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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE

National Advisory Council on Regional Medical Programs

Minutes of the Twenty-seventh Meeting 1/ 2/
June 5-6, 1972

The National Advisory Council on Regional Medical Programs convened for its twenty-seventh meeting at 8:30 a.m. on Monday, June 5, 1972 in Conference Room M of the Parklawn Building, Rockville, Maryland. Dr. Harold Margulies, Director, Regional Medical Programs Service presided over the meeting.

The Council Members present were:

Dr. Michael J. Brennan
Dr. Bland W. Cannon
Mrs. Susan L. Curry
Dr. Michael E. DeBakey
Mr. Edwin C. Hiroto
Dr. Anthony L. Komaroff
Mrs. Audrey M. Mars
Dr. Alexander M. McPhedran
Dr. John P. Merrill
Dr. Gerhard A. Meyer
Dr. Clark H. Millikan
Mr. Sewall O. Milliken
Mrs. Mariel S. Morgan
Dr. Alton Ochsner
Dr. Russell B. Roth
Dr. George E. Schreiner
Dr. Benjamin W. Watkins
Mrs. Florence R. Wyckoff
Dr. John D. Chase 3/

A listing of RMPS staff members and others attending is appended. Doctors Chase, DeBakey, Millikan, Ochsner and Roth were present on June 5 only. Dr. Brennan was present beginning on the afternoon of June 5.

I. CALL TO ORDER AND OPENING REMARKS

The meeting was called to order at 8:30 a.m. on June 5, 1972, by Dr. Harold Margulies. Dr. Margulies called attention to the "Conflict of Interest" and "Confidentiality of Meetings" statement in the Council Books. He then called upon Mr. Baum to make some routine announcements concerning the conduct of the meeting, dinner arrangements and Council materials.

1/ Proceedings of meetings are restricted unless cleared by the Office of the Administrator, HSMHA. The restriction relates to all materials submitted for discussion at the meetings, the supplemental material, and all other official documents including the agenda.

2/ For the record, it is noted that members absent themselves from the meeting when the Council is discussing applications: (a) from their respective institutions, or (b) in which a conflict of interest might occur. This procedure does not, of course, apply to en bloc actions--only when the application is under individual discussion.

3/ Representing Dr. Marc J. Musser for the Veterans Administration.

II. CONSIDERATION OF THE MINUTES OF THE FEBRUARY 8-9, 1972 MEETING

The Council considered and approved the Minutes of the February 8-9, 1972 meeting (Transcript, Vol. 1, page 8)

III. INTRODUCTION OF GUESTS AND NEW RMPS PROFESSIONAL STAFF

Dr. Margulies introduced a number of guests attending the meeting and two new members of the RMPS professional staff, Dr. Larry Rose, Senior Health Consultant, who is in charge of Emergency Medical Systems activities in the Division of Professional and Technical Development, and Mr. Robert Walkington, Chief, Evaluation Branch, Office of Program Planning and Evaluation.

IV. CONFIRMATION OF FUTURE MEETING DATES

The Council confirmed the following future meeting dates which had been set previously. (Transcript, Vol. 1, page 10)

October 16-17, 1972
February 7-8, 1973
June 5-6, 1973

V. REPORT BY DR. MARGULIES

A. Budget Outlook

After considering all the variables, the maximum amount that may be available to RMPS for obligation in Fiscal Year 1972 will be about $112 million. RMPS is prepared to utilize that full amount with no difficulty because of the variety of activities which it has developed.

It is too early to predict what the final outcome will be with respect to the Fiscal 1973 appropriation. The Department's request was for $131 million, which contrasts sharply with the previous request for $52.5 million obligational authority for FY 1972, and apparently recognizes a rising interest in what Regional Medical Programs are doing. Various other proposals range up to a maximum of $229 million.

B. Pulmonary Pediatric Centers

The Congress has required through express language in the FY 72 Appropriation Act that pulmonary pediatric centers be funded at the level of the preceeding Fiscal Year. RMPS will, therefore, be receiving a number of pulmonary pediatric activities in order to maintain a $1.7 million total for such centers.

C. Automated Multiphasic Health Testing

The Council's attention was called to the report of the conference on automated multiphasic health testing which was held in Rockville,

Maryland on March 8-9, 1972. The conference was called in response to the Council's request for additional information on the status of 12 automated multiphasic health testing projects funded by RMPS.

There was considerable discussion of one project summarized in the report which showed that only 50% of those persons referred, as a result of screening, actually see a physician. Dr. Margulies indicated that questions raised in the discussion exemplified the need for further study of the utility of AMHT before further investments in these kinds of activities are made by RMP.

The Council raised no objection to the Report or its major conclusion that the RMPS moratorium on funding of AMHT projects be continued. (Transcript, Vol. 1, page 50)

D. Three-Cycle Review of Grant Applications

The shift from 4 to 3-cycle review is taking place smoothly. Anniversary dates have been changed as necessary, and RMPS is negotiating new levels for affected regions on the basis of their new fiscal years.

In the process of shifting to the new 3-cycle system, RMPS was able to achieve two other things. One is to schedule staff visits to the regions three to four times per year, on a regular basis, giving greater attention to those regions which have shown up poorly in the review process. The other is to cut down on staff paperwork, which accounts for the changes in some of the materials being provided to the Council.

E. Regulations

Dr. Pahl and Mr. Baum discussed proposed draft Regulations. The draft provided for consideration of the Council was developed in legal form and language by the Office of the General Counsel (OGC) to reflect both the current RMP legislation and current program policies and procedures. RMPS staff has drafted several additional sections to be added to the materials drafted by OGC. These relate to Grantee-RAG-Coordinator relationships, Section 910, and construction projects.

Dr. DeBakey and others expressed the opinion that certain language appeared to rigidly set ranked priorities for certain types of activities which Dr. Margulies and Dr. Pahl indicated was not the intent. Other objections were raised to the use of the term "care," without an adequate definition.

The Council was advised that RMPS would revise the material along the lines suggested, and resubmit the revised draft at a later date for further Council consideration.

F. Coordination with National Center for Health Services Research and Development

Dr. Margulies called upon Dr. Robert Van Hook, the new Director of the National Center for Health Services Research and Development. Dr. Van Hook stated that through its programs, the Center would participate in and carry out studies on how health services are delivered, the components of the related service activities, and their effectiveness. He indicated that apropos of the previous discussion of multiphasic health testing, one of the Center's main concerns is the level of patient acceptance, patient followup and other response to whatever professional guidance may be given. Another area of emphasis for the Center concerns resource utilization and productivity. Efforts in this area will focus on testing techniques which can measure proficiency and productivity and feed necessary information into the educational system, as well as licensing and certification programs.

