government. I think in practice it has turned out that there are many other agencies involved as well.

Hopefully, in the relatively near future we are not going to have that difference, we are going to have planning agencies covering the entire country; but there is

no way, there is no requirement that an RMP get comments from anybody other than a federally recognized and funded areawide planning agency.

MRS. FLOOD: But in reality they do, they go to the areawide planning agency, recognized though unfunded, that does fulfill this role. So my question would then lead to: If this policy statement should be adopted, would it be forwarded by your office, Mr. Rubel, to these unfunded yet functioning areawide groups? Through the (a) agency, perhaps, if you use that mechanism for dispersing information.

MR. RUBEL: Well, we certainly would be telling it to the (a) agency people. We have no formal communication channel to the unfunded areawide agencies.

MRS. FLOOD: Well, that is an interesting fact when you consider that the regional offices would require a review and comment from even the unfunded agencies before they consider applications that are not directly related necessarily to RMP but to other funding sources.

In light of the fact that this particular policy statement then perhaps dispersed through the (a) agencies would reach even thse unfunded agencies, I would also feel that it is a high-handed approach and would cause many problems for Regional Medical Programs.

Thank you.

DR. PAHL: Thank you.

Dr. Gramlich.

DR. GRAMLICH: Dr. Pahl, a question of information. Is there anything in DRMP regulations which requires that DRMP staff and council not fund an otherwise appropriate project which has received a negative comment?

DR. PAHL: No, the regulations, policies merely require that the applications before being considered have gone to the CHP(b) agencies for review and comment, and that such comments be received, considered, and in some way disposed of, affirmatively or negatively; but beyond that there is no requirement.

And I should say, and this will come up as we go through our RMP applications, we made a very strong effort, as we have in the past, to make sure that despite the short time periods for the present applications, that our applications did go and be reviewed by CHP(b) agencies, and this placed a very heavy burden on the (b) agencies.

The time requirements were very, very strict. We have received the comments from the RMP's about the (b) agency comments and what their actions are, and I think we have tabulated these, and both Mr. Rubel and I are quite satisfied that everything that could be done in the periods that everyone had available has been done and it has been really a remarkable performance by both the CHP(b)'s and the RMP's.

That is not to say sweetness and light exists in all quarters, but it is far less than what people believe. And, as with most things, a few cases of dissention seem to color what is not truly a generalized situation.

MRS. SILSBEE: Well, in practice, some of the (b) agencies did have difficulty because they have such a tremendous load on -- and have been sending in comments that -- to Mr. Rubel and copies to us and to the Regional Medical Programs.

In some cases the review committee had those late-comers. In every instance we felt that the information would be accepted, but the real forum for discussion was back at the regional advisory group, and we have been trying to get information about what the process is that is going on locally.

DR. PAHL: Thank you, Mrs. Silsbee.

Dr. Sparkman.

DR. SPARKMAN: I'm John Sparkman. I am Director of the Washington last-guard unit, chairman of the steering committee coordinator; I can't speak for them, but I think I reflect their views, and I would like to take a different approach.

It seems to me that the approach so far has been to tell RMP's, you just must abide by CHP review and comment, and we have had this mandate laid on us.

On the other hand, I think what the authors of this particular statement had in mind was that the CHP should at the same time be told, Yes, you have a mandate to cooperate with RMP's.

I would agree with what Herb has said, or what Mr. Rubel has said relative to the fact that in general relationships between CHP's and RMP's are good, and they are better than the general rumor has it.

I agree further with what Mr. Rubel has said, that there is no point in looking back and having recriminations, when we should be looking forward.

But the fact remains that everything that has come out of the central office has not seemed to be to this effect, and I don't have specific comments, but I know from speaking to my fellow RMP coordinators that they feel that Mr. Rubel doesn't quite reflect to his colleagues in CHP what he says here to us.

Now, I don't question his honesty, but this is the feeling that still exists, and it seems to me that the first part of this, down to "furthermore agrees and instructs" does in fact include a positive recommendation to say: All right, RMP is going to cooperate, CHP's are going to do likewise.

But I think I would agree with the scratching of an ad hoc RMP review committee and staff, to set aside any

influence of negative CHP comments. But then I would think it is reasonable to ask the CHP agencies to describe the criterion and description of the review and comment process, and to list the (b) agency's objectives and the priorities, and the basis on which their judgment was made.

I know from the facts that our own region, but I don't know on what basis a judgment was made, and I clearly think they should be told this, and I see no objection to this.

It seems to me this is a positive thing to do, and not a negative thing. And I further think that it is the responsibility of this council to look at this and act on it.

Let me say that the coordinators hold this distinguished group in great respect. We recognize that from the beginning the national advisory council have played an exceedingly important role in RMP and determining policy and quality by actually setting policy, and I see this as a policy, and also by the careful review of applications which we are all going to do, which is an important part of determining quality.

So I see this as a positive thing, and I see it as your responsibility.

DR. PAHL: Thank you, Dr. Sparkman.

Are there other comments?

Dr. Merrill.

DR. MERRILL: I would just like to reply to that.

In my comments I did not mean that I didn't think this was at all a fine thing to do, but I think this is entirely the wrong way to do it.

What this proposes is that this council formally request that the national CHP leadership transmit; now I have a very strong feeling, perhaps shared by other members of the council, that it will never get any further than that and might simply irritate people.

I think there are other ways of effecting the kind of thing that is intended here, and I think this might be done without a formal statement.from the national advisory council of RMP.

I would suggest perhaps that it might be done on a personal basis, or a man-to-man basis. I think you're quite right, it would be nice for a local RMP to know the (b) agency objectives and priorities; but I think for the (b) agency to transmit these to the local RMP by reason of a request from the national advisory council, coming from national CHP, has the effect of making more of an issue out of it, I think, than is warranted.

DR. WAMMOCK: You're talking about that local people make this comment rather than the national level, is that right?

DR. MERRILL: Well, I would suggest in this stage that the national RMP people and the national CHP people get

together at the request, when and if it originates -- and I think it's reasonable -- should come from the national CHP without the tag of the RMP, which would only serve to be a sting.

MR. RUBEL: If I could just make several comments.

First of all, in terms of our attempts at suggesting that RMP's and CHP's work together, I would point to the covering letters that went to both organizations when this funding cycle first began, and I will leave that for the record to judge whether we have or have not attempted to suggest that there are very meaningful relationships to be carried out.

The second point, the very essence of the planning process, within a comprehensive health planning organization, is its openness and the ability of virtually anybody to participate in that process.

If we have to have a mandate from Washington that tells people, Well, we've already told them what they have to do, it's very much in the open, to open it up some more, then we have failed even more than some of us here think we have.

It is very true that there are many planning agencies that have not articulated very clear objectives, but that same thing is very true of RMP's.

It is very clear that we have CHP agencies that have

not responded very well with specific comments to a proposed project, but it is also true that many RMP's have not justified a project in a way that a CHP agency could respond.

What I am trying to say is we have a lot of problems. To the extent that you ask us to communicate with CHP agencies, I promise you we will so communicate. My own personal conviction is that all it will do is exascerbate problems that we have, and it will not be a positive influence. Let's face it.

The July applications are just about on the way. Who are we telling, you know, you've got to communicate before you submit applications. For what purpose are we doing that?

I would wholeheartedly agree, to the extent the current legislation will continue, that we need to find better ways of communicating with each other, and if I have anything to do with it, if concurrent legislation were to continue, we would seek to do that.

But, in light of where we are, I think it's a little meaningless to try to start doing that from this point on.

MRS. MORGAN: I don't believe we as a national advisory council have any control over CHP agencies at the present time to demand what they should do. We can over

RMP's groups, but we certainly cannot over CHP(b) agencies.

DR. PAHL: Mrs. Mars?

MRS. MARS: I would like to make a motion that we do not adopt such a resolution as being inappropriate for the council, and perhaps along with that, however, adding a directive, such as Dr. Merrill stated, perhaps you would like to phrase that a letter be sent or something in softer terms, rather than adopting such a motion.

Would you like to add an amendment to that?

DR. MERRILL: No, I think that the thrust of what we all are thinking is very clear to Mr. Rubel and Dr. Pahl, ad I don't think it really needs to be put into writing. I am sure they could follow our wishes.

MRS. MARS: Well, leave it then just as a motion to not adopt such a resolution as being inappropriate on the part of the council.

DR. MERRILL; I second it.

DR. PAHL: It has been moved and seconded to not adopt the proposed resolution.

Is there further discussion by the council?

[The question was called for.]

DR. PAHL: All in favor say "aye".

[Chorus of "ayes".]

DR. PAHL: Opposed?

[No response.]

DR. PAHL: So moved.

The second statement, which I believe is one that the review committee was very interested in bringing to your attention, I think is fairly obvious, particularly from this morning's presentations by all of the speakers, namely, we know we are in a transition period. Each speaker has indicated that it is necessary, essential, highly desirable for the local RMP's to order their own affairs, and seek closer, more effective relationships with those groups in their own regions, be they governmental or non-governmental, so as to look in a positive way to the future developments as we perceive them at this time.

And this recommendation by the review committee, I think addresses itself to that statement.

I would like to read it into the record, and then have the council consider this.

"Action to preserve RMP Experience and Relationships.

"Recommendation for Council Policy:

"In view of legislative developments now underway for further evolution of RMP, in association with the CHP and Hill-Burton programs, in the interests of national health planning, Council encourages RMP's to develop organizational readiness and any remaining regional relationships which are appropriate to lead, participate in and accommodate the anticipated new operating structures and requirements.

The purpose of this orientation is to preserve for the new formats within the States and regions the capabilities and voluntary cooperative relationships which the RMP experience has created."

I believe I should convey to you the committee's intent here when they say "organizational readiness", that they are stating that the local RMP's should look to their own internal staffing patterns and structures so as to be in a better position to be responsive to both the regional needs and the developing legislation as we all see it.

So this is not encouraging, by any means, RMP's to adopt different forms of grantee organization, but rather to look internally to their own staffing, structural patterns.

Now, with that as background, I would like to invite council's attention to this recommendation.

DR. JANEWAY: I believe that this is anticipatory of federal legislation, and one cannot read the intent of people who propose this to council, and I think it's open to a variety of interpretations, and in its present form I could not support it, a resolution such as this.

DR. PAHL: Mrs. Mars.

MRS. MARS: I would just reiterate what Dr. Janeway has said. I feel the same way about it.

DR. PAHL: Dr. Watkins?

DR. WATKINS: I believe -- I was going to say that I don't even believe that we should have the responsibility of voting on either of these things that came up today; we should have returned them to them with the comments that were made, without a vote at all. Because we are negating something that we're not responsible for.

DR. PAHL: Dr. Schreiner?

DR. SCHREINER: This reminds me of a story about a Czechoslovakian sheriff in Colorado, and due to local budgetary difficulties they had gotten down to one deputy, and they had a gang of about thirty outlaws holed up in a shack, and the sheriff said, "Well, men, since we're outnumbered, I suggest we split up in groups and surround them."

[Laughter.]

I think the RMP's that have lost a lot of staff know that they are in trouble and are trying hard. I don't think they are going to be helped by this kind of a resolution.

I think the ones that have the staffs, the reason they have good staffs is because they know this is a problem, and they are getting ready for possible future legislation. I don't see that anything is going to be accomplished by this type of resolution.

DR. PAHL: Well, I think, unless there is further discussion, the Chair understands the sense of the council,

and we will transmit such discussion back to the review committee, so that they will know the disposition of these.

Before we break for lunch, I would ask once again whether there are any further points to be made by council members or the public on any of the matters we have discussed this morning.

Dr. Haber?

DR. ABER: Yes, I would like to comment at this meeting about the proposed outreach of the arthritis proposal. I construe this as being very important and possibly a mechanism in which the treatment of arthritis can escalate and elevate itself up to a much higher plateau.

The reason for this is that most arthritis is not treated in hospitals, it's treated on an outpatient basis by a variety of practitioners, some of whom may not be qualified.

And I think if I sense the meaning of outreach here, there will be an opportunity for physicians who are a tertiary kind of physician, who are involved with research and teaching and so on, to be able to relate much more closely to the primary-care physicians.

That is to say, the resources of the hospital, the school of medicine, and all the rest which have been devoted

largely to life-threatening diseases on an inpatient basis, will now be turned toward this very important area of arthritis.

I would commend you for this, Dr. Gramlich, and I think it's a very important step which could raise the whole complexion of arthritis treatment in this country.

DR. PAHL: Thank you very much, Dr. Haber.

Are there further comments by the council?

Mr. Rubel, I believe, had a statement.

MR. RUBEL: One further thought. I mentioned before that we have reached a settlement or at least there is a proposed settlement of litigation, and that we have agreed at least that unless any RMP objects, that $5 million will be used under Section 910.

It is our current intention to spend all of that money, using the contract authority, and that would therefore not require review by this council.

On the other hand, by the time we meet in August, we have to have our plans, very hopefully, firmed up and I anticipate that we will be discussing with you how we intend to use that money.

The thrust of that effort is to help us do research into the technology of planning, as I call it, the methodologies to be used, I believe the coordinator says, with major emphasis on criteria and standards for expensive

services like open-heart surgery and the like.

But we will have a very complete plan worked out by the August 8 session, and we do want to share it with you, and get your -- whatever suggestions you have for us. We are going to be a little bit in the middle of a -- we can't go ahead until we get the court order signed. I am not sure exactly where we are going to be on August 8th.

Wherever we are, it's my intention to fully report to you exactly where we are with regard to that $5 million.

DR. PAHL: Thank you, Gene.

Mr. Rubel has just distributed to you, because it will be important to take this up in a closed session, which we will convene following lunch, the minutes of the ad hoc arthritis review committee, wherein you will find the premises, guides, resolutions and recommendations for follow-up by this agency in the arthritis program.

And if you should have a few minutes that you could look at those, I think our discussion and adoption of these would be more meaningful following lunch.

I would like to also thank Mr. Robert Tarr, the the HEW Committee Management Officer, and Mrs. Robert Skinner who was our agency Committee Management Officer, who is attending this morning, and just state again that we could not be here and have the paperwork done that is before you

without really the great help and assistance that they have given to us in establishing and moving forward through a rather complicated complex process.

The papers for the establishment of these two committees that we have been reviewing this morning, and thank you for attending; it's nice to have you here.

With that, I will adjourn the meeting for lunch, and suggest that we be back at five after two.

[Whereupon, at 1:05 o'clock, p.m., the committee recessed, to reconvene at 2:05 o'clock, p.m., the same day.]

- - -

end em

WD fls

AFTERNOON SESSION 2:15 P.M.

DOCTOR PAHL: The Council will please reconvene, now that the Acting Director is here. I apologize for being a few minutes late.

We continue to get communications from Regions; we do like to have the latest information as we go into the review cycle, but I think we have to call a halt to it at this point and get to the business at hand.

I think that -- Judy, just let me ask whether you would prefer to give your general comments now, or after Doctor Gramlich treats the arthritis program?

MRS. SILSBEE: I think it would be simpler if we just concentrated on the arthritis.

DOCTOR PAHL: Because of the schedule, which permits Doctor Gramlich to be here today but not tomorrow, we have decided to ask him at this time, again, to present now in this closed session, the Arthritis Review Committee's considerations, together with a specific recommendation on the applications, and to give you a full picture of those events, and then to ask Council to take appropriate action.

Now, in opening this meeting, I would again remind you that the proceedings from this point on are confidential, both the materials that you receive as well as the discussions that will ensue, so we ask that you keep that in mind, and also, should any application, either within the arthritis

program or within the Regional Medical Program, be discussed from the area from which you come, or if you know of some other conflict of interest as a result of your own involvements in consultantships and so forth, please excuse yourself from the room during the discussion of that specific Region's application.

Are there any members of the public who are here, because if so, I will have to ask you to leave the proceedings at this point.

Doctor Gramlich, will you please proceed with your discussion, and in that connection, I have been requested to announce that because of the low ceiling and the airconditioning, it is hard for the Reporter and the staff to hear the comments, so please use the microphones when you have occasion to make comments or address the Council.

DOCTOR GRAMLICH: I think there are several things that merit emphasis that I didn't pressure quite enough this morning, in terms of discussion time limitations.

First off, just a small subjective observation, which, in addition to the listing of the Technical Review Committee members, which I described this morning, I would simply comment that this was a very hard-working, extremely conscientious group of people.

DOCTOR PAHL: Pardon me, Doctor Gramlich; can you put the microphone a little bit closer? I am afraid the air-

conditioning units at this end are makkng it difficult to hear you.

DOCTOR GRAMLICH: Is that any better?

DOCTOR PAHL: Yes, thank you.

DOCTOR GRAMLICH: This Committee was an able group which devoted a great deal of attention to the problem, as witness they went to work at 8:00 o'clock in the morning -- none of this 9:00 o'clock business, and on a couple of occasions worked until 8:30 or 9:00 o'clock at night, or on one occasion they worked that late. The Saturday morning -- or the Saturday session -- lasted until mid-afternnon, so in effect they put in three days of hard work in reaching the conclusions that they did.

That's a small personal aside. I was there as an observer. I have been credited with the good work they have done, which I would like to assume the responsibility for, but my position merely was that of, hopefully, a bridge between them and the National Advisory Council.

I did not contribute because I have no expertise in arthritis or rheumatology.

Now, down to the work. I think it is extremely important that the Council is quite cognizant of the guidelines that this Technical Review Committee developed, because it was the basis on which they made their objective decisions as to which grant applications should be funded, which should

be disapproved, and the numerical ratings and prioritization of the ones that were approved.

The purpose of using this format was to make it considerably easier, hopefully, for the Council to do its own job.

Now, I have very summarily named off and listed, briefly, the guidelines that they came up with. But you have only just recently received an opportunity to read them in detail.

I would first off ask Council whether they would like to discuss these in detail, or whether they feel satisfied and comfortable with the guidelines as they have been given to you on the written sheets that you have? If you want to discuss them, I will be very happy to do so; if you think that there is no need to waste time on that, that is agreeable to me.

DOCTOR PAHL: Is there any comment by Council as to whether we can proceed?

Have you had an opportunity to review these, either prior to or over the lunch hour?

I think, Doctor Gramlich, we might assume then that they are in agreement with the understandings reached by the Review Committee, and you might proceed with the report.

DOCTOR GRAMLICH: If that is true, then I would suggest, as a matter of the least confusion, that it might be

appropriate for me to move that Council accept the report listing the guidelines.

DOCTOR PAHL: Is there a second to this motion?

DOCTOR WAMMOCK: Second.

DOCTOR PAHL: It has been moved and seconded for the Council to accept the report of the Review Committee in which these guidelines and recommendations are given in detail.

Is there discussion about any of -- Doctor Merrill?

DOCTOR MERRILL: Yes. I have one rhetorical question which I have asked Doctor Gramlich before; I know the answer to it but I'd like to have it for the record.

