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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGIONAL MEDICAL PROGRAM SERVICE COUNCIL MEETING

Rockville, Maryland
Tuesday, 9 November 1971

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P R O C E E D I N G S

DR. MARGULIES: May I have your attention, please.

Dr. Wilson is on his way down here, and since he is going to open the meeting, I thought we could prepare for his coming by having me remind you of the conflict of interest and the confidentiality of the meeting, the statement in the front of the books, to remind you of it, and to take the opportunity while he is on his way here to introduce two new members of the Council who are here for the first time today, although one of them has been appointed for quite some time, Mrs. Audrey Mars of The Plains, Virginia, who is here on my right. Mrs. Mars has had a long experience with RMP in Virginia and has been closely associated with cancer activities and other kinds of voluntary efforts for a number of years; and Mr. Robert Ogden, who is President and General Counsel of the North Coast Life Insurance Company of Spokane, and has served in a very distinguished manner as Chairman of the Regional Advisory Group.

Now, since the introductions are complete, Dr. Wilson, would you care to take over.

DR. WILSON: Thank you, Harold, and welcome to the new members of the Council.

I don't have any long message for this morning. I do want to do two or three housekeeping types of things.

Number one, although I haven't had word from

downtown yet, I think our new organizational structure has been approved. I talked to you, I think, about this at the last Council meeting, at least briefly, and it cleared the last hurdle and was to have hit the Secretary's desk the last part of last week. Things never stay on his desk very long. I wish the same could be said for a number of other desks in HEW North. But so far as I know, we are now functioning under the new HSMHA organizational pattern. That, of course, brings me then to the direct introduction of someone with whom you may have had previous contact. Did you introduce Jerry earlier before I got here?

DR. MARGULIES: No, just to a few people.

DR. WILSON: I just did. Jerry Riso, many of you have known, was the Deputy Assistant Secretary for Health and Scientific Affairs with Roger Egeberg, and has been willing to come out to serve with us wearing one hat here and then another hat within the Department as a whole. The hat he wears for us is Deputy Administrator for Development. This is the organizational pattern I am now saying I think is cleared downtown, and in that role Jerry has the coordinating responsibilities for my office for Regional Medical Programs, for Comprehensive Health Planning which is now a separate program from Community Health Services and the other 314 programs -- it has been moved over and is now under this general direction -- for National Center for Health Services Research and Development,

for Hill-Burton, the Federal Hospital Services or whatever -- Hill-Burton is always easier -- and finally for the Health Maintenance Organization activity.

Now, these grouped together in our terms were called development but the Secretary has another term which seems to be in use now pretty heavily in the Department, and that is what is called institutional reform or change agent type programs. You can call it either you like, but nevertheless these are the programs where we pay for very little in the way of direct health care but spend most of our energy and resources trying to see if we can work with the providers or with the community in changing the way health care is given.

Jack Brown -- I don't see Jack around anywhere -- is the Associate Deputy Administrator. Jack has been Special Assistant to me and will be working directly with Jerry. They are officed up on the 17th floor and will be carrying a major share of the responsibilities in those programs. YOu will be hearing a little more from Jerry in a little bit.

The other hat which Jerry wears is Director of the Health Maintenance Organization Program for the Department. This is the technique that we have been working with with the Department, for instance Burt Brown, who is Director of NIMH and is now the Deputy Administrator for Mental Health, for the agency as a whole, which spreads across several programs. Also a special assistant to the Secretary for drug abuse, and

we are doing this same thing with the Health Maintenance Organization where we have got a highly mobile program, one that's moving at a fairly rapid rate. We find that we can get the attention of other agencies, and indeed other departments, if the individual has a direct assignment of responsibility in this special area from either the Secretary or the Assistant Secretary. We are not really particularly proud about titles but we'd like a little action, and this seems to be one of the ways you can get action.

So Jerry has a substantial set of responsibilities. You will be seeing more of him within the RMP programs as we get his office sort of staffed out. Did we get the reply on Jordan's papers?

MR. RISO: No.

DR. WILSON: Well, we have had one appointment we have been working on since last April which also was supposed to have been announced yesterday, and we will check on that today, the directorship of the Health Maintenance Organization Program within HSMHA.

In any event, I kind of wanted to update this Council because you will be seeing and working with Jerry a good bit as a part of the overview approach that he has for our development programs.

Now, let me go back and refresh your memories on something where part of you will recall clearly. For some of

you it will be news because you weren't at the meeting in Chicago. We did discuss at the Chicago meeting the fact that we would be looking to RMP to provide advice and counsel on issues that fell within its domain that extended beyond the monies that were assigned to RMP. This organizational change is that same approach, and so you as a Council will continue to get more and more requests looking at the role of the provider in maintaining quality in the health care system, and looking at the role of the provider in responding to found need, and that assignment you will hear more and more about as we get further and further along with our delineation of job description or roles for the program. We are working very intensively. It takes longer than I guess I had anticipated when I talked to you in Chicago to get a Federal program sort of reoriented, but you can reorient them, it just takes longer, and we are still moving in that same direction. It is taking a bit of time but we will be coming back to you and asking for advice and counsel on issues that fall within the domain of RMP that do affect all of the HSMHA programs and in turn at times affect all of the HEW programs.

We still have 15 different programs, and that's a lot. We still are struggling with the other issues that we have discussed lightly in previous meetings of how one can go about the combining of the talents of several councils for specific issues where time is an element, because you still

don't get involved when a new issue comes up. We are struggling with two right now that have implications for national policy and we don't have a good way of getting councils involved in time-limited issues. We think that there must be a better way, whether it's an executive committee arrangement or whether there is some kind of a small task force kind of group.

However that may be, we will be asking Jerry to work with that and come up with ways so that his office, as it provides extraordinary coordination for me, will have your advice and counsel not only at regular Council meetings but in interim periods as well.

I repeat one statistic that always sort of amazes me. We do have about 2,000 people who give us advice through councils, committees, or consultant appointments. We have not at all learned how to use that advice well, either from the point of view of the use of your time, or from the point of view of solving the problems in which we have a mutual interest, but we haven't given up and we solicit your suggestions and counsel. We do have now about completed a paper on -- what do we call that -- talent banks, skills banks?

MR. RISO: Skills inventory.

DR. WILSON: Skills inventory. We have used all kinds of titles. Nevertheless, we are working with our own staff to try out a sort of a brief questionnaire. If it

works out you will get it before too long, which is an attempt to see if one way or another we can kind of catalogue what people would like to do, a little bit of what their availability is, and then when we have one of these crash programs perhaps we can get you more purposely engaged in the conversation than just sheer memory allows.

The only other thing that is quite different that I would like to bring to you, there are a number of -- the Washington scene calls it new initiatives running around. I am not sure any of them are new, but the emphasis certainly has changed in the last period of time.

The one to which this Council will need to rather carefully address its thought and purposes over the next year at least, and perhaps longer, is the issue of the extension of the physicians' energies or the professionals' energies. Now, that in the past has had a very heavy tendency to lean on auxiliary, allied professions, you know, physician assistant type of approach of one sort or another, and I see no evidence that the interest in that kind of activity is going to wane. I think it's beginning to crystalize along certain lines and will be a little more focused.

The one that is picking up and which needs very careful watching is one which Bland and I spent a lot of time talking about as long as four or five years ago, and that's the role of technology in the health care field, and it turns

out that with the appointment of Mr. MaGruder, whom some of you know in science and technology in the White House -- he is the gentleman who worked with SST for a period of time and they didn't get the SST off the ground so now he is taking his talents to something else. We are now undergoing a great deal of review that I think is exploratory at the moment, but which should be in our minds as we look at our limited resources and attempt to decide how we can best get our job done.

The basic issue is one in which there are about six different panel groups under the general guidance of the Federal Council on Science and Technology, each of which is dealing with a service area, a service oriented area, personal services oriented area, like the building of houses, for instance, which uses an awful lot of manpower and a relatively low degree of automation, or like the health care field.

As they are looking at these, what really is being said is that the economists feel that for a nation to continue to prosper from the point of view of economics, any field must have a certain degree of technology in it, that if it's totally personal services oriented it tends to level off and become self-defeating. You lose the growth potential and that becomes not an advantageous part of the program of building the economics of the country.

Now, what is going on in these several groups --

I chair the one for health services -- what's going on in these groups is a very vigorous search for an appropriate role for technology in the personal services oriented field. These are people of national stature who serve on the panels. The report will go through the Federal Council on Science and Technology. This is not an HEW report. It's a general governmental report. And my guess is that as each of the personal services oriented fields make their own case for the advantages for investment in technology in their field, that will finally be waived from the point of view of where would it be best to invest in technology from the point of view of economics, not from the point of view of the health field or the building of buildings or something else, but who can make the best use of an investment in technology.

I never was one to feel that we ought to sit around and wait to see what happens. It seems to me that the signals are in the newspapers and several panels and they are around. It's very clear, to me at least, and I hope to you, that if you look at the cost of providing health care in its present mode and you look at the number of people who cannot get health care, then you try to think about giving what we agree we must have in its present form that you can't get there from here, that 20 percent of our nation are under-served, and if you take our present manpower and its increments then you talk about investment in the system, that we just can't live up to

the promises we've made. And I think it's equally clear that there are a great many places where, without at all interfering with the physician or the professional patient interface, we still could do things a lot more effectively, and use the extender of our energy a lot better than we are at the current time. I won't debate that point at the moment. I will be glad to, but I am making I think just the general overview statements at the moment.

So as you look at the various kinds of opportunities for sponsoring new activities with RMP, I think you need to keep this issue very much in the back of your mind from a tactical point of view, since I have some considerable feeling that we are going to see a substantial investment in the field, and I do think it will be substantial when the decision is made.

Harold, that's about all I'd want to make as an opening statement. I'd be happy to try to clarify any confusion I've invoked.

MR. OGDEN: Could I ask a question?

DR. WILSON: Yes.

MR. OGDEN: What input, if any, will your office have in this study being done by the Office of Science and Technology?

DR. WILSON: Well, I chair the committee. There is a group of -- the panel itself is a panel of twelve. Palmer

sits on it, who is on the Board of Trustees, for instance, of the AMA. Max Berry, who is a practitioner in Kansas City, who has had a substantial interest in the Weid problem-oriented system, is on it. Ralph Berry, the economist from Harvard who teaches medical economics, is on it. I can't give you the whole list. Wendel Musser is on it from the VA. There is someone on it from DOT, as I recall it, and from DOD. There is a wide variety of people picked basically by the Council on Science and Technology. There are some physicians among them and of course people from the other fields as well. We will have pretty good input. We are staffing it.

MR. OGDEN: Fine.

DR. WILSON: And I think it would be perfectly appropriate to address anything through Harold or through Jerry that you want to that you think ought to be contemplated by the panel.

Well, Harold, they all look either overwhelmed, not yet awake, or totally satisfied and I can't tell which.

(Laughter.)

MRS. MARS: Let's say totally satisfied.

DR. WILSON: Okay, then, I will turn it to Jerry, and I will be here for a little bit although, of all things, even the Administrator dissipates once in awhile. I have two meetings out in the Middle West in the next two days, and I looked that schedule over and decided this weekend was a

good weekend to go goose hunting, so I will be leaving this afternoon, and I am in the process of attempting to get stuff cleared off the desk, so you will have to pardon me if I sneak out. It really is a dissipated life of an administrator.

MR. RISO: Thank you, Vern. I am delighted to have joined HSMHA. Several months ago when Vern asked me to consider coming to HSMHA and wearing two hats, he promoted the idea on the basis of it being a very significant professional challenge and a job that needed to be done, all the kinds of things Vern tells you when he is trying to promote an idea. But he never did tell me that part of the challenge would be to hold a position that has not yet been created, to head an organization that has not yet been established, and to coordinate subordinates who have not yet been appointed. But we have been operating this way for about six or seven weeks and it has been all of the challenge that Vern indicated to me that it would be, and I will cover some of that.

There are some visible signs of progress, however, despite my having been here six or seven weeks. I found my way to this room without any help, and that I can tell you is progress in this building.

I have spent the last six or seven weeks becoming acquainted with some of the programs and some of the individuals within the programs. I really can't give to you a direction in which we will go because I am still finding the

directions in which we are currently heading. I just give to you some of the questions that I am asking with respect to the programs I am working with, and from these questions and the answers I think you will find the elements of our agenda during the next several months.

I am basically raising questions on how can we improve our ability, our being for people within HSMHA, people who participate with HSMHA and other people within the health field -- our ability to recognize and define our health needs. How may we better relate our research activities within HSMHA to these needs? How may we better identify early in the game those concepts and practices which we consider at least to be of significant value, at least we think they will be of significant value, and therefore ought to be introduced to the field? How may we promote the introduction of these concepts to the field under appropriate kinds of safeguards, appropriate testing? And finally, how can we improve the working relationships and the communications among our programs? And finally, to the extent that all of this results in two kinds of things: One, clearly identified areas in which change ought to be made and, secondly, rather comprehensive agreement on the nature of the changes and the way in which we would do it, how may we implement it. It's a rather tall order, I know that, and if our success will be measured in terms of two things, one, the time and energies of people around here,

then I am reasonably confident we will achieve some measure of success.

The other hat that I wear might be of value to you because we have moved, I think, far ahead with respect to the HMO's as in comparison to where we were several months ago, and I do wear these two hats at this point in time.

I'd like to describe to you some of the fundamentals upon which we are building our HMO program and give to you some indication as to the kinds of activities we are going to be engaged in during the balance of this year, and it will help set the tone, I think, and the momentum for subsequent activities.

I hope we are taking a fairly practical and pragmatic view of HMO's, and part of our responsibility is to correct some misconceptions that are held by many people about HMO's, and it might be valuable to start with just that.

We are not suggesting, and we will not be party to suggesting, that there should be any element of compulsion within the HMO program. We will not participate in programs that appear to have this element of compulsion.

Secondly, we recognize many virtues are assigned to HMO's which in our judgment are not warranted. I do not regard the HMO as a substitute for health insurance. Secondly, health maintenance may be a broader phrase to many people than is implied within the kind of activity that an HMO will in fact become involved in. I think we are taking pains to

make that clear to people who are reaching for us with respect to requests for information, and in some instances requests for specific guidance on next steps. There is an astounding degree of interest in HMO's today. I think we have had in the last six weeks something like 300 inquiries. They range from casual interest on the part of a group to a specific request for information and assistance on steps that a group of people might take to develop an HMO.