G. Delegation Concerning Educational Projects

Council's attention was called to the need for a new delegation of authority to enable the Director, RMPS, to fund small projects (under $50,000) stemming from the January St. Louis conference. The projects in question are community based extensions of RMP activities which deal with educational goals appropriate to RMP. It was moved, seconded and carried that the delegation be approved. (Transcript, Vol. 1, page 64) The resolution, as passed, is reproduced as Appendix A of these Minutes.

H. Remarks by Mr. Chambliss

Mr. Cleveland Chambliss, Director, Division of Operations and Development, reported that four members of the RMPS Review Committee: Drs. Spellman, Besson, White and Mayer would be completing their terms at the end of June. Dr. Mayer, the present Chairman of the Committee, will be succeeded by Dr. Alexander M. Schmidt. Mrs. Maria Flood of El Paso, Texas, has accepted an appointment to fill one vacancy on the Committee. Specific individuals have been invited to fill two other vacancies, but have not yet responded.

Mr. Chambliss also discussed a General Counsel's opinion relating to rights to and income from materials developed with grant funds (video-tapes being the case in point). The grantee can sell or otherwise dispose of the rights to such materials without prior HEW approval. The Department retains the right to reproduce such material, irrespective of copyrights by the grantee or others, and any income up to the cost of production is treated as grant related income. Such income may be recovered by RMPS or waived to the grantee for grant related purposes.

I. Governing Principles for Discretionary Funding

Council's attention was called for information purposes to a proposed policy statement entitled, "Governing Principles and

Requirements, Discretionary RMP Funding," dated May 26, 1972. The statement, reproduced as appendix B of these Minutes, tries to set forth general principles for rebudgeting funds by regions within their level of support and also states the conditions under which prior RMPS approval must be obtained. No objections to the proposed policy were expressed.

J. Grantee and Regional Advisory Group Responsibilities and Relationships

A second proposed policy was brought before the Council for explanation and action. This relates to "Grantee and Regional Advisory Group responsibilities and Relationships." Dr. Pahl called the Council's attention to the salient points of the proposed new policy. Among other things, the Council's attention was specifically called to the following key statement in the draft:

> "The grantee organization shall manage the grant of the Regional Medical Program in a manner which will implement the program established by the Regional Advisory Group and in accordance with Federal Regulations and policies."

This language is intended to make it clear that as a matter of policy the Regional Advisory Group and not the Grantee is responsible for establishing an RMP's program.

It was also pointed out that the statement clearly indicates that the Coordinator is an employeee of the grantee, and that he is nominated by the RAG,but selected by the grantee. Similarly, the RAG Chairman is selected by the RAG and confirmed by the grantee. These procedures are designed to insure that both the Coordinator and the RAG Chairman are acceptable to the RAG and Grantee alike.

It was moved, seconded and carried that the statement be approved. (Transcript, Vol. 1, page 112). The statement is reproduced as Appendix C of these Minutes.

K. Kidney Guidelines

Dr. Hinman reviewed the new kidney disease "Guidelines and Review Procedures Statement." The guidelines require that each kidney proposal be reviewed at the local level by at least three kidney experts who do not reside or work within the Region submitting the application. The written comments of these reviewers would be presented to the Regional Advisory Group. The RAG would approve or disapprove the project and send it in to RMPS where it would be presented to the Review Committee for priorities concerning funding, but not for further technical evaluation.

There was extensive discussion of two points concerning the policy as a result of which it was decided that RMPS would issue a clarification of the term "full-time transplantation surgeons," as

used in item 6B on page 2 of the guidelines document. A proposal advanced by the Review Committee that technical reviews be conducted only by experts selected from a roster maintained by RMPS (i.e., a closed national panel) was not accepted. Subsequent to the discussion, it was moved, seconded and carried that the guidelines be approved as presented with a letter to be distributed later clarifying the meaning of full-time surgeon. (Transcript, Vol. 1, page 124). A copy of the guidelines as discussed, is attached as Appendix D of these Minutes.

VI. INPATIENT BEDS FOR SEATTLE CANCER CENTER

Mr. Richard Russell, Acting Chief, Western Operations Branch, reported to the Council on the applicant's justification for 20 inpatient beds in the Center. This material was submitted in response to the Council's previous recommendation that "the provision of space to accommodate 20 beds which were isolated from the Swedish Hospital Medical Center be reconsidered with further justification for review and approval by the Council."

Mr. Russell also reported that three other conditions to the grant, which were previously set by the Council, had been met by the Cancer Center. These were: (1) that all relevant State, Federal and local requirements for the construction of the proposed type of facility be met, (2) that the University of Washington and the Swedish Hospital formalize their relationships with the Cancer Center, and (3) that all conditions contained in the Council's November 10, 1971 statement on a Cancer Center to serve HEW Region 10 be satisfied.

Subsequent to the report, it was moved, seconded and carried that the grant award be approved, including approval for inpatient beds in the Center, on the basis that the other conditions established by the Council had been met.

VII. EMS PROJECTS

Dr. Margulies introduced Dr. Leonard Scherlis, who served as Chairman of a special committee which reviewed proposals for grants for Emergency Medical Systems. Dr. Scherlis described the review of EMS proposals.

The Committee reviewed 35 proposals requesting a grand total of $33 million for three years. Of these, 5 were disapproved, and the remainder recommended for funding in the total of $11,663,059 for the three year period.

Dr. Margulies raised the question of whether funds recommended for EMS, should be treated as raising the level of commitment for the RMPs involved. After a brief discussion, he stated the sense of the Council to the effect that the "emergency medical activity is of high priority and should be given full consideration in any executive funding."

Subsequently, it was moved, seconded and carried that the recommddations of the special EMS Review Committee be approved. (Transcript, Vol. 1, pages 143 and 147.) Specific amounts approved are shown in Appendix E of these Minutes.

VIII. PROPOSALS FOR RMP HEALTH SERVICES' EDUCATION ACTIVITIES

Dr. Margulies called on Dr. Warren Perry, a member of the RMPS Review Committee who served as Chairman of a special review group established to review request supplementary requests from RMPs for educational programs. He indicated that these proposals are largely an enhancement of what RMPs have been doing for a long time to improve the education of health professionals and the relationship of that education to the delivery of services. Because of uncertainties about funding, the projects in question have been clearly separated out from anything that appeared to be an area health education center as originally or currently defined.

Dr. Perry indicated that requests were received for $10,229,881 and that, of these, a grand total of $6,874,996 was recommended for approval. He described the review process and cited a number of the specific proposals. He indicated that several factors had led to disapproval of some proposals. These factors included excessive emphasis on continuing education, need for more adequate community involvement, availability of alternative funding, and lack of key components of the Consortium.

Dr. Margulies then called upon Dr. Chase with respect to the VA point of view concerning educational activities of the type under consideration. Dr. Chase stated that the VA is enthusiastic about the approach and is again committing another $3 million as its contribution for the 1974 Fiscal Year.

Next, it was moved, seconded and carried that the special Review Committee's recommendations be adopted including a list of priorities for funding included in the group's report. (Transcript, Vol. 1, page 215) A list of individual actions and priorities included in the action is attached as Appendix F of these Minutes.