I assume that there were no sticky points in any of these recommendations you made which you felt needed the advice and concern of the Council? There were no problems which you felt should be dealt with at this level?

DOCTOR GRAMLICH: I recall none. Matt, were there any that came up?

DOCTOR PAHL: Mr. Spear, would you please comment?

MR. SPEAR: I can't recall any. There were specific cases -- having established these specific guidelines, there were specific cases -- I think the best answer, if I interpret your question correctly, Doctor, is that the recommendations and guidelines that the Committee adopted for its own guidance were done so with a recognition on their own part

that these were not carved in stone, and if there were a reasonable basis to violate them, they would do so, and at the moment, off the top of my head, I'm aware that they did so in only one case.

DOCTOR PAHL: I think it should also be perhaps noted for the record that the guides and resolutions, in part, form the basis for the recommendations for follow-up by this Agency, and in that sense there would be continuing involvement by Staff to help make effective the recommendations of the Committee, insofar as these guidelines were utilized during discussion of any specific application.

So the two together are the package, the recommendations of the -- to the Agency, as well as the premises on which they discussed the individual applications.

Is there further discussion by the Council?

If not, I would ask the question; it has been moved and seconded to accept this report.

All in favor?

(Chorus of "Aye")

Opposed?

(No response)

So moved.

Doctor Gramlich?

DOCTOR GRAMLICH: I would then think that perhaps the next step would be the assessment of the list of the

recommended disapproved and approved grants, and the allowance therefor.

In the sheet -- or, in the folder which has been titled "Arthritis," which has been just recently handed to you --

Now, you will note -- these are alphabetized -- that there were -- you'll note several things first off.

There were grant requests totalling $15,866,581, for the payable funds $4,275,000, but the Committee, of course, was always cognizant of the need to keep the approvals and the funds recommended within the $4,725,000 figure -- I'm sorry -- the $4,275,000 figure.

Therefore, they went through the grant requests one by one, with a primary reviewer reporting on his or her objective observations, and a secondary reviewer either confirming, denying or altering the review of the primary reviewer.

In each instance, when each grant request was considered, this process was followed by total discussion by the entire Committee. That is one of the reasons it took three days.

There is -- the recommended funding for those approved programs came out surprisingly close to the amount that was available. They didn't realize at the time this was being done whether it was going to come out close, below or above, so they took the obvious route of prioritizing them,

and ranking the score, giving them a numerical rating as well as the dollar figure.

Out of the 43 applications that were considered, 12 were disapproved en toto; the remaining 31 were ranked, and the recommended funding noted.

I have just discovered a minor discrepancy, I'm afraid, in that on the first page of my listing of the Committee's recommendations, the rank score has been left out.

Does yours have the numbers on it?

MR. SPEAR: We didn't put it on the first page, Doctor.

DOCTOR GRAMLICH: Oh, okay; very good.

So what you see there, then, is on the basis of zero to 100, the Committee's estimate of the quality of the grant request -- on the second page, now -- the total amount requested and the total amount recommended by the Committee.

I would --

MR. SPEAR: If I could inject one comment, Doctor, the rank score is a ranking after the application had been modified by the Committee.

DOCTOR PAHL: Thank you very much, Doctor Gramlich. I think this give you a picture of the recommendations -- that is, the final dollar recommendations for the approved programs, and before asking for any action on this, I would

indicate to you that the earmarked funds for this program are $4.275 million, and the approved programs exceed that amount. What we would intend to do, following Council action on approved and disapproved programs, is to notify those Regions that have had programs approved that we are also sending some dollars with that notification, to the extent that we can, but for those programs that were approved by the Review Committee but which go beyond the actual earmarked funds available, we would indicate that the Region may, at its discretion, use its RMP funds from the June and August Council awards if it is in their best interests to do so to fund the programs.

In other words, we would assume that they could incorporate that into their total consideration of priority listings as to how to use the RMP funds that we are making available to them through this next June 30th.

Those programs that have been recommended for disapproval by this Council would receive a letter stating that their application has been recommended for disapproval, and therefore they may not use RMP funds for the support of that program, and that the application basically is ended from that point of view.

So, with that, John would you care to introduce a motion for the Council to consider?

DOCTOR GRAMLICH: It would seem to me the easiest

way to solve this problem, if the Council is comfortable in so doing, would be to accept the list as prioritized, and suggest to the RMP's that those programs that fall within the total funding, starting from the top and working down -- of $4,275,000 -- be approved en bloc.

Now, that leaves a question about the ones that were approved but ranked low, and therefore do not fall within the funding purview of the amount available.

If you look at the list on the second page, the gross total after Albany -- sixth from the top -- comes close to the funds available. That figure is $4,239,750. After Albany, and before Puerto Rico.

You probably also have noted that Puerto Rico has the same score-rank as Albany. This poses a minor problem, in that if Albany is accepted and funded, we stay within the $4,275,000, but Puerto Rico has the same rank, according to the Committee's deliberations. So there is an element of unfairness to that.

If Puerto Rico is added to the list, the figure that then totals out for the funds to be allocated is $4,332,950, which is about $60,000 over the allotted $4,275,000.

I would suggest -- and this is an independent suggestion, that if we deem it possible -- if Council approves -- that an additional $60,000 might be found somewhere which would allow Puerto Rico as well as Albany to be funded, and

therefore would make the following motion.

That Council approve the funding of the arthritis grant requests within ranking limits, and if all Regions -- all RMP's, including Albany and Puerto Rico -- accept the recommendations of the Technical Review Committee and Council, that additional funding to include Puerto Rico be found, if possible, from other sources, so that it also would be included in the approved and funded list.

That's long and complicated.

DOCTOR PAHL: I think the Council has the sense of your discussion, though, and I would ask if there is a second to this motion?

MRS. FLOOD: Second.

DOCTOR PAHL: It has been moved and seconded. Is there further discussion?

Mrs. Mars?

MRS. MARS: How does the incidence of arthritis in Puerto Rico compare with Albany, and what is the comparison between population figures?

That in fact might be a very decisive factor.

MR. SPEAR: That -- we don't know. To the first part of your question, Mrs. Mars, no one knows, other than that there is a higher incidence in deprived areas and in areas in which family income is below $5,000 a year.

MRS. MARS: Yes, but the climate also has a great

deal to do with it.

MR. SPEAR: The field discourages that. They do not believe that that is true, according to present thinking.

With regard to present thinking, I regret to say we do not have those figures.

MRS. MARS: Well then, how can you base it as being equal, so to speak, that one should have as much money as the other?

DOCTOR PAHL: Well, there were a number of elements that went into the consideration of the review, which ultimately led to the ranking priority of 40. It is just coincidental that it comes out with Albany in the ranking.

MRS. MARS: I meant to say in rank, rather than money.

DOCTOR PAHL: Surely.

MRS. MORGAN: Can we really give them more money than what has been appropriated?

DOCTOR PAHL: I think the sense of the recommendation -- or, the motion that is before us, is to fund through Albany, and if it is possible for the Administration to find additional funds, to fund Puerto Rico.

That is the sense of the motion, and this merely gives us guidance as to what the Council wishes to do, and we will attempt to carry out this request if that motion is carried. If it is not possible for us to do this, obviously

we will then fund as far down the list as possible.

It also could be that one Region or another would find it inappropriate to accept their award because of the modifications that have come about as a result of the Review Committee deliberations, and thus we are not certain that these will be the final ultimate ones in all cases that would be the approved, funded projects.

That is why we have a slightly longer list to take care of, which must be the result of negotiation following Council -- Doctor Merrill?

DOCTOR MERRILL: Because perhaps Puerto Rico is a favorite of mine, but would it be feasible, let's say, instead of dropping Puerto Rico entirely, in the event that you can not find $60,000, to take $2,500 from each of the 24 above it and allot it to Puerto Rico? It's not a lot to take away, and yet it would assure that Puerto Rico was funded.

DOCTOR PAHL: I think Staff has the flexibility for negotiating within this rather strange dollar figure as a ceiling amount, and I believe we can receive the guidance of the Council and feel reasonably sure that there is a possibility of funding Puerto Rico without actually being able to commit to you definitely, sitting here at the table today.

MRS. FLOOD: Also, Puerto Rico is a favorite of mine, but also with a concern for equal ranking, and an arbitrary line drawn for equal ranking, may I ask -- I would doubt

that any Region would turn down any funds that might be offered, even though I find it interesting that Ohio Valley, for example, with a request of $711,000, receives a recommendation for $46,500, and another marked one, although perhaps not quite as large, would be Wisconsin, with $267,800 and a recommendation at $62,000.

May I -- there is one other here --

DOCTOR MERRILL: Look at Iowa right below it. Compare Iowa and Ohio Valley.

MRS. FLOOD: Yes. Then there is Mississippi.

Might I ask of Doctor Gramlich, how would -- with such extremely high ratings of these regions above could their funding recommendation be so starkedly lowered?

MR. SPEAR: There are many reasons, and I will try to recall some of these to you.

Many of the Regions went the usual RMP route, in which they came in on their applications with a full-fledged, Region-wide care-delivery kind of program, and we had tried to make that clear in the guidelines that with limited funds, and with the language in the Congressional authority, this was not what we were after; that we looked for pilot efforts.

And one of the reasons in some of these where you see such a stark distinction is where there was a very sharp cutback to just a pilot activity.

For instance, in a number of states where they had

divided their states up into a number of various areas, and then down into sub-organizations of other kinds, and they had pooled people, activities, in all areas of the states, the Committee said: only go for one or two of those and try it out, and see if it works, and provide yourself a working basis which is demonstrated and proved. That happened.

Some of them had very large requests for things that by resolution the Committee had decided not to -- film-making, videotape-making, development of publications, and the printing of them. Large computer data operations, patient registries -- all these are much needed in the country, but this is not the program to support those kinds of things.

I know there are two or three other reasons; they'll come to me. Maybe if we take a case --

MRS. FLOOD: Choose Mississippi.

MR. SPEAR: Choose Mississippi? Let me think about it.

Mississippi has a very fine, very gorgeous hospital being built in the state, I believe in Jackson, and the application surrounded that installation, that facility, and as the Committee looked at all the various components in that application, they came to the conclusion that what the program was really being asked to do was to underwrite the first year's operation of that institution.

And they said: "Thanks, but no thanks. What we will

do, for those kinds of very small but meaningful outreach activities you propose to do with that institution, we would like you to start them now and do them."

And that is what they funded.

MRS. FLOOD: But you rated it 80.

MR. SPEAR: We rated it 80 with that modification. Without the modification, they would have turned it down.

These rankings are with -- at the lower recommended amount, the ranking relates to that, and not to the request.

MR. BAUM: Matt, there was also in that one, as part of an example, a request for something like $385,000 for making motion pictures related to arthritis, and that is one of the reasons for the sharp drop in money, since that was completely chopped out of the approved project.

DOCTOR PAHL: Thank you, Mr. Spear and Mr. Baum.

Doctor Haber?

DOCTOR HABER: The same question was bothering me; here comes Iowa, way down the list with 97 percent of what they requested. But I think the explanation is clear, that the rank-score relates to the excellence of a particular part of the project, and the total sum may be unrelated to what --

DOCTOR PAHL: Mr. Spear?

MR. SPEAR: Just an idea, there.

You see, you have -- like yourselves -- many people sitting together making these kinds of determinations, and it

is hard to tell on what basis a particular reviewer will make his ratings.

Sometimes it was the excellence of people who were underwriting a program. Sometimes it was the excellence of planning; sometimes it was the specifics of what they were trying to do, in which they knew, by similar activities, or for some other reason, that this was going to be a going concern.

All of these things came into it, and we are not quite sure in some cases what was the balancing factor.

DOCTOR PAHL: Is there further discussion on the motion?

MR. HIROTO: One.

DOCTOR PAHL: Yes, Mr. Hiroto?

MR. HIROTO: Does the RMP plans which were disapproved -- were they primarily disapproved because they fit into the resolutions of "non-activity"?

DOCTOR GRAMLICH: They were disapproved on a multiplicity of bases.

Some were disapproved because the program that was recommended was entirely outside the guidelines; other were that it was felt that the personnel involved were not capable of doing what they claimed to do.

I think in this guise it is important to emphasize once again a point that Doctor Pahl has made, and so has Matt

Spear, that of the approved programs, if there are other RMP funds available, too, the Council says in effect it is all right; if you can find the money someplace else, go ahead with the part of the arthritis program that is not funded.

For the disapproved programs, as Doctor Pahl has pointed out before, no RMP funds of any sort can be used -- should be used for that particular program.

DOCTOR PAHL: Is there further discussion, comments, questions?

MRS. MORGAN: I don't know whether I understand or not, when you say that they may use other RMP funds.

You're not saying they can use other RMP funds for making movies and that sort of thing, are you?

DOCTOR PAHL: No. It would be within the --

MRS. MORGAN: Within the guidelines?

DOCTOR PAHL: Within the guidelines.

I would like to act on this motion and the come back to that point, in view of Council's consideration last February. I would like to act on the motion to accept the Committee's rank-ordering and overall recommendations, together with funding through the rank score of 40 to the extent that Staff can negotiate this or obtain permission to exceed the earmarked level that has been given to us.

If there is no further discussion, all in favor, please say "Aye."

(Chorus of "Aye")

Opposed?

(No response)

So moved.

Now, in connection with what I indicated to you before, as to our interest in sending letters to those Regions that did have approved applications, but are not within that funding range, to provide them the opportunity to use their own RMP funds to support the approved programs as modified by the Committee, I have had my attention called by Mr. Baum to a resolution that the Council made in February, which I would like to read into the record, so that there is no misunderstanding or conflict between the two Councils, particularly in view of the fact that we have a large membership.

In February, the Council approved the following resolution in relation to the arthritis centers, and that is on page 6 of the minutes of the Council meeting. Quote:

"Whereas the Congress has earmarked in connection with Public Law 93-192 certain RMP funds for planning and development of pilot arthritis programs, be it resolved that the National Advisory Council on Regional Medical Programs recommends that activities in the field of arthritis be recognized for support under Title 9 of the Public Health Service Act to the extent that funds have been appropriated for this function."

Now, I believe it is fair to say that the spirit of that resolution would be contrary to what I have just indicated to you, and very frankly, in the press of things which I have been concerned with, I had forgotten that we had this, and so I am glad you reminded me so that we can bring it to the surface and ask this Council, now meeting in June, whether you would like to reaffirm, if you will, this resolution that was passed by the Council, which would limit then the funding of the total arthritis programs to those that can be fitted within the earmarked, or whether you wish to reconsider that, since it is the Council's resolution, and endorse the position which I indicated to you was my intent, and in all honesty, having forgotten the earlier resolution, for which I apologize to Council.

MRS. MORGAN: Could we say, take two percent or one percent of all the others above and be able to fit Puerto Rico in?

DOCTOR PAHL: I wasn't referring to Puerto Rico; I was referring to the fact that there are below that, four additional approved applications which obviously are beyond the earmarked.

And so it is in the interests, I think, of this Council to consider whether it wishes to permit RMP's to use their RMP money, if they see it to be their priority, in those approved Regions, to support the programs, or whether you wish

not to make that opportunity available to those additional Regions.

MRS. GORDON: Could you give us the rationale for this particular decision?

DOCTOR PAHL: Well, I think the rationale -- I am trying to reconstruct; I am afraid our minutes are perhaps abbreviated here, but it would seem to me that that was the interpretation of what the earmarked meant at the time, and also at that time, when the Committee met in February, we were very uncertain as to just what level of funding -- I am sorry; when the Council met in February,we were very uncertain as to just what funds we would have to support the RMP program.

Having the Court order before us, we felt we knew, but there was also some uncertainty because of various considerations that had come into play, and at one point in time a rather large sum was thought perhaps to be better used for other purposes, and I am making a report to you now that something like $110-115 million will be available to support programs -- the regular programs of the RMP's.

So there is a question here of whether the Council feels it important to permit RMP's to support programs -- approved arthritis programs beyond those which reach the ceiling mark or whether it is not.

Doctor Merrill?

DOCTOR MERRILL: I wonder whether the Council might

consider, in that light, modifying the February resolution to say that these other funds not now earmarked for arthritis might be utilized for this upon application to the Director, and with his approval in special instances?

DOCTOR PAHL: Mrs. Silsbee?

MRS. SILSBEE: Doctor Pahl, I think Council's resolution in February related to the earmarked and the way in which we administer the earmarked.

Once those funds are put out under the earmarked, the Region does not have flexibility. That money must be used for arthritis.

DOCTOR PAHL: That's targeted.

MRS. MARS. Well, I also think it was also to not dip into RMP funds at the time, to be used for the specific arthritis programs, that we felt that some had been allocated and was adequate and ample.

And I think that the resolution should stand, even in view of the fact that we now do have further funds.

DOCTOR PAHL: All right.

Is there additional discussion on this point?

Mrs. Mars?

MRS. MARS: Certainly there can be somewhat of a distribution of funds, as it stands now, and send it back to the Review Committee to see if they can reallocate.

DOCTOR PAHL: I am afraid we dc not have the time available for us to obligate these funds by June 30th.

(Discussion off the record)

DOCTOR PAHL: I think that obviously the Staff will do its best to negoatiate with Regions to fund as far down the list as possible, but I think we need a clear statement from this Council as to the reaffirmation of the early resolution, which is your point, or whether that resolution should not stand, because I have misinformed you, in a sense, quite out of ignorance, if you will, or of not remembering that earlier point.

So let me suggest that, Mrs. Mars, you make it as a motion and let's test it.

MRS. MARS: Very good. Yes; let the resolution stand as it was previously passed.

DOCTOR PAHL: All right. The motion has been made that the February Council motion stand.

Any second on the motion?

Mr. Rubel?

MR. RUBEL: I would just like to ask if in 1971 or '72, if the Washington-Alaska RMP had put in its proposed project for $175,000 for this kind of activity, would that have been accepted -- acceptable at that point?

Is this something that an RMP could have done?

DOCTOR PAHL: Under the original guidelines, yes.

MR. RUBEL: Do we have any other kind of quotas that we are using here for kinds of special projects? Have we said in here that we could only use -- I understood that the essence of the RMP philosophy was to allow a Region itself to determine what its priorities were.

MRS. MARS: I don't think that has anything to do with this at all. This was simply that we did not want to supplement this four million -- whatever it is -- and take it out of RMP funds.

I don't think it interferes in the least with the idea of a legitimate project on the part of any RMP, whether it concerns arthritis or anything else.

DOCTOR MERRILL: Still, with the uncertainty that has prevailed, perhaps between the time of the original application, let's say, for other funds, and this arthritis application, priorities might have been reassessed, and if the total amount of money from out of our pocket was not changed, but simply an intramural reevaluation from one pocket to another, in light of changing priorities, if this had the approval of the Director with proper application, would it not be the prerogative of local RMP rather than perhaps the Council to have a flat "No" to this kind of thing, without knowledge of the fact that priorities situations might have changed between the two applications.

DOCTOR PAHL: Is there further discussion by the

Council on the motion?