Our program has essentially three or four elements to it, and I will just touch upon that. We are engaged in, and will continue to be engaged in during the course of this year, a rather comprehensive program for technical assistance to prospective HMO developers, and this will be assistance from -- it will be limited by our resources, of course, but it will be a wide range of technical assistance services that will cover, among other things, problems with respect to organizing an HMO, problems with respect to the kinds of management systems necessary to manage the HMO, technical assistance in the area of conducting actuarial studies. There have been requests for assistance with respect to marketing the HMO concept with respect to a specific developer, and there will probably be requests for services which we have not yet anticipated. All I can say to you at this point in time is that the demand for this kind of assistance is going to far outstrip anything we could reasonably and practically offer,

and that will introduce into our thinking some constraints as to not which group or what kinds of groups ought to be discouraged, but it will limit our ability to serve adequately and at some point in time we will have to focus upon a number as contrasted to a reaching out to everyone or being in a position to respond to everyone who conceivably might have this interest.

A second area that we are operating in is we will conduct and are in the process of conducting a better educational program, educational in the sense of providing to people who want information about HMO's, at least some reliable information, and secondly, at least identify for them sources other than ourselves which might be helpful to them in thinking about HMO development.

We are conducting, it's not a modest grant program, but we have no intentions of a massive grant program, of financial support and technical assistance to a number of HMO developers. We concede openly that some of the best advice we will give to some prospective HMO developers is that their thinking is not sufficiently mature about the plan so that they ought to pull back a bit.

I think some of the best advice we will give to some prospective HMO developers is that their plan is not viable and that they ought not to proceed further, and that for others, that we will, or at least we hope to describe

for them some of the problems they may anticipate, and so introduce into their thinking a degree of realism that could be lacking.

As I say, there is a great deal of interest. The interest ranges from large numbers of physicians, substantial numbers of consumer groups, some business organizations, some labor unions, and how many of these will go from the point of general interest to a specific application for a grant is extremely difficult to predict, but I guess within the last four months we have had on the order of 150 grant applications for assistance. Some are very good and some are very poor, and some of the poor ones are the ones we'd like to see started, so that is part of our problem.

We are also concerned with the HMO programs of making available to individuals the option within their own health insurance programs, the HMO option. There has been some interest on the part of business organizations, some interest on the part of labor unions, in knowing more about HMO's, because they might in their own thinking elect to introduce into their own health insurance programs the HMO option for their employees, and we propose to stand ready to provide them with what we hope is objective advice and what we hope is good advice.

By June of this year -- this one last comment with respect to HMO's. With respect to the current activity in

HMO's, most of the activity is planning and development. That is, groups which either in June or before that or even now are interested in knowing more about it, and having reached that point of decision and saying to themselves, "Are we sufficiently interested in proceeding further, and therefore, we will engage in the feasibility planning and the administrative planning necessary to become operational."

At this point in time, almost all of the groups we are dealing with are in various stages of planning and development. It is our guess, and it is a reasonably informed guess, that a number of these will reach within the next six months a go or no-go decision with respect to ongoing operation, and at that point the nature of our activities may change, and at that point in time I think I will be better prepared to discuss that.

In summary I am delighted to be out here. I am astonished at how few things I can get done in given days but then I realize there are just so many things to be done. It's a long work day out here, and Vern, coming out of the Midwest, starts it earlier than most. We check each other by our cars in the parking lot, and sometimes I hide behind a pillar until after he leaves so I impress him by having my car there. It's a long day. It's a fascinating thing for me, and maybe, just maybe, we will have many things done within the next couple of months, and even before our organization is

established. Thank you.

DR. MILLIKEN: In this development of HMO, is there any emphasis being given to the establishment of criteria for control mechanisms?

MR. RISO: Yes, I have asked Harold to take the lead. I have asked the RMP program to take the lead in developing -- I don't mean it in this sense, but standards of performance for HMO's and what criteria ought we to apply to the performance of HMO's, and at what point in time will we be in a position, or anybody be in a position, to say this HMO has or has not performed. We are going to do this from a professional basis because the rate at which you increase enrollment is no sign of anything, and the fact that you have in fact kept your expenses below your income doesn't prove anything if you have not provided care.

I am delighted that Harold has seized this initiative and is working with the HMO group, but the definition of the quality of care within the confines of the HMO's is the responsibility of the RMP program.

MR. MILLIKEN: I think this is very necessary because a lot of applicants that I have seen have no concept of the fact that there must be controls.

MR. RISO: That is true, absolutely.

MR. MILLIKEN: And this is very evident in the application.

MR. RISO: As I say, the interesting thing about this -- and yet you have to expect this -- you have to expect that when you actively promote, as we have and others have, the concept of HMO's or of anything else, there are going to be all sorts of people and groups interested in pursuing it further. We cannot control that. On the other hand, recognizing that, it's our view that we can through mature and objective advice, siphon off, if you will, those people who really ought not to be encouraged.

Secondly, then having hopefully confined ourselves to a number of groups, that have at least some hope of success, expose them to some fairly sophisticated management analysis in terms of the viability of the plans, economic viability, the standards, how will they work, how will they enroll people, how will they in fact provide resources for people who today don't have financial resources, and then at that point in time we might discourage those people or those groups that really deserve to be discouraged because there are elements in their plan that simply make it a marginal HMO.

I think we have to face the fact, though, that despite our efforts we are going to have some HMO's that for any number of reasons, either poorly conceived, poorly managed, or any of those things, become marginal. We'd like to hold that number down, and it is highly likely you will have some HMO's fail, and we are actively concerned about the problem of

the HMO that fails and as a principle -- I am speaking personally now -- your obligation is to the person who enrolled in that HMO as contrasted to, as a matter of principle, sustain in operation every HMO that gets started. I don't think we will have to live with the prospects of some HMO's failing, and that in some instances where that HMO is a drain upon a parent institution, I think it would be quite valuable to have that HMO fail.

Now, in other instances there may be some that we do not want to see fail and would actively support;as a matter of principle at this time we do not contemplate assuring every HMO that gets started continued operation. I think we'd defeat the purposes of the program.

DR. WATKINS: I am wondering if we need an A, B, C of eligibility. Because in New York I feel that Columbia PNS, Mount Sinai and Einstein are going to be the prototypes of HMO's when there are churches and other small groups that would like to be involved, and they feel they are not eligible because they don't have a union background or a $20,000 group census to work with. So perhaps if we had an A,B,C eligibility it would avoid people putting in months of work and spadework and then being turned down.

MR. RISO: That's probably a good idea. The only surprise I have is that given the number of contacts being made with us, and given the variety of sponsorship, I am

somewhat surprised to hear that there are some groups not fully cognizant of the fact that they have the same option of negotiating an HMO development as any other, but if there is a question with respect to a specific group you have in mind I'd urge them to reach for the HMO program director within the regional office and receive whatever reassurance they need both with respect to their eligibility and, secondly, with respect to the specific steps that they should take to at least bring the issues to whether or not they should proceed or not to a head. I'd urge any group in any part of the country with that kind of question in mind to reach for the regional office and then if you don't get an answer, a good answer or one you like, but an answer, then please call our HMO program here. We'd be happy to do that.

DR. KOMAROFF: Some of us are being asked some specific questions by people interested in HMO's in our regions. Can you give us an idea as to how much grant money to supplement the initiation of HMO's might be available, after July 1st or sooner, when the deadline for submitting applications is, and in what form, or with what degree of development an application has to present itself here.

MR. RISO: There is in process right now a review of a number of grant applications that were generated over the period of July to about two or three weeks ago. In fact, the review process in the regions is going on today. Those awards

are likely to be made before the end of this calendar year.

The objective we have in mind with respect to those, very candidly, we know are going to make some people unhappy, but that's a fact of life both here and downtown and everywhere else. What we will be doing is taking a look at the original contracts that were made back in May, look at what has been accomplished both with respect to the type of sponsor and geographic dispersion of these particular HMO grants and contracts, evaluate the current round, and look at those and see whether the pattern that evolves out of two rounds gives us an adequate spread both with respect to geographically and with respect to type of sponsorship. There is a plan for another round in around February and another one by the end of the fiscal year, three in all.

Now, the levels at which we propose to fund we have identified at this point in time a sum of money. We don't have as yet legislation as you may know. The magnitude of our activity in February and July or June will be determined by legislation, and the November level will be modest, but at the same time enough to encourage those HMO's that should be encouraged, and not enough to encourage those that should not be.

DR. KOMAROFF: Thank you.

MRS. WYCKOFF: Are you discouraging the rural type of HMO which has very limited resources?

MR. RISO: Not at this point. What we are not doing is establishing as a rule of thumb that we are going to discourage them right off the bat. But what we are doing, and we will do for the first time in the November cycle, we will consider that for some HMO's -- and the average planning grant is estimated to run at about $100,000 to $150,000. It's my view it's much too much, to come to a conclusion you ought not do it. And so we will entertain a notion of modest funding in the order of about $20,000 or $25,000 to some prospective HMO developers, to allow them to pursue, with some assistance, the question of whether they should go into an HMO or whether there are some factors that are clearly identifiable that would really mitigate against further encouragement.

So it's quite possible that some groups in rural areas wanting to go into HMO's, which on the surface might appear to be viable but after spending some time and effort and providing professional resources to them to explore, come to the conclusion that you really can't because you've got a different kind of problem that an HMO was never designed to solve.

MRS. WYCKOFF: At thatpoint are you giving them any help or alternatives for them?

MR. RISO: I would hope so, because you start with a need, and the HMO is just a vehicle for meeting that need, and whether or not some people get that answer is going to be

dependent on the quality of assistance we provide them, and I suspect that will be spotty. It depends on who you draw.

But we are indicating clearly, however, to people who will work on these, that in the process of coming to a determination that an HMO in a given area is not viable, their responsibility as professionals ought to go beyond that in terms of at least telling people what the next steps might be to resolve the problem. But part of the value will be in at lease increasing the awareness of the problem.

Thank you.

DR. MARGULIES: Thank you, Jerry.

I also have some housekeeping things to announce, but mine are less Olympian than Vern's. They have to do with things like coffee and doughnuts and so forth. It's my nature.

We will have a coffee break at 10:15 and 2:30, and to show you how non-Olympian I am, the coffee is 15 cents and the doughnuts are 10 cents each, and we ask you all to pay according to that amount, no more, no less.

(Announcements.)

DR. MARGULIES: We have introduced some of the new members of the Council. I'd like to add to that the fact that we are also losing some members of this Council. I think you are all well aware of the fact. Our losses are severe ones, and we will have an opportunity this evening to placate

ourselves for those losses depending on how much cash you take to the bar.

But just to remind you, Dr. Crosby's term ends this time. He is unable to attend. Dr. Everist, who is here with us, also has his last tour of duty ending today at this Council meeting. And Dr. Hunt, whose tour was relatively brief, but a very vigorous one -- he was serving out an unexpired term, and as a consequence his period of duration with the Council is a little less than some of the others.

I'd like to also announce or introduce to you -- I think most of you know -- that we have been most fortunate in obtaining a new Director for the Professional and Technical Division. Dr. Ed Hinman, who we pursued for a period of many months, has had a very distinguished career, most strikingly as the Director of the Public Health Service Hospital in Baltimore, which he was able to use as a mechanism for extending his interest in improving community health services. He has been here for upwards of three months, I think it is.

Ed, would you care to stand? He will be discussing with you later on during the morning some of the activities for which he is assuming responsibility. That particular division I think will be highly productive and in some very specific areas which this Council has addressed frequently at levels of concern for program development and for clarification for what we believe is the state of development of a

number of specific activities with which we are concerned.

For example, our responsibility for dealing with the issue of monitoring the quality of medical care which has already been referred to, lies in that division. Our concern with developing ideas about what is meant by an Area Health Education Center lies within that division, et cetera. And I think by maintaining a consistent base of knowledge we will be able to do more for this Council and consequently for the RMP's than we have in the past.

I'm not sure how many of you know that we also have suffered a loss in the death of Dr. Philip Klieger, who has for many years been a part of the Regional Medical Programs and who was extremely active in the whole area of rehabilitation. He had surgery, returned home, and apparently had a myocardial infarction and expired quite suddenly. His loss is a very severe one. His contributions to the RMP have been consistent, and we all have expressed, through the Regional Medical Program, and I hope it was understood it represented the interest of the Council, our sincere concern to his widow and to members of his family.

One other change which I would like to bring to your attention which is already in operation, which is again housekeeping but somewhere closer to the Olympian level, is the fact that Mr. Ken ~~Bond~~ BAUM is going to be responsible, and already is, for the Council affairs. This is working out

extremely well. It's a matter of not only pulling these Council activities together but keeping you informed, sending out quick reports on Council activities, developing minutes, and in general maintaining the staff intelligence on Council affairs. If you don't know him, I wish he would stand so you know who he is.

We need to talk for a moment about a confirmation of meeting dates. We have set them up at the present time, and I want to recheck them with you, for February 8 to 9 for the next meeting. I think you have them before you: May 9 and 10; August 15 and 16.

I am not going to discuss at this moment something which we have considered, however, because it requires a little more planning, but there is some thought going into the idea of reducing the number of meetings to three a year rather than four. As we are getting into the triennium, and as we are able to handle these triennial applications more effectively and in consideration of staff responsibilities, this may turn out to be not only desirable but quite practical. But for the time being we would like to confirm with you those meeting dates and to check with you to see if in any way they prove to be a serious conflict with other activities.

If not, we will consider them confirmed, and I would like at the present time to have a motion, if one is appropriate, regarding the minutes of the August 3-4, 1971,

meeting which were distributed to you by mail.

DR. ROTH: I move they be approved.

DR. SCHREINER: Second.

DR. MARGULIES: Is there any further discussion?

All in favor say aye.

(Chorus of ayes.)

Opposed?

(No response.)

The minutes are approved.

I have a series of very quick reports which I would like to bring to you to bring you up to date on a number of activities, most of which are continuation of prior interests. Some of them will elicit interest on your part, and some of them will raise some questions for your specific action, I do believe.