IX. SPECIAL ACTION FOR INCREASES IN NAC-APPROVED LEVELS FOR CERTAIN REGIONS

The Council was requested to increase the approved level for six Regional Medical Programs. These increases would permit the funding of pediatric pulmonary centers in accordance with Congressional action, and would provide RMPS with flexibility in dealing with requests from certain Regions where actual funding either was at, or approaching the Council-approved level, and where progress indicated a possible need for additional funds during the extended period established to phase all regions into the new review cycle. It was emphasized that funds would actually be awarded only after consideration of specific requests from the affected Regions.

It was moved, seconded and carried that the levels be adjusted as proposed. (Transcript, Vol. 1, page 222) A list of the individual Regions and the specific amounts included in the Council's action is attached as Appendix G.

X. HEALTH MAINTENANCE ORGANIZATIONS

The use of RMPS funds to support HMO feasibility and planning studies was debated vigorously and at length by the Council. Extended

discussions on this subject took place at several different points in the meeting and involved at times the Administrator, Dr. Frederick L. Stone, Special Assistant to the Administrator, and Mr. Gerald R. Riso, Deputy Administrator for Development. None of them were present during all of the discussion.

Dr. Gordon Macleod, Director, Health Maintenance Organizations Service, HSMHA, was introduced to the Council. He described the HMOS review process and asked the Council to consider block action on 29 projects for $4.3 million as recommended by the HMOS review. He indicated that there is existing authority in the RMP and other legislation to do certain things with respect to the health care delivery system in the country, and stated specifically that the Office of the General Counsel has issued an opinion authorizing the utilization of RMP money for HMO activities if the activity is limited to the planning and developmental phases.

Dr. Roth raised the following points:

1. It is premature to foster new HMOs in the absence of specific legislation, appropriations and a legislative definition of an HMO. Presently such legislation does not exist. Pending HMO bills differ and have little chance of passage in the current Congressional session.

2. HMOs are no longer experimental. Thirty existing groups which serve 7.5 million people have been formed without Federal funds.

3. There is a question as to the legality and appropriateness of using RMP funds to support HMOs. HMO projects relate to development of a reimbursement system rather than the dissemination of knowledge or development and use of manpower.

4. All of the RMP funds reserved for support of HMOs should be released to RMPS. The program is not limited to the support of Regional Medical programs and has great flexibility under Section 910.

Dr. DeBakey advanced the following opinions:

1. There are no Congressional earmarks for HMOs.

2. The Council should be consulted on the use of appropriated funds.

3. There is a question of whether HMOs, given the limited resources available to RMP, should have sufficiently high priority for RMPS funding.

4. There has been inadequate advance discussion with the Council of the substance of HMO proposals, and there is insufficient evidence that the support of HMOs advances the Regional Medical Programs, particularly within the intent of Congress.

Dr. Cannon, Dr. Komaroff and Dr. Watkins, who participated in the final HMO reviews in Washington as representatives of the Council, reported that:

1. The HMO review process is adequate.

2. Thirty eight percent of the HMO applications did not include an educational component which is essential to initiating some quality control.

3. The subcommittee did not consider the desirability of using RMPS funds for the general support of HMOs.

Other points brought out in the discussion by various Council members were:

1. RMPS funds should not be tapped more than once for HMOs.

2. There should be no objection to RMPs initiating or participating in HMO related activities.

3. The Council has repeatedly taken the position that a quality control element should be an integral part of every HMO.

Dr. Margulies served as the principal spokesman for the HSMHA position in favor of funding the HMO proposals. He indicated that the Department had every reason to believe that HMO legislation would have passed months ago. He pointed out that every government administrator has to find the resources to anticipate new programs and, indeed, RMP would have benefited from preparatory work prior to the passage of Public Law 89-239. In line with this, the Secretary has indicated in testimony to Congress that RMP appropriations would be used only once for HMOs, and would not be used for such purposes again.

No RMPS grant or contract funds have been used to date for HMOs except for intra-RMP, HMO-related activities. Because of the slowdown in HMO funding, all of the RMP funds reserved for this purpose will not be utilized, leaving additional funds for the regular RMP program.

Dr. Margulies further stated that it is not possible to have good control programs in a poor delivery system. Allocation of RMPS funds on a one-time basis will be a useful investment in improving delivery. In addition, the funding of HMOs involves considerations that extend beyond the RMP program alone. A narrow definition of program purposes by RMP and other programs would impede innovation and encourage fragmentation of Federal efforts.

By a narrow margin, the Council voted to approve the action recommended by HMOS with a stipulation that a quality control element be included as an integral part of every project. Further discussion showed that the Council was uncomfortable with its action, and it was moved, seconded and carried, with one dissenting vote, that the previous action on HMOs be set aside, and that a subsequent ballot be taken either by mail or

another meeting of the Council after provision of further information demonstrating how grant funds for HMOs would contribute to the purposes of RMP. (Transcript, Vol. 1, pages 197 and 200.)

Additional information was mailed to the Council members and the following resolution passed by a substantial majority:

"It was moved and seconded that the National Advisory Council approve the award of grants under 910(c) authority of $4.3 million to the 29 HMOs selected by the HMOS review process for continued planning and development with the understanding that RMPS grant support would be limited to one year and that adequate attention be given to the quality to be provided. Council members have been assured by HSMHA staff that such grants can be made within authority of 910(c) and it is understood that an affirmative vote on this issue is conditioned by that assurance."

X. CONSIDERATION OF RMP APPLICATIONS

A. Northeast Ohio[1]

Moved: Dr. Schreiner
Seconded: Mrs. Morgan

Approval at the recommended level of $600,000 (Transcript Vol. II, pg. 229, lines 1 and 2)

B. Ohio[1]

Moved: Dr. Schreiner
Seconded: Mrs. Mars

Approval of the Review Committee's recommendations for disapproval of the 3 kidney proposals and approval of the general funding level in the amount of $1,200,000 for the 01 year and $1,305,000 for the 02 year. (Transcript, Vol. II, pg. 234, lines 3-8 and 23-25.)

C. Nassau Suffolk

Moved: Dr. Komaroff
Seconded: Dr. McPhedran

Approve "the Review Committee's recommendation on Nassau-Suffolk for $1,099,000, and approve the plan of joint funding of the RMP and CHP provided that both advisory groups vote in favor of that and defer a recommendation on the regional project." The vote included funds for a kidney project for a regional owner-donor program in the amount of $27,060 for the first year. A second kidney request for a home dialysis training program was disapproved. (Transcript Vol. II, pg. 38 and 39; vote pg. 41, line 15.)

[1]Mr. Milliken absented himself during the consideration of this application.

D. South Dakota

Moved: Dr. Cannon
Seconded: Dr. McPhedran

"To fulfill the request of $424,662 and to expedite the funding of the EMS and health services education program." (Transcript, Vol. II, pg. 41; Vote pg. 46, line 8.)