DOCTOR GRAMLICH: I am not sure I understand the motion.

Is that in effect saying that we can not support Puerto Rico from funds other than this grant?

DOCTOR PAHL: He is saying that we would not support with funjs beyond the earmarked any approved -- beyond earmark lvel, any of the approved applications. That is, we would not be giving the right to Regions to utilize their funds for the support of these applications.

DOCTOR GRAMLICH: I put a little different reading, then, on this resolution in February. You know, it is easy to put all sorts of readings on it, since I wasn't there and don't remember what the Council had to say about it.

But it strikes me that the Council, in its February action, where it says:

> "...be recognized for support under Title 9 of the Public Health Service Act to the extent that funds have been appropriated for this function."

is perhaps serving as saying: "we don't know what funds we are going to have for Fiscal-74-75. Let's take these while we can without having to obligate anything else, out of moneys that we don't know that we're going to get, and that perhaps all they were doing was just accepting PL 93-192 and the money

that went with it under Title 9 without considering any subsequent possibilities.

DOCTOR PAHL: Well, I would suggest that since we are a full Council now, that this Council act as to what it sees to be the best interests of the program, because there is full knowledge before you as to our current situation and the applications and the funding recommendations, and I believe you have the right, as the Council, to make whatever reaffirmation or change you wish from an earlier point.

MR. MILLIKEN: This is going to be an amendment; is that right?

No? It's a restatement?

MRS. MARS: NO, it's merely reaffirming the motion made in February by the Council. Reaffirmation.

DOCTOR PAHL: Mrs. Flood?

MRS. FLOOD: Perhaps being a little repetitive, but let me clear now in my mind -- we are saying that should we overrule the policy action of the February Council meeting, or substitute a newer, broader policy statement, nonetheless, we would limit the Regional Medical Programs to expenditures of earmarked funds plus their own funds, to the categories of activities approved by the Review Committee?

In essence, we would not allow Mississippi to go ahead and use general funds to bring their expenditures in an arthritis project, for example, up to the level listed here as

their request; we would give them only the authorization to augment their -- well, they are above the cutoff. Let's take someone else.

Lakes Area, for example, that is below the cutoff line. They would only be in a position to use $45,000 of their funds for that component part of their application.

This is the interpretation I'm hearing?

DOCTOR PAHL: Yes.

MRS. FLOOD: Thank you.

DOCTOR PAHL: In other words, what we have is a preliminary review group that has looked at the technical merit and has established guidelines for a national pilot arthritis center program.

In order not to abuse the whole process, we would apply the same restrictions on all approved Regions so that they could not do locally what wasn't really approved nationally; otherwise, there would not have been much purpose in going through a national review process.

The question here is that we will pay through as much as we can fund, and through the negotiations which have to take place, post-Council, with the Regions, we will ride as far down on this list as we can with the full sense and discussion -- understanding of the Council discussions.

The further consideration is whether Regions who have received a true approval for their applications, but

where there is insufficient money, whether they may use their own RMP funds to support what we can't out of the earmarked, and that represents, I believe, the consideration that is before us.

And the motion, as I undertand it, that has been made and seconded, would be to limit the 53 RMP's in the pilot arthritis center program to those Regions' approved applications to the point where the earmarked funds have run out, wherever that point happened to be.

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

(Chorus of "Aye")

Opposed?

(Chorus of "No")

Well, perhaps we might have a show of hands, if you will, please. All those in favor of the motion, please raise your hands.

(Show of hands)

Four hands.

Opposed?

(Show of hands)

The motion is not carried.

Now, we will entertain a different motion.

DOCTOR HERRILL: I would like to make a motion that the funds appropriated for the arthritis project -- that those applications for which funds are not available from the

arthritis project be allowed within the limits of the recommended total, to apply other funds now in their possession to the arthritis project, upon application to the Director of RMP and subsequent to his approval.

DOCTOR PAHL: All right. Is there a second to that motion?

VOICE: Second.

DOCTOR PAHL: All right, that motion has been made and seconded.

For clarification, I believe, Doctor Merrill, you would want to state not necessarily the funds "now in their possession," but funds currently available to them or those which are to be made available to them as a result of June and August Council decisions, whatever they may be.

DOCTOR MERRILL: Yes.

DOCTOR PAHL: Is there discussion on that motion?

MRS. KLEIN: Mister Chairman, I didn't get that limitation straight in my mind. Is it a limitation on the amount they applied for, or the amount that was granted, within which they may use their other funds?

MR. MILLIKEN: The amount that was granted, right? Is that what you mean? The funds that were granted.

DOCTOR MERRILL: Yes. Not applied for; granted and approved.

DOCTOR PAHL: The recommendation of the Review

Committee.

MRS. KLEIN: Well, Mister Chairman, that, then, would be an extremely limited motion, would it not, and would apply really to these last two applications, possibly, because -- is it my understanding that there are sufficient funds available to fulfill all the other commitments?

DOCTOR PAHL: There are sufficient funds to pay all except perhaps -- $500,000 total amount of recommended applications, so it only has impact to that extent. It's important to those regions.

MRS. KLEIN: I see. Thank you.

DOCTOR PAHL: Is there further discussion?

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

(Chorus of "Aye")

Opposed?

(No response)

The motion is carried.

All right. Doctor Gramlich, are there any comments you have, or Mr. Spear might have on the arthritis activity?

DOCTOR GRAMLICH: I would make one brief comment, Doctor Pahl, and that is that the Technical Review Committee seriously considered the follow-up activities, at intervals during the grant year and at the conclusion of the grant year.

I would suggest that the Council urge the RMP's to carry out their follow-up activities within the limits of

feasibility.

Does this require a vote?

DOCTOR PAHL: No, I think --

May I just please pass along the comment that it is not possible for us to get a record of the meeting with multiple conversations going on in the room. It is just a poor room for the acoustics, or perhaps it's overly sensitive for acoustics, so please keep the individual conversations down if you can so that we can get a record of the Council meeting.

Doctor Gramlich, the Staff, I think, understands through the discussion of the Council and the acceptance of the minutes and so forth that the Council would wish us to engage in these activities that were recommended by the Committee, endorsed by the Committee -- the Council, which hopefully would lead to an effective program over the year, which would mean that we would be calling together the Directors of these projects, asking for periodic reports, and trying to work with them and give assistance to them in those areas such as common data retrieval, systems, provide assistance in finding appropriate limited sources for the production of audio-visual aids and things of this nature.

So I don't believe we need a formal Council action on this, but we would accept it certainly as the Council's desire.

DOCTOR JANEWAY: I just wanted -- I'm new, and I would like to ask a question for information.

Would you define for me, to make me a little bit more comfortable, about the meaning of a priority score of 20?

DOCTOR PAUL: I would like to ask either Matt or Doctor Gramlich. I think it's important --

DOCTOR JANEWAY: Because it's a little bit different then I'm used to hearing.

MR. SPEAR: I am trying to recall, Doctor Janeway, just what that meant, and it doesn't come to me at the moment. I can look up the records, if you want to take a few moments while I do that.

DOCTOR JANEWAY: No, no --

MR. SPEAR: But -- those Regions listed below Puerto Rico have had their successes, and lesser successes along the way.

What the Committee was looking at were in some cases -- and these were some of them, certainly -- in all cases to the Regions that had an extremely short time to put these programs together, and the applications reflected that.

We had extraordinarily well set-forth plans; the Committee recognized this, and were able, through their personal contacts and knowledge of the field, to know where the strengths existed that were not even reflected in the applications, and I would take Tennessee-Mid-South as an

example, although I'm not sure it applies specifically to this case.

Where there was an underlying feeling that there were better resources there and a better capability than they were seeing, and it raised a little question in their minds as to the real intent and the real commitment to what they were reading was in terms of carrying out -- insofar as carrying out those things the Committee was willing to recommend.

In some cases -- for instance, Puerto Rico would -- which is a 40 -- in the area of known extreme needs for this kind of thing -- not that it doesn't have many, many other extreme needs, and it was sort of a joke among the Committee, because in the Central Hospital of Puerto Rico, there are 14 rheumatologists, and there are large areas up in New England, for instance, that don't have that.

And as they went through the rest of it, they kept saying: "I wish we could pass out some of those rheumatologists in Puerto Rico."

But you know, their plan never told us who was going to direct it, and that is something that, going back to them with this Council's approval, that is the first thing we are going to ask them: "Who's your Director up there?" No one was named.

But the need was known, the 14 rheumatologists and

some allied health people -- the capability was recognized and there was some outreach in it that looked like a good thing to do. But they would have had a much higher score if they had told us who was going to run it.

So for instance, you see, these kinds of things affected rankings of this kind.

Am I being adequate for your question?

MR. CHAMBLISS: Maybe I can help just a bit there, Doctor Janeway.

Rank-score is simply a technique that the ad hoc Committee used to sort out, and in its sorting out it assigned certain numbers to each of them. Some of the ones below had rankings below the 40, or below the 20, and it was just a way of laying out its work so we could establish a pay-line and some relativity between all the contracts.

DOCTOR JANEWAY: I understand that, but the intent of the question was different than that.

DOCTOR PAUL: I understand the intent of the question, and I think the discussion we had before places the burden on the Regions when one is reaching one of those scores, but regardless of that other action, they would have to work within the framework of recommendations established by the Committee itself, the resolutions.

So that they couldn't, for example, develop the arthritis program as submitted, but it would have to be within

the guidelines developed by the Committee, which is an answer in support of your question.

MRS. GORDON: In conjunction with his question, would this then be -- would your ranking be sort of a combination of the need and the Committee's feel for their ability to meet the need? Would that be a combination?

DOCTOR PAHL: Yes, I think those were essentially certainly elements that entered into the ranking score; yes.

MRS. GORDON: You could conceivably have a tremendous program, but yet you really didn't it as much in this area as positively as you did in another, and this then would give the one with the greater need maybe a higher score or a higher ranking?

DR. GRAMLICH: Competence of staff to carry out the program, the abilities of the organization to supervise, to make sure that funds were properly spent, and all these variables.

DOCTOR PAHL: I would not know which element went into any one particular score, but those were considerations for each and every application -- part of the criteria; yes.

We will, as Staff, subsequent to the Council meetings, be working with the Regions and eventually we will report to you, certainly at the next Council meeting, the disposition of these moneys and the exact dollars, should they change during the negotiations.

We also will make the awards for the arthritis applications within the same official award statement, after this Council, that we have for the regular RMP applications, so that on the one award statement there will be shown the funds for your arthritis applications and there will be separately identified so it will be used for that purpose within the earmarked.

Again, we remind you that certainly the rankings and the dollar recommendations and actions are confidential and we will be working with the Regions as soon as we can to effect Council's decisions in this matter.

Now, I would suggest that we just take a five-minute break -- Doctor Gramlich?

DOCTOR GRAMLICH: May I make a final comment? I won't delay the stretch more than 30 seconds.

As an exercise in crisis management, this has been very interesting. You must remember the Congress only authorized these funds last fall. RMP was not even sure they were going to be available until mid-March, and in that interval it has put together a program which will have measurable impact on the health care of the American citizen.

But more importantly, it again demonstrates the viability and the flexibility and the ability of RMP's.

DOCTOR PAHL: Well, thank you very much, Doctor Gramlich, for your report, and Mr. Spear, and let's take a few

minutes to stretch, and in five minutes come back and we will get with the RMP's.

(Whereupon a short recess was taken.)

- - -

DOCTOR PAHL: We are going to reconvene now with some introductory comments from Mrs. Silsbee, and then we will immediately move into applications in general.

We wished to take these up alphabetically, but because of the schedules of some individuals, not only on the Council, but who are in the audience, and have something to contribute, there will be some departures from that alphabetical arrangement.

I am going to have to ask the head table particularly if they might wish to refrain from smoking, because I have had a request from one of the charming members here that this isn't conducive to thinking about all these complex resolutions.

Judy, why don't you just proceed now, if you will?

MRS. SILSBEE: All right.

Dick, would you come on up?

This is the operations part of the Staff that is taking over at the head table here, and people tend to talk in shorthand around here, and when you hear the name "Silsbee" they really mean Russell, they may mean Nash, they may mean Van Winkle, they mean Postel and they mean Cardell and all of their staffs. They don't mean Silsbee; they mean collective efforts of a really tremendous staff.

We started back, when we realized we were going to have two review cycles, to get together a list of people that

we could use in ad hoc review capacity, because as you recall, the Council last November had to do this themselves, and in February when they were faced with this prospect, asked Doctor Endicott specifically for a first-level review to help them, so that Council could concentrate on the policy issues that were involved.

And Doctor Endicott promised to do this, and we were operating under two possibilities for quite a while. But in contact the people we explained this: it was important for this review to have people who knew something about Regional Medical Programs and had had experience in either the Review Committee at the national level, the Council, or in Regional Medical Programs.

In the material behind your Agenda is a list of individuals that were contacted and who are going to serve on the Review Committee, which as it turned out, did become a Committee. Three of the members that were listed on there were unable to make it at the last minute, but we did have 23 people scheduled originally; 19 of the original list, plus one member from a former -- from a -- a former RMP member, staff member, served as the committee.

Because we had 53 total program applications, it became apparent in the three days that we had set aside that it could not operate as a total committee during that entire time, so the format was to have the committee open as a group

to discuss the general policies under which they were going to be operating, and then we broke into two panels, with the Regions that were served by the South-Central staffs and the Mid-Continent staffs in the one panel, and the Regions served by the Eastern Operations Staff and the Western Operations Staff in the other panel.

Essentially, this was sort of an even group. The first panel was chaired by Mr. Chambliss, and the second by Mr. Peterson.

Each of the applications had a thorough discussion by its respective panel. The applications have been sent to two reviewers, and they served as the principal spokesmen for the Region, but the issues that were involved quickly became the Committee issues and were discussed, and each Region was discussed by the panel.

Then on the third day, one panel had chosen to go back over its entire array of recommendations and make sure that they felt they had not acted in a different fashion for the early Regions as opposed to the later ones, and they reviewed their actions, and in three instances changed their recommendations, based on their re-review.

Then the two panels met together, with Doctor Pahl as the Chairman, and heard the other panels' recommendations. They were given the brief synopses of the Regions and their recommended funding levels.

At that point the two panels recognized that one panel had made some recommendations and they began to wonder if some of those regions had been in their panel, whether the same recommendations would have come out. But in those instances where an individual thought there was some discrepancy, these issues were discussed.

The Committee as a whole did not make changes in the panel recommendations, and I believe you have all received both the composite recommendations and the individual recommendations on each Region. That constitutes a review process.

Now, this afternoon we originally were going to go through these Regions alphabetically. But because Doctor Merrill can only be with us today, and Doctor Gramlich today, and for a couple of other Regions that have people here today, we are not going to use that methodology.

We will get through the ones that Doctor Merrill and Doctor Gramlich reviewed; we will then include Inter-Mountain and South Carolina.

So this will be the order in which we go today:

California,

Georgia,

Louisiana,

Mississippi,

North Carolina,

Puerto Rico, and

South Dakota.

MRS. MARS: Would you mind repeating those, please, Judy?

MRS. SILSBEE: California,

Georgia,

Louisiana,

Puerto Rico --

Now, this is not alphabetical, because Doctor Merrill isn't leaving alphabetically.

Mississippi,

North Carolina,

South Dakota,

Inter-Mountain, and

South Carolina.

All right; just one general statement, now.

In both the instructions that were sent to the Regional Medical Programs and the instructions that were sent to the Review Committee, there were certain materials that were outlined, and we asked the Regions to provide information in their applications that would allow the reviewers to make some judgment along these lines, and we asked the individual reviewers in the Review Committee to give us a rating sheet based on the criteria.

I am not going to read out the specifics on each item, but I do think the general points might be important to

you at this point:

Program leadership,

Program staff,

Regional Advisory Group,

Past performance and accomplishments.

Objectives and priorities as outlined in the application.

Proposals.

Feasibility.

Likelihood that these activities and projects can be successfully implemented with some results in the time and budget proposed.

CHP relationships.

And then the overall assessments.

Now, our suggested way of moving today -- and it is up to Council as to whether you will proceed this way -- is because of the need to have some general statement on the Region and the Committee action, and because the material we sent to you was sent at such a late date, I will ask each of the respective Branch Chiefs to make a brief statement on the Region and the recommendations.

Then we will ask the principal reviewer of Council to carry on the discussion, and if that format is all right with you, we will proceed.

California: Mr. Russell.

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

CALIFORNIA REVIEW

MRS. SILSBEE: Let the record show that Mr. Hiroto has absented himself from the room.

Mr. Russell?

MR. RUSSELL: The California Committee on Regional Medical Programs, as shown on the green sheet, was rated as above average.

Regional Medical Programs. In all the areas that Mrs. Silsbee mentioned, the program was rated from good to excellent, with the exception of the proposal, which was satisfactory.

Feasibility satisfactory.

Relationships with CHP average.

The staff is strong, very active.

The Regional Advisory Group is a stable group and does control the program.

The RMP has a good track record regarding continuation of activities.

The CHP relationships; as noted in the green sheet, the problems are primarily in the Bay area of the San Francisco area, and in San Diego, and speaking with the Deputy Director just the day before yesterday, these areas are being addressed and they are negotiating their differences.

MRS. SILSBEE: Doctor Merrill?

DOCTOR MERRILL: I would like to preface my review with a couple of remarks which I think are applicable.

My review of these things will be brief, but I think I can tell you why they will be brief.

First of all, the proposals arrived before the rest of them, and there were some eight of these which I was to review, without the benefit of Staff or the Ad Hoc Committee, and I read through them, and as you might imagine, was totally confused except for the specific proposals.

There then arrived this wonderful little series of green and yellow sheets on which all the questions I was supposed to answer had been thoroughly researched and had been answered, and not only did we have a typewritten evaluation -- several typewritten evaluations, but we had tape recordings and transcripts, complete with laughter but without expletives and deletions.

And it was a very thorough evaluation which answered just exactly the kind of questions that a member of this Council can not answer by himself. Of course, some of you who have been here before know about problems that none of us could have been aware of, about the reliability of the Director of the Program, his relationships, let's say, with his associate -- his associate's wife, for that matter -- but little things which might interfere with the day to day running of the RMP, that would not be available to us, and

which are critically important. All of these things are contained in here, and were really a tremendous help, and I think the new system is going to facilitate certainly our work.

All of you remember the classic example of Puerto Rico; again, I was the principal reviewer of that, and certainly on paper, it looked just awful. When we went down and found out what the real story was we found that it was a very good proposal.

I think the kind of thing I was looking for previously is all in here.

Now, as far as California goes, I have read it, I have marked some questions, things that I thought were good and things that I thought were bad. I did this before the other sheets arrived, and I found that most of the things that I had marked were in agreement with the other reviewers.

Their overall program report, for those of you who have the big thing, which begins on page 123, I think, explains what they have accomplished, explains their structure, it explains committees which have been developed for such things as development programs in monitoring of operations, and for review and progress of application proposals with a view to improving the overall quality of project proposals while they are in operation.