We have agreed to have a meeting of the coordinators, a national meeting of the coordinators, in January. It will be January 18 through 20 in St. Louis. This was not done because a meeting of the coordinators is a good thing to have on occasion, but rather because this appears to be the time for the coordinators to move together in a common way. I don't really believe there is much sense in simply having meetings because at periodic intervals that is a desirable thing to do. We meet very frequently with the coordinators. We spend a considerable amount of time with the coordinators

where they work and we meet with them in groups, but what we have felt is important at this time in the history of RMP is to change the pattern from prior meetings of coordinators -- and I think it's of great interest to the Council as well and we hope that as many of you can attend will -- the time has come to recognize the fact that RMP has had enough experience and has obtained enough maturity to begin to talk about some things which represent professionalism in the Regional Medical Program. It is a special kind of profession. It is a special effort towards institutional development of a different kind and one which has become increasingly important.

Consequently, it was our decision, and the steering committee representing the coordinators was in happy affirmation, that this should be an expression of what the coordinators are doing and think and need to know by their own efforts and as a product of their own skills. We will, we hope, have present also people like Jerry Riso, Vern Wilson, Dr. Duvall, to keep ourselves in touch with HEW HSMHA interests.

But what we are planning to do is to center the meeting around an input on the part of the coordinators, around the central theme of increasing access and availability to medical care, with some specific sub-subjects which they will develop.

Now, this is going to be done, has already been done, by asking them to meet, the coordinators, on a sectional

basis and begin their deliberations before they reach St. Louis. This will allow them to utilize their time effectively, will obviate the usual need to get together, form ideas, reform them, and go home again over a very short period of time. So that in a sense this conference has started. It has started under the aegis of the separate members of the steering committee who represent on a sectional basis the coordinators.

They will be competent, therefore, to come into St. Louis with a representation of ideas which have been generated by the interaction of coordinators and staff at the sectional level. They will be talking there in the form of panels about such high level interest subjects as area health education centers, health maintenance organizations, improved utilization of health manpower, et cetera, all of which is related in a programmatic sense, rather than a theoretical sense, to the improvement of access to medical care and as an expression of RMP competence. These panels, then, will be so designed that there can be smaller meetings in which each of the panelists acts as a chairman of a section dealing with a subject, and there will be a final plenary session on the last day at which time we hope to reach some working conclusions, decide what questions need still to be resolved, perhaps raise issues for further R&D within HSMHA, and perhaps give people like Jerry Riso some guidance in what programmatic

emphasis we think is necessary or needs to be generated. You will get further information about that as time goes on and you will all be officially invited to attend.

In your book is a description of the reorganization of the Operations Division. It's under Tabs X, C and D and E as information items in the agenda book.

We announced to you earlier that we have set up a method of dealing through the Operations desk on a geographic basis. That in fact has been put into action, and when you have the time to do so you will be able to look it over and see how it has been worked out. It has already produced evidence of a higher level of coherence in the management of RMP from the RMPS point of view, by allowing each desk to deal with a Regional Medical Program in toto rather than in the fragmented fashion which seemed to characterize our management in the past.

I'd like to just stop for a second and say that these kinds of changes, which I think is becoming more and more obvious in the Regional Medical Programs, is due not only to a large staff effort but one which Herb Pahl has led in a very striking way. I hate to say anything complimentary about him when he is so nearby me, but his ability to see issues, to organize people, to bring them along, and to accept change, which is always difficult, is extraordinary, and I would be unforgiving of myself if I didn't -- I'll never say

anything good about him again but at this particular point I feel required to do so.

The next item I would like to mention -- and this is going to become an issue which is going to be of real concern to you -- I don't know whether we want to get into it at the present time, but we can, or we can delay it until late in the day when I think we may have an executive session on two or three issues which will require that kind of attention.

We have over some time been developing an updating of our regulations. These regulations in turn have gone to general counsel for their validation and for preparation for publication within the Federal Register, making them thereby official. This is an essential part of our activities. Since we operate in the public interest we should be viewed publicly.

Some of the questions which are going to be looked at there, and some of the decisions which are going to be made in those regulations, refer to such long-term sticky issues as the proper relationship between grantee agency, Regional Advisory Group, coordinator and core staff. These have been defined, and I think with some clarify, but as with all regulations there will remain room for interpretation which is going to be a responsibility over time of the Council. When these have been moved from the early draft stage to a point of finality, they will become something for your deliberations and certain sections of them will certainly be

familiar territory.

Back again to the Council -- and I am not bouncing around; this is all part of the pattern -- Council functions are clearly spelled out in the regulations which are being developed as are the Regional Advisory Group functions and their interrelationships.

The make-up of the Council, however, is not a part of regulation but a part of practice or a part of Administrative preference. This Administration has a strong preference for the ladies, and that I must assume we all join. As a consequence, the two ladies who are here will over a period of time have company, and it is our hope that by the time we have filled vacancies which are occurring -- Bruce, this will be heartwarming to you -- you will be replaced, I'm sure, in a manner which will be inadequate in one sense, but fully adequate in another. We don't think we can replace you. The best we thought we could do is to seek for someone of the opposite sex who could do through her special skills something which will compensate us for what we lose with the loss of your special skills. I don't know what I just said.

(Laughter.)

But in general, we are going to increase the female complement on this Council.

I think you will also see some reflection of our hope to create a better balance both in terms of a minority

membership and in terms of a balance between the sexes by the present make-up of the review committee. It is now at full strength, and the new members, who are not here, of course, but whose names I would like to give to you, include Miss Dorothy Anderson, who is an assistant coordinator in Area 5 in California; Dr. Gladys Ancrum, who is Executive Director of the Community Health Board in Seattle; Mr. William Hilton from the Illinois State Scholarship Commission in Chicago; Mr. Jenus B. Parks, who was with the United Planning Organization in Washington; Dr. William Thurmon from the University of Virginia; Mr. Robert Toomey, who is the Director of the Greenville Hospital System in Greenville, South Carolina.

These are all pretty much in the nature of announcements, and I think now we will move into some issues which are going to remain of some concern to you.

One of them has already come up for some brief discussion, and that is the current status of area health education centers.

We have had under discussion the general concept of AHEC for some months, and in fact when we reviewed the activities of RMP since its origin, we found that we have been in the AHEC business for quite awhile. You will recall that at the last meeting of the Council there was a presentation of the activity in Watts Willowbrook, which represents many elements of what we are talking about in the AHEC.

As with the HMO, no legislation has been passed to make the Area Health Education Center a newly defined legislative program. The Regional Medical Program legislation, however, contains all of the necessary substrates for AHEC development. Regardless of how the legislation comes out and the alternatives are primarily three -- one of them is that it won't come out, which is one alternative. The second is that it will be passed in the form that was introduced originally giving the primary responsibility to the Bureau of Education and Health Manpower Training at NIH; and the other one is that the primary responsibility would be under Title 9 and Regional Medical Programs.

Those issues are still being debated, and of course the outcome is unpredictable. In any case, it is quite clear that the RMP will be involved in AHEC's, working closely with the Bureau regardless of where primary responsibility is, and working closely with the Veterans Administration under any of these circumstances. It is also clear that whether we call it AHEC or something else, the RMP's are moving strongly in that direction, and the kind of ferment, Jerry, which you have described in the HMO area, is closely paralleled by that which is in the AHEC area.

There are some interesting differences, however, in perspective, and from my own parochial point of view, I think that the RMP does represent an absolutely essential ingredient

in the development of at least one kind of AHEC. There may be several. Because one can regard the Area Health Education Center as an extension and an expansion of the educational activities in the University Health Science Center and elsewhere, or it can represent it as a kind of community-based activity, designed around service needs, which is so planned that the educational activities specifically serve those service requirements, which is the way I interpret it.

Now, as a matter of experience and practicality, the likelihood of developing a strong community base for an Area Health Education Center, by proceeding through the Regional Medical Program, with a balance between University Health Science Center and community, the possibility of doing that effectively I think is high.

The possibility of going through the University Health Science Center as the primary agent to the community to develop that relationship exists, but I think it is lower, because the University Health Science Center has its own responsibilities. It has grave financial problems. It has prior concepts of curriculum. And it is in fact bound to academic requirements which have been long developed. I have made no secret of the fact in moving around the country that I think that one of the potential virtues of AHEC is to challenge the institutional practices of University Health Science Centers, and to in some ways assist them in their

efforts to move out of their accustomed resting place and into the community. I think many of them wish to make that move. They find it very difficult. And I think that RMP, and specifically RMP with the AHEC under the Veterans Administration collaborating, can make that move which I think will occur, move more rapidly and more effectively.

Now, we are not in the position in RMP to put out a paper which describes what we think the AHEC ought to be. It would be inappropriate at a time when the whole subject is being debated and the resting place for lead responsibility is still uncertain. But we have shared these views with the Bureau, and the Bureau has been generally in accord with them. Certainly Ken Endicott does not believe that the AHEC should be an extension of the University Health Science Center and a satellite thereof. On the contrary, he believes that there has to be devised a method of producing within the community real competence for relating education, particularly education at the middle level, with service requirements, with the results determined, evaluated, measured by the manner in which they improve the delivery of services.

Now, this jumps over the accustomed measurement of educational activities which is the completion of curriculum and the acquisition of a diploma, certificate or degree. And if it is done effectively enough, that certificate, diploma or degree will become secondary, and the effectiveness of the

services being provided will become primary, and since I presume that is our goal, I hope that we can be effective in pursuing that kind of an activity.

This Council will, I am sure, begin to receive, either in partial or in complete form, applications for what represents that kind of an AHEC activity. We will also in RMPS be working very closely and in a more formal fashion with the Bureau to expand our activities so that we can do with the Bureau of Education and Manpower Training those combined investments which up to the present time have been found difficult to locate. The climate for it is good. There is little or no difference in our views of what needs to be done. So that I think, Jerry, we feel safe in saying that we are going to get on with the AHEC. To what degree we will assume stewardship for it, and to what degree we will be cooperating with someone else is as yet uncertain, but it will be an active program within the RMP.

Would you like to add anything to that?

MR. RISO: No, I would hope that I get that paper today.

DR. MARGULIES: It was there last evening.

MR. RISO: Good. This thing ought to come to a head in rather short order. I am confident that it will come out, too, one, that it will come out in a way that we can work with it; secondly, it will come out in a way in which RMP

will take a significant leadership role in the development of these. I am delighted with both.

THE CHAIRMAN: Bland.

DR. CANNON: Maybe you and Jerry will clarify Paul Sanazaro's department. I can't quite relate this now in HMO's and AHEC's and sort of get the feel of where our Council stands.

MR. RISO: That's one of the questions I'm raising. The proposed plan of organization of HSMHA places upon the National Center a distinct, and not necessarily new but a much clearer role in terms of being part of a leadership activity here to bring about change in health care delivery.

The question -- and I don't have an answer; let me jump to that one and tell you that at the outset -- the questions I am raising are essentially threefold: One, in looking at the Center, and in looking at the kinds of activities where it spends its money, looking at the amounts of money it spends, the questions that I do propose to raise are: Are these the areas where money ought to be spent, is the program in which the programs that we support through the National Center, programs that deserve the level of support that we are currently providing -- that is, with respect to priorities and such. Secondly, from an operating point of view, can we be satisfied that the results being developed by the National Center are (1) clearly known, (2) are adequately reacted to by the RMP

and other programs, and (3) do we have the management system for putting those particular findings, those particular projects that we think are valuable, into ongoing programs?

Intuitively I'd say that those systems do not exist and that there are major improvements necessary in working relationships and communications, and so the fact that you raised the question is perfectly understandable, because I work here and I can't answer those questions and I am raising them.

MRS. WYCKOFF: We do need to know more about what they are in terms of HMO's.

MR. RISO: You are absolutely right. We all do.

And it is an item, not for concern in a negative sense, but particularly with respect to the new plan of organization, and particularly with respect to clustering five programs which together, and then working both independently and with other programs within HSMHA, are supposed to have a significant role in "institutional change."

Well, it is obvious and necessary that your research arm has got to be an integral part of this activity, and this means that there have to be consistency between their objectives and the objectives of the group, and some -- I don't mean duplication now but some consistency between the priorities in areas they spend money, areas in terms of programmatic areas, and the areas we are interested in. And then finally some effective working relationships which allow

communication in terms of where we stand, and think of it as a series in terms of moving from research to field testing to evaluation to full-scale production, to go back into the world I come out of, and those relationships really -- I am not confident -- I couldn't assure you those relationships, one, exist today, and that the current relationships will remain the same five months from now or less.

DR. MARGULIES: Let me now bring you up to date on what we are doing with the Section 907 activity. For those of you who don't recall, Section 907 is that part of our legislation which requires us to provide through the Secretary a list of those hospitals which represent the most advanced skills for heart disease, cancer, stroke and kidney disease. We have made good progress, and we have reached a level of understanding by bringing together a very competent group of people from around the country who can accept the idea that we can do this effectively and usefully by depending heavily on the contracts which we have had in the past for developing guidelines, and modifying those in such a manner that we can set up institutional criteria. I believe even the cancer contract produced enough data for institutional criteria so that we are going to be able to find it useful for that purpose. The heart guidelines and the stroke guidelines, of course, are effective for that purpose, and then we have, in addition to that, put together a group of consultants for

kidney disease which is simpler because it is dealing primarily with dialysis and transplants so that we can establish some criteria.

We will probably be working through contract with the Joint Commission on Accreditation of Hospitals, and we will try over a period of time to move through this process so that the level of skills which are identified and kept current will apply not only to the hospitals with the most advanced, but also those which are of necessity related to such institutions, so that we have a series of reports which will allow the profession and the public to make wide choices in how they seek help.

I think it is moving along well, and since there are no more details than those, I think that we probably needn't pursue it further. We will want your assistance, however, as we move into the final statement of criteria, and as the Joint Commission converts these into a method of inquiry which fits with their techniques, because you have to establish criteria first and then convert them into a useful form.

Clark, unless you'd like to comment further on it I think that's probably as much as we need to do with it now.

Now to some more specifics about the RMP's and your prior recommendations. Over the last several meetings there have been several Regional Medical Programs which have been the subject of particular attention, usually because

there are problems. We have met with all of them in depth and there have been some results which may be of interest to you. I don't know that what has occurred can be analyzed in full, but there are some symptoms which I think are worth noting.

In Central New York, Dr. Lyons has resigned as of November 1st.

In Rochester, Dr. Parker is resigning January 1st.

In Susquehanna Valley, a coordinator who resigned, as I think you already knew, and a new one is being sought. He will be an M.D. and they are close to a resolution and a selection there.

In New Mexico, Reginald Fitz has been replaced by Dr. Jim Gay. He is a neurosurgeon. We will live with that fact, but he appears to be all right anyway, Bland.