E. Missouri

Application is for second year of triennium. It was brought before the Council (1) because increased funds were requested; (2) the Review Committee recommended a reduction in the committed level; and (3) a technical site visit for the computer project resulted in an unfavorable report.

Moved: Dr. McPhedran
Seconded: Dr. Komaroff

Disapprove funds for the automated EKG, automated physician's assistant and bio medical information service. Disapprove the Developmental Component. Approve a level of $1,625,417 each for the 02 and 03 years of the triennium and recommend that a site visit be conducted during the summer of 1972 to express the Council's concern with the Region's poor performance and to clarify areas of misunderstanding. Dr. Margulies agreed to bring the Region's next anniversary application before the Council even through still in triennial status.

F. Nebraska

Moved: Mr. Milliken
Seconded: Mrs. Wykoff

Approve a funding level of $725,000 for the 02 year and a tentative recommended level of $700,000 for the 03 year. Advise the Region to utilize the $25,000 above the requested program staff budget for initiating small planning and feasibility studies which result in short-term pay-offs. Disapprove the two kidney disease activities and advise the Region to develop a statewide kidney plan. (Transcript, Vol. II, pg. 80, lines 1-20.)

G. Oklahoma

Moved: Dr. Komaroff
Seconded: Mrs. Mars

Accept the recommendation of the Review Committee that the Region's current level of $739,000 be

increased to $839,000. Advise the Region to recruit a strong coordinator, strengthen the advisory group, encourage subregionalization and relationships with CHP. Also advise the Region to continue the initial experimentation with health care delivery issues shown for the first time in the present application. (Transcript, Vol. II, pg. 82, lines 12-35.)

H. Oregon

Moved: Dr. McPhedran
Seconded: Dr. Watkins

Accept the Review Committee's recommendation for an award of $921,530 for the 05 year with no developmental component. Award a developmental component of $75,000 for each of the next two years and provide $250,000 of growth funds for those years to cover the costs of the patient transportation system development, computer review system, development and patient orientation study. (Transcript Vol. II, pg. 89, lines 2-13.)

I. Puerto Rico

Moved: Dr. Brennan
Seconded: Mrs. Mars

Accept the Review Committee's recommendation for $1.1 million authorization for the third year for the Puerto Rico Regional Medical Program (Transcript, Vol. II, pg. 92, lines 8-10.)

J. Mississippi - Kidney proposal

Moved: Dr. Merrill
Seconded: Mrs. Curry

Recommend for all three parts in the total amount of $183,634 direct costs for the first year, $161,915 for the second and $120,403 for the third.

K. SARP Recommendations

Continuing Applications from the following Regions which were reviewed by SARP and proposed actions by the Director were called to the Council's attention:

Kansas
Mountain States
North Carolina
South Carolina
Western Pennsylvania

There were no Council comments with respect to these applications. (Transcript, Vol. II, pg. 94 and 95.)

I hereby certify that, to the best of my knowledge, the foregoing minutes and attachments are accurate and complete.

Harold Margulies

Harold Margulies, M.D.
Director
Regional Medical Programs Service

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Appendices to Minutes of June 5-6, 1972 Meeting

Appendix A - Delegation Concerning Educational Projects

Appendix B - Governing Principles and Requirements, Discretionary RMP Funding

Appendix C - Grantee and Regional Advisory Group Responsibilities and Relationships

Appendix D - Kidney Disease Activities -- Guidelines and Review Procedures Statement

Appendix E - Action on EMS Proposals

Appendix F - Action on Proposals for RMP Health Services' Education Activities

Appendix G - Action for Increases in National Advisory Council Approved Levels for Certain Regions

Appendix H - Action on HMO Proposals

Appendix I - Attendance List

APPENDIX A

DELEGATION OF AUTHORITY FOR APPROVAL AND FUNDING OF COMMUNITY BASED EDUCATIONAL ACTIVITIES FEASIBILITY STUDIES

The Council, recognizing the need for expeditious action and flexibility in funding feasibility studies that would permit RMPs and local areas to assess the potential and feasibility of developing community based educational activities, delegates to the Director of RMPS authority to award supplemental grants to individual Regional Medical Programs for such purposes. It is understood that (1) no local area shall receive funds for such feasibility study in excess of $50,000 (total costs), and the duration shall not exceed 12 months; (2) no single RMP shall receive funds in excess of $250,000 for such feasibility studies in any 12 month period; and (3) approval and funding of such feasibility studies by the Regions will be within such general guidelines as RMPS may establish.

It is further understood that Regions will first utilize "free" Developmental Component funds, where available, and that the general policies and procedures of the individual Regional Medical Programs with respect to review, approval, and funding, including RAG concurrence, will apply.

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* Approved: National Advisory Council on Regional Medical Programs, June 5, 1972

APPENDIX B

GOVERNING PRINCIPLES AND REQUIREMENTS DISCRETIONARY RMP FUNDING AND REBUDGETING AUTHORITY

A. Principles - The following principles shall be generally applicable in all situations.

1. No activity shall be undertaken that is contrary to the RMP (P.L. 91-515) and other applicable legislation, regulations, and written Departmental, HSMHA, and RMPS policies.

2. Any activity undertaken with the Requirements enunciated below shall be subject to the regular review, funding, and rebudgeting requirements and approvals of the particular RMP and its grantee organization and Regional Advisory Group.

3. Any operational activity or project initiated by an RMP within its discretionary authority must have current RAG approval. That is to say, it must have been approved by the RAG in the budget period during which it is begun or, the immediately preceeding one. If not, such an operational activity must be reapproved by the RAG before it can be undertaken.

4. When there are any substantive questions or doubts as to the scope and applicability of the discretionary funding and rebudgeting authority, the grantee or the coordinator on its behalf shall communicate with RMPS for advice and guidance.

B. Requirements - Prior RMPS approval is required in the following instances.

1. RMPs approved for a triennial period must obtain prior approval for any proposed program or operational activity involving:

   a. Alterations and renovations in excess of $25,000 or any new construction. (Present policy generally precludes the latter.)

   b. Human subjects. (This represents programmatic approval as differentiated from approval of the grantee's system for safeguarding the rights and welfare of human subjects.)

   c. HMO related feasibility studies.

   d. End-stage treatment of kidney disease (e.g., dialysis, transplantation and supportive facilities and services.

   e. Other specialized activities which may, from time to time, be identified by HSMHA/RMPS.

2. RMPs not yet approved for a triennial period must obtain prior approval for:

   a. Any activity enumerated above except that any alterations and renovations regardless of cost must be submitted.

b. Any new operational activity not generally covered by its program as approved by the Council.

C. Notification - New activities may be initiated by an RMP without prior RMPS approval in accordance with the discretionary funding authority stated above and the criteria for rebudgeting contained on page 4 of Instructions for the Financial Data Record. RMPS should be notified in accordance with those instructions at the time the activity is initiated, whether or not there has been a redistribution of funds.