The specific proposals from California, the record

of accomplishments, which is listed on 134, I think is very clearly spelled out, it seemed to me, with some of the exceptions noted by the Reviewers, which I gather are being corrected. They've done a good job.

The proposed programs, which you will find on page 137, for those of you who have it, seemed to me quite reasonable. They have, for instance -- well, before we get to that -- they have, for instance, emphasized the thing that we think is so important, the continuation of project activities beyond the period of RMP support.

86 major project activities have terminated since July of '71, and of these 86, 76 were designed as on-going efforts which have been continued by other sources of funding. That seems to me a pretty good track record.

With regard to their proposed programs, they seem to me eminently fitted to the aims of RMP; one of them has to do with manpower, and I note, as again did the reviewers -- and I would remind you that I made this note before I saw the reviewers' work -- so that we certainly are in the same ballpark, that they have engaged or recruited the cooperation of more than a -- more than a hundred colleges and universities and 120 hospitals and clinics, as members of the consortia to work on their regional health services and educational activities program.

They have begun a high blood-pressure control, which

probably more effective than it was in the past, in terms of management of the activities.

MRS. SILSBEE: Doctor Merrill has been -- has made a motion, and it has been seconded, to the effect that the California application be approved at the level of $7,353,000.

Is there any discussion?

DOCTOR WATKINS: Just a simple question.

I would like to find out how it is that California is in a seven million dollar bracket, and others are three million? I wonder if they had any inside information?

MRS. SILSBEE: Historically, Doctor Watkins, the California program, since it has about 18 or 19 percent of the population, has been funded at a fairly high level.

This particular application represents continuation, primarily.

MR. RUSSELL: That is correct.

MRS. SILSBEE: All of these Regions will be coming in with additional applications for more funds at another time, but this essentially is a continuation question.

Any further discussion?

All in favor?

(Chorus of "Aye")

Opposed?

(No response)

California approved.

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

GEORGIA REVIEW

MRS. SILSBEE: The next Region will be Georgia. Mr. Van Winkle?

MR. VAN WINKLE: Well, I am only going to give a few of the highlights.

The reviewers had nothing but good to say for the state of Georgia. The reviewers rated this Region as a superior Region; they gave it excellent remarks in terms of its experienced leadership, its strong Regional Advisory Group, its committee structure.

The same blessing was bestowed on their experienced program staff; they noted they had good CHP working relationships, and considered it to be a well-managed and well-administered Regional Medical Program.

Georgia had requested $3,629,757, and did not propose to come in July 1 for any further moneys. The Committee recommended approval at the requested level.

MRS. SILSBEE: Doctor Merrill?

DOCTOR MERRILL: I was delighted to have that report on Georgia, because in viewing their proposals, I was not struck by the same degree of thought, precision, and possibly applicability in making these proposals.

I would specifically like to ask about, to begin with, about the patient and family education proposal, which

couched in the most general terms, which is a kind of "God, love and motherhood" thing, which gives no specifics whatever.

An example of this is:

"Specific activities of this program will implement and expand patient and family education programs. Projects should be an integrated type of activity; projects should be patient centered. Projects should include modern instructional technology."

Oh, yes; and it is "anticipated" that ten hospitals will be selected from many requests to develop and to expand the programs.

Well, I see no specifics in this at all. Do they have something more than this?

MR. VAN WINKLE: Doctor Merrill, what you are reading there is the request for proposal that went out to all providers in the state. That was the broad general guidelines that they were sending out, saying: "This is what we will receive applications in."

Now, Joe does have more specifics on that, that have come in, I believe.

DOCTOR MERRILL: You are not this is what went out to them?

MR. VAN WINKLE: That is the broad guage outline that went out to the providers, saying: "These are the areas that we are interested in supporting."

DOCTOR MERRILL: But this Section D says:

"It is anticipated that ten hospitals will be selected for any requests to develop..."

MRS. SILSBEE: Mr. Jewell is the Operations Officer who is responsible for this Region. I wonder if you could give us some insight here?

MR. JEWELL: Doctor Merrill, this morning in the mail we got some further amplification on this. Would you believe it? I have a letter dated June 4.

I have it here, and I didn't want to load you up with another piece of paper, but here are the ten hospitals. They sent out this request for proposals, and here is the list of hospitals they are going to fund these activities through -- proposed to fund these activities through.

DOCTOR MERRILL: But nevertheless, what I am reading here is typed up as a proposal from Georgia, not as a guideline sent to Georgia.

Now I see the reason that they talk about these ten hospitals, but it still leaves four paragraphs which seem to me very vague. It sounds to me as though they may well have copied your instructions and sent them back to you.

MR. JEWELL: What you are reading, Doctor, is proposed by Georgia. We don't have any guideline on that patient care.

DOCTOR MERRILL: That is exactly what I am saying.

I thought Lee was saying these were the guidelines.

MR. VAN WINKLE: No. They are guidelines that Georgia sent out to the providers within the State of Georgia.

MRS. SILSBEE: Doctor Merrill, I think perhaps the general statement on the application from Georgia might be in order.

This program -- in order to get this application in, they wanted to have a year in which to do things. It did propose this umbrella operation, with the specifics undergoing review after we received the application.

What Mr. Jewell has there are the specific areas in which this activity is to take place.

DOCTOR MERRILL: All right.

Well, I will then say only that the comments I have made apply also to the application for stroke, cancer and kidney, and I gather that this is the reason they did, and if you are all satisfied that they are coming in with good specifics, I would certainly agree with the recommendation.

MRS. SILSBEE: Mrs. Morgan, is this one that you had?

MRS. MORGAN: I didn't go over the entire program. I have gone over the yellow and green sheets, and I second Doctor Merrill's motion -- did you make a motion?

DOCTOR MERRILL: Yes. I make a motion, in light of the more recent comments, that the application be approved

in the amount of $3,629,757, which is the same as that requested.

MRS. MORGAN: I second this motion, and it is on the basis that they do not come back in for our August meeting for more funds. This would carry them through.

They have a Ccordinator who has been there for some time and is doing an excellent job, and I second it.

MRS. SILSBEE: The motion has been made and seconded that the Georgia application be approved at the level of $3,629,757.

Is there any discussion from the Council?

DR. GRAMLICH: What is meant by "target figure" on the yellow sheet? $3,528,000.

MRS. SILSBEE: Doctor Gramlich, when we were sending out these instructions in March, it was thought to be important that we give them some ballpark figure in which they might apply for funds. We took the '73 level, and I won't attempt to explain how that was arrived at -- Mr. Gardell could do that if you want particulars -- and based on the amount of money we thought we might have, we gave them -- say, took 140 percent of that '73 level, and that will be sort of a target figure. It is just a ballpark figure which doesn't mean anything except that. And that was Georgia's figure.

Mr. Hiroto?

MR. HIROTO: In your earlier mailing, you sent us

the Regional Medical Program and the panel and then the reviewers' overall assessment, and the Review Committee recommendations, and that reflected a percentage of the request that was being suggested.

There are several in here that were called superior that are not receiving 100 percent of their requests. Is this because your reviewers may have been on the different teams, or is it for more specific reasons?

MRS. SILSBEE: I think we'll have to talk in terms of the specific reasons. I think there is no overall principle you can derive from that.

In the case of Georgia, the reviewers -- one of them had been on a site visit to Georgia, so understood the whole development of that program, which has had a long history in terms of the area facilities development, thought the program was well-managed, and in terms of the criteria they were operating against, both of them thought it was excellent, and I think that is why the 100 percent figure came up.

MR. HIROTO: Thank you.

MRS. SILSBEE: Any further discussion?

All right; all in favor of the motion to approve at the three million-plus level, say "Aye."

(Chorus of "Aye")

Opposed?

(No response)

The motion is carried.

WHD-57

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

LOUISIANA REVIEW

MRS. SILSBEE: The next one is Louisiana, and this is Mr. Posta.

DOCTOR MERRILL: Louisiana was an interesting one to me, because, again not having read it over without benefit of the review and the staff work, I thought it was rather a good program, and that it hit specifically at the areas in which Louisiana was weakest, and attempted to correct these, and it had some specific methods by which they proposed to correct them, which I thought were singularly appropriate, knowing something about Louisiana.

I do remember, from reviewing the previous Louisiana request, that there were some personal problems; there were problems particularly with integration in the private sector into the RMP programs, and while I don't see that specifically mentioned here, perhaps someone could comment on that.

MR. POSTA: Could I give you a quick overview of what happened at the ad hoc group? I have asked Mr. Zivlavsky, the Operations Officer, to stand by in case you wanted to discuss this particular application further.

The ad hoc review panel considered the Louisiana Regional Medical Program to be below average, and we obtained that from the two individual reviewers who read the entire

application and had graded it individually, and we came up with a composite score.

Louisiana has never achieved a triennial status, and appears to have content in the past to apply for the annual type of grant application.

The Coordinator has been, up until recently, serving on an only 25 percent basis; as of July 1st, he will be increasing his time to 50 percent.

The Regional Advisory Group has several outstanding members, particularly its Chairman, and its Evaluation Committee leadership.

Its track record in the area of management of funds has been good, and its unexpended balances on previous grant awards have been relatively nil.

The grantee itself is a not-for-profit organization in contract to medical schools, and its indirect costing has been minimal.

The reason that the Review Committee approved the entire request of $895,212, which in essence, speaking of target, is 77 percent of the target, was because nine of the new activities were directed to bringing services to people who appeared to have been denied them up to the present time. And with that, I'll turn it back to you, Doctor Merrill.

DOCTOR MERRILL: Well, your last sentence delights me, because that is exactly what I said before I heard you.

And that appears to me to be the real strength of that program.

Without going into too many of these things, they do have a program for surveying medical education and physician utilization in Louisiana, with the aim of finding out how many graduates or trainess stayed in Louisiana, why they leave, why they go into the specialties they do, and how they might be persuaded to go into specialties which are more needed. And that certainly is singularly appropriate for Louisiana.

They have a program on the assessment of quality medical care, which certainly -- and consultation service, which certainly is important, because again, as pointed out in the transcript here, one of the reviewers suggests that they have two kinds of medical care and that the two don't necessarily go together.

Now, perhaps he is referring to the problem which I brought up earlier; is that correct?

MR. POSTA: Yes, sir.

DOCTOR MERRILL: And has anything been done to rectify that?

MR. POSTA: I would a lot rather have Mr. Zivlavski answer that.

MR. ZIVLAVSKI: Could you be a little more specific?

DOCTOR MERRILL: Yes.

It was brought out at one of the Council meetings that the problem with Louisiana was that there were two systems of medical care; one for the indigent patient, and the other run by private clinics for the more affluent patients, and that the so-called private doctor did not necessarily see eye to eye, and indeed tended to resent the activities of RHP's.

MR. ZIVLAVSKI: Several of these project activities here -- the new ones, specifically 55, the Earl K. Long Charity Hospital, this is one of the activities on a new proposal; project 54 is a Charity Hospital of New Orleans activity. Project 53 again is Earl K. Long Charity Hospital-sponsored.

Project 49 is the Lafayette, and the main thrust for the indigent in the inner-city is Lafayette.

In project 53, they are talking about the inner-city and the rural indigents --

DOCTOR MERRILL: Excuse me; what pages are these on?

MR. ZIVLAVSKI: I am using the project numbers on the second page of the yellow sheet. The staff summary on the yellow page.

DOCTOR MERRILL: That's all right; I just wanted to see them.

MR. ZIVLAVSKI: Looking at Louisiana's history, these new proposals probably reflect a change in the leadership of the RAG Chairman, and more of an outreach in the rural communities of Louisiana, as well as some of the indigent population in the cities.

I think these are some plus marks, where previously in the past they haven't had a good track record in the cities, because of what your --

DOCTOR MERRILL: Yeah; now, that is certainly one of the plusses, and I'll mark those that you have.

I think the Lafayette plan is particularly good. I think the EMS, the high-risk neonates, the transportation system for the indigent -- are all things which are eminently appropriate for Louisiana.

But again, my concern was: are there two groups of physicians in Louisiana who do not see that these kinds of programs are important for the indigent of Louisiana? And are they working in harmony?

MR. POSTA: Doctor, could I respond a little bit with just a little bit of background information on this dual health system that has been identified by Council in the past?

The Louisiana program -- or, the State of Louisiana has what is known as a charity-hospital system. Close to 70 hospitals, and up to recently, most of your indigent poor have gone specifically to these hospitals for care, and

throughout the reviews of the Louisiana applications by both the Review Committees and Councils, this has been hard-hit as far as the overall philosophy of the state in having this dual system.

Now, that is not to say anything at all as far as the taxpayers going to the charity system, but to respond specifically to your question: have they done anything about this, are they doing anything about it?

The ex-Surgeon General, who is living in Florida now, has been elected as the Chief of the Department of Social Services, where, in the new reorganization, the charity system fits in. Specifically just where, and how far that would lead into the future is conjecture on our part at this time, but I hope that answers your question.

DOCTOR MERRILL: Well, I think -- and particularly because of the thrust of the burdens of the new programs, and perhaps with some reservations about the personnel, I would agree -- although not as enthusiastically as with the others -- and make a recommendation that they be funded at the full requested level of $915,212.

MRS. SILSBEE: Doctor Janeway, did you have an opportunity to look at this?

DOCTOR JANEWAY: No. The same questions come to my mind as did to Doctor Merrill, but you don't have a Title 6 violation, or anything like that?

MRS. SILSBEE: No.

Doctor Schreiner?

DOCTOR SCHREINER: I just wanted to make a comment that although those charity hospitals are separate, and they customarily regard a private sector, they are very closely tied into Louisiana State Medical School.

I was just going to say that I am familiar with some of the lateralization of the charity hospital systems, and this was originally designed under state aegis to follow the horizontal east-west main transit line across the roads, that tied trade areas together in Louisiana, from east to west, and this hospital system, while it's true it doesn't tie into things like the Oxner Clinic in Tulane, it does tie in very closely to Louisiana State schools, and there are rotating house staffs. There are rotating full-time faculty members in each hospital, so that by comparison, for example, to the urban systems that are under Louisiana State Medical School, I don't think they would suffer much by comparison.

They might by comparison, perhaps, with some of the private clinics in New Orleans; they are not abandoned, they are directly tied into Louisiana State.

DOCTOR MURRILL: I think I ought to make myself clear. That really wasn't the point I was making, George.

The point was that one of the real objectives, and I think important objectives in Puerto Rico, which is a similar

kind of territory, has been their enlistment of private physicians and private hospitals in cooperation with these other kinds of activities, and that, I think, has not been true of Louisiana.

DOCTOR SCHREINER: Well, it is pretty tough on the people, because all these people are on the state payroll, and they are really on a full-time salaried basis in the hospital.

It would be pretty hard for a private doctor; most of these doctors are on a full-time salary.

MRS. SILSBEE: Doctor Merrill, would you like for us to ask the Region to address itself more specifically to this in their July application? In how they see this working out?

DOCTOR MERRILL: I think, since the question has been raised a number of times, I think it might be well to do that, and I certainly would like to know the answer. I think I understand why the question has not been raised in previous Council meetings with great fervor, up until recently, but I do think it is something that ought to be answered.

MRS. SILSBEE: You have made a motion; I don't think I heard it seconded.

The motion was that we accept the Committee recommendation for approval at $935,212.

DOCTOR GARETHY: Seconded.

WHD-65

MRS. SILSBEE: The motion has been made and seconded.

Is there any discussion?

All in favor?

(Chorus of "Aye")

Opposed?

(No response)

The motion is carried.

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

PUERTO RICO REVIEW

MRS. SILSBEE: The next one is Puerto Rico.

Oh, I forgot; Mr. Nash, who is the Chief of the Eastern Operations Branch, has been called away because of his father's illness, and so I am going to wear that hat for a minute.

But since Doctor Merrill and Mrs. Flood are much more expert on Puerto Rico, I am going to defer to Doctor Merrill.

DOCTOR MERRILL: Well, as you know, we site-visited Puerto Rico, following a very unfavorable review, simply from their application alone.

We were, I think, very pleasantly surprised by the enthusiasm of the staff, by the ability of the Director, and particularly of the Associate Director, at that time, and by the loyalty of the people, and particularly by the number and variety of individuals who were interested in the program.

I myself -- and I think the rest of us, too -- were very much impressed with the fact that their programs seemed to address themselves, again, exactly to the kinds of things which were needed in Puerto Rico, such as emergency health services, planning for health and manpower training, evaluation of progress -- projects, and things I mentioned a moment ago -- the integration of self-help services in which a private

hospital -- health services, rather -- Ryder Memorial Hospital, was associated with the area government health center, and although two new hospitals were being built, they made every effort in the instruction and planning of the administration, to see that there was no duplication of services, and these things worked in harmony and supplemented each other.

Essentially, this grant request puts on paper some of the things we saw at that time, and I am enthusiastic about it.

It apparently was called above-average by the reviewers, but it was recommended that it be funded in full at the rate of $695,862, and I would agree with that.

I would like to know if anybody could answer this question on Staff: whether or not some of the staff people who have left the program have come back in anticipation of this, or will come back?

You may remember that one of the things that struck us was that although some of the staff had worked very hard on the RMP had left when they believed that funding was not going to be adequate, they had gone into other jobs in the nearby medical school, and were actually working part-time or occasional hours without salary, and many of them had expressed their willingness to come back full-time into the program, if it were funded.

I wonder if anybody has any answer to that?

MRS. SILSBEE: Doctor Merrill, you have now hit bottom as far as the Eastern Operations. The Staff member who accompanied you on the site visit in January has now gone to work in the VA.

Mr. Nash, who also accompanied you, had to be called away, and that represents the sum total of direct knowledge.

Mr. Stoloff?

MR. STOLOFF: Mr. Peterson was Chairman, and from the deliberation there was indication of what happened to the staff. I thought he wanted to say something there.

MR. PETERSON: Well, I think Bill Furman was one of the reviewers, and he had been on the site visit with you, and I was trying to quickly refresh my memory from the transcript -- laughter included.

Bill -- and I have no first-hand knowledge, either of the site visit or from other things, but Bill described that the situation down there is one that did not cause him any concern, because it was sort of like a floating crap game. These are my words, not his.

And that Puerto Ricans in that State Health Department, Medical School, RMP, there was a great deal of floating that had gone back and forth and when RMP was threatened, they floated back into the medical school, and unlike certain other situations, as I recall Bill's comments, he did not -- he

saw this as a way of doing business in Puerto Rico, and did not, as perhaps in a few other similar situations where the Council and Review Committee have had concerns of two kinds: is there adequate staff, because they don't -- except for Government accountants who chase red, white and blue dollars -- I think he didn't have a substantive concern.