We had an extremely direct meeting with Oklahoma, with Dale Groom and with Dr. Helio. The discussion was frank. We have no formal announcements of further alterations but they understand what kind of directions would be more appropriate for them, and there may be further specific changes there in the very near future.

Greater Delaware Valley also has a new coordinator. Dr. Wollman has been confirmed as -- he was acting and he is now the regular coordinator of the Greater Delaware program.

Nebraska, which was in issue, has a new coordinator.

Dr. Marcie has replaced Dr. Morgan.

South Dakota has also a new coordinator named Dr. John Low.

In Albany we had a meeting in depth, and I had the feeling that we left with both of us relatively unaltered. There was a possibility of some change, however, because among those who came down were some people who had some real fire in them, and I think we will have to pursue that one with a little more vigor.

We don't play games in this Council so we have to discuss things pretty openly, Jerry, so that one remains of some concern. However, Stu Bonderant, who is on the Regional Advisory Group up there, understands what needs to be done. We have put a very definite time limit on the program, which has most characterized the Albany program, and there is no question that it will be phased out before the end of the year. So that they will perforce be seeking new directions.

We will be having a site visit with the metropolitan D.C. RMP in the very near future, and that also may be an extremely difficult one for a number of reasons because there is not only the issue of the D.C. RMP, but there is also a question of a kidney proposal which Dr. Schreiner I think has some faint knowledge of.

In California, in Area 3, Dr. John Wilson, who was acting as coordinator, has been replaced by a full-time

coordinator, Dr. Faulks, who I think you are all familiar with who is an extremely good choice also.

There are three RMP's where new coordinators are either being sought or have been selected and not announced. As you know, Al Eustice did resign from Michigan. It's no secret by now they tried very hard to get Bob Chambliss to go out there as coordinator, and we gave him a very long rope which extended as far as 50 miles short of Michigan so that he could go as close to it as he wished, but we pulled him back and he's remained here as the Director of the Operations Division, and that set them back a little bit because they thought they could snatch him. They don't have a coordinator, but they are seeking one.

Pete Doan is resigning from the Colorado/Wyoming. Both of these resignations were time-based. They are both at the age of mandatory retirement. And I believe Al Hoffman will stay. So these are replacements which are based upon institutional regulations on resignation.

We have, as I indicated, met in depth with all of the programs which have difficulties. I have not discussed Ohio. I have not discussed Delaware. Both of these are special issues which I think we will preserve for the period of time when we go into executive session. We will also be talking at that time about the new construction for a cancer center in the Seattle area.

Now, before coffee break I'd like to bring up one other issue, which is not a perennial one, but rather one which has emerged in new form as we have created a different kind of RMP review structure, and that has to do with the relationships between kidney activities and the RMP activities otherwise.

We have been accused by the review committee, by people outside and inside RMPS, of being very inconsistent in the way we handle the kidney activities relative to the way we handle the Regional Medical Program review. That accusation is absolutely accurate. We are inconsistent, and we are deliberately inconsistent, and we will probably perform better if we understand the reason for the inconsistency.

The kidney activities, which are essentially, as we review them, concerned with end-stage treatment, with dialysis, transplant, and with all the necessary requirements for dialysis and transplant, is categorical, unblinkingly, plainly categorical in its approach. And as a consequence, and because we wish to go about the management of that categorical activity through the creation of a national network with a minimum of unnecessary duplication, we do have to perform two kinds of acts which we hope we can perform with effectiveness. One of them is a review as we in the past reviewed projects, technical review. That technical review has to take place in a special form. What we propose to do for technical review will be tied in with the way in which we are going to

reorganize the kidney activities, about which I will speak in a moment. The nature of the technical review Dr. Hinman will describe to you either before coffee or immediately after. But the essence of the process is this: That we will understand that a technical review is necessary, that that technical review will be brought to the review committee as a project type of deliberation. It will also be brought to the Council where we now have kidney competence -- well, we have always had kidney competence, but we have supplemented Mr. Wyckoff by having two more kidney experts on the Council, and they will be in a position better than they were this time to receive at an early date the technical review and consider it on the merits of its technical competence.

Now, that does not separate us from the responsibility to consider this with two other issues in mind. One is how this relates to a Regional Medical Program, and the other is what it represents in the way of funding. So far as the RMP mechanism is concerned, it is necessary that we recognize the fact that a technically effective kidney activity may be proposed by a Regional Medical Program which has so many problems and is having so much difficulty functioning as an RMP that a serious question is raised about whether it is appropriate that they take on this responsibility.

This can be true for two very broad reasons. One of them, because it will divert their energies into something

which is less meaningful than it should be for total regionalization. The other is because it will make them believe that they are achieving something by having been awarded a fairly sizable grant when in fact they are achieving too little. But the underlying element is the fact that we are insisting that if we do approve something which is technically sound, that it be managed with regionalization, and that it serve the maximum public interest within that region. If the RMP has not achieved effective regionalization of provider services, then there is a very great likelihood that it will have a sound kind of an activity with little or no regionalization. That issue will regularly come up and it will require deliberation by this Council to resolve the differences.

When the kidney project is technically unsound there is no issue. When it is technically sound and the RMP is sound, there is no issue. When the two are out of phase there is an issue.

The other question has to do with the way we look at the funding of a kidney activity, vis-a-vis the basic funding of the Regional Medical Program. That is simpler than any of the other issues, I believe. It becomes self-evident when you look at the basic commitment which we may have to an RMP, that a large kidney activity cannot be approved for support if we limit the funds available to that activity to that which has already been awarded to that Regional Medical

Program. Sometimes an RMP may be operating at a level, say, of $650,000, and it gets approval for a kidney activity in the range of $200,000. Clearly, this would be an award of an activity which is meaningless because it couldn't possibly support it.

So we do, when we are able to do so and when we know enough about our budget, anticipate a level of funding, since this is still a categorical project type activity, which sets aside when we can do it, as I say, an amount of money which will go into kidney programs, and we operate, as we understand our budget, within the constraints of the funds which are available. When you approve a kidney activity at whatever level it may be, we look separately at the total funds which we hope will be available for kidney activities and make at least some of our determination for final award on the basis of that total resource. Since this varies according to the allocation of funds to RMP and the other demands for funds within RMP, we are never sure until a little later in the year, and we are not sure at this moment what that total allocation is.

In the past fiscal year, through contracts and grants, we were investing approximately $5 million per year in the kidney activities through RMPS. We hope, if we get a larger, final allotment of funds in the RMPS, to increase that in accordance with the total amount available, and in accordance

with what project activities come in. So that we have to also operate on a separate fiscal review, as well as on a separate programmatic review basis.

Now, I think that that is a reasonable enough explication of our inconsistency and I hope that we can live with it. I also hope that we can confine that kind of inconsistency to the kidney activity and not acquire new categorical programs which tend to move in the same direction, because all else that I can see which represents new interests, either through Congress or through the Administration, can be developed most effectively by having a sound delivery system rather than by having an isolated kind of project-related effort.

DR. MERRILL: I wonder if I could ask you or Mr. Riso to respond to the following question: If kidney is to be treated as a technical review, and perhaps correctly so, would this perhaps have any bearing on the discussion that you told us of new negotiations, the role of technology in the health field? Certainly a good many of the kidney activities depend for that efficacy upon advances in technology, and I think the new apparatus for dialysis, the production of anti-lymphocyte globulin, and a good many others. Will this have an input into the technical review in a way in which kidney funding is considered by the RMP?

DR. MARGULIES: I think I'd have to answer no to that, John, from what I understand. I think what Vern was

talking about might be related to this, but he is essentially emphasizing new technology of the automated kind, the type of thing which was produced by space explorations out of NASA interests, the types of communication networks which can be established in rural health care delivery systems, some of the remarkable things that Washington/Alaska is doing with the use of the satellite, that kind of thing, rather than scientific technical development.

DR. MERRILL: Perhaps the computer would fit better in this.

DR. MARGULIES: Perhaps.

DR. SCHREINER: Well, while I agree with your cautions, I'd just like to raise one additional aspect to what you mention. I think the problem of strong kidney programs and weak RMP's is going to be with us for a long time. While it is true you have to be cautious, I would ask that you think in another direction, namely, that where there has been a problem in coordination in RMP that has been difficult to solve over a period of time, it's just possible that because of the tight organized definitive way that kidney care is delivered that it might be the means by which you inject the starter fuel into that particular program and get it moving. I can remember several institutions where no surgeon talked to an internist until they had to do a transplant together. And I don't think we should keep saying they've got to talk to each

other first in order to do that. It may be that the doing of it may be the means by which you get them to talk to each other.

DR. MARGULIES: I think you're quite right. There are no absolutes in this and we have also considered that possibility, but these are the general kinds of ground rules. I do think it's time for a coffee break. I'd like to say that when we come back I will bring to your attention some questions which the review committee raised about kidney programs. I think that I have at least brought you up-to-date on our thinking, but you will want to respond and you will want to go a little farther on the reorganization of the kidney activities within the RMPS.

Let's see if we can be back in, say, twelve minutes.

(W hereupon, a short recess was taken.)

DR. MARGULIES: May we reconvene, please. We are still not through with the kidney issue. I wonder if we could get back on to the agenda, please.

There are two issues which we wish to discuss further regarding kidney. One of them is broader than the kidney issue alone that has to do with Section 910 and its potential usefulness. But first, I would like to have the Council receive for their consideration the expressions of interest from the review committee during their last cycle, specifically related to kidney disease. They asked four

questions, and it seemed to me that some of them were of doubtful relevance to Council deliberations, but you can form your own judgments about that.

I will give you all four of them, and then we can go back and consider them one at a time.

Following consideration of the individual applications, the committee passed the following motion regarding guidance from the Council:

1. Whether Council recommends that money apportioned for renal disease be considered in a proportional ratio to the total amount of money of the RMPS budget.

2. Whether the total amount of money spent in a given region for renal disease should be in proportion to the total amount of dollars being spent in that region. I presume they mean by that RMP dollars.

3. Whether renal programs funded by the regions will come out of their total budget or out of a separate budget.

4. Whether renal programs should be considered outside of the total regional activities or not.

Now, I attempted to address these issues in general in what I said before the coffee break, and I wonder if we might not go back with any kinds of comments you care to make on those particular questions.

The first one was whether the Council recommends that money apportioned for renal disease be considered in a

proportional ratio to the total amount of money in the RMPS budget.

DR. MILLIKAN: How was the dollars arrived at? Did that just sort of happen? You mentioned in your initial comments about $5 million.

DR. MARGULIES: Actually, the final decision on budgetary dispersal is an administrative decision in which we only participate partially. If we get any sum of money, as it appears we will, above the level of last year's funding, this will be associated with a considerable amount of administrative negotiation. We will say what we want. HSMHA will say what it wants. HEW will participate, the OMB will, and there is a round-robin of activities.

The figure of $5 million or any other level for kidney cannot be arrived at on any basis of need, because it clearly is inadequate for the needs. It's strictly an internal budgetary issue, and one decides that that's how much you can afford relative to RMP support, relative to area health education development or manpower utilization, or whatever may be the competing elements within the program.

DR. MILLIKAN: Then the answer to that question is really, as far as the review committee is concerned, just the explanation you have given.

DR. MARGULIES: They felt a little uneasy with it. They felt maybe the Council should decide it.

DR. ROTH: This is probably asking the same question

in a little different format, but when RMP assumed the mantle of guidance in the kidney effort, did it accumulate any specific additional funds to do the job?

DR. MARGULIES: In the very initial stages it carried some contract activities from a prior time, but in fact there have been no additional funds made available for kidney.

DR. MILLIKAN: No earmarked funds?

DR. MARGULIES: No earmarked funds. The legislation says you may spend up to $15 million, and then they immediately reduced the total amount available well below what it had been previously, so that regardless of what was recommended by Congress or by the appropriations process, we had even less for kidney than we had before the legislation was passed, if you want to look at it that way.

DR. SCHREINER: I wouldn't want to look at it that way, because what happened, they reduced the appropriation first, and after we went to the Appropriations Committee they added earmarked funds for kidney, and then the Bureau of the Budget froze it. And then in the conferences, since actually the kidney people who are working on this appropriation were not particularly pushing for earmarked funds, realizing the problem there is in administering earmarked funds, but were using it to try to identify the interests of Congress and the interests of the Congressional committee.

So the earmarking was taken off when the money was

thawed. But I think the intentions -- and this was by agreement -- the intentions of the Appropriations Committee were to increase the total appropriation. Of course we'd like to see it increased more, obviously, because it isn't meeting the need.

DR. MARGULIES: I think there is no question about it being the intent of Congress to increase the investment in kidney disease activities, and there is no question about our intent to do so. I really think what the review committee is asking the Council to do is to assume an administrative responsibility which it's in a poor position to carry out. We are not in a very good position ourselves because we only, as I say, enter into this discussion. You might ask the same question -- I hope you won't -- about the money for pulmonary pediatric centers. One could just as easily say that the amount of money should be equivalent to what you give for kidney disease. The needs exceed the funds available for both, so the decision is actually a fiscal decision, which is not related to total needs, but actually related to relative competition for funds. If we could do so, we would like to increase the kidney investment in the range of 50 percent over what it has been in the past, which would be in fact out of proportion to the increase in funds potentially available.

But it isn't on that kind of a basis the decision has been made. It's really also determined by what the

potentialities are for good projects which can be supported and maintained over time, et cetera.

DR. SCHREINER: I'd like to just comment so it's not misunderstood. It's so easy, I think, to keep kidney categorical, but the official position of the legislative committee in the National Kidney Foundation was against earmarked funds. They simply were trying to point out that if you add a job to an already existing job, that you need to provide additional money, so on the one hand we are talking about additional appropriations for the added job. On the other hand, they were not in favor of putting bridles on the money in terms of the way it should be spent administratively.

So I think they are not thinking categorically in the implementation, but I think when you go and ask for a new task that there ought to be something to go with it and not take away from the existing appropriations.

DR. MARGULIES: Perhaps I can clarify this first question by recounting to you the kind of logic which was generated for asking it. It went like this:

The appropriations said that not more than $15 million should be spent on kidney disease. This meant $15 million. $15 million is such and such a percent of the total appropriation. Therefore, the percentage which should go into kidney activities should be whatever percentage that presumed $15 million is of the total appropriation.