APPROVED: National Advisory Council on Regional Medical Programs
June 5, 1972

APPENDIX C

RMPS POLICY CONCERNING GRANTEE AND
REGIONAL ADVISORY GROUP RESPONSIBILITIES AND RELATIONSHIP

May 26, 1972

A. Introduction

There are three major components of the Regional Medical Program at the regional level: the grantee organization; the Regional Advisory Group; and the Chief Executive Officer (often referred to as the RMP Coordinator) with his (or her) program staff. The responsibilities that each has and how they relate and interact with one another are important factors in a successful Regional Medical Program. The following outline sets forth a framework for these responsibilities and relationships.

B. Grantee

The grantee organization shall manage the grant of the Regional Medical Program in a manner which will implement the program established by the Regional Advisory Group and in accordance with Federal regulations and policies. This shall include:

1. Initially designating a Regional Advisory Group in accordance and conformance with Section 903(b) (4) of the Act. Such designation includes selection of the Chairman until such time as the bylaws of the RAG have been approved by RMPS. (This is a responsibility of the applicant organization which requests planning support for the establishment of an RMP).

2. Confirming subsequent selection of RAG Chairmen.

3. Selecting the Chief Executive Officer on the basis of Regional Advisory Group nomination.

4. Receiving, administering, and accounting for funds on behalf of the Regional Medical Program.

5. Reviewing operational and other activities proposed for RMP funding with respect to:

   a. their eligibility for and conformance with RMPS and other Federal funding requirements,

b. capabilities of affiliates to manage grant funds properly.

6. Prescribing fiscal and administrative procedures designed to insure compliance with all Federal requirements and to safeguard the grantee against audit liabilities.

7. Negotiating provisional and/or final indirect cost rates for affiliates.

8. Providing to the RMP all those administrative and supportive services that are included in the grantee's indirect cost rate.

Chief Executive Officer

As an employee of the grantee, the Chief Executive Officer -- the full-time person with day-to-day responsibility for the management of the RMP -- is responsible to it; he is also responsible to the Regional Advisory Group which establishes program policy. His responsibilities include:

1. Providing day-to-day administrative direction for the program in accordance with the procedures established by the grantee and the program policies established by the Regional Advisory Group.

2. Providing adequate staff and other support to the Regional Advisory Group and its committees for effective functioning.

3. Developing the RMP staff organization, selecting program staff, and supervising their activities.

4. Insuring both the effectiveness of operational activities and integration of all operational and staff activities into a total program.

5. Monitoring grant-supported activities to insure that all Federal requirements are being complied with.

6. Establishing and maintaining an effective review process in accordance with RMPS requirements.

9. Approving any delegations of authority, including those relative to specific budget allocations, to the Chief Executive Officer, its executive committee, and others.

APPROVED: National Advisory Council on Regional Medical Programs
June 5, 1972

APPENDIX I

GUIDELINES AND REVIEW PROCEDURES STATEMENT

Kidney Disease

BACKGROUND

Nowhere in medicine does the same gap exist between technology and delivery as in the area of treatment of patients with end-stage renal disease. Technological developments in recent years have made possible the rapid expansion of programs to provide patients with hemodialysis in institutional settings. Innovations which allow self-dialysis by the patient in his home, or in a low overhead facility, vastly extend the utilization of delivery resources, and reduce the cost to the patient. Techniques of organ harvesting, preservation, and transplantation have made renal homotransplantation a service entity, no longer a research tool.

It is estimated that of the approximately 50,000 persons who die each year from kidney disease, 7,000 to 10,000 are suitable candiates for chronic hemodialysis and/or renal transplantation, and that an additional 10,000 to 20,000 might benefit from each treatment. At present, the annual increment of new patients being offered treatment for terminal kidney disease is probably not more than 3,000.

CURRENT RMPS PROGRAM EMPHASIS FOR KIDNEY DISEASE PROPOSALS

Although national priorities for kidney disease programs will be established and modified over time as appropriate by a panel of renal authorities, for the present it is necessary to focus on improvement and expansion of the delivery of care to end-stage kidney disease patients. RMPS is primarily concerned with the development and implementation of kidney disease programs which will provide the therapeutic tertiary care services of dialysis and transplantation to patients who do not now have access to such life-saving care.

The substance of such programs includes:

1. Procedures to assure early identification of patients in, or approaching a terminal stage of renal failure.

2. Rapid referral of such patients from the level of primary care (private physician) to tertiary care facilities for dialysis and transplantation.

3. Early patient classification with regard to tissue type, and other pertinent factors.

4. Dialysis and transplantation facilities which assure treatment alternatives to both the patient and physician.

5. Effective cadaver kidney procurement operations, coupled with rapid kidney donor-recipient matching.

6. Selective training to meet the specific needs of the above program.

The characteristics of such programs include:

1. The patient has access to conservative management before kidney function has ceased.

2. The patient is registered in shared recipient rosters to assure optimum tissue matching, and maximum utilization of harvested cadaver kidneys.

3. The patient can be trained to carry out dialysis at home, or if not eligible for this mode of care delivery, has access to satellite dialysis, or in-center care.

4. Dialysis facilities encompassing all three of the above modes of dialytic treatment will serve, or be an integrated part of a system which serves a population of no less than 500,000.

5. The patient can gain access to transplantation if such therapy is his choice, with his physician's concurrence.

6. Transplantation facilities are centralized to:

   a. limit duplication of high cost facilities and services.

   b. assure maximum utilization of full-time transplantation surgeons.

   c. assure availability of complementary backup services required for special patient evaluations and treatment.

   d. provide the coordinating point for patient referral, donor-recipient matching, patient data exchange, and organ sharing.

7. Transplantation centers will serve populations of 3-4 million persons.

8. Maximum utilization is made of services and facilities for kidney disease patients.

9. Continued development of third-party payment mechanisms is pursued to support expanding kidney patient care services.

10. Integration of renal disease patient services with other patient services and facilities is organized at all levels.

11. Pediatric dialysis and transplantation services are coordinated with adult facilities to provide optimal use of services.

REVIEW PROCEDURES

The openly categorical nature of end-stage kidney disease activities, and the need to effectively coordinate integrated dialysis and transplantation systems indicate the need for continued central direction for development of a national program. Thus, applications for kidney activities will be handled in a manner different from other Regional Medical Program applications, but modified from the procedures followed heretofore.

1. Policy Preclearance - immediately upon an indication of interest in the submission of a kidney proposal by a source within an RMP, the RMP should contact the appropriate RMPS Branch in the Division of Operations and Development (DOD). It is suggested that a brief abstract or letter of intent be submitted which outlines the nature of the prospective activity, the probable role the proposal would play in the Regional program, and the need which will be satisfied within the overall renal disease program of the Region. The Branch which serves the Region will utilize the Region's written inquiry to confer with staff of the Division of Professional and Technical Development (DPTD). RMPS will advise the Region whether it is desirable to proceed further. The RMP, of course, may accept or reject this advice.