He certainly didn't have a concern that there was a rip-off, which sometimes had been -- also, but again, this is based on what I quickly recall from Bill Furman's review; he had been there, and I have less knowledge than you and Gerry, but having chaired the panel and listened closely, particularly because Bill was such a forceful and picturesque reviewer, it is not too difficult to recall some of his comments relating to this point specifically to this point, Doctor Merrill.

DOCTOR MERRILL: Well, I saw that situation actually as an asset, because it meant that-they were available, and loyal and willing to come back.

MR. CLAYBLISS: Doctor Merrill, I can add a bit there, in that I have visited that Region, and did meet many members of the staff, and was concerned about that same problem as I read the application.

I think by and large their staff has been replaced for the most part, because in looking up the names, I did not begin to see many of the names that I remembered there before.

MRS. SILSBEE: Mrs. Flood?

MRS. FLOOD: I might add some explanation.

They have a lengthy list of staff people in the application, and as Mr. Chambliss commented, there are few familiar names there, but there are some new names, and we do not have a part-time Deputy Coordinator up there now. We have a full-time Assistant Coordinator, at least by virtue of this particular core-personnel breakdown.

They certainly seem to have a full complement of staff, although they have a few positions vacant, and some are at the health educating level, and one, a secondary associate coordinator slot here, and perhaps that was where the other physician was in.

But they certainly seem to have more staff than when we visited them, and I would like to reiterate Doctor Merrill's support of the Committee's review.

They are definitely involved in concept development on the island that are needed there, and they have accomplished tremendous goals in trying to combine the private sector with the public health regional hospital system. They have shown tremendous success, and interestingly, have the most strong support I have ever seen in a Regional Medical Program from the lowliest consumer level, as being possibly the only neutral ground available in Puerto Rico to which they can rally to get action to begin to answer their needs.

I would second the recommendation for the funding as recommended by the Review Committee.

MRS. SILSBEE: The motion has been made and seconded that the Puerto Rico application be approved at the requsted level of $695,662.

Is there further discussion?

All in favor?

(Chorus of "Aye")

Opposed?

(No response)

The motion is carried.

Doctor Merrill, we appreciate your rapid-fire review there; I'm sorry you have to leave.

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

MISSISSIPPI REVIEW

MRS. SILSBEE: Now, Doctor Gramlich, we are going to put you on the grill.

Mr. Van Winkle?

MR. VAN WINKLE: I am sorry Doctor Merrill couldn't stay for this one. He did site-visit this Region.

One of the reviewers was a former site-visitor, and he was highly complimentary of Mississippi. He felt they deserved quite a few pats on the back.

They were considered to be an above-average to superior region, their program leadership was considered to be strong and viable; they have a competent leadership staff, their past performance was -- program staff, I should say; their past performance was impressive, and we felt they were very perceptive in establishing goals and objectives to support the accomplishment of those goals.

The proposal as submitted was felt to congruent with the goals, and they mesh well as a total program.

Excellent CHP relationships, a well-done proposal that shows a high degree of strength.

Now, the reviewers, in arriving at the recommendation, made recommendations to Staff about reductions in a number of the projects, but the overall theme seemed to be based on a rather large number of new activities, and whether that could

be realistically accomplished in the timeframe remaining for the program.

Mississippi requested $2,350,409; the Committee recommendation -- $2,200,000.

MRS. SILSBEE: Doctor Gramlich?

DOCTOR GRAMLICH: I would like to comment, first off, that I find in my yellow folder, which we received on arrival today, a transcript of the Review Committee's comments, which would have been very helpful had they been early enough, when I had had time to read them.

MRS. SILSBEE: Could I make a comment about those?

Those transcripts are put in the folder and we don't want them to get out of the -- out of this room. We did think they would be helpful; we would have liked to have sent them to you in advance, but because of the confidentiality of the proceedings, we chose this method.

But I agree; I wish we could have had them, too, but because the Committee didn't know that they were going to be used in this fashion, we felt that it was important to just have them for you here in this room.

DOCTOR GRAMLICH: I suppose then as a corrollary to that, we would leave these books with you?

Well, Mississippi, generically speaking, unfortunately, in that all of the Regions to which I was assigned as a primary reviewer were superior or above average to superior

-- which makes the job easier, of course, and I was interested in the figure that was reached, because I reached mine in a somewhat different way, in a more programmatic fashion.

I looked in some detail at the projects request, and noted for example, that there were several programs, as was observed somewhere by Staff, that really raised a lot of questions as to whether they were RMP-oriented or not.

For example, solid-waste management training, which is a program whereby the State Board of Health -- or, through the State Board of Health, aims to train landfill operators, which seems to be pretty much a Public Health operation, rather than a flat-out RMP plan.

I am looking at the yellow sheet, and the number of this particular one is C-137.

C-145's Food Service Training Program might more appropriately be Public Health Service.

Also in the yellow sheet, in C-140 to 144, I had a special observation about this, because these four programs were cancer-related, but were all to be managed by the American Cancer Society Regional program, and although they were small amounts, it struck me that perhaps these were programs that would be really just supplementing things that the American Cancer Society has already done.

I have had some concern about RMP visibility, and I read into these programs, probably erroneously, but I can

imagine the situation whereby the RMP would provide the funds and the Cancer Society would get the credit for it.

Now that may be paranoid, or it may be realistic. They were small amounts, I grant.

I had some question about C-159, which called the Quality of Service for the Mentally Retarded; it struck me this was an unusual request. It didn't really lay out any program at all.

I had an equivalent question about C-162, which was a hypertension survey, Pearl River County Hypertension Survey, in which they proposed that the emergency room nurse would take blood pressures on all patients who came into the emergency room, and a flag went up that perhaps that nurse who takes the blood pressures should take the blood pressures whether she is being supported by RMP program or not.

Again, a small program -- $10,000 -- but it did strike me as a little costly for the doing of a routine duty that the nurse should ordinarily do.

There was a cable TV program for $38,000, and I would be the first to admit that I don't understand it carefull -- or, thoroughly, but as I read the program, I wondered if the payoff was really justified by the expenditure.

Again, other areas -- C-164: Medical Costs at Home. This is specifically a Welfare Department function, and again, C-168, "Flouridation of Publicly-Owned Water Systems;" the

program sought to pay for half the costs of installation of flouridation equipment.

I wonder if RMP is interested in that sort of project?

In "New Projects," which are the last several on that page, I was struck by the last four -- O-36, 37, 38 and 39, each for $160,000, which appear to me to say:

"Well, these are some new projects that we think are pretty good; give us some $600,000, we'll spend it as we can develop the projects."

It sounds good; the titles are fine, but this looked like a blank check saying:

"We are a good outfit; give us the money and we'll spend it wisely."

Now, just as a matter of philosophy and policy, if this is an appropriate way to go for RMP, fine, and there is no question but that the titles of the projects are good, but there is no substance behind the projects, in terms of planning and process.

MRS. SILSBEE: Mr. Van Winkle?

MR. VAN WINKLE: The application itself does address those, Doctor. Other than this yellow sheet, these four items are the same thing that you were looking at on the Georgia application; these are-where they had sent out written requests for proposals. They do have the request in-house; they have

many more requests than they have money to support.

Now, at the time that the decision is handed down by Council as to how much money they received, their RAG will meet again in terms of their priorities of what they can fund within those general areas.

Now the primary reviewer raised the almost identical same questions on the same projects that you were mentioning, and they did -- we do have a list of all of those. They will be communicated to the Mississippi RMP. However, he did not choose to say that "You can not fund this, fund that, or fund the other."

He said that he thinks they have a very low priority, and felt that they should be allowed to determine within that unless it was against Council policy to decide.

MRS. SILSBEE: Mrs. Flood?

MRS. FLOOD: Is this an A-rated region with a triennial status?

MR. VAN WINKLE: Yes, it is, or it was at the time that we were doing that type of thing.

MR. CHAMBLISS: I might mention also, Doctor, that we in Staff have raised the same questions, almost to the letter, that you have.

We need the help of Council here on the solid waste, and "Peter the Pelican" and his other brothers here, and to get your guidance as to whether we should specifically deal

with some of these projects on an individual basis, and seeing that they are eliminated on the grounds that they do not fit within historical RMP operational activities.

DOCTOR GRAMLICH: Incidentally, and somewhat tangentially, for the benefit of the Council's advice, Pierre the Pelican appears to be a how-to-raise-children program.

MR. VAN WINKLE: That is correct.

Now, back to the original point about the $450,000 request. You said that information was available justifying these, but is it anywhere in these grants requests? Because I didn't seem to find it as I went through.

Anyway, the point is tbat it made it hard for me to sensibly review what appeared to be a blank check sort of request for funds. I realize that in some Regions, some RMP's, that probably is a perfectly legitimate way to go, just to get the funds, but how do we know that as we go through this?

MRS. SILSBEE: Well, I think all reviewers are concerned about just depending on the written word, and it is hard to convey this.

Did you have an opportunity, Doctor Gramlich, to talk with Doctor Merrill before he left?

DOCTOR GRAMLICH: About Mississippi? No.

MRS. SILSBEE: I am sorry he had to leave, because he had been on a previous site-visit, which was a couple of

years ago.

You mentioned that you went through this programmatically. Did you come up with any kind of a level of funding?

DOCTOR GRAMLICH: A figure? It was interesting. There were some that I had question marks on a programmatic basis entirely, some that I felt -- like this cancer society business here -- maybe if you fund one or two of them you get whatever little mileage there is to be gained from saying:

"Yes, we are indeed in support of you, the American Cancer Society."

I scratched the ones that were obviously Public Health Service and should, in my opinion, be in that area, unless Council decides otherwise. There were some that I had some question about; I didn't diminish on that basis.

I think the four items that were $150,000 apiece, the four projects, that on the basis that it was a superior RMP, I diminished it by half, subtracting the ones that obviously should be in the Health Department, the one that was for cable TV --

MRS. SILSBEE: What figure did you come up with, Doctor?

DOCTOR GRAMLICH: I came up very close, within $200,000 of the same figure.

MRS. SILSBEE: Well, they may have very well gone

through the same process in their review. Do you feel that the $2,200,000 -- the concerns you have will be conveyed to the Region; there is no question about that.

The figure I came to was $2,031,000, which was so close they shouldn't worry

Do you want to do that in the form of a motion?

DOCTOR GRAMLICH: Just to get out of Mississippi, I would move that we accept the figure of $2,200,000.

MRS. SILSBEE: I would prefer the proviso. Do you want to word something in general terms, not specific projects?

DOCTOR GRAMLICH: Let's have a little discussion about it, and then make a separate motion.

MRS. SILSBEE: The motion has been made.

MRS. FLOOD: My comment would be that I think you are being a little generous.

This is blatantly transfer of funds to Public Health Service; it's not just sort of obviously, and they are in small amounts, but this is traditional public health work, and I don't see anything innovative about it. It certainly does not show that it will develop into any reputable state new look in the way you are going to address these programs, that you could use across the state.

This has no impactual program as such; I can't find any objectives or goals listed in the application that this addresses itself to. Food-handlers' classes? My goodness!

Really, that's exactly what it is.

MRS. SILSBEE: What action do you want to take with this concern?

MRS. FLOOD: Well, I wasn't the primary reviewer or the secondary, so I didn't have an opportunity to look at the Form 15's to see how many of these are new.

I hope all of them are new and that they haven't been continuing for some time.

DOCTOR GRAMLICH: All of these are new.

MRS. FLOOD: I would take a closer look, and it would take me a minute to figure out how much I would give them, but I certainly would delete the public health issues more strongly than just to recommend to them that they do it.

DOCTOR WAMMOCK: Why don't you list what they are, so we will know?

MRS. FLOOD: 137, Industry employee education; there's another one.

DOCTOR WAMMOCK: Solid waste management, C-144.

MRS. FLOOD: C-144, 145.

DOCTOR GRAMLICH: C-168 is the Public Health one.

DOCTOR WAMMOCK: Then there's another one in there.

(Discussion off the record.)

DOCTOR GRAMLICH: 165, Medical Foster Homes, is really not Public Health; that is a welfare program.

DOCTOR WAMMOCK: 168?

DOCTOR GRAMLICH: 168 is flouridation, another Public Health.

That is roughly $80,000, Mrs. Flood, which doesn't really --

MRS. FLOOD: I know; it doesn't really slap their wrists.

DOCTOR GRAMLICH: I wonder if it would not be simpler if we accept the figure, vote on that, and then discussed the problem of reassignment of inappropriate areas, and too, the open-ended request, which I am not totally satisfied with.

But there are two separate areas, and I think they might be separated, and this might apply to other Regions.

MRS. SILSBEE: Doctor Wammock?

DOCTOR WAMMOCK: For information, at the risk of exposing my ignorance, what is a "Smoking Withdrawal Clinic?"

MR. CHAMBLISS: Maybe I can answer that there.

Some years ago, the smoking and health activity was an integral part of our RMP's, because we felt -- we fell heir to it from the Chronic Disease Program, and we have funded in years past smoking and health activities under the aegis of RMP.

This is simply a throwback, I would assume, to a previous activity, funded by RMP in the past, and it is simply a method of controlling the smoking as a preventive

measure to stroke and heart disease, and so on.

DOCTOR WAMMOCK: Do you know what has happened since then? Public Health Service gave its report in 1966 on smoking, and the purchases of cigarettes increased, and so forth and so on.

MR. CHAMBLISS: We are very much aware of that. Yes.

DOCTOR WAMMOCK: I'm sure you are.

MRS. FLOOD: Doctor Wammock, the application refers to the faxt that they will have smoking withdrawal clinics that will run five nights consecutively, for two and a half hours, in which trained laymen will assist doctors in the presentations, and the objective of the smoking withdrawal clinic is to offer aid and assistance to the public, and they'll hire a staff man to find such things as interested clientele, procurement of meeting hall and availability of trained personnel and medically accepted procedures to man the clinics. And it is the Cancer Society's application.

It is a very small amount--

DOCTOR WAMMOCK: Don't think it belongs --

MRS. SILSBEE: Doctor Wammock, if you would like, we can get you some additional information on this smoking withdrawal project.

MRS. FLOOD: The problem is not the item; it is that it does not fit a program emphasis.

MRS. SILSBEE: I think we are in danger of trying to

do Review Committee work or do Regional Advisory Group work here.

Doctor Gramlich has suggested that you take a look at the funding level which he made a motion would be at the Committee recommendation.

DOCTOR GRAMLICH: $2,200,000.

MRS. SILSBEE: Which is $2,200,000.

Now, there has been a motion made.

DOCTOR WAMMOCK: I'll second it.

MRS. SILSBEE: Do you want to discuss that further?

All in favor?

(Chorus of "Aye")

Opposed? Two Council members opposed.

The motion is carried.

Now we have the simple issue of the advisability of Regions pursuing this particular course, and I think you are really trying to get back to the Region in terms of their decision-making.

MRS. MARS: And I assume those three million dollars they are going to request in July and August will be reviewed?

MRS. SILSBEE: Oh, yes.

MRS. MARS: Because this is something, I think, that we should look at very carefully, this further request.

DOCTOR GRAMLICH: May I ask, is it appropriate here to discuss the principle involved in the last four projects,

which were for $150,000 each, without particular justification or programmatic support?

Now, this applies, perhaps, in this area, but it may well apply in other areas, and it is a matter that came up a couple of times during the arthritis Technical Review Committee meeting, where a good strong RMP said:

"Give us the money and we'll do the job," but they didn't exactly say what the job was.

Maybe this doesn't occur very often, but if it does, we should have some guiding principle.

MRS. SILSBEE: There is an application that you will be considering later -- Texas -- that brought up this very same issue and the Review Committee told us to take a different kind of action, waiting until they got the particulars.

So this is --

DOCTOR GRAMLICH: Does that solve the problem?

MRS. SILSBEE: No, not as far as Mississippi is concerned. I think you have solved it, probably, in your funding recommendation."

MR. VAN WINKLE: That is precisely what the Committee attempted to do, to resolve it by their funding level.

MRS. SILSBEE: Doctor Janeway?

DOCTOR JANEWAY: Just an observation, that if one makes the assumption that the funding level, as recommended,

ID-36

deletes these programs speifically. That is his one set.

If on the other hand the funding level is set on the basis of certain other things having been deleted, and then one specifically proscribes the utilization of these funds, these funds for Public Health purposes, then he --then it gives even more latitude, wider latitude for the use of RHP -- in the use of non-programmatic-oriented funds.

MRS. SILSBEE: Well, it seems to me you have a lever here that you would not ordinarily have, and that is that they are coming in with a proposal in July, and you could very well insist that you have, at the time, specific information about how the Regional Advisory Group has chosen to outlay these funds, with advice, in terms of the concern that you have, and you could look at the Region again.

That is not an opportunity you have very often, in terms of this short timeframe.

DOCTOR GRAMLICH: That solves one of my concerns, which is simply that it is entirely possible that the program will be very good, exactly what it should be, but since the request is the open-end technique, it makes it very difficult for us.

I would hate to say: "No, you can't do it," because that is not what we are saying at all. I would like to not only -- since the request is open-ended, I would like to evolve a way whereby we could leave the response open-ended

too, so that if a good program could be developed, it would not be destroyed or undermined by any actions the Council took adverse to it.

MRS. SILSBEE: In terms of the advice we give to the Regional Medical Program, this concern will be conveyed, and certainly in terms of the July application, if there were any repetition of it, I think we would just say absolutely no.

But you have two issues here. One is these inappropriate type of activities you think they are proposing, and the other is the open-ended part, and I do believe you have a better chance to see how the Region responds to your concerns in July.

DOCTOR GRAMLICH: That answers my problem.

MRS. SILSBEE: Is there any further discussion about Mississippi?

DOCTOR GRAMLICH: Yes. Let's take up the point about the inappropriate funding in Departments or agencies which should be otherwise funding.

Is it RMP policy to take over public health functions, to take over American Cancer Society functions, or support them, or have nothing to do with them?

MRS. SILSBEE: No, it is not RMP policy to do either of those things, Doctor Gramlich. However, I think it is, in general; the fact that it is sort of blatant, the

fact that we don't have sufficient knowledge as to why they do it -- I think you can direct this back to the Regional Advisory Group, as to why they chose to -- you are looking at the quality of the decision-making there, and we could ask for additional information on that for you, too.

DOCTOR PAHL: I think we would like to go back to Mrs. Flood's point, that a lot of their activities don't fit in with their own objectives and goals and programs, so that I don't like to have a policy that rules out anything that smacks of public health. It may make sense for that Region if it is part of their program, but in general, we are not designed to take over those kinds of activity, and there are so many good uses for the funds that I would think the RAG could receive this advice and perhaps act more appropriately.

Certainly they could look at their objectives and overall programmatic goals and how these would fit into it. That is the kind of thing that we are interested in, but I personally don't believe we should have an absolute rule that public health is therefore inappropriate to our funding. But it does have to be looked at carefully.

MISS MARTINEZ: I was just wondering if we are going to ask the local RAG for their answer on this? And are we going to get it by July 1st?