Now, unfortunately, there are a few flaws in that logic, one of which is no more than $15 million does not mean a minimum of $15 million, and it simply breaks down at that point; nor is in fact the budgetary process ever subject to that kind of percentage logic.

DR. EVERIST: It seems to me we can give a monosyllabic answer to the last two questions, and the first two are not appropriate to the Council.

DR. MARGULIES: Would you care to do so?

DR. EVERIST: I will make that motion.

DR. MARGULIES: What is the monosyllable that you wish to use?

DR. MILLIKAN: No, yes, no, and so forth. He's proposed we can answer the first two. I would suggest we say no, no, yes, and no, in the following sequence.

MR. OGDEN: I agree.

DR. MARGULIES: You would have the renal programs funded by the regions come out of their total budget? That's a sort of meaningless question because it will have to be their total budget if you give them the money.

DR. EVERIST: Right.

DR. MARGULIES: Rather than a separate budget.

So what you are proposing is that the answer be no, no, yes, and no.

DR. SCHREINER: The only provision I would like to

introduce on No. 4, it's conceivable that in the areas where there is little or no regional activity at the present time, that this could be the opening wedge. In that sense it could be outside of existing regional activities, because there even are regions that haven't formed yet in some of those areas and this may be a way of doing it.

DR. MARGULIES: I wonder if we could have a second to this and then a discussion of it. The motion was that the answers in numerical order are no, no, yes, and no.

DR. ROTH: I'll second it.

DR. MARGULIES: Okay, it has been moved and seconded. John, do you want to say anything?

DR. MERRILL: Well, only to comment again on question No. 4. Philosophically, at least, it might well be possible that a renal program in and of itself might subserve exactly the purposes for which RMP was created, and in so doing I should think we should fund it as any portion of RMP and not necessarily as a renal program in itself.

Secondly, if we consider, as you have stated we will -- and I think it is probably true at least at present -- that this is a technical activity related to dialysis transplantation, there are a limited number of people which can be served by this, and insofar as that is true, I would think that renal programs should not be a major drain on the activity as a whole. But where they do serve the purposes, in

many instances they have actually led the field in showing the way in serving these purposes, I would think that they should be considered on their own merits.

DR. McPHEDRAN: Dr. Margulies, do we really have to answer these questions? I mean if we really don't agree with the premises from which the questions were derived in the first place, I mean that they are really significant questions, which I think many people on the Council perhaps don't, since we don't have much regard for that percentage calculation of the budget, and since that is the premise from which this is derived, maybe we don't have to answer the question. Maybe Dr. Everist will correct me, but I think to some extent his answers are a little bit facetious because you can't just no, no, yes, and no these things. There are obvious qualifications to each one.

DR. MARGULIES: I welcome your thought, Alex, because what is lying under this -- and it comes up regularly on the review committee -- is a desire to move from review at their level and review and policy formation at your level, into administrative activities, which I can fully understand, but some members of the review committee would like to believe that there is a way in which the review process can actually determine budgetary allocations in a very specific sense and carry out the whole fiscal management function, which in the days when Joe Murtog was on the review committee would usually

get set down in short order because he had plenty of NIH experience proving that that doesn't work very well.

So if you want to say that you think at least those questions which relate to budgetary determination are inappropriate for the Council, that also is your prerogative.

MRS. MARS: I think they are asking just for a guideline, really, aren't they, so to speak? I know this came up in the site visit that I made, and I can well understand the review council's problem, but I think that we should try and set some sort of a guideline rather than just saying yes and no, so to speak, because each specific renal project does have to be considered and treated individually, as Dr. Merrill said, according to its merits. And the necessity for the money and the ratio of total amount of money being apportioned, must be granted accordingly. So I think in all fairness to them that we should try and set some sort of a guideline and not just answer that way.

DR. MARGULIES: If you pursue that thought, which I think is reasonable, it comes around again to the question which they struggled with, and that is: Should we review in accordance with the funds available or review in accordance with the technical or, in the case of the RMP, total programmatic competence of the program? And we have felt very strongly that anything which is tied to a presumed budgetary level rather than a presumed level of competence is an

undesirable review mechanism. Not only that, it is impractical because we don't know what money we are talking about. We don't today.

DR. MERRILL: I think in essence, then, what you are saying is what Mrs. Mars and I are saying, is that they should be considered on their own merit regardless of budgetary considerations.

DR. KOMAROFF: I hate to introduce a complication, but do you ever conceive of 910 authority being used to fund renal projects across several regions, and does that complicate our answer to No. 4?

DR. MARGULIES: I don't think it complicates the answer but I had intended to talk about 910 in this connection, and I will as soon as we are through with this discussion, because there is no reason why the 910 mechanism should not be used for this and for other activities.

Well, let's talk about it for a minute and bring some of you up-to-date on what it is we are talking about. The 910 section in the RMP legislation, among other things, allows for the award of a grant or a contract on a multi-regional basis so that if there is something which is of concern to more than one region, there is a way in which they can join together, make application and get funds which serve a common purpose. Sometimes this can be a single activity which serves multiple RMP's. In other cases it may be an

interrelated RMP activity which is located in several areas.

We have not utilized it during the past year for the very simple reason that we were down to bedrock on funding and there was no possibility. On the assumption that the funds will be greater, and also on the assumption that we will put more money into kidney disease, the utilization of Section 910, particularly for some of the projects which are being promoted in the kidney area, is perfectly reasonable, and there is no reason why we shouldn't utilize it. But it would still leave the question of review on the basis of merit versus review on the basis of funds available one to be answered.

DR. EVERIST: I don't think we can change our philosophy for one disease.

MR. OGDEN: Harold, perhaps what you are saying in answer to Dr. Komaroff, that perhaps the answer to Question 4, when you are talking about total regional activities, may include Section 910 for purposes of regional concepts.

DR. MARGULIES: Right.

MR. MILLIKEN: What's the time phasing on this? Would this be a policy forever, or would this be reassessed by the Council?

DR. MARGULIES: Well, I don't think we have any forever policies. The issues can be broken down here, now that we've gotten into it, and I think it's more important

than just the questions that are being asked: One of them is whether the Council feels that it is in a position to advise or to make policy on the way in which the various portions of the RMPS budget are to be subdivided and allocated over time, or whether it should confine its activities to policy and to the review of programs and projects in this case on the basis of their merit.

Now, quite frankly, if you were to advise us in HSMHA and HEW that you would determine what our budgetary distribution would be, the advice would be received but nothing would happen. It would be nice for you to say it if you want to but it isn't going to occur because there is another process known as the Executive Branch of the Government which takes care of that.

DR. McPHEDRAN: Well, I'd like to be in the position of complaining to the Executive Branch when I think that their budgetary limitations frustrate our professional purposes, and I wouldn't hesitate to do that. It's just that I think that these questions are really too precise or they require answers in too great precision about budgetary management for me to want really to vote on it. I guess that's what I was trying to suggest before.

DR. MARGULIES: So we're hung up. We do have a motion. The motion is no, no, yes, no.

DR. MILLIKAN: With explanation.

DR. MARGULIES: If it is the sense of the Council that you wish to continue to review on the basis of the merit of the proposal, that you are not in the position to determine year by year budgetary allocations, that you would like to be in a position, however, to criticize the budgetary decisions which are made and have some accounting of how those budgetary decisions were made, and that you mean by regionalization of being associated with regionalization of kidney activities, that this can be either through an RMP or through a Section 910, but that it should be designed in such a way that it services the broadest possible public interest, I can add those kinds of comments back for the review committee along with however this vote comes out, which we haven't yet taken.

Is that, without complicating the issue too much, what you are saying? May we have a vote now on the motion?

DR. MERRILL: Could I ask a point of semantics first. No. 4 reads, "Whether renal programs should be considered outside of the total regional activities or not." Does the "no" mean they should or the "no" not.

DR. MARGULIES: I think they are saying we should not be -- that's a little difficult, isn't it? I think what you are saying is that the Regional Medical Program should not be considered outside of total regional activities.

DR. EVERIST: That's the way I read it.

DR. MERRILL: I thought Section 910 did authorize that.

DR. MARGULIES: It's still regional, but regional with a different kind of distribution.

DR. SCHREINER: Point of order. Could I ask the proposerof the motion to change it to no, no, yes, maybe?

DR. MILLIKAN: May I comment on this as far as No. 4 is concerned? I join Alex, in a sense, I guess. I am just amazed that they asked this question. I won't editorialize on that any further. Looking at it literally, it says, "Where renal programs should be considered." Well, I think they should always be considered in the context, if we are a Regional Medical Advisory Council, they should be considered in the context of the regional activity in which they are being developed -- in which each regional program is being developed. I heartily agree with George's earlier comments that a renal program may be a vehicle for accomplishing some kind of RMP activity which has not been accomplished through any other vehicle. Well, my answer does not exclude that answer at all. I am simply giving a forthright answer that should they be considered outside of the total regional activities or not, my answer to that is no. They should always be considered in the context of the regional activities, but the decision may vary widely depending upon the wisdom of the review committee and the Council.

DR. ROTH: I have a very simplistic view of why these questions have been asked. I think the review committee

is saying, "If we make a recommendation based on each one of these four, is this going to be countermanded on account of an established Council position?" And to me it seems very clear that if they recommend money that is not apportioned for renal disease, proportional to the total money in RMPS, we are not going to rule it out on a policy base. And the answer to question 2 is that we are not going to rule it out on an established policy base. We are taking the position pragmatic, that whatever money that goes in is part of their total budget, so the answer is yes. And the final answer is no, they should not be considered out of the total regional activities. They are an integral part of it.

DR. MARGULIES: I think you might get a little sense of the lack of solemnity, or at least analysis in their question, if you look at No. 2. The implications there are that the region receives a lot of money, gets more money for kidney, a little money for kidney, which really makes no programmatic sense whatsoever.

MR. OGDEN: Move the question.

DR. MARGULIES: The question has been moved. All in favor say "aye."

(Chorus of ayes.)

DR. MARGULIES: Opposed?

DR. KOMAROFF: Are we voting on the no or maybe?

DR. MARGULIES: The maybe was not accepted by the

primary mover.

DR. MERRILL: Are we including in the answer to No. 4 your comments about Section 910?

DR. MARGULIES: Right.

Now, I would like to continue with the kidney discussion because it's an extremely important area and one that has been a little confusing.

We have completed plans to change internally the way in which we manage the kidney activities. One of the changes has been to try to integrate the competence of the people in the Division of Kidney Disease with those in the Professional Division and in the Operations Division, so that with very little delay there will be an opportunity for the professional people to move into a total professional environment, the operations people into a total operational environment, and this will allow us to have greater continuity with the management of kidney activities, will expand the potentialities not only of those divisions but also of the individuals in those divisions who are otherwise restricted in their own career activities to a single portion of a single disease. That will have been completed in the very near future. It will enhance our ability to deal with an expanding program and will allow us to maintain the competence which we already had. That is an internal mechanism which will place the professional responsibility for the kidney activities under

Dr. Hinman's direction, and I would like to have him now speak to you about the kind of functional directions which he anticipates in that kidney activity after which I think we can consider the discussion of the kidney activities closed unless further issues come up.

DR. HINMAN: I was asking Harold if I should just cover kidney to begin with because I am going to have the opportunity to discuss some of our other areas of interest with you a little later on.

We looked at this issue of how we would be able to identify and review appropriately the applications that would be forthcoming from the regions in support of a national program that would attempt to alleviate the shortage of resources to treat patients with chronic renal disease.

If you will recall, you all issued a policy statement in November of 1970 to the effect that there should be a national network, and it went into greater detail.

It appeared to us that we should make an effort to try to get it back into the regional review process and within the regional activities as much as possible but still not lose a certain special emphasis upon it so it would not get lost because of the nature of the problem.

So that the plan is as follows:

Effective very shortly, when we get the various pieces of paper ready to go out to the regions, we will notify

the regions that there will no longer be a central ad hoc technical review of renal projects. However, we are going to ask that they handle them somewhat specially. As soon as someone in the region identifies that they are interested in sending an application to the Regional Medical Programs, through their local region, they will be asked to contact RMPS here in Washington to discuss with someone on the staff as to whether the activities proposed will fit within the priorities that have been established for funding activities. We see that it would be most unfortunate to encourage a group to actively pursue planning for a renal endeavor if it were totally outside of the scope of RMPS funding. This would not mean they could not send an application in, but they would not be encouraged by us.

Secondly, as soon as they were proceeding along to develop the project, they would be required to establish a local technical review committee. We will prepare a list of consultants who they may select from if they wish. They would have the opportunity to use other individuals. This would be their option. But they must show evidence of using experts in the renal areas in their review of the project before it went to the Regional Advisory Group.

We would hope to have close enough contact that we would know that the technical review was an adequate technical review to be able to advise the coordinator of the

region when it was presented to the Regional Advisory Group. Obviously we cannot stop the process but we can give them advice as to how we see the review process going on in the local area.

Assuming that it gets through the Regional Advisory Group, when it comes here, it would be our responsibility to certify to you, to the review committee and to you the National Advisory Council, that appropriate technical review by competent individuals who did not have a vested interested in the project, had indeed been carried out, and to indicate to you our estimate of where this fit in the total national priorities as established.

At that point in time it would be up to you to make the decision of whether it would be funded and the funding level.

Now, in this context it is our plan to update the November 1970 policy. It's a very broad policy and implies that we might be willing to fund essentially any type of activity. Obviously those of you familiar with the problem realize that we cannot fund all activities, and if we are going to get the greatest utilization out of our dollars we are going to have to be selective in the areas in which they are invested.

We are hoping with this new emphasis on kidney to get together with the various institutes at NIH, the Division

of Biologic Standards, and the Food and Drug Administration, to develop some method of approaching such issues as anti-lymphocyte globulin, so that funded activities will result in information that at the end of a period of time, a year or two years, would allow a decision as to whether this should be a licensed drug or not. Because if we go at it strictly by individual project bases, like HLA typing or ALG or any other type of immunosuppressing activity, we are going to end up two years from now without knowing whether we really have the type of information to license a provider, license a firm, to manufacture the drug.

So it's our proposal to call together representatives of these various Federal agencies and try to develop a coordinated Federal strategy on certain issues, hopefully especially on ALG, so that at some time we will know where we will go.

The National Institute of Arthritis and Infectious Diseases had a conference in Texas just a few weeks ago looking at some of the issues about typing. We hope that we can coordinate these activities because we all have limited dollars, and what we are really after is access to services for patients with end-stage renal disease, and continuity of services, and we are going to have to use a very tight coordinated method to make our bucks go to spread this direction.