2. Technical Program Review - prior to submitting application for a renal disease program, the RMP is expected to obtain a technical review of the proposal by a group which has not participated in the program's development. The technical review group must be comprised of at least 3 renal authorities from outside the geographic area served by the Region. Payment of the costs of such consultant services will be made by the requesting RMP.

   The Region may obtain the names of consulting renal experts by calling the appropriate Operations Branch for assistance. The Division of Professional and Technical Development maintains a list of renal consultants, and is responsible for coordinating their assignment. Should the RMP desire to choose its own review panel, the names and curriculum vitae of prospective consultants must be cleared with the DPTD.

   Technical reviews of renal programs need not always be made by consultant site visits, but may be accomplished by mail when appropriate. The RMP will negotiate any compromise needed should conflicting technical advice be given by the technical reviewers.

3. Forwarding Proposals - only those proposals which are recommended favorably by the local Technical Review Group (paragraph 2., above) shall be eligible for consideration by RMPS. In addition, an opportunity must be provided prior to consideration of the proposal by the RAG for review and comment by the appropriate CHP agency(ies) as required by Section 904(b) of the Act.

The RAG shall consider any CHP comments and comment on the ability of the RMP to manage the kidney project without hindering the development of the overall RMP program, and the reasonableness and adequacy of the kidney budget proposed. The RAG is responsible also for indicating how major issues raised by the local technical review group will be resolved.

Since kidney proposals are reviewed separately at the national level, the RAG need not give priority ranking to kidney proposals in relation to other non-kidney RMP operational activities. Kidney proposals shall be considered by RMPS in relation to national priorities.

The complete comments of the members of the Technical Review Committee, and any CHP agency comments, must be included in the forwarded proposal.

4. RMPS Staff Review - the initial review at RMPS shall include:

   a. the contribution of the project toward kidney program objectives.

   b. the completeness and nature of the comments of the RAG (point 3., above).

   c. comments of CHP agencies.

   d. the preferred method of funding.

5. RMPS Review Committee - RMPS staff will summarize for the RMPS Review Committee available information as to how each kidney proposal proposes to support the National Kidney Program objectives, and the substantive points developed through local review processes by the Technical Review Committee, the RAG, and the CHP Agency. For those applications for which the RAG; CHP Agency; Director, RMPS, or RMPS Review Committee has indicated a concern apart from the technical merits of the project, the RMPS Review Committee will be asked to make a recommendation to the National Advisory Council.

   The RMPS Review Committee specifically will not review on a technical basis the merit of the proposal, or establish formal numerical ratings for individual proposals.

6. Council Review - all kidney proposals shall be submitted to the National Advisory Council for final recommendation. In keeping with the categorical nature of the kidney disease program within RMPS, the Council will review and recommend funding levels for kidney proposals separately from the funding level of the specific RMP. Kidney program funding will be in addition to other RMP program funding.

PREPARATION OF APPLICATIONS

Effective July 1, 1973, all kidney proposals must be submitted as part of the RMP's regular annual application in accordance with the Region's assigned anniversary date. Prior to July 1, 1973, kidney proposals may be submitted in accordance with the document "Procedures for Requesting Supplements to RMPS Grants, April 7, 1972".

Sponsors of applications for support of kidney disease projects should submit them to the appropriate RMP in the format which the RMP prescribes. An application involving 2 or more RMP's may be submitted where appropriate. In such cases, one RMP should be designated to act as "applicant" and submit a single application. Such applications must be approved by each RAG and shall include a description of mutually agreed upon arrangements for administration of the project. In view of the preliminary clearances which are called for in these guidelines, it may be helpful to develop and submit a letter of intent to the appropriate RMP's before an application is prepared.

In addition to the summary information to be provided on the forms specified for applications, narrative should address in detail the program elements specified below. Descriptions which are comprised only of generalized narrative will not be acceptable; disease control needs and the applicability of the proposed program must be presented on the basis of solid data relating to patient populations and distribution, specification of existing services and resources, and clearly documented commitments of cooperation and participation from key persons and institutions. Assistance can be obtained from the program staff of the RMP.

Program elements to be addressed are:

1. the magnitude of the renal disease problem.

2. facilities and programs currently in operation and the needs they are meeting.

3. the needs which the new proposal will meet and how the program will integrate with existing programs to improve patient care services without duplication of existing services or facilities.

4. existing and potential sources of third-party payment for care and how these resources will be developed.

5. the commitment of cooperating institutions, groups and health practitioners whose collaboration is essential to insure the success of the program.

6. training, when pertinent to the plan, which is directly related to the projects comprising the plan, or judicious expansion of existing programs.

7. the system or method of program evaluation which will be employed.

8. a decremental rate or proportion of Federal (RMPS)contribution to the program over time.

9. the program's phase-out as an RMP-supported activity.

Program costs related to the Federal share of support should normally be identified with personnel and equipment requirements in tertiary care facilities.

RMPS will not fund ALG-related activities. Such funding may be included in the future if standardized production and testing is achieved and its efficacy is demonstrated. The NIH is sponsoring research in ALG through a contract.

AWARDS

Awards for kidney projects will be issued as a part of the total award to the Regional Medical Program. The amount allocated for the kidney activity will be specified in Item 14, under "Remarks", of the Notice of Grant Award, Form HSM-457. Funds awarded for kidney activities must be spent for such activities, except that unexpended balances may be rebudgeted in certain cases provided that prior approval for such reprogramming be first obtained from RMPS.

In some cases, a kidney proposal may be approved by RMPS but unfunded. An RMP may fund such a kidney project through rebudgeting other RMP funds to the kidney activity. Rebudgeting of this nature should be undertaken only after the RAC has carefully considered the effect of such action on the remainder of the RMP program. Likewise, a kidney project may be expanded as determined by the RAC by rebudgeting of funds to the kidney activity in addition to those specifically earmarked for kidney in the Notice of Grant Award.

OTHER

A glossary of kidney disease terms is enclosed for your information.

GLOSSARY OF KIDNEY TERMS

1. ALG, ALS - Abbreviations for AntiLymphocyte Globulin; AntiLymphocyte Serum. Both are products of animal serum used to prevent rejection of transplanted organs, especially kidneys.

2. Artificial Kidney - Total system used for hemodialysis consisting of dialyzer and dialysate delivery system.

3. Belzer Machine - Special type of perfusion equipment developed by Dr. F. Belzer. There are others, some devised by local hospitals. Perfusion machines preserve harvested cadaver kidneys in a viable condition, sometimes for periods of up to 48 hours.

4. Backup Dialysis - Dialysis given patients trained for self care who, under special circumstances, are unable to perform dialysis without additional assistance. Also, pre- and postoperative dialysis provided transplantation patients, particularly when the newly grafted organ is unable to assume its full function immediately.