MRS. SILSBEE: If we don't get it by July 1st, we

will bet it shortly thereafter, because they do have to allocate these dollars, and we will get that information.

DOCTOR GRAMLICH: And there is one other element in this same problem that relates to grantsmanship.

It is entirely possible that these were in their -- and our -- opinions perfectly legitimate, but the reporting we received was insufficient to enable us to make a judgment.

Now, I think this message might be conveyed, because if we misinterpret what we read, it is either because we read it wrong or because it was written wrong.

MRS. SILSBEE: Is there any further discussion on Mississippi?

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAM

NORTH CAROLINA REVIEW

MRS. SILSBEE: Okay; how do you feel about North Carolina, Doctor Gramlich?

DOCTOR GRAMLICH: Have I got some ideas about North Carolina!

In the first place, that airplane. I am taking the programmatic apart.

It has a superb RAG, it is well staffed, it's a good organization and has done a good job. Its track record is fine.

$50,000 for air transportation. That is hard for us to see - 001, second item.

North Carolina has a lot of outreach clinics throughout the state, and it's a big state -- not as big as some others. They like to transport their residents, their -- nursing staff and consultants to these various outreach programs by air, and this makes some sense, but as I read the grant request, it raised a question in my mind about whether it was an exorbitant expenditure, or whether it could perhaps be supported for a year with the understanding that if it is that important, then the state legislature of North Carolina ought to sponsor it.

There is some hint about this in the grant request, but not a specific answer as to whether it was an opportunity

to pick up some funds that might otherwise not be there.

The only thing that struck me significantly about North Carolina's program was that they have their -- they are big on hypertension, and beginning at 66-A through 66-L they have a total of about a dozen programs all related to hypertension, and in terms of dollars they represent $459,739.

I realize that North Carolina is a very good RMP and they might be able to pull off all these various and sundry projects successfully, but it did strike me that that was a lot of expenditure for one particular disease, when most of it was related to screening and education and development of service personnel.

They have some very good programs.

On the second page, again, there was a very large block of programs, starting at 67-A and ending at 67-G, on the providing of rural health care, and I like this general approach, and I think most of those were pretty good programs. It seemed to be well integrated and tie into each other without a lot of duplication, which I couldn't say for sure about the hypertension block.

There seemed to be some overlap in that area.

The rest of the Region -- the RMP -- seemed to be top-flight, and using a somewhat obscure technique, came up with exactly the same figures.

MR. VAN WINKLE: The Committee was also quite

concerned about the medical air operations. They singled that out immediately; they also were concerned about 63, which they considered, as near as they could determine from the information provided, to be a pure PSRO, and thus considered inappropriate for funding by RMP.

DOCTOR GRANLICH: May I interrupt just one second?

I didn't pick that up when I was reading it. 63 appears to overlap directly with 41-E, which is called "Area Health Systems," but when you read the request, it is a PSRO training program.

MR. VAN WINKLE: They also expressed considerable concern about 69, Doctor, which was the university-linked hospital libraries. They thought this was completely overambitious; they didn't feel there was any guarantee it would ever be continued, and more appropriately, they felt this was something that these hospitals should be doing anyway. They said libraries were nice, but they didn't really see that this was going to have any great effect on the system there.

That one they had real concern with; they also mentioned the ten components in that rural health clinic, and they only made mention of it. Their concern wasn't that great. I think they felt much as you do about that.

They also expressed some concern about the fact that this Region, coming in with 45 new projects, they were a bit concerned about their ability to carry them out, but they

went along with it based on their past performance.

MRS. SILSBEE: Mr. Milliken was the secondary reviewer. Did you have anything?

MR. MILLIKEN: I would agree with what's been said. I think we could simply not go along with allowing these misappropriations to be not challenged. We should certainly challenge them in terms of allowing them to stay in.

MRS. SILSBEE: Doctor Wammock?

DOCTOR WAMMOCK: I would ask a question here which was raised in 63. This matter pops up at every turn, and I know that some way or antoher we are going to have to address ourselves to this.

MRS. SILSBEE: We are trying to work with the PSRO staff to try to get that resolved.

DOCTOR WAMMOCK: I realize there are implications here, and I am asking for information as to -- well, what is the relationship, or what are they endeavoring to accomplish?

I mean, I say this with lots of reservation. I didnt' want to bring it up, but in my own particular mind, I am -- well, I'm for a peer review system, period. I'll say that without any reservations whatever.

MRS. SILSBEE: Well, as you may recall, back in september of '73, the Regions were told to come in with requests that were confined to five different areas, one of which was quality assurance, and another of which was hyper-

tension. So some of these things which you see in here were the result of that directive, which has not been turned around.

DOCTOR WAMMOCK: Putting it in PSRO?

MR. RUBEL: If I could, I have had some discussion with the people in the Department responsible for PSRO, and there is at least the possibility that some of the specific applications here as well as some that might come in in the July cycle, at least to the near view, are an attempt -- a possible attempt -- an alleged possible attempt, at circumventing the PSRO program, and we are very much concernd with that. I doubt very much that the Department would fund any activity that would do that.

We are in the process of working with the PSRO staff, looking at the specific applications here, to make sure that that doesn't happen.

DOCTOR WAMMOCK: Well, I am in favor of this business of quality assurance, or whatever you are talking about here, because I mean, we grope with this problem every day, the question of question of whether you are going to call it PSRO, or whatever it is -- quality assurance or survival --

MRS. SILSBEE: Mr. Rubel talks about trying to circumvent the thing. That is looking at it from one point of view, and I was trying to look at it from the point of view of the continuity of the directive that we gave them last

September.

I do think that we both agree that we can't have this funded in two different places with two different sets of priorities.

DOCTOR WAMMOCK: That was what I was thinking about.

MRS. SILSBEE: Mrs. Flood?

MRS. FLOOD: Well, I would just like to reinforce the Review Committee's statement about Number 69, which was the network of hospital libraries throughout the state linked through the University Health Science Center tied with library resources.

This is appropriately -- there was a time when funding for this was available through the National Library of Medicine in small library development resource grants, and possibly some of that funding could be available, but it is a massive undertaking, even at this funding, for a one-year development, and should not appropriately be addressed, because indeed, this never finds continuation support if the hospitals have not already shown the interest to do it on their own.

MRS. SILSBEE: Just from listening, Doctor Gramlich, you had arrived at the same relative figure that the Committee had, and then I began to hear a lot of other concerns. Where do we stand?

DOCTOR GRAMLICH: Well, the full funding was not recommended by the Committee; they were reduced by something

over a million dollars, which seemed reasonable. That seemed reasonable.

So I move that we accept the Review Committee's recommendation of $2,375,522.

DOCTOR JANEWAY: Second.

MRS. SILSBEE: All in favor?

(Chorus of "Aye")

Opposed?

(No reply)

Carried.

Now, we will get this back to the Region, your concerns, to the Regional Medical Program.

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

SOUTH DAKOTA REVIEW

MRS. SILSBEE: South Dakota. Mike?

MR. POSTA: The South Dakota Regional Medical Program request is $729,417, which was approved in the total amount requested.

As some of you might recall, South Dakota used to be, several years back, associated with the Nebraska program. They got a divorce, and I think the separation has caused both programs to impfove tremendously.

Because of the divorce, both South Dakota and Nebraska have been among the most funded regions of the 53 that we have funded now.

For instance, the 12-month annualized current funding level for South Dakota right now is $428,152.

Although the Region has never attained triennial status, it has been considered up until, if you remember the last Council, as a planning Region rather than one that has achieved operational status.

The reviewers scored the Region as an above-average one. The uniqueness of the South Dakota program is in the fact that it is the only one that I know of whereby the CHP, Council and the RAG RMP are one and the same. They do provide great strength to the state.

Program proposals were considered well defined and had priorities well meshed in with the identified health needs of the Region.

All there is is a small staff that is being paid by the RMP; there are many other consultants who have given additional extra strength to the program.

I think that would suffice as an opening.

MRS. SILSBEE: Doctor Gramlich?

DOCTOR GRAMLICH: This is going to be a very short report. I would make only one comment on the staff assessment, and that is the Region was assessed by reviewers as not above-average but as superior.

MR. POSTA: I stand corrected, sir.

DOCTOR GRAMLICH: I could find nothing wrong, I have no comment; I move that they be funded at the rate of $729,417.

This is supplemented by a 17-page confidential report, which says exactly the same thing. The transcript of the reviewers' comments, a 17-page report, that they couldn't find a significant thing wrong with it.

MRS. SILSBEE: Mrs. Flood?

MRS. FLOOD: Well, I only have concern about one program, and that was the project Number 12, which I felt really reflected a sort of a middle management in nurses' capabilities, rather than a nursing skill development in the

manpower program, but with the newness of their independence, and with their well-documented analysis of their objectives for the Region, and the fact that this might in truth be the cause of a tremendous nursing personnel turnover, I would concede that it might possibly be an adequate manpower development type of project, and I would accept the others' recommendation.

MRS. SILSBEE: Is that in the form of a second, Mrs. Flood?

MRS. FLOOD: Yes.

MRS. SILSBEE: Any discussion?

All in favor?

(Chorus of "Aye")

Opposed?

The motion is carried.

All right. The Reporter has asked for a short break, and we still have two Regions, and because Mr. Sidel from the Region -- or perhaps it's Doctor Sidel; I don't know -- will not be here tomorrow, and Mr. Rubel will not be here, tomorrow, we have been asked to look at Inter-Mountain and South Carolina before we adjourn.

(Whereupon a short recess was taken.)

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

INTER-MOUNTAIN REVIEW

MRS. SILSBEE: All right, let's get started.

I have been caught between a dilemma: Mrs. Mars and Mr. Rubel, and Mr. Rubel has given way, so we are going to take Inter-Mountain up first.

MR. POSTA: Inter-Mountain. The reviewers rated the Inter-Mountain program above-average. The program has good leadership, a talented staff, and a most active Regional Advisory Group.

The Committee recommended funding in the amount of two million dollars, which was a substantial reduction below the $3,849,425 requested.

Support for the reduction was based on, one: the relatively large, unexpended balances in this Region over the past couple of years; two: the large amount of requested funds was considered overly ambitious, and an example of this was that 38 new proposals are included in the particular application.

I am sure that Mrs. Mars and Mrs. Flood will wish to go on with some more specifics of the program, and perhaps they might want to bring up the funding of the Health Development Service Corporation, which had been brought up at the Ad Hoc Review Committee meeting as a potential problem.

MRS. MARS: I really was rather incensed over the

Review Committee's cutting this program down to 52 percent of their requested funding.

This program I have site-visited twice. The last time was -- how many months ago, Mike?

MR. POSTA: It was January 15th.

MRS. MARS: It was January of this year.

The program is under new leadership, very capable new leadership, and before I go further with it, I think that to cut this program down to 52 percent is plainly a slap in the face. I think it will absolutely kill all of their incentives.

The program had a man running it previously who did run a very tight ship. However, he also did not get much done as far as outreach, and this was one of the recommendations that the site-visit team made at that time. This was being corrected, and of course, partly this HDSC does carry on that philosophy to a certain degree.

The outreach program is benefitting minority groups, it is adding -- the program itself is adding minorities to the staff. The caliber that is required is something that is very difficult to find in that area; however, except for the Indians, minority groups are very much in -- well, the percentage is very small.

One of the things that the site-visit team recommended at the time was a better interrelationship between the

Mountain States Regional Medical Program, the Colorado-Wyoming, and the Inter-Mountain. This is being carried forward, and they have kept me apprised of their activities.

This was another thing that the site-visit team recommended and was very concerned about, this turf problem. Everything that was asked by the site-visit team has been met, and the whole thing here is, I agree the program has been overfunded in the past -- I can't argue about that, but I think, under the new leadership, that this money will be expended and used very, very wisely.

The HDSC -- Health Development and Service Corporation, which should parallel a non-profit independent corporation, this IRMP was developing as a project, and it is going to be totally separated from the IRMP, which certainly should relieve some of the concerns that were expressed by the Research Administration of the University.

I see no reason why this can not materialize. The relationship that the organization has now with the grantee organization is a very much improved one, and I think they will work very closely together to eliminate any problems and to eliminate the HDSC from really becoming a support project of the IRMP.

The HDSC has applied for funding from other sources, and they have received acknowledgement that they would receive this funding from the Robert Wood Johnson Foundation. This

has been successful, so that continued funding of the project is assured and should not require IRMP funds to support it.

I told you the Tri-Regional Coordinators have met twice; they have a new RAG Chairman who is one of the most enthusiastic dedicated members of the public that I have ever come across. He is giving more of his time than any individual that I know of that acts as a RAG Chairman .

There has been a tremendous amount of rapport developed; the system now is very good, this is the assessment of their projects, and I simply feel that if we accept this degree of detrimental funding here, it is just -- the money is simply -- the whole program is going to fall apart, because I think the discouragement is going to be so great.

The doctor is a pediatrician, I believe, by profession, was he not, who is now the Coordinator?

MRS. SILSBEE: He is an orthopedic surgeon.

MRS. MARS: I couldn't remember what he was.

He is giving so much of his time to the program now -- he was not originally a full-time Coordinator, I believe; is that correct? His time was --- but he is giving more of his time now to it, day after day, and it is just a shame to do this to a program such as this.

I would certainly recommend that the amount of funding be increased at least to $2,849,000, taking a million off of it. The program is obviously above-average; there are

so many things which come into this program that you can't read in the book.

There is a religious philosophy there. The Church has dominated the program until the last few years, and certainly now, under Doctor Studt's leadership this is not true.

I have nothing against the Mormon faith; I think it is a great faith, but it has dominated this entire area, and I think these are things -- the philosophy has also dominated the University. The grantee was milking the program at one point, but this is no longer true, and the whole thing has completely reversed itself, and I think they should be given a fair chance to carry on their program.

So I would recommend $2,849,425 against the $3,849,425 that they had requested, taking a million off but raising the level of funding that the Committee has recommended. And I would suggest that when they do apply for this extra $400-500,000, we can look closely at that, and if at any time we are going to deny funding, I think it should be at that time rather than now.

So this is my motion.

MRS. SILSBEE: Mrs. Flood?

MRS. FLOOD: My views of the Region differ in quite a few respects from Mrs. Mars'.

I would agree with her that the influence of the

University of utah, and by its very nature, that of the Mormon Church, did permeat this program, b ut I can not speak as strongly to the facts as Mrs. Mars presents, that that is no long true.

I feel that there is still a strong controlling influence toward the attitude that only the things which emanate from Salt Lake City can be done in a quality manner.

Doctor Studt, the Coordinator, is making an extreme effort to bring this program away from that concept, and move projects from the strict University base.

There is, though, a lack of professional capability in the Region to the degree that has been expressed in the, past, both by the RMP and its RAG, but not to the extent that we have been led to believe.

The minority issues in the state have not been addressed. I do not feel that they are adequately addressed yet, and the addition of one minority administrative staff person, an American Indian, does not in any way solve the problems of the realistic linking of attitudes toward the needs of the minority people in the areas that are served by Inter-Mountain.

The request is excessive. Perhaps the recommendations of the Committee are a little harsh, in the light of the fact that the continuation projects and their staff costs as listed in the proposal would total $1,600,000-plus, which

would leave them less than $300,000 for new project start-ups with this year's funding.

But their request is excessive, even with the skilled staff that they have, in light of the fact that the majority of the projects presented in the application still are based from the Salt Lake City area reaching outward, and not reflecting strong interest in developing their limited capabilities of the Region to stand alone and develop its own expertise in attempting innovative projects on their own.

This Region had a belief, whether erroneous or not, that they could only use the contract mecahnism to provide funding for projects in their Region and they never indeed offered a full grant project fund to a proposer.

The site-visitors recommended that their administration and core staff investigate broadening the scope of this, and if they have indeed done so, there is more potential there for developing the capability at the local level that they had ignored in the past.

I would agree that the recommendations of Committee are a little harsh, but I would not grant them the $2,800,000-plus that Mrs. Mars suggested.

I would alternately offer $2,300,000 plus the odd cents and dollars, if possible, as a suitable figure to give them the capability to address some of the Region'priorities.

I also must inquire, in Doctor Studt's letter of transmittal to Council, to RMPS here, he stated that the Regional Coordinators -- the Tri-Regional Coordintors -- would meet the first part of May, and Mrs. Mars tells us they have met, and I would like to inquire for my information if Doctor Curtis did indeed attend and participate in the Tri-Regional Coordinators' meeting?

MRS. MARS: I do not believe he was there. Just a minute; I have the letter here:

"On Friday, June 7, representatives of the Regional Advisory Groups of the three RMP's serving the Inter-Mountain area met in Salt Lake City.

In attendance were Mr. Thomas K. Young, RAG Chairman of Colorado-Wyoming Regional Medical Program."

This is not what you are referring to. But however, they did meet, the RAG's met. I have the other letter; I'll find it in a minute, so we might as well get on with this.

MRS. SILSBEE: Mrs. Mars, answer her question specifically; Doctor Curtiss was present.

MR. POSTA: All the RAG Chairmen and all the Coordinators were there.

MRS. MARS: This meeting was purely the three RAG's from the various Regions, and there were representatives of all of those. The meeting was a fruitful one; it included an agreement to provide at the RAG level any detailed type

of information of any project plans that will involve overlap areas, how each RMP is to handle notification, coordination of any projects that might move beyond the overlap area, and impact communities served -- situated in locations served exclusively by another RMP.

Agreement to urge each Coordinator to implement a regularly issued exchange of information among reporting activities any activities that other Coordinators should be aware are contemplated or under way.

Agreement that each RAG sees that internal communication is strengthened within its staff organization so every member can be expected go support and foster each RAG's commitment.

Mutual cooperation among the three RMP's.

At least twice during the year, each Coordinator will be urged to attend at least two RAG meetings at each of the other two RMP's. Coordinators, with at least one other staff member, are expected to attend all Turf meetings, and after each RAG meeting the Chairman will telephone his counterpart in each of the other two RMP's whenever matters introduced at the meeting should be shared.

The RAG Chairmen will meet together at least annually, and any RAG Chairman may call an interim meeting if he feels it advisable to do so.

A joint meeting of the Colorado-Wyoming RAG will be

held at Jackson, Wyoming on June 23rd, so that takes care of the RAG's.

MRS. SILSBEE: Well, it doesn't really, Mrs. Mars. The Turf problem is one that they are finally addressing, but it does leave -- it does need considerable work.

MRS. MARS: Oh, I didn't mean it takes care of the Turf problem; no, not entirely.

MRS. SILSBEE: We have to keep on top of that all the time. The minutes of the last meeting indicated that a number of the activities had to go back to their respective county Regional Medical Programs, to make sure there wasn't some problem, so they have not really gotten at the intent of the whole Turf in the Regional thing.

MRS. MARS: This is always going to be a problem there. The way the Region is set up it must be a problem, and it always will be.

The Tri-Regional Coordinators have met, this time with two of the RAG Chairmen present. It was a most worthwhile meeting and we are following it up with a trip to visit Mountain States RMP in Boise today.