In the context of our method of operations in our

division, we will be task-oriented in our activities. We will keep a task group together on the issue of chronic renal disease. And those of you who heard Dr. Scribner's presentation in New York a couple of months ago in which he spoke of a life plan approach, I think is a very excellent summary of the method we should think about, that our endeavors should be to see that all groups work from a life plan approach rather than support of home dialysis by itself or support of institutional dialysis or support of transplantation.

This is not a retroactive change, as Harold was reminding me; this is prospective. There are applications before you today that are not in this context. They were reviewed by the ad hoc technical renal review committee and went through that process. There are a couple that are in the hopper right now which will be handled on an individual project review basis so that no one will get hurt, we hope, in this conversion to the decentralization.

As. Dr. Margulies has said, we wish to be consistent in our approach, and you all have decided to decentralize as much as possible the total review process. We are following it with kidney but putting in some additional check marks because of the magnitude of the problem.

DR. SCHREINER: May I compliment you. That was very succinct. I think almost everyone of those represents a very substantial improvement.

DR. MARGULIES: Why don't you just stay here because I want you to get back to your divisional activities.

There is one other item of action which came up with the review committee which I think is of real importance and should not be considered without an expression of Council attitude.

This had to do with the distribution and use of the letter which is written to the Regional Medical Program after the review process has been completed. As you will recall, what happens in the total review process -- let me just say as an aside, that the RMP's to a surprising degree look on the site visit as the beginning and end of all of the review process that they undergo, and we must somehow disabuse them of this idea, because it's one incident in what is I think an increasingly painstaking review cycle.

But they are concerned not with the summary of the site visit, and not with the material which goes to the review committee and to the Council, but rather with the letter which then goes to the RMP. These have increased in their quality very markedly over the last several months. We are not satisfied with them but they are improved and they are pleased with the level of improvement. It is the proposal of the steering committee rather than the review committee -- no, this was both -- that the site visitors receive a copy of the letter which finally goes to the RMP after the process

has been completed.

Now, this has been regarded in the past as a rather special communication which goes to the coordinator or goes to the chairman of the Regional Advisory Group or the grantee, whatever the arrangement may be, for them to utilize as they wish. It is also understandable that site visitors, particularly those that are going to continue to be site visitors and going to go to the same or other regions, would feel a sense of continuity and would gain information out of receiving that advice letter which cannot otherwise be obtained. I have no objection to it. We think that there might be some real value served.

On the other hand, the question of whether this represents confidentiality is an issue at stake.

What we have done is asked the steering committee, which represents all the coordinators, for their view of it. They thought it was a good idea. We have also said we wouldn't proceed with it unless we gave an opportunity to the coordinators, which we have, to express their concerns or any reservations they may have about it. But I really think it's the kind of an issue which the Council should act on because it does represent in varying degrees some very forthright statements which go after your review to the Regional Medical Program.

MRS.MARS: Have the coordinators proferred any

objection to this letter going out?

DR. MARGULIES: We have had no objection to date but they have actually had too little time for a reaction. They had it a few days ago.

DR. MILLIKAN: Could we discuss it in January at the coordinators meeting?

DR. MARGULIES: We could discuss it at the coordinators meeting, but I think that probably the individual would rather react to it in his home base than he would in a larger group. He may have misgivings that he would be unwilling to express in public. But the steering committee responded with no evidence of hesitation.

MRS. WYCKOFF: I think it would certainly help those of us having to make a second site visit knowing what came out of the first site visit. The confidentiality is the other way. They don't get a copy of the site visit report.

DR. MILLIKAN: You are not discussing the site visit report.

MRS. WYCKOFF: No. That's where the confidentiality is.

DR. KOMAROFF: As the advice letters have become more candid, which they clearly have in the last few months -- in fact, the latest one I saw was almost a verbatim copy of the site visit report -- I see no ethical problem at all. If the site visitors have received a copy of the site visit

report, which is the most candid document of all, I see no problem with their receiving a document that was probably watered down to some degree. Furthermore, the process of toning down the language is a very sophisticated one that I think the site visitors can sometimes assist staff in doing. In fact, I have participated in two such language alterations of letters in the last few months. I think it's very valuable.

DR. MARGULIES: I think the other advantage to the site visitor is to get some sense of what further modifications occur beyond his part of action within the review cycle, and I think it gives him a sense of proportion.

So if someone would like to make a motion on this subject I'd appreciate it.

MRS. WYCKOFF: I move we do it.

MRS. MARS: Second it.

DR. MARGULIES: It has been moved and seconded.

DR. KOMAROFF: Could we even consider an amendment that perhaps members of the site visit team or the review committee or Council members see the letter before it goes out? Does that add too much complexity to getting it out?

DR. MARGULIES: That really becomes logistically extremely difficult. We would like to do that, it's ideal, but it's very difficult to do.

DR. KOMAROFF: Okay.

DR. MARGULIES: I would assume that if we are

going to make these available to the site visitors that we would therefore be perfectly free to make them available to the Council members as well, including those that have not been site visitors. At the risk of burdening you, I think particularly when you're talking about triennium, which is a very major event, you should receive copies of those letters, and I will assume that that also is an acceptable procedure.

All in favor say aye.

(Chorus of ayes.)

Opposed?

(No response.)

DR. MARGULIES: Now, I'd like to have Dr. Hinman take over for just a few minutes to describe what is happening in the Professional Division because it has so much to do -- it will probably have as much to do as anything we do in RMPS toward the development of Council policy. It will be one of the major sources of input to your deliberations.

DR. HINMAN: Thank you, Harold.

I will say now I am very happy to be here. I sat through your deliberations in August, but since it was before I officially joined here -- as a matter of fact, some people didn't even know I was coming yet -- we decided I would be an anonymous attendee.

We see the Division of Professional and Technical Development as being responsible for taking an identified

problem, defining it adequately, seeing what solutions there are available to solve that problem, and then trying to get the region to implement those solutions.

Now, this sounds very simple. It becomes a little more complex in the doing, and this is what we are trying to do to be able to do this.

We are organizing on the basis of a task force approach, a project approach, as has been used by various consultant firms, aerospace industry and other areas, in which once a problem is identified -- now, the identification of the problem may be here at the Council,and there are two of the problems that I am going to mention that you all have identified that we are working on; it may be in the region; it may be within our own staff; or it may be at higher levels within HEW. But once the problem becomes identified, we will establish a task force with assigned professional and supporting staff, and a time frame in which it is hoped that a definitive answer can be arrived at. We are obviously going to find problems for which there is no answer. And Dr. Cannon, this is where we see the National Center fitting into the scheme of events.

If, in our looking at the solutions to a particular problem, there is not a solution that we think is acceptable or the region thinks is acceptable, we would hope to be able to go to the National Center and stimulate their

interest in trying to go out and find the answer through R&D activities. We see our efforts those of the development of the region to be able to solve its own identified health care needs. We will provide technical and professional assistance through policy papers, through consultations, through individual help, through the review process or whatever means seem best to assist the regional activities.

Now, to this end we have identified several major issues that we are working on right now, and I'd like to very briefly bring you up to date on them. The one that has taken the most amount of time to date since I've been here is the issue of the monitoring of quality of care in health maintenance organizations.

Now, as Dr. Wilson and Mr. Riso mentioned, we have been given the lead responsibility for developing standards that will be utilized by the HMO's in monitoring quality of care. This is a very specific task oriented around a particular Federal support program and has a short time frame. We see the issue being a much deeper one, and one that will be an ongoing activity for us in attempting to pull together work that has been done in other areas on the issue of monitoring the quality of care.

As you know, the majority of activities in the past have focused on inpatient care. We realize this is not the bulk of where health care is delivered so emphasis has to be

placed on ambulatory care and on the linkages between the various levels of care. We also are quite concerned about access of all types and at all levels.

We put together a beginning philosophy and methodology. We hope to be field-testing it within the next month. It has been reviewed by a couple of outside experts. We developed it after reviewing what was being done in established health care delivery systems.

As you go around and look at what's actually being done, it becomes a little depressing to see that it's very fragmented and does not really cover the whole spectrum of care that's being delivered by the particular organization or institution in most instances. So that this will be a large ongoing activity and you will hear more of it as we go along.

The second major area is the one Dr. Margulies addressed a little earlier. This is the Area Health Education Centers. We have a task planning group working on that right this minute. We have had discussions with the Bureau. We have been in meetings with some of the VA deliberations on their site visits and their direction, and we are hopeful that this activity can be a continuing activity regardless of the legislative home of Area Health Education Centers for the major funding activities. If they are going to be related to the delivery issue of a particular region, the RMP

is the logical agency to be intimately involved because after all we are the instrument of direct acess to providers at all levels.

Other areas of concern: As you know, we have sponsored two allied health conferences in the past. We will be sponsoring a third one this spring in Idaho, and this will be a large activity in attempting to keep the allied health personnel coming into the team and being actively utilized in health care delivery.

Two specific responses to policy issues that you have taken: At the last National Advisory Council meeting there was a preliminary report on a potential policy statement on computer analysis of electrocardiograms. As a follow-up to this, we are hosting a conference here on November 30 with a small number of invited experts and users of this area to address themselves to certain questions, basically the question of whether this is a service that has reached a level that a region should be pushing it at a service level.

Specifically, does it release physician manpower or technician manpower sufficiently? Is it something that does not require validation on each and every electrocardiogram? What are the circumstances in which it might be used even though its unit cost is higher than another method of reading electrocardiograms? Issues of this type will be addressed at this November 30 session. Staff will then take

the results of this, attempt to come up with a policy statement present it to you in February, and the American College of Cardiology, if our plans hold true, will have a crack at it in May when they are meeting here in Washington, and will be discussing the issue of computer analysis of electrocardiograms.

Secondary is multiphasic health testing. In the spring you all took a stand on support of these activities. You recommended that evaluation efforts by RMPS be increased. I don't have the date on this particular evaluation conference but we are going into a sequence that will lead us to evaluation of the individual projects and the collective support projects from the standpoint of the goals of RMPS, not from the standpoint of whether it can be done or the long range epidemiologic questions, but the short-range health care delivery to individuals right now.

We are concerned in the areas of emergency medical services. This is an area that needs a systematic approach. It needs the involvement of all the providers, and we see the region as being a key element in the development of networks to improve emergency medical care throughout the country.

World health delivery. Mrs. Wyckoff asked the question about HMO's in rural areas. Many of the rural areas will not qualify for HMO's because they don't have a large enough base or sufficient resources. That does not mean they

should be abandoned, and again the logical focus we think for the activities to try to support the health care needs of rural populations is the RMP, and we will be working on trying to get information to support them in these endeavors.

The whole issue of manpower utilization is one that I'm sure you're familiar with. We won't go into that now but we will keep an ongoing effort on that.

All forms of experimental or new systems of delivery of care. These are things that the regions must be concerned with. After all, the bag of RMP is the linkage between the provider and the consumer and getting more services to the consumer. The RMP should be doing the ground work that makes possible the introduction of new systems of care, whether these be HMO's or these be these experimental health service delivery systems funded through HSMHA.

Our activities would be in the development of the information about where the scarcity of resources are, what resources there are there, and working with CHP, looking at what the needs of the communities are, and trying to get some mix that will solve needs by improving resources. This requires all type of resource development, personnel, physical facilities, even have to get into some of the funding activities.

I think I've covered my list. There are other things that we are working on, but these are the ones that I thought would be appropriate to bring to your attention this

morning.

Now, in doing these various tasks, we are planning to reorganize the division as a whole. We currently exist in a classic division, branch, section structure. We feel that it would give us greater flexibility for program activities and greater flexibility in career development of the members of the division to go into a nonstructured division with our activities being done, as I say, on a task force basis, and this proposed reorganization is pending at this time.

Are there any questions that I could answer?

DR. EVERIST: I hope so, because the very sticky problem of monitoring quality, the stickiest are medical records, and I didn't hear you mention them, and particularly medical records on outpatients and how this relates to the new technical help that we are supposed to be receiving, and have you considered some standardization of outpatient records which are at the moment lousy and very difficult, I think, to come up with any kind of quality monitoring.

DR. HINMAN: I agree with everything you said. The issue of what is the best record system is one that is being addressed by at least two HSMHA programs at the time. We will have to become concerned with this as an activity in support of the quality of care spectrum. In the elements that we have identified of quality of care, one of the key ones -- well, there are two keys that are pertinent to the

record -- one is the linkage of the records. In other words, is it an intact record on an individual at any one point? If you are going to have an HMO, for instance, that is not under one roof, how do you assure that there is a unit medical record on that individual? Now, it may not be unit in the sense that every piece of paper is all in one spot. We may have to settle for some form of abstracting or some form of encounter form or some other form of getting the information back to the home base, but there must be a unit historical account of the contact of that individual with the system.

We don't think that we are ready to start talking about standards or uniformity of records. There is enough concern -- the introduction, for instance, of the problem-oriented record, as espoused by Weid, certainly seems to be very attractive in trying to get some systemization out of the record. The actual implementation of this has led to some problems in some ambulatory care areas. There are groups that are working on trying to simplify it and get it into something that will be adaptable to computer links. Because I think there will be a time when we will need record bases and need methods of exchanging information. We can't even at this moment say what needs to be in that record, to be able to talk about the technology. The computers are there. We can put into computers and share anywhere in the country any amount of information you wish to have included, but this

would become a monumental task if every bit of every out-patient and every inpatient record was to be in that computer memory. So that we have to get some better handle on this.

Interestingly enough, one of the HSMHA programs, the Indian Health Service, has made some dramatic strides in developing a working system on the Papago Reservation in Arizona, based out of Tucson. They have developed a health information system that has two major hospitals, three or four major clinics, plus public health nurses, sanitarians, other types of health workers, inputting information into the system and able to get information back out of it. It is currently working. They are in the process of planning an expansion of it to another area. We hope to work with them in gleaning information from this. The Arizona RMP has been interested in this themselves and in using this data base and other things to develop data base.

I didn't identify specific task force, but Dr. Everist, you are correct, we've got to be concerned about records.

DR. McPHEDRAN: Is that a problem-oriented system, the last one you've talked about?

DR. HINMAN: Yes, it is. It's not a pure Weid system, but it's basically a problem-oriented system.