5. Cannula - Surgically prepared, exposed connection made between an artery and a vein. The exposed connection between artery and vein is made with plastic tubing.

6. Care Facilities

   Primary - The initial facility to which a patient seeks medical advice and care; may be the physician's office.

   Secondary - A general hospital or equivalent capable of rendering definitive diagnosis and treatment. Also, a satellite dialysis facility.

   Tertiary - Sophisticated medical center. In the case of kidney end-stage disease, it is a facility capable of performing transplantation, supportive dialysis therapy, and consultation to primary and secondary facilities.

7. Decremental Funding - System of phased reduction of the Federal share of the costs of an activity, usually by increased assumption of costs through earned income and local third-party payments.

8. Dialysate - The solution used in an artificial kidney to rid the body of accumulated waste products in the blood.

9. Dialysate Delivery System - That part of the artificial kidney which supplies the dialysate and regulates such critical items as rate of flow, temperature, and concentration of dialysate.

10. Dialysis - Process by which waste products are removed from the blood by diffusion from one fluid compartment to another across a semipermeable membrane. In the case of kidney dialysis, blood is one of the fluids and the bath solution or dialysate is the other.

11. Dialyzer - That part of the artificial kidney through which waste products pass from the blood to the bath solution or dialysate.

12. End-Stage (Renal) Disease - That stage of renal impairment which cannot be favorably influenced by conservative management and which requires dialysis and/or kidney transplantation to maintain life and health.

13. End-Stage (Renal) Treatment - Refers to either dialysis or kidney transplantation or both forms of therapy.

14. Fistula - Surgically prepared unexposed connection made directly between an artery and a vein to allow repeated and ready access to the blood stream. Dialysis access to the blood stream is obtained with large hollow needles, creation of a fistula is an alternative to surgical insertion of a cannula.

15. Functions of the Kidney - The normal kidney's work includes 1) control of electrolyte concentration in the body, 2) maintenance of proper water balance, 3) maintenance of the body buffer system, 4) excretion of the by-products of cellular metabolism (urea, creatinine, and uric acid).

16. Kidney Disease - Spectrum of ailments which directly or indirectly affect the kidneys and compromise their function. (Frequently involves the entire urinary tract.)

17. Low Overhead Facility - Any kind of a building where the expensive operating costs of a general hospital can be avoided. Such facilities are used for dialysis services, making minimal use of physician time in staff required.

18. Organ Preservation - Maintenance of the kidney after it has been removed from the donor and until it has been transplanted into a recipient. Organ preservation is an integral part of a kidney transplantation program.

19. Organ Procurement - The identification of a prospective donor; the surgical removal and transportation of a donor kidney.

20. Peritoneal Dialysis - An alternative to hemodialysis - the process by which the dialysate is introduced into the abdominal cavity using the peritoneum as the semipermeable membrane.

21. Satellite Facility - A resource providing limited, specific services under the general direction of a secondary or tertiary care facility.

22. Self-Dialysis - Dialysis performed by a trained patient at home or in a special facility with or without the assistance of a family member or friend.

23. Shunt (noun) - The means by which blood is passed through other than the usual channels. There are two types of shunts used in dialysis 1) the cannula, 2) the fistula.

24. Tissue Typing - Laboratory procedure used to determine the degree of compatability between the donor organ and the recipient of a kidney transplant.

25. Urinary Tract - Collective term referring to the kidneys, ureters, bladder, and urethra.

APPENDIX E

Action on EMS Proposals*

Name of Region (# of Projects)	Priority Rating	Funds Requested	(Direct Costs) Recommended
Recommended for Disapproval			
Albany	0	$1,198,726	0
Florida	0	1,548,445	0
N.E.Ohio	0	815,150	0
Oklahoma	0	140,690	0
Oregon	0	532,950	0
Recommended for Approval			
Alabama (2)	4	5,268,559	450,000
Arizona	3	116,386	65,000
Arkansas (6)	3	1,103,228	102,456
Bi-State	3	1,316,549	200,000
California (2)	2.5	517,773	100,000
Central New York	3	261,705	261,705
Connecticut	3	328,095	19,000
Georgia	3	934,313	50,000
Hawaii	3.5	2,143,376	1,759,549
Illinois	3.5	1,525,327	1,039,327
Intermountain	3.5	667,825	667,825
Lakes Area	3	824,819	250,000
Louisiana (4)	4	363,089	325,940
Maine	4	209,280	209,280
Memphis	3	1,117,781	67,038
Metro D.C.	2	79,475	79,475
Missouri (2)	2	4,269,023	77,000
Mt. States (3)	3	657,576	150,000
New Jersey (2)	2.5	223,250	40,000
New Mexico	4	712,110	712,110
N.Y. Metro	3	156,798	50,000
No.N.England	4	72,060	72,060
Northlands	4	310,050	63,800
Ohio Valley	2	62,970	20,000
Rochester	3	572,946	186,256
South Dakota	2	470,468	50,000
Tri-State	4	2,542,357	2,542,357
Virginia	3	30,250	30,250
W.Virginia (3)	2	197,742	63,375
Wisconsin	5	1,959,256	1,959,256
	Total - 01 Yr. -	$14,071,987	$ 5,788,122
	02 Yr. -	10,875,664	3,302,464
	03 Yr. -	8,302,746	2,572,473
	Grand Total -	$33,250,397	$11,663,059

* Approved: National Advisory Council on Regional Medical Programs, June 5, 1972

Action on Proposals for RMP Health Services' Education Activities *

Name of Region	Project Number	12 Mos.	18 Mos.	2 Yrs.	3 Yrs.
1. Alabama	#45 (Tuskegee)				$ 335,286
2. California	#104 (Somona, Area I)				1,159,418
	#105 (Area III San Mateo et al)				572,870
	#106 (Area IV San Joacquin Valley, Fresno VA)		$170,000		
	#107 (Area IV San Fernando-Model for interdisciplinary action)				455,493
	#108 (Area V Inland Empire)		45,370		
	#110 (Area V L.A. East Consortium)		249,242		
	#111 (Area VI, Loma Linda)		100,000		
	#112 (Area VII San Diego and Imperial Valley)		150,000		
	#114 (Management by CCRMP)				191,922
3. Connecticut	#44, #45A-#45C				283,979+
4. Intermountain	#44	$ 42,060			
5. Kansas	#51	50,000			
6. Lakes Area	#29A-G, #29J-N	325,000			
7. Maine	#27-#37				1,500,545
8. Mountain States	#23	50,000			
9. New Jersey	#30	200,000			
10. N.E. Ohio	#15			$180,000	
11. Northlands	#68-#74	100,000			
12. Ohio	#15		Approval without funds.		
13. South Dakota	#2	115,000			
14. Tri-State	#19				598,811
	Totals -	$882,060	$714,612	$180,000	$5,098,324

* Approved: National Advisory Council on

Grand Total - $6,874,996

APPENDIX F

PRIORITY PROJECTS *

Name of Region	Project Number	Amount Recommended
1. Alabama	#45	$ 335,286 (3 Yrs.)
2. California	#104	1,159,418 (3 Yrs.)
	#107	455,493 (3 Yrs.)
	#110	249,242 (3 Yrs.)
3. Lakes Area	#29A-G, #29J-N	325,000 (1 Yr.)
4. Maine	#27-#37	1,500,545 (3 Yrs.)
5. New Jersey	#30	200,000 (1 Yr.)
6. Northeast Ohio	#15	180,000 (2 Yrs.)
7. Northlands	#68-#74	100,000 (2 Yrs.)
8. South Dakota	#2	115,000 (1 Yr.)
9. Tri-State	#19	598,811 (3 Yrs.)