"We mutually accepted each other's applications with the provision that on certain specified projects we would coordinate closely with the other involved RMP before proceeding with the implementation."

"The only project which has been of any concern has been a request by the University of Utah for funds to identify the proper role of the University as a referral training center in what has been characteristically considered to be its trade area."

And so on and so forth.

MRS. SILSBEE: And that is signed by Doctor Studt, is it not?

MRS. MARS: Yes, it is.

MRS. SILSBEE: Well, the one that we got from all of them has a slightly different tone.

MRS. FLOOD: Who is serving as Chairman of the Tri-Regional Coordinators?

MRS. SILSBEE: He is.

MRS. MARS: The other thing that I would like to say is that the projects were also all submitted to the eight CHPB agencies and they were approved, the recommendations. Those that were not approved were also not approved by the RAG's, so the relationship between the CHP(D) agencies, of which there are eight is certainly a very close one and a very good one.

As far as going back to the minority problem, they have a project going for the migrant workers; this is being developed, and this is a minority group, which of course becomes a very large percentage of the minority population

during the time of the harvesting, and certainly, the needs of it are being addressed, and I would say that this program will develop into one that will eventually fill the needs.

But I do feel that we must give them an opportunity.

MRS. SILSBEE: Miss Martinez, you have a question?

MISS MARTINEZ: I would ask, of the migrant project, how community oriented and controlled it is?

It is one thing to serve the population without their input or direction, and it is another matter altogether to have the community itself set the goals.

What kind of a policy is it?

MRS. FLOOD: I might respond there.

That is one project I have always watched closely in that Region, and they can point with pride to that one, and we don't need to view with alarm, too greatly.

It is a community based operation with a fund in Salt Lake City for the services to the migrant. It is not based in the rural outreach area; it is based in Salt Lake City, but it is a primary flow area, so it does serve its purposes, and it does have some continuation funding in this proposal.

But from the total amount of their funding request, it is really a relatively small portion, when you consider the needs of the rural communities of that area and the need

to break away from traditional programs based based only in the urban centers of that Region.

MRS. SILSBEE: Doctor Sidel, did you have anything you wanted to say? He is from the Denver Regional Office.

DOCTOR SIDEL: Thank you.

In view of the discussion and the relationship between RMP and some of the Regional programs in my region -- and my Region, incidentally, consists of the two Dakotas, Montana, Wyoming and Colorado-Utah, so it's somewhat different in the context that we usually think of a Region in.

But a major concern of mine and the Region I represent, which is that of resource development in the Denver Regional Office, has been to improve the level of expertise in the planning area, and I am talking about specifically health manpower, and also, planning for all health resources development within the Region.

We find that the general level of many of the decisions are based not on practical information, but sort of -- decisions which involve millions of dollars, both in Federal and state money, as a matter of fact, so sometime ago, we initiated a contract action through a source of soft statements to establish a Regional Health Planning Resource Center.

The concept behind the Center is to provide -- to improve the level of planning through four different channels:

1. Technical assistance in the skill area, planning methodology and these types of things;

2. Education, and education based on-site; that is, in a sense, in the work setting, so when people ask for technical assistance it is provided in those areas where it is needed, but then at the same time it also has educational content so that those people are trained to do their own training more effectively.

3. The other is to improve the communication between those groups involved in planning.

4. Through special studies, let's say in the area of health policy determination, which may impinge on area designations or a variety of other questions.

In response to the source of soft statements, actually what it came in with at one time was a proposal perhaps to form a consortium of all the RMP's in our Region, to get development together and develop a resource center.

Now, this of course -- we sent him an RFP; he responded to the RFP -- that's a request for proposal, and the response to the RFP came from HDFC, since we were more interested in putting money -- in dealing with the non-profit corporation than actually putting money into the -- one of the RMP's itself.

Now the q uestion then arose, of course, in terms of the legal status of HDFC; it is a recognized non-profit corporation, they have had a ruling from the Attorney General on that. We had had no previous experience dealing with this particular corporation, so we have had to ask for an audit,

both in terms of fiscal accountability, and in terms of the institution and organizational arrangements, and in particular the conflict of interest question.

We do not have a receipt of that audit yet, which should be in next week sometime, because we need that prior to any contract action that we can take.

The response to the RFP in other respects is very good. The Committee that we have reviewing these in the Regional Office thought that it was innovative, dynamic and a superior proposal in all respects.

The other question that has come up most recently is one that I will have to get some clarification on, which is basically a staff decision as to whether funds, for example, that are awarded to IRMP can be transferred to HDFC, because actually, in the fiscal proposal we received from them, they list four proposals -- 132, 133, 134 and 135, as direct allocation to their Health Planning Resource Center.

So unless you know they can in fact achieve this, they are not in a position to follow through on whatever contracts they make.

I have been rather amazed at the ability of IRMP and Mountain States to get together.

MRS. SILSBEE: Thank you, Doctor Sidel.

Mr. Russell, do you have anything to add to this in terms of your recent tour through the four states -- the four mountain states, as far as the CHP-RMP or anything?

MR. RUSSELL: I am really not quite sure what I can say. If I decided what I could say, I am not quite sure how I should say it.

In our recent visit to the Mountain States Regional Medical Program, to verify their review process, we found some evidence that there was conflict, perhaps hanky-panky involved, between some CHP activities and the Inter-Mountain Region. Mike may want to address this, because I didn't have a chance to follow it through.

We also found that the Inter-Regional Executive Council, which was set up to eliminate the problems associated with the overlap Turf, really had not been very effective; a lot of this was due to phaseout, but as Mrs. Silsbee referred to earlier, we have to stay on top of this rather closely.

So we did, before this last Review Committee, send out a letter saying that we had to have these assurances. The Inter-Regional Executive Committee, or Council, as it is called, did meet and give us these assurances, and we haven't had time to analyze the multitude of projects involved.

I don't know if this helps, but --

MRS. SILSBEE: Mike, do you have anything, any input?

MR. POSTA: No. Essentially I agree with what Dick has just mentioned with reference to the CHP involvement, and

why perhaps Inter-Mountain has a little bit more rapport with the CHP(b) and (a)'s in that area. It is primarily because they funded a lot more things to them, and a lot of things they funded have been good.

But again, this is only human nature, and maybe I shouldn't even be on the record, but with reference, I do think, to the representative of Region 8 concerning the Health Development Service Corporation, $415,000 in this particular application that came in from Inter-Mountain was earmarked to go to this corporation.

There are considerable -- or, there are some doubts as far as the IRMP staff is concerned about this organization, about his free-standing position, but you take that primarily because we get the same views from the grantee institution, and I think the grantee's institutional policy will prevail; if the grantee recognizes the Health Development Services Corporation as a free-standing organization, and is convinced that their assets and their talent and staff -- to be recruited -- will be able to carry on the activities of HEW, particularly the RMP philosophy, they will probably be funded, but I think Staff's position here and in previous conversations under this subject, would be to recommend at this time that the -- to hold funds in abeyance to that particular corporation until all the concerns of both DRMP and the grantee have been fulfilled.

DOCTOR PAHL: May I inject myself into this for just a moment?

This question of the non-profit corporation is one that we really do not wish to have a Council recommendation upon, because we are not able to provide you with all the information on which you can make an intelligent recommendation.

The reason we can not provide you with the information is that we currently are in active negotiation, both with IRMP -- that is, Doctor Studt and staff, as well as the grantee organization, as well as discussions with the Regional -- the HEW Regional Office, and I believe at the beginning of last week, the grantee organization had one of its representatives come and meet with our Staff.

There were a number of issues and concerns raised, and the negotiation status is that we are now awaiting some official word from the grantee as to how they respond to certain questions that we have.

So, we are not in a position, really, and I don't think Council is in a position, to act upon a matter on which we don't have the full picture, the full information, and I don't really think that is important to this application, very honestly.

What we are looking at is the review and the merit on the funding level of the Region. The funds which are tied

up possibly in this new organization are hard to identify if the funding level is below -- that is, if the recommendation by Council is below in the request. We are not sure; it is up to the RAG then as to what it wishes to do.

So I would like to divorce, for your consideration, the status, legality, appropriateness and so forth, of the HDFC aspect and return, if you will, to the merits of the overall program, and we will be reporting to you at the August Council meeting the conclusion of whatever these negotiations happen to show.

We are just not able to make a determination ourselves at this point.

MRS. SILSBEE: At this point in time I need some help from a parliamentarian, because Mrs. Mars made a motion to the effect that the recommendation be $2,849,425, whereupon Mrs. Flood made a -- seconded the motion, but she suggested that it be $2,300,000.

Now, what do I do to get this resolved?

DOCTOR SCHRIENER: Mrs. Mars has the option of accepting or not accepting the amendment.

MRS. FLOOD: If I may, I believe I said $2,349,425, and I will just run it to $2,350,000, which -- you know -- solves all these small figures, if Mrs. Mars accepts.

MRS. MARS: No, I do not accept.

MRS. SILSBEE: All right; Mrs. Mars had made a

motion to the effect that the Region be approved at $2,349,425, and it has no second.

Is there a second?

MRS. MARS: Then we have another motion.

MRS. SILSBEE: All right, the motion dies for want of a second. I am ready to entertain a new motion.

MRS. FLOOD: Mrs. Silsbee, I would recommend that we approve a funding level for Inter-Mountain Regional Medical Program of $2,350,000.

MRS. SILSBEE: Is there a second?

MISS MARTINEZ: Second.

MRS. SILSBEE: The motion has been made and seconded that the Inter-Mountain Regional Medical Program be funded at a level of $2,350,000.

Discussion?

MR. MILLIKEN: What would the instructions be with this to accommodate the difference between what they have asked for and what they are being provided?

I have some anxieties that some things may be cut out that we think should not be, if they are allowed to do this. I see no assurances.

MR. CHAMBLISS: The activities of the corporation will certainly undergo some discussion here in Staff, and that might very well be --

MRS. SILSBEE: Now, Mr. Milliken, if you take your

viewpoint to its fullest extent, the only thing you could do is to approve the level they have requested.

So in terms of advice, if you would like to specify something, we would be glad to follow up on that.

DOCTOR WAMMOCK: I only want to say one thing.

I looked at this and there are six states involved, and that is a lot of territory to cover, and I can see some inherent problems -- transportation difficulty and all these other things, and I don't know what the answer to it is, whether $2,350,000 because you have a large territory to cover there, and I do not know what the total population is of these six states, whether it would be 6,000,000 people or whether it would be 3,000,000 people.

MRS. SILSBEE: Well, Doctor Wammock, that same large territory is also covered by two other Regional Medical Programs.

We have a motion on the floor.

MR. MILLIKEN: Do Staff have some insights into this, or recommendations for instructions to this applicant?

MRS. SILSBEE: I think the instruction that we would try to interpret from your discussion is that you have felt that on the one hand the IRMP needed to get into the outreach, looking at the needs and the -- try to assist in the health care of population groups that have been under-served, and on the other hand you feel that the Region is

overfunded and that they should concentrate on these areas, at a reduced funding level.

MR. CHAMBLISS: We will express to the Region the concern coming from Council about the minority issues in terms of project activities; you have cited the fact that the Region has hired one minority individual, and I seemed to hear you saying that this is a continuing concern.

I further hear you saying that the project activity touching on the minorities, and there are several minorities in Utah -- the Indians, the blacks, the Chicanos, that there is concern from Council that their health needs be addressed in a more positive way.

MRS. SILSBEE: The motion has been made and seconded that the Inter-Mountain Regional Medical Program be funded at a level of $2,350,000.

All in favor?

(Chorus of "Aye")

Opposed?

MRS. MARS: No.

VOICE: No.

MRS. SILSBEE: Let the record show there were two opposed, but the motion is carried, and let the record also show that Mrs. Klein has been absent during this discussion, and Doctor Gramlich.

All right; do you want to call it quits for the day?

SOUTH CAROLINA REVIEW

MRS. SILSBEE: Now we will take up South Carolina. Lee, do you want to put it in perspective?

MR. VAN WINKLE: It was considered to be an average or above-average Region; they had requested $3,000,000, and the Committee recommended $2,200,000.

The basic reason for this reduction was that here again, this Region had requested escrowed funds, if you will -- blank checks, as I heard referred to earlier. With another Region, they were asking for authority to spend funds in the area of regionalization of services -- health manpower development and improvement, strengthening quality assurance, and other activities.

The Committee did not buy this, or did not accept it; they did not think that these activities had gone far enough through the review process in South Carolina for it to be acceptable, and that is how they arrived at their reduction.

There are many other things that could be said, but I suppose they will be covered by the reviewers.

MRS. SILSBEE: The primary reviewer for South Carolina is Doctor Haber.

DOCTOR HABER: In reading the May-June review on the yellow sheet, and the confidential comments in the

proposal, I sometimes wonder if I am looking at the same project.

With four different perspectives, it became difficult to reconcile these all.

Very briefly, because the hour is late, their proposal goes through a narrative history which is a very good focus. It shows the development of a typical Regional Advisory Group.

There are a couple of comments in this that I think are worthy of reiteration. One of them is that the Regional Advisory Group has maintained its integrity, quantitatively -- and one must assume qualitatively -- in the face of what they call a limited future outlook, but they proudly aver that not one member has resigned.

The organizational structure has been modified since the inception of this program; they have gone through a number of changes since their inception in 1966, and they now have a triple-headed Regional Advisory Group -- I'm sorry; a triple-focused Regional Advisory Group structure which seems very adequate to the task at hand.

The review process and their relationships with the CHP(a) agencies look good in spite of the somewhat tortuous relationships in South Carolina, and the comment is made that there are at least five different types of planning groups, CHP agencies -- (a) and (b), the Appalachia Group, the

Regional Advisory Group, and a new group composed by the Governor, and the comment is made that this group is the line to his office, through a dotted line which seems to imply a tenuous future.

The caliber of the people involved, although I have not had the benefit of a site review, seems to be exemplary. I don't think we can fault them on that.

The individual projects themselves, I think are worthy of comment on reviewing. I would disagree with Doctor Gramlich's previous expression of dissatisfaction with concentration in one area. They have a number of projects related to hypertension, and I think this is good.

They have a number of projects which are related to the detection of hypertension through kidney disease and neuropathy, in black female children, in the adult male population, in general screening, and I think they are moving into an area very solidly, conceivably with some overlaps, but a massive approach on this important debilitating and life-threatening disease is evident.

Some of their projects look a little naive to me. There is one in improving ambulatory care, which would apply certain statistical models to ambulatory care. There are such models in existence, and it seems to me they are trying to invent the wheel.

I am concerned, although I don't have enough infor-

mation about this World Mobile Health project; it seems to me it is inadequately funded for all the wonderful things they intend to do.

I was concerned about the nurse-midwife project, which has been approved but not funded, and then withdrawn, apparently because of the difficulty of getting people. It was very modest funding; it seems like an eminently worthwhile project, and I would hope the Council could somehow help them in going ahead with this.

I think that this shows a good balance of projects between rural versus urban populations, minorities, between various kinds of diseases, and I would say that in total it seems to me their organization is sound.

The Regional Advisory Group has fared better than the RMP, which has lost, I think half its personnel. The quality of people is good; the proposals seem in the main well-balanced.

I think it has been judged average to above-average and I would concur in that, and I would also agree with the target that has been set for them; they asked for $3,000,000 and $2,200,000 seems eminently reasonably.

MRS. SILSBEE: Mrs. Mars?

MRS. MARS: I agree with Doctor Haber and with the Review Committee's recommendation.

I felt that it is a particularly well-structured RAG,

has a good review process, but there are so many of these projected activities that have not had time -- I have not had time to go through this entire process by any means, so that they are really requesting funds for some projects which are still very problematic, so I agree entirely, and I second the motion.

MRS. SILSBEE: Mr. Rubel?

MR. RUBEL: I would like to address one specific project that the RMP has proposed; I don't know how the numbering system works here, but it is something like 32-F; is that it?

Which is that -- an attempt at setting up an organization that would plan for the implementation of legislation that I spoke about this morning.

I would like to present you with two facts and see where it goes from there.

The Governor has expressed his very deep opposition to our funding this project without approval by the Health Council that he set up. Governor West has devoted a major portion of his last two years to working on health problems in this state, and very frankly, he feels that setting up of this organization is an attempt at by-passing the state entirely and trying to position the RMP in such a way that it would become -- or play a dominant role in whatever kind of organization comes about as a result of discussions on

Capitol Hill.

Governor West has on several occasions discussed what he is doing in health with the Secretary, and Doctor Endicott, and many other people. The Department, for one reason or another, is doing all kinds of things in South Carolina -- I don't even know about them.

There is a lot of interest; that's point Number 1.

Number 2, the HEW Regional Office in Atlanta has expressed a lot of concern about this project for a number of the same reasons.

It is feared that the RMP is dominated by the medical profession and that, as I said before, there is perhaps an attempt at posturing here, that they are very concerned about. While it is alleged in the application that the CHP agencies are in favor generally, the Regional Office has been told by many of the (b) agencies that they are very much opposed to it.

I don't understand all the politics of this state of South Carolina, and certainly not the medical politics, but we have a very difficult situation on our hands here.

I certainly think we would very much appreciate getting your recommendation on how to proceed here. I would like to just set out four possibilities, and while it is true that the Council usually does not deal with specific proposals, it has on many occasions said Yea or Nay to specific ones

when the occasion warrants.

Before I get to the possibilities, in going through all the applications in front of us, there are other states -- there are other Regions that are proposing something like this, but I think it is fair to say that South Carolina's is the most blatant, or perhaps the most forward, depending on how you might view it.

We certainly know, and as I discussed this morning, that RMP's as organizations, and the people that work in them, are thinking about the future, and are trying to do all kinds of contingency planning, and in fact different places work in different ways.

You just heard something about what goes on in Inter-Mountain, and that is going on around the country, and we can't ignore that.

On the other hand, to what extent do we want to allow money being -- coming through this channel to serve as a base for one organization or another here?

Essentially, the four possibilities are:

1. Tell them, you know, you decide what you want to do, based on whatever level of funding the Council recommends, which essentially says that if that gets to be important they can go ahead and do it.

Second alternative is to say: "You can't do it." Period.

The third alternative would be to say: "Go back and

you had better start negotiating with the Governor, and as part of the application due on July 1, if you can get their approval, or it you can't, at least if you want to propose it again, please do, but we won't fund it during this cycle."

The fourth possibility is a conditional approval, saying that there is a requirement for coordination here and for working together which has not been demonstrated, that you may proceed and do this but only after you have consulted and gotten approval of the other factions that are involved, that are going to be involved, in whatever the legislation covers. If you can get their approval, then you can proceed.

Those are the four possibilities, as I see them. Perhaps there are others.

MR. VAN WINKLE: The Review Committee -- this was one of the thrusts, Mr. Rubel, that the Committee addressed, and this was what they based their reduction of funding on. This was one of those that they said they could not consider at this time.