DR. MARGULIES: I think one of the issues that will have to be addressed regarding this particular subject

is some position that we will have to take, even though we may not be ready to do so, to recommend a kind of a record system. The problem of uniformity is well understood, and the need to have consistency in the record covering wherever the patient is and one way of following him regularly. I haven't seen evidence up to the present time that any of the R&D activities have reached the point where they can say this is the best record system.

DR. EVERIST: They are not going to.

DR. MARGULIES: And they are not going to, that's right. As a consequence, I think we will have to reach a working conclusion in which we can make some strong recommendations so that we are at least able to solidify present knowledge and get something achieved, whether it's a problem-oriented medical record or some other kind of record system. I think we would be better off with a less than perfect activity if it's consistent, rather than waiting for the perfect and remaining totally inconsistent. I think we will have to reach that kind of conclusion.

Jim, I don't know whether you want to comment on what the VA is thinking about in this area of medical records or not. Do you feel free to?

DR. MUSSER: Well, we have groups in 50 of our hospitals working with substantially the Weid system, and I think at this particular time our people think this is the

direction we should be going. Now, the extent to which we might find in our system certain modifications of the Weid program are in order that we don't know, but we'd be happy to work together with your group in this regard. And I think we have the advantage, because of size, of getting answers to a number of questions, particularly as they involve fairly large groups of patients, both inpatient and outpatients, getting these answers quite quickly.

DR. HINMAN: I had forgotten to mention that, Dr. Everist. The VA efforts are ones we are watching with a great deal of interest because this is an attempt by a system to make a conversion.

DR. MUSSER: We also have moved a bit toward the automation of the record. We have several other projects, for instance one in Boston that is working on an automated history, and we have tried several others. We tried the Duke system and found that not to be suitable, but we will have some information on these several projects within the next month or so.

DR. MARGULIES: Good.

Dr. Watkins.

DR. WATKINS: It would seem to me, whether you like it or not, a good surveillance or a pure review system might be requisite.

DR. HINMAN: Well, medical audit, pure review is

the cornerstone of our methodology on quality care monitoring. But in a nutshell, what we were planning to do is to identify the elements that the individual HMO would have to keep surveillance of, specify some of the things that would have to be included in each element, let them work out the particular method of review. For instance, in clinical evaluation it would be basically around the medical audit. There are several types of medical audit of clinical evaluation that might occur. One would be the retrospective format in which a diagnosis was selected, certain standards established, and then retrospectively a sequence of 50 charts or something like this could be reviewed.

Another one, one that appeals to me personally the most, would be a prospective one, in which the physicians on the staff of the individual group practice would agree that in, for instance, urinary tract infections, that certain things would have to occur if that diagnosis were made. Certain diagnostic points should occur, certain therapeutic types of activities, and certain follow-up activities. I would not propose that the medical staff would necessarily say that the dose should be thus and so, but then that the individual physicians would review their performance on the standards that they had helped set.

It is a very interesting exercise, because the expectations that an individual physician has of his

performance, and his actual performances are not always the same. So we think that prospective review audit is appropriate as well.

Random sampling is appropriate because no matter what format you set up for selecting diagnoses or prospectively setting things, you are going to miss some, so we are recommending some random sampling occur.

Another thing we are concerned about is particularly those HMO's that have pharmacies, that they should have a method of identifying abnormal drug profiles and reviewing those cases, or they might say that they would review a sample of all the cases that are on tranquilizers or all the cases on antibiotics beyond 14 days, or some other type of drug activation of the audit process. Again, it would be a pure medical audit, but it would be activated by something out of the pharmacy.

Another area is one out of the laboratory. It would seem appropriate at some point in time to sequentially review what happens to abnormal blood sugars, how many of them went on to charts, and nothing was ever done about it, as a for instance.

Or the one that is even more frightening, if you go into a laboratory and you ask for the record chart numbers on all positive acid fast cultures over the last six months, and then you go and pull those records and see how many of

them have been missed, this can be frightening in some institutions, particularly when it's an ambulatory collection of the sputum specimen.

So we think the laboratory should be a method of activating an audit process. By the same token the X-ray department should be as well. It might be appropriate to review sequentially a certain sample of GI series or something like this. The issue being that there is continuity of care, that when a physician has identified that some procedure should be done to attempt to make a diagnosis or to support a therapeutic decision, does this procedure that is ordered then feed back and either support his initial decision or change it, or does it get wasted?

DR. MARGULIES: I just want to say that this emphasizes again the need for a good record system, because none of it can be achieved unless you can derive this information in a consistent fashion.

Mrs. Wyckoff.

MRS. WYCKOFF: I am concerned about the fact that we have at least 50 million Americans that move every year, and that we live in such a fluid society that you will have to develop the kind of thing that can follow the 50 million wherever they go and be of some use wherever they are. Otherwise, it's wasted. There was an attempt over the last ten or fifteen years to do something like this in that small

program covering migrant workers. There is a record that was developed at that time which is used very successfully in some places and not used at all in others, simply because nobody asks for it. This is something that might be looked into.

DR. SCHREINER: I would just point out that I think part of the at least beginnings can be simply to make people aware of what has been done to exchange records, because a lot of the physician expectation can be done by self-selection. At least we have changed our records three or four times when we thought they were great because we saw another one that was better, and if you don't see the other one then you are never going to make that potential comparison. But there are two activities along Mrs. Wyckoff's line. One is Dr. Falkner, I believe, is the one who initiated the medical passport concept which is a private group, and then there's one that's carried by State Department people here. I have a few of them as patients, and they carry a very succinct record because it's an absolute necessity. They go to Africa or India or somewhere and they have to have fundamental data on drug sensitivity and innoculations and major procedures.

So there are some very, very brief record forms that have been developed. One is the medical passport, which was originally developed at Cornell, and the other one is

the State Department form, and you have a third, the migratory workers. So there are some systems that have started, and a lot of people don't know about these.

DR. HINMAN: The Department of Defense has had experience in this for years because the active duty military individual when he is transferred from one place to another, his personnel records, his 201 folder, and his medical record. This has been extended in some situations to dependents also when their sponsors are transferred from one area to another. So there is some precedent in it. Of course, this is still just pieces of paper. It does not include the X-rays or electrocardiograms necessarily. And there are radiologists and others who are going to push that when an individual moves from one area to another they should take their X-rays with them. This gets them out of dead storage, because as you know, most X-ray departments, every three to five years, burn all old records that are not in their teaching files. This would assure, if the individual didn't lose them, that there would be the continuity of all his chest films and what-not over a period of time. But there has got to be a better system, as you say, Mrs. Wyckoff, with patients moving from one area to another.

DR. SCHREINER: Could we get the help from Mr. Riso on this kind of thing? It would seem to me, within the feasibility of existing technology, for example, to devise a

uniform system to reduce X-rays to a microfish kind of thing, and then devise a standard machine that would blow them back up again so that the person could carry these in a succinct passport, because nobody is going to carry around folders of X-rays like this.

DR. MARGULIES: Especially if he's a doctor shopper. George, this is exactly the kind of thing which we were talking about at the beginning of the morning. There is no question that we have the technical competence to do that kind of thing. It's very simple to reduce information to a manageable size. It's also perfectly possible -- and I wish we could move more in this direction particularly in some of the rural areas -- to maintain these kinds of information in a central computer bank. I rather suspect that we will reach the point at sometime in the future -- there's no point in waiting for it -- where there is a central repository. It would be much simpler then to simply be able to pull out of a central bank all the pertinent information which the patient has control over. He can maintain confidentiality with no difficulty. But it's that kind of advanced technical skills, using what we already know how to do, that we have to get on with.

MRS. WYCKOFF: There is a central computer bank for migrant school children now operating.

DR. SCHREINER: The computer is probably not

technically good for visual material.

MR. MILLIKEN: I was just going to say some cities have developed some uniformity of medical records between out-patient clinics, public health clinics, and school health programs, and to avoid this problem of moving and loss of records and duplication of medical work-ups, and these could be studied. I mean these are available. This is more on the preventive, early detection angle.

DR. MARGULIES: I was struck on a visit to Seattle not long ago with the fact that they have a patient way up in Alaska who has a pacemaker, and instead of requiring him to travel tremendous distances from there down to Seattle, they are monitoring it off a satellite and getting radio communication 90 percent of the time, keeping him under control, reducing costs. These are simple things to do. They seem way beyond ordinary events, but they are really not, and it's that kind of thinking that I believe we were talking about today that we have to start moving with more formidably.

MRS. MARS: Most hospitals, though, are very reluctant about wanting to release any records? How do you get over that? They'd rather burn them than give them to patients.

DR. MARGULIES: They are very reluctant to release records, except at the same time it's amazing how many people can get at them.

MRS. MARS: I mean to the patients.

DR. MARGULIES: The patient has a right to information, and if it is kept under the control of the patient, which it can be by the proper kind of keying method, then there isn't any question of having control.

MRS. MARS: But I think it is a problem and it has to be considered.

DR. SCHREINER: In general the input systems are better developed than the retrieval systems. It's not hard to put an X-ray on microfish but it's hard to get it back in a cheap fashion where you can blow it back up again so you can read it.

DR. MARGULIES: I think this discussion -- I'm sorry, Bob, you wanted to say something.

MR. OGDEN: I was going to say that I think, Mrs. Mars, in the forthcoming programs of national health legislation, which are obviously going to come, that perhaps something ought to be included about the patient's right to his records.

MRS. MARS: Exactly, because otherwise I say just try and get your records. You just can't.

DR. MERRILL: There is one small point about that which is perhaps a little too technical for this discussion, but there are patients' records which include notes by physicians which only other physicians can interpret, and

which the patient does not have the ability to interpret correctly, and which can frighten him to death in many instances, so that would have to be controlled.

DR. HINMAN: As Dr. Margulies mentioned when he was introducing me, I have been involved in getting a hospital working with a community group on some of its health care problems, and we attempted to get a decision from three hospitals running ambulatory care areas and inpatient areas and patient groups concerning the ability of the patient to carry some part of the record with them between each institution. Because the plan was to be able to cover all the hours that different institutions which sponsor the night clinic and the weekend clinic at different times, and the question came up about the record. And some of the community participants were quite concerned about whether they could convince their peers, their associates, to bring the records with them. So it's not a simple problem.

DR. MARGULIES: Well, I think we have recognized the fact up to this point that Dr. Hinman will not be worrying what to do with his free time, if that question ever arose.

We are moving along quite well through the morning agenda and should be able to get to the review activities this afternoon with no difficulty. There are some additional kinds of pertinent information which I want to bring to the Council before that occurs. One of the more important ones

is the current procedure for reviewing anniversary applications. We had a discussion of that at the last Council meeting and promised to come back to you with some more crisp information, and I'd like Herb Pahl to pick up at this point on that subject.

DR. PAHL: I would like to just take a few minutes to give you what our current position is with respect to the review of the anniversary applications because there are two other reports which are of importance to you prior to lunch time.

I believe that the best starting point is the letter that went out to you,dated November 1, from Mrs. Lorraine Kyttle, who is the acting chief of our office of grants review, and which contained a statement about the staff anniversary review panel, contained an overall chart showing the procedures by which the various types of anniversary applications are now reviewed, and also a membership list of the staff panel.

So rather than try to review all of that, which you have had an opportunity to look at, I would merely try to give you a bit of a conceptual framework. As you will recall at the last Council meeting, there was a statement concerning the review responsibilities under the triennial review system which you endorsed and which delegated to the Office of the Director a set of responsibilities relative to our

management of those applications within the triennial review period, and the implementation of that delegation of responsibility has resulted in the establishment of this staff anniversary review panel.

The review panel basically is charged with reviewing those applications for the 02 and 03 years of support within a triennial period, and making recommendations to the director as to whether further technical review by the review committee, or by other outside consultants, is necessary, and what, if any, kinds of action should be brought before this council, and what should be brought merely to your attention for information purposes.

In the present book of applications, I'm sure you have seen that there are on pink sheets the summaries under the anniversary applications of the statements by the staff anniversary review panel.

We have presented the conceptual framework and the mode of operation of this panel to the review committee at its meeting in October, and I'm pleased to say that it was very graciously received in the manner in which it was presented to them, namely, we would like to have that group, as well as Council, devote more time to the review of three-year programs and advice to us as deemed necessary, rather than devote so much time to those aspects of matters which we feel our own staff is quite capable of handling.

So the review committee did feel that it was an improvement in the review process in that only a portion of those types of matters which formerly had been presented to them would now be coming to them in the future.

Now, concomitant with the establishment of this new review panel by internal staff personnel, is the requirement on us to bring both to the review committee and to you that kind of information over the triennial period particularly which will keep you in touch with the regions and their activities. In other words, we are asking neither the review committee nor you to review the entire program year to year as you have heretofore. Consequently, we are interested in trying to display information for you as we go through this three-year period, in such a way that you will feel comfortable with what is developing, the changes of directions and activities in the region, so that when you do come to that point in time where you have occasion to review the region again for a subsequent three-year period, you will not feel that it is a stranger to you because there has been this time interval where you have not reviewed it in such detail as you have before.

In addition to reviewing the applications within the triennial period, we are asking our staff anniversary review panel to look at those applications which are requesting one year of support before a triennial period.

These always include new projects, so these applications for one-year support automatically will go from the staff review panel to the review committee, but with a somewhat different perspective than they have before.

The review committee this time, I believe in the case of North Dakota, received the application and comments from the staff panel and endorsed the staff panel's recommendation completely, which in a sense was a vote of confidence in the new procedure.

I don't believe I will go into the mechanics of it except to say that the panel has met once. It acts as a minor council, if you will. There are people on it as you have seen from the membership list who are not in the Operations Division, so that we do believe we have objectivity, impartiality, and a real sense of trying to review the region's application.

Prior to coming to the staff anniversary review panel, there is a thorough staff analysis, as has been done heretofore, and an actual presentation by operational desk staff to the review panel, and then there is a formal voting procedure and a rating procedure, such as is conducted in the RMPS review committee.

We believe that this is an improvement in the review process, primarily because it better utilizes the talents of our professional staff who are knowledgeable and

in daily contact with the regions. We also believe that it better utilizes the time of our advisers and consultants, and we would hope that as we go through this new process, both you and the review committee would advise us as to how best to keep you in touch with the activities that you now will be somewhat more remote from except for these three-year periods, and we would appreciate some constructive advice and criticism in this regard and in other matters that you may see.

Now, I think with the time available that probably constitutes sufficient information, but I will be very glad to try to answer questions about this, and we will keep you advised of procedures if you have any specific concerns.