* See note, Page 1, Appendix F.

APPENDIX F

DISAPPROVALS *

Name of Region	Project Number	Funds Requested by the RMP
1. Alabama	#44	$ 75,354
	#46	215,000
2. California	#109	27,598
	#113	94,075
3. Florida	#58	455,585
4. Intermountain	#41	193,720
5. Missouri	#83S	947,200
6. Northeast Ohio	#14	243,659
7. Ohio	#16	870,169
	#17	186,975
8. Rochester	#31	175,895
9. South Carolina	#63A-#63F	696,652
10. Tennessee Mid-S.	#61	3,691,581

* See note, Page 1, Appendix F

APPENDIX G.

REQUESTS FOR ADDITIONAL FUNDS REQUIRING INCREASES IN NAC APPROVED LEVELS *

REGION	BUDGET PERIOD	ANNUALIZED FUNDED LEVEL	ANNUALIZED NAC LEVEL	ADDITIONAL FUNDS REQUESTED	NEW NAC LEVEL REQUESTED
1. Colorado/Wyoming	1/1/72-12/31/72	1,102,346	1,102,346	190,000 (40,000 Ped. Pul.)	1,292,346
2. Florida	3/1/72-4/30/73	1,927,706	1,927,706	321,000	2,248,706
3. Metro. D.C.	3/1/72-4/30/73	1,009,000	1,009,000	105,414 (Ped. Pul.)	1,114,414
4. New Mexico	9/1/71-12/31/72	1,036,719	1,036,719	22,000 (Ped. Pul.)	1,058,719
5. South Carolina	7/1/71-8/31/72	1,550,000	1,550,000	98,186 (Ped. Pul.)	1,648,186
6. Tennessee Mid--So.	1/1/72-4/30/73	2,166,139	2,166,139	216,613	2,382,752

* Approved: National Advisory Council on Regional Medical Programs, June 5, 1972

APPENDIX H

Action on HMO Proposals

HSA Region and Applicant	Previous Award	Amount Requested	Amount Recommended
Region I			
Health, Inc.	121,858	73,400	-0-
Harvard	98,785	248,224	191,224
Matthew Thornton	21,000	21,375	21,375
Aonoki	167,679	161,136	161,136
Region II			
Montefiore	57,689	63,408	63,408
Mt. Sinai	53,029	145,975	145,975
N.Y.C. Health & Hospitals	100,000	289,752	-0-
Nassau M.S.F.	64,000	186,871	110,000
Group Health Foundation	212,540	504,110	334,110
Region III			
Georgetown	130,892	243,377	29,312
Region IV			
Florida Health Plan	75,000	260,635	208,000
Health Facilities Research	55,000	103,828	103,828
Tenn. Group Health	250,105	733,508	106,000
HMO, South Carolina	25,000	120,000	112,440
So. Carolina Bd. of Health	25,000	124,764	121,764
Region V.			
Detroit Health Facilities	79,650	61,150	-0-
Lincoln Memorial Hospital	56,000	30,500	20,000
Shawnee (Carbondale)	70,785	260,947	50,000
Cuyahoga Hospital	80,075	230,085	90,000
Marion Health	25,000	95,000	115,000
Columbus Health	25,000	129,320	-0-
Detroit Medical Foundation	25,000	137,255	70,000
Region VI			
Lovelace	114,601	188,255	188,255
Bexar	63,820	122,340	122,340
New Mexico Health	25,000	224,600	224,600
Tulane	81,707	86,096	-0-

3/ Representing Dr. Marc J. Musser for the Veterans Administration.

ATTACHMENT K

HRD Region and Applicant	Previous Award	Amount Requested	Amount Recommended
Region VIII			
Rocky Mountain	33,000	222,162	210,036
Alamosa	66,516	180,578	180,578
Missoula	55,985	165,504	-0-
Poudre Valley	25,000	163,427	163,427
Blue Cross/North Dakota	25,000	120,300	120,300
Region IX			
M.C.F./ Sacramento	122,266	295,232	190,367
Health Services/San José	103,500	274,900	219,850
S.W. Comm. Hlth. Plan/Lutheran	100,000	380,455	290,855
Sonoma	102,750	218,206	128,206
St. Joseph	25,000	130,284	-0-
John Hale	25,000	300,294	208,104

APPROVED: National Advisory Council on Regional Medical Programs as of June 5, 1972 per mail ballot pursuant to Council Resolution of that date.

ATTENDANCE AT THE NATIONAL ADVISORY COUNCIL MEETING

June 5-6, 1972

RMPS STAFF

Mr. Kenneth Baum
Mr. Cleveland R. Chambliss
Mr. Richard Clanton
Mr. Tom Croft
Dr. John Farrell
Mr. C. T. Gardell
Mr. Sam O. Gilmer, Jr.
Mrs. Eva Handal
Mr. Charles Hilsenroth
Mr. George Hinkle
Dr. Edward J. Hinman
Mr. Walter Levi
Dr. Harold Margulies
Dr. Herbert B. Pahl
Mr. Roland L. Peterson
Mr. Michael J. Posta
Dr. Lawrence Rose
Mr. Richard Russell
Mrs. Patricia Schoeni
Mr. Matthew Spear
Mrs. Sarah J. Silsbee
Dr. Margaret H. Sloan
Mr. Jerome J. Stolov
Mr. Lee Van Winkle
Mr. Frank Zizlavsky

OTHERS ATTENDING

Mr. Arthur Broering, NLM-NIH
Dr. Margaret H. Edwards, NCI-NIH
Dr. Manning Feinlieb, NHLI-NIH
Dr. Alan Kaplan, EMS
Mr. John Korn, Smoking and Health
Dr. Gordon MacLeod, HMOS
Mr. E. E. Olexa, OS-ASC-AA
Mr. Dave Perry, OMB
Dr. Warren Ferry, Review Committee
Mr. Gerald Riso, OA-HSMHA
Dr. Leonard Scherlis, Review Committee
Dr. Frederick L. Stone, OA-HSMHA
Dr. Robert Van Hoek, NCHSR&D
Dr. Vernon E. Wilson, OA-HSMHA