MR. RUBEL: It is one thing to provide the reduced funding; it is another to preclude money being used for this purpose.

MRS. SILSBEE: Does the Council have any suggestions as to how we proceed? This refers specifically to that one project.

DOCTOR WAMMOCK: Is that 32-F, did you say?

MR. RUBEL: That is 32-F. They are proposing, essentially, to spend $165,000 to set up a new organization.

DOCTOR WAMMOCK: With the RMP funds?

MR. RUBEL: Yes, sir.

MRS. FLOOD: But all of the 32's -- A,B,C,D,E -- except for F, aren't they rather nebulous? Or at least, is it D that is sort of a blanket fund that will be spent on non-RFP's?

MR. VAN WINKLE: All of those are in that nebulous category; yes.

MRS. FLOOD: They add up to a million-four.

MR. VAN WINKLE: Yes.

MRS. SILSBEE: That, as I understand it, was why the funding recommendation was cut back.

Now Mr. Rubel is suggesting that not only the funding recommendation be cut back but that there be some kind of outline or alternatives which -- and they were all valid alternatives, and we need to have some motion in terms of the funding level and what you do about that particular thing.

DOCTOR JANEWAY: Can I ask a question, Mrs. Silsbee, before we get a motion?

That is, can the Review Committee make any specific comments relative to the areas that were discussed? Because it could be circumvented and not be a Council policy if there were specific recommendation from the Review Committee as to

deletion.

MR. VAN WINKLE: Not in terms of addressing this particular issue, no.

MR. CHAMBLISS: As a matter of fact, there was a correspondence that came in since the Review Committee.

DOCTOR JANEWAY: They were not privy to this information; is that correct?

MR. VAN WINKLE: That is right.

DOCTOR JANEWAY: Because it seemed to me the sense of the Council, considering the second resolution of the Ad Hoc Review Committee was such that we were not in principle going to consider that proposal, that RMP organizations prepare themselves for some possible future role.

MR. VAN WINKLE: They did not address that. All they said was they don't think these activities are sufficiently developed at this time for them to consider.

But if they come back in in July, then they will consider them, is essentially what they say.

MRS. SILSBEE: Doctor Janeway is saying that the Council's previous action with regard to that proposal -- the resolution, that the Committee in a sense answers this.

DOCTOR JANEWAY: It doesn't have to be dealt with in any substantive sense on the basis of this particular Council.

MR. RUBEL: I should point out that this is referred

to as a Phase 2, that the RMP has been involved in these activities. They did sponsor a conference back in January which Doctor Endicott did attend. Then here they have a very specific proposal here; this is not nebulous. This is -- it says:

> "We're going to do something. We're going to set up an organization, and until we set it up we are going to use RMP's staff to do it and what it is supposed to do."

So we can't fall back on: "We don't know what this is all about."

DOCTOR HABER: Well, can we approve all save that particular project? And then adopt one of the four alternatives that he outlined for us? Can we do that?

MRS. SILSBEE: You can do -- yes.

DOCTOR HABER: Well, I so move.

I move that we adopt all -- that we fund this at the level recommended, with the exception of that particular portion to which Mr. Rubel has reference.

MRS. FLOOD: 32-F.

MRS. SILSBEE: Now, in terms of that particular portion, are you saying Option 2, no-go? They could not fund it?

DOCTOR HABER: I am trying to separate that out from the rest of the program. If we can get a motion approved that

all but that would be approved, then we can handle this for those four options. That is holding up the whole thing.

MRS. SILSBEE: IS there a second?

VOICE: Second.

MRS. SILSBEE: All right. The motion has been made and seconded that the South Carolina application be approved at the level of $2,200,000, with the exception of 32-F.

Any further discussion?

DOCTOR WAMMOCK: If you look up there at 32-D and 32-C, and 32-B -- I mean, I see no description here at all; it is only just by title here. It seems to me it all falls pretty much in the same category.

MRS. SILSBEE: In terms of the issue that the 32-F is directed at, which is that the Governor's Council -- that is a slightly different issue.

DOCTOR WAMMOCK: It's got a different twist to it.

MRS. SILSBEE: That is right.

Further discussion? All in favor of the motion?

(Chorus of "Aye")

Opposed?

(No response)

The motion is carried.

Now, do you want to deal with 32-F?

DOCTOR HABER: Can we have those four options again, Mr. Rubel?

MR. RUBEL: First, you can leave it where it is, let the RAG, based on the decision you just made, determine its priorities.

Second is a flat: "You may not perform; this project is unacceptable." Just as we said earlier that any of those unapproved arthritis applications can not be done by the RMP.

Third is:

"Come back in your July 1 application, but satisfy us that you have worked together with all these other bodies and that they agree to it."

DOCTOR HABER: That is the option I want, and I am making a motion on that.

MR. RUBEL: The fourth says:

"You may use the two million whatever it is, or part of it, for this project only after you have worked with the other groups and only after approval by the Director of the Division of Regional Medical Programs."

And that would only occur after he is assured that those groups have been consulted.

Three kind of puts it into the next cycle; Four says it is okay under this cycle, provided certain conditions are met.

MRS. GILSBEE: Doctor Haber, in terms of your consideration of this, of Number Three, it is now June 13th, and they have to come in on July 1. Now, whether they can satisfy

all the things you are talking about by July 1, I --

DOCTOR HABER: We know they are not going to satisfy all --

MR. RUBEL: Perhaps it would be useful for me to read to you a paragraph of a letter from Chairman of the South Carolina Health Policy and Planning Council:

"I told you in Washington I would not consider writing this letter without the full knowledge and consent of the Governor, and without my being personally assured that he completely understood the issues involved.

This I have done, and I am now writing with his full knowledge and consent, and in fact under his direction, at the request that any application or communication seeking recognition or funding for any purpose in this field in South Carolina, which might be filed with the Department of Health, Education and Welfare, not be considered without having been referred to the South Carolina Health Policy and Planning Council, which is the official State body created by the Governor's Executive Order in January 1973 with the specific responsibility for planning, reviewing and coordinating all health efforts here in South Carolina."

DOCTOR SCHRIENER: There are two ways of saying: don't do it.

MRS. SILSBEE: I wouldn't want to enter into this, but in terms of the Council, you are in a position to do what you think is best.

DOCTOR SHCRIENER: Oh, I think that is best.

DOCTOR HABER: I would still make a motion for the third alternative, and I do so. And I put that motion before the Board.

DOCTOR WAMMOCK: Would you so state what we are going to vote on now?

MRS. SILSBEE: The alternative Three is that the -- that Region may not do that with these funds. If they choose to go back and negotiate with the agencies and the Governor's Council, the Council would entertain a request in the July 1 application.

MRS. KLEIN: I hesitate to talk about this because I know so little about it, but it seems to me that the Ad Hoc Committee did approve this, did it not? The funding that we are discussing, this aspect of it, and they had not had this opposition expressed to them at time?

Well, it seems to me then that if they did, as far as the merits of it are concerned, that we are agreed that it is proper, then also, if they negotiate with the Governor, knowing how they sometimes operate, there is a possibility that they could clear this portion up, and for that reason I would certainly feel that we ought to go along with the

fourth proposal, and that is to approve it and then permit them to make their peace, if they can.

So I suppose the way to handle this would be to vote on the preceding motion, or I might offer a substitute motion, if that is in order with the procedure that you use here.

MRS. SILSBEE: I am the poorest parliamentarian going, but -- Doctor Haber?

DOCTOR WAMMOCK: She is making an amendment now.

MRS. SILSBEE: She is offering a substitute motion.

MRS. KLEIN: This would preclude the other one, so I suppose it would be a substitute.

DOCTOR HABER: I would accept that.

MRS. KLEIN: Well, I would suppose that was proper. I would second the motion, then, as amended.

DOCTOR WAMMOCK: Well --

MRS. KLEIN: He accepted it and made a new motion, which in effect I am seconding, just so we can get a vote on this.

MRS. SILSBEE: Mrs. Flood?

MRS. FLOOD: I have a question, or perhaps it is a concern, that by making the statement that we would fund this type of a project, should North Carolina -- should South Carolina RMP make amends and get friendly with the Governor, we have set the precedent then for a request for funding for

just such organizational structure out of RMP dollars across the country.

Now, we just said earlier that we did not want to encourage, or at least we wouldn't accept as a policy statement, a statement that said we encouraged the staff to start investigating the administrative structure that they might endeavor to approach in light of potential new legislation.

But here we are talking about setting the precedent for buying the complete service or development.

MR. RUBEL: As I tried to indicate before, this kind of activity is going on in every Region in the country.

MRS. FLOOD: Yes, but not at $165,000.

MR. RUBEL: Well, you know; you can do it in various and sundry ways. You know that it is happening; as I have been going through the book here I have managed to detect very similar kinds of projects, and some people have a better way of hiding them than others, in I would guess, at least a half-dozen other Regions.

So it is not a question of: this is the only one. They are the only ones that are doing it quite as blatantly, but remember this went through a review process and nobody really picked it up. Nobody said; there is nothing I read, and I mean, the first I heard about it was when I got this nice cozy little letter here.

MR. VAN WINKLE: They refused to consider it for a

different reason, too.

MRS. SILSBEE: Mr. Rubel, I think there is, in terms of interpreting the messages that have gone out to the Regional Medical Programs, and in terms of the whole thing, it would seem to me that the Region is trying to respond in a way to a national initiative, and I guess I am a little concerned about the idea that it is trying to get there "firstest with the mostest."

Now they are there, you have asked them to get ready, and they have used various ways of doing that. I just don't think -- and they have the money, so the fact that they have the money doesn't mean necessarily that they are not being involved with the others.

Miss Martinez?

MISS MARTINEZ: In some of these other states that you mentioned, that are doing this thing, is there the same opposition from the Governor?

MR. RUBEL: There might be if he knew about it.

You know, I know of many, many situations where there is a fair amount of conflict there. It is very difficult to say, because these applications haven't been reviewed by Governors, so we don't know whether they are opposed or not.

MISS MARTINEZ: I think whether or not it is happening on a smaller scale, I think with several of the

smaller projects, and whether or not it is a response to a possible national direction, I don't quite agree with the policy of spending program moneys on the possibility of a change when they are -- there must be better ways to spend program moneys.

I don't quite agree with that kind of philosophy.

DOCTOR WAMMOCK: Mr. Rubel, what does South Carolina have? What is her plan called under the Governor, if you would please state that again?

MR. RUBEL: South Carolina Health Policy and Planning Council.

DOCTOR WAMMOCK: Well, there you are, see? He is in direct control of that.

MR. RUBEL: And that is right over the Department of Health.

DOCTOR WAMMOCK: I venture to say they are the very first state that have a program that is controlled by the Governor.

DOCTOR SCHRIENER: I just wanted to say that I am not terribly swayed by the argument that some of these may be buried in other proposals. The point is that we are discussing this proposal; I think this -- I personally don't think it is a good way to spend RMP moneys, and I will vote against any other proposal that has it, just like I am going to vote against this one.

it until they have shown us that they have already done it.

MISS MARTINEZ: I still think it sets a bad precedent.

DOCTOR WAMMOCK: Me, too.

MRS. SILSBEE: Do you want to vote on that motion?

MRS. GORDON: I would like an exact wording of the motion. You are saying the same thing different ways, but it isn't the same thing.

DOCTOR JANEWAY: I was wondering, if we are talking about "safesmanship," if one really wants a motion? And a vote, on something whereby you are going to establish policy by exception.

And it seems to me that Staff could sense the feeling of the Council with reference to this particular portion of the grant request and indicate to RMP the strong feeling of the Council in this regard.

Because you are getting into two situations, it seems to me. One is, you are overruling a Technical Committee of the Ad Hoc Review Committee, which we have the right to do, but it is not the general order of things. It is a specific project.

And if it is a motion, it is not only intent, it is policy.

Now, I think Doctor Watkins made an extremely valid

point very early in the meeting about whether we were indeed required to vote on proposals that we elected not to have come before us. And the sense of the Council would carry the weight of a vote without having any.

MR. RUBEL: We in HEW are going to have to deal with this one way or another; you know, if you decide to let it go to the extent that you disapprove it, that is the end of it. There is nothing we can do.

But if you decide to let it go, we still have to deal with it, one way or the other. You can choose to tell us which way you would like us to deal with or, or you can let us deal with it ourselves.

The problem is not going to go away; the Governor is going to be there tomorrow, and he is going to pick up the phone and call the Secretary and we are going to be right in the middle of it.

MRS. SILSBEE: Mrs. Klein?

MRS. KLEIN: We would be setting another precedent if we refused to approve this, or approved it in such a manner that it implied that the Governor's approval approval would have to be had for every funding that we undertook from now on.

That would be my concern; I would be more concerned in that direction than I would be in the direction of asking

them to cooperate in getting approval by the Governor and these other agencies before they actually went ahead with the program.

MRS. SILSBEE: Miss Martinez?

MISS MARTINEZ: Isn't the issue one of the RMP duplicating part of the function of the Governor's Council, and isn't that why, rather than all that RMP -- I don't think this would set a precedent for approval of all RMP projects. It is simply a matter of RMP duplicating its committees.

DOCTOR SCHRIENER: Mrs. Klein has a point as far as I am concerned. I don't think it is a very good expenditure of RMP program money.

MRS. SILSBEE: Well, Mrs. Klein?

MRS. KLEIN: I am sorry to be so persistent about this, but this, to me, would be sort of a flimsy reason for disapproving the program.

If the Ad Hoc Committee approved it without knowing of this problem, as far as I am concerned, it must have had some serious merit, and I am not in a position to say there wasn't -- you know, that it should be disapproved, possibly because I don't have the information, but my problem here is coupled with the Governor's need for approval and that sort of thing, and I don't think we ought to -- I think it would be a bad policy to require that approval before, you know, we do any funding. Otherwise it certainly would get us back to

the point where we would -- what are we here for?

MR. MILLIKEN: Point of information.

Does the Ad Hoc Committee indeed approve or disapprove, or do they recommend to this Council?

MRS. SILSBEE: They recommend to this Council a funding level. Yes.

DOCTOR WAMMOCK: I am sorry, but when you look at the titles again across here -- whatever in the name of God that means, I don't know; the specific categorical entries -- Prime Health care, and Advanced Health Resource Planning?

MRS. SILSBEE: Are you looking at the print-out, Doctor Wammock, or the individual 15's?

DOCTOR WAMMOCK: It is the print-out here, you see, for this whole thing. It is all described here, and it seems to me -- Health Sources Development Initiated Phase 2, Advance Planning, Corporate Mechanisms in South Carolina, and another one, "Program Needs on March 1st announce Health Manpower Development Improvements; one of the six really broad program areas which were eligible for consideration in the future contracts for project funds."

I believe it is semantics; it is all semantics. They are all going in the same direction.

MRS. GORDON: Did I not understand you to say that one of the reasons for the cut in funding, or for the cut, was because the Review Committee did not see the value in these

particular programs?

MR. VAN WINKLE: Not that they did not see the value. These are thrusts that this program is making; it has been approved by the RAG. This is the way they intend to get into it.

But in this application the program had not developed far enough for them to consider it. They said: "If it comes back in July we'll look at it," but they don't have - who they are going to contract with, they don't know wno the project directors are; we don't know the amounts of the budgets. Until they provide us with that, they are just not going to look at it, is what they said.

So therefore, we are going to cut the proposal by $800,000.

DOCTOR JANEWAY: Then the Ad Hoc Committee has already said this.

MR. VAN WINKLE: That is in their recommendation.

DOCTOR JANEWAY: That is all we have to say anyway.

MR. VAN WINKLE: They did not consider the proposals at all. They just said: "At this time we don't know enough about it."

MR. MILLIKEN: Question, on the motion.

MRS. SILSBEE: There has been a motion made, and I don't know that I have the exact wording, but maybe, Mrs. Klein, you could reword your motion, since it has turned out to be

yours?

MRS. KLEIN: I don't know that I have the exact wording either.

I would prefer that someone else word it. My motion -- all right; I'll make an effort.

As to these programs that we are discussing -- and I don't even have the information about them --

DOCTOR HABER: IT is the Health Services Development Initiative, Phase 2, Project 32-F.

MRS. KLEIN: Funding was approved by the Ad Hoc Committee, was it not?

(Discussion off the record)

MRS. KLEIN: They did not approve it?

MRS. SILSBEE: They did not specifically disapprove anything. They reduced the funding level, with advice to the Region that they should come back with specific information in July if they wanted anything.

MRS. KLEIN: Well now, I have made all of my motions. I am really gumming this up. I have made all of my motions with the premise that the Ad Hoc Committee had approved the funding.

MRS. SILSBEE: They reduced funding for the Region.

MRS. KLEIN: They actually reduced the funding without knowing of the Governor's opposition, and the motion now would be to go contrary to the recommendation of the Ad

Hoc Committee by approving the funding?

MR. RUBEL: The issue, very succinctly -- given the funding level that they have gotten, $2.2 million, may the RMP embark on this project?

And as I understood the motion that you made, it was that they may embark on this project within the limit of the $2.2 million, only with the specific approval of the Director of the Division of Regional Medical Programs, and that approval is contingent -- conditional on acceptance by this Council and the (b) agencies in the state of South Carolina.

MRS. KLEIN: In effect, then, this motion would go contrary to the recommendation of the Ad Hoc Committee.

VOICES: No. No.

MRS. SILSBEE: No, because it just further specifies the recommendation.

MRS. KLEIN: I see. In other words, their approval was just on the reduced funding, and this motion would increase the funding?

MRS. FLOOD: No, it would leave the funding the same.

MRS. KLEIN: All right; that is the motion then, as to these specific projects, that the funding be approved subject to their obtaining the approval and cooperation of the Governor and the other agencies.

MR. VAN WINKLE: One project.

MRS. SILSBEE: One project.

The motion has been made and seconded that the South Carolina RMP be funded at the level -- at the previously recommended level Council has already acted on of $2,200,000, but that any funding by the RMP of project Number 32-F is conditoned upon the Region indicating to DRMP that they have the backing of the (b) agencies, the (a) agencies and the Governor's Council.

Is there any further discussion?

All in favor?

(Chorus of "Aye")

Opposed?

(Chorus of "No")

MRS. SILSBEE: Could we have hands on the "aye's?"

(Show of hands)

Six "Aye's."

Four "Nay's."

The "Aye's" have it.

All right; now do you want to call it quits?

MR. CHAMBLISS: May I just say this? I think the Committee should know that there is one-sixth of its workload completed.

I don't say that to deter the discussion; simply to let you know where you stand in terms of the overall workload that you have accomplished.

MRS. SILSBEE: What time do you want to meet tomorrow? The Staff will be present, because a lot of them have already gone.

At 8:30? Would you rather start earlier?

All right; 8:00 o'lock it will be.

(Whereupon, at 6:25 P.M. the Council recessed until 8:00 o'clock A.M. June 14, 1974.)

- - -