DR. EVERIST: I think this is beautiful. It would actually cut down on the amount of time necessary for this one by one-third, you use one-third of the time you have always had to use before. I think it's great.

DR. PAHL: Thank you.

DR. MARGULIES: Well, if you think of anything bad about it later, let us know.

Two other items to bring you up to date before the lunch break so that you will be ready for the reviews themselves: I'd like to have Ken Baum give us a status report on the present local RMP review process activities which we have been carrying out. Ken.

DR. BAUM: They always put me on when lunch is

approaching. I guess that's to keep me from being too long-winded.

My job is to bring you up to date on what we are doing with respect to verifying whether the actual review process that the 56 RMP's go through in reviewing individual operational activities in fact meets the review process requirements and standards that have been set by RMPS.

You will recall that in the transition from individual project types of review that this Council and the review committee formerly conducted to the type of program review which is going on now, we have as a quid pro quo for giving the individual Regional Medical Programs authority to review their own projects from a technical standpoint, set a series of review process requirements and standards.

These have been sent out to all the Regional Medical Programs three or four months ago, and they have been reviewed and cleared by the various kinds of internal processes that are required.

Essentially, the review process requirements and standards cover such things as the fact that there will be a Regional Advisory Group set up in accordance with the law, that they do in fact review projects, that there will in fact be technical review groups that look over the projects before they get to the Regional Advisory Group, that there will be a set of regional objectives and priorities, and that these

will be made known to applicants and project sponsors, that there will be feedback of comments to applicants and project sponsors, that conditions of funding will be made known to them, that there will be an appeal process in the event that an advisory group other than the Regional Advisory Group can turn down an individual application. So these are the kinds of things that are covered in our requirements and standards.

What we are doing now is going through a process of verifying the fact that the review process in the 56 Regional Medical Programs does in fact meet those requirements. At this stage, two site visits have been conducted, one in western Pennsylvania late in September, the other in Tennessee Midsouth on the 4th of October. A third one has been scheduled for Washington/Alaska sometime in December, but I don't believe that an actual date has yet been set.

As a result of the first two visits, we have done quite a bit of soul-searching. The two regions that were initially selected were selected because they were thought to be easy ones that we wouldn't run into any problems with, and it turns out that perhaps none of them are going to be easy, so we have taken longer than we anticipated in developing a response to the regions, but in both cases now an advice letter is either completed and on its way up the line or is in final draft stage.

It is expected that the four operational branches

that have been set up on a geographical basis will take over the bulk of the site visiting that will go on. It is also hoped that in order to minimize the number of site visits we will be able to develop a procedure that will enable us to piggyback perhaps a review process verification visit with the normal three-year site visit procedure, perhaps with the regional office man filling in later on the types of information that can't be obtained in the normal site visit process.

Then, too, we have a series of management assessment visits that are conducted by the grants management staff and look into organization and management of Regional Medical Programs. I believe eight or nine of those are scheduled for the year, and we are also now experimenting with combining the management assessment visit with the review process verification.

So we will try to do this in the most expeditious manner and cut down on the number of duplicative site visits or repeat contacts that we will have to have with the Regional Medical Programs in order to do this.

We hope that as a result of this process that we will not only find that most Regional Medical Programs will conform out of hand, and that we will be able to easily rectify any that do not conform to the standards fairly quickly. But the outcome of this should be a local review process in which the review committee and this Council can

have confidence in terms of their carrying out capable, technical reviews of individual operational activities, and one in which the applicants themselves can have some comfort in feeling that their applications are being looked at on the local level in a manner that is both fair, reasonable and technically competent.

DR. MARGULIES: Any questions, elaborations?

Well, that's a status report, and I think that as indicated -- I suppose in retrospect, unsurprisingly the first ones did bring up some issues which have taken additional time, but which, as in many such experiences, will ease the rest of the process considerably because it helped to settle some issues that needed to be settled.

Finally before lunch I would like to have Mr. Peterson bring us up to date on the modification of the review criteria in the rating system since the last meeting, so that as you enter into a review you will know whatever slight changes have been carried out. You will find them relatively moderate, and so is he.

MR. PETERSON: I did report, Dr. Pahl and I, to the Council last time on the fact that we had developed and tested with the review committee a rating system in the course of the July-August cycle, and we reported on that to the group, so I'm not going to spend any great deal of time except to note as I did to the group last time some modifications were

made in the review criteria and the scoring system itself as a result of our initial trial. They were, I think, specifically enumerated for you.

Let me simply say that the review criteria in their modified form and the scoring system were used again in connection with this review cycle, the October-November review cycle. I think the level of acceptance by the review committee was significantly high. Our analysis of this second go-around did not point up,with one singular exception which I would like to make reference to in a minute, anything considerably different than what I discussed with the group last time in August. What you have in front of you are the modified criteria and the modified weights that we discussed with you last time. I pointed out at that time the kind of changes we had made from the initial one which essentially revolved around such things as breaking minority interests out as a specific singular criterion as opposed to having it in a number of places, the feeling on the part of the review committee that they were uncomfortable with some conglomerate types of criterion such as organizational viability and effectiveness, and we've broken those down, as I mentioned last time, into several components, the coordinator, core staff, RAG, grantee organization.

I think based upon the second trial with the review committee, we had very little in the way of suggested

modifications. One of the few specific suggestions that came up did relate to the weight which we had given to the coordinator of eight. I think there was some feeling, at least on the part of several review committee members, that time and time again the coordinator is a singularly important critical element in an RMP, and perhaps we ought to reconsider that weight in an upward way.

We, as staff, will be looking at that based upon what other outcomes we see from our more detailed analysis, but I would not think that any major modifications would be made in this now as a result of a second use, and if there are any slight or minor modifications that they would be very, very few in number.

Now, let me mention a second aspect of this, and you will be seeing that in the course of the meeting. You will recall that as a result of the first use of these criteria in the scoring system, the review committee came up with ratings which were grouped for your benefit -- regions were grouped in three groups with a range of ratings indicated.

I would note that in their first go-around, the average score given to a region was 244. This was back in July. We find the second time around, I think not an unexpected phenomena, that as they have greater familiarity with the system, and also as they look back and saw all kinds of scores, and we discussed this with them in much the same

manner as we had with you last time, that there has been a significant increase in their average score, so that as a result of the October scores the average was 297.

I might just add also, because Dr. Pahl has alluded to this, the staff anniversary panel is using the same criteria and doing the same kind of scoring. That panel came up with an average score of 306, which is fairly comparable, and 300 would sort of be the median conceptually.

We have, and you will see this, because of the significant difference between the average score in July and the one in October, applied a weighted mean to in effect equalize the earlier scores with the subsequent round. This application of a weighted mean does not in any way alter that initial series of groupings in terms of A, B, and C, upon which certain selected funding decisions were made by Dr. Margulies subsequent to that.

I think our own feeling as staff is now that we probably are in a position, with some possible slight modifications still, to sort of freeze the system and let's see how it works for two or three more cycles before we do any more tinkering with it. I think quite apart from that, however, we do look forward as staff to being more helpful to the review committee and anniversary panels particularly, but certainly the Council also, in that to a far greater extent we would hope that we could be able to target and display information

that is relevant to some of the criterion where that can be done in a fashion that will add to the judgmental as opposed to the intuitive process that is involved.

The final thing I'd like to say, again -- I think it can't be repeated too often -- is that the rating system, including the criteria and the scoring system, represents only a tool, and it's one device which the director and the Council needs to take into account in looking at regions, but it is not the answer, or the only answer, but it is an assist or a tool.

DR. MILLIKEN: In our last review meeting several of the applications indicated that there was a great need for the coordinator to have a high level and very competent assistant coordinator to be visible and to carry some of the load, that some of the problem was a lack of such a person.

I have been thinking since that meeting that this is such a common thing, that it would not be well in the future to consider adding in the rating system some visibility for this position so that it does get attention.

DR. MARGULIES: I think that's a good point. The issue came up more with reference to coordinators who appeared to be getting along feebly and needed some propping up. The same thing is true, however, in regions in which there is strong leadership but in which there is obviously need for some back-up for that strong leadership, and I think it would

be a wise thing to identify, particularly -- well, this is true in nearly all circumstances. I have had some of the better coordinators talk to me about this with great concern saying this is just fine, but I need to have someone who can take over at some point when I am not here and we need to be grooming him. I think it's a good idea.

DR. KOMAROFF: Have the coordinators or their staffs looked at this rating scheme and given their opinion to the steering committee or otherwise?

DR. MARGULIES: They have had a full opportunity to go over it, and unless we hear some evidence of a general dislike for it, which we have not up to the present time, we will consider this the process that we will continue to work with. We will not at any time reach the conclusion that it has to be just like this, but it has reached the point of a remarkable consensus as a working method, and unless we hear something which represents serious objection of a widespread kind, and unless you find that during the course of the deliberations today and tomorrow in some way ineffective, we will use it as Pete has indicated over a long period of time.

MR. PETERSON: I failed to mention that, Tony. After we did discuss this matter with the Council last time, we then made a mailing to the coordinators of the review criteria with an explanation of how the system was being applied, and I think there was some favorable feedback from

the coordinators' steering committee that we are giving them an opportunity in a sense to comment and take exception.

DR. MARGULIES: In fact, the steering committee, when we discussed it with them, was enthusiastic. It was not just grudging approval. They thought it was a darned good idea. So I think we are on a very positive level.

I'd like to do just two more things before we break for lunch. One of them is to again draw your attention to the items which have been included under X. We have covered some of them under the information only, but you will find under some pink sheets a list of members of RMPS review committees, some information on the experimental health services delivery system, the selected vignettes which are going to be updated and kept current and general, and something about the evaluation of earmarked funds. Now, these, if they require further discussion, we will provide time for.

The other thing I want to mention is that we will schedule a meeting in executive session at the end of the afternoon. The main things we want to talk about at that time are the status of activities regarding the Ohio program, some issues involving the Delaware desire to be a separate Regional Medical Program, and some questions involving the establishment of a cancer center in the Northwest. If there are other issues that need to be discussed at that time, we can add them to the agenda which is fairly unstructured.

Let's plan now, unless there are further questions, to reconvene at 1:30 when we can get on with the reviews.

(Whereupon, a luncheon recess was taken, to reconvene at 1:30 p.m.)

AFTERNOON SESSION

DR. PAHL: May we come to order now.

Now that we have finished the business of the morning, I think we might appropriately turn to the review of the applications. We are aware of the fact that Dr. Roth and Mr. Hines have departure schedules, so that we will have to make sure that we get Dr. Roth's in this afternoon and Mr. Hines first thing tomorrow morning, if not this afternoon. If there are others who have to depart prematurely, please let me know so that we can schedule the discussions on these, but we would hope that the rest of you would be able to stay through the rest of the proceedings, and we would presume since we have the major part of this afternoon to devote to applications that we could finish up our business before early afternoon tomorrow, unless we get into some extensive discussions on the applications.

I might also add that because of lack of efficiency in communicating all of the necessary papers to Dr. Schreiner and Dr. Merrill, unless there is an indication otherwise, we will leave the discussion and formal review and voting of the kidney aspects of the proposals,and those few applications which are devoted solely to the kidney activities, until tomorrow morning, so that Drs. Merrill and Schreiner will have the opportunity to read and consider these a little bit more at length this evening.

With those few remarks, and welcoming Dr. Brennan to our meeting, I think we might turn to our first application, which is Arizona, where Dr. Cannon is the principal reviewer, Dr. Ochsner is the back-up reviewer, and Mr. Smith is our primary staff person.

Dr. Cannon.

DR. CANNON: Well, I would like to recommend that we accept the review committee's recommendations, although the review committee did not support entirely the site visit recommendations so far as the amount of funding.

In looking at this objectively with their comments, it seems appropriate that although Arizona deserves additional funding, that maybe the site team went a little bit far in the amounts, and I believe that the review committee recommendation is more realistic.

One of their recommendations is for a revisit before 04. That means if they can expand the core activity with the amount of additional funds given, that some consideration for further funding might be reconsidered. Is that the way you interpret the site visit, before 04?

DR. PAHL: Let me ask Mr. Smith, Mr. Russell or Mr. Smith.

MR. RUSSELL: I think this was the intent, Dr. Cannon, that the review committee felt that since here again Arizona has many RMP's and really are on another exciting

threshold, and with this new look they should have a year to try to revamp their program along their new directions, and that by going back with the site visit, that if the changes had occurred that we do anticipate will occur, that perhaps additional money could be recommended at that time.

DR. CANNON: So the recommendation is for, as the review committee has suggested, $1,211,000, 03, 04, 05. The developmental component is $71,000-plus.

If you want to go into a further discussion about the program, I would be happy to do it, but I don't think it's necessary.

DR. PAHL: Dr. Ochsner, do you have anything to add?

DR. OCHSNER: I don't believe I have. I would second the motion.

DR. PAHL: It has been moved and seconded to accept the review committee's report and recommendations. Is there further discussion by Council?

DR. SCHREINER: What are you proposing?

DR. CANNON: That's excluding the renal component. We will have to take that up separately, as I understand it.

DR. PAHL: Yes, sir. The motion does not include the renal proposal. Is there further discussion by Council?

Does staff have any further comment to add?

All in favor of the motion to accept the review

committee's recommendation, please signify by saying aye.

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

May we next turn to the triennial application from Arkansas. Mrs. Mars is the principal reviewer, Dr. DeBakey, who is not here, is backup reviewer, and Mr. Says is our staff person.

MRS. MARS: I made a site visit on the 16th and 17th of September to Arkansas. Dr. Mitchell Spellman, the dean of the new postgraduate medical school of Los Angeles, California, was the chairman, and our major concerns were with the leadership review program project review, the region's developmental component request, and we did give considerable attention to the interrelationships of the projects, their correlations to regional planning, and their contribution to regional goals.

We spent quite a lot of time examining the achievements of the ongoing programs, the priorities and the program goals, and their relevance to the RMP goals, and objectives to the region's critical health needs.

We also gave intense scrutiny to the region's evaluation mechanism. This was the first site visit by a team since July 1969. Ours was the third operational one.

And during that time they have had new leadership, and I think the new leadership must be given some recognition because Dr. Silverblatt, who replaced Dr. Bost, is an exceptional man. He is an extremely dynamic person, and a very capable coordinator with the most overwhelming enthusiasm and consciousness for his work that I think I've ever met in anyone. He has a very deep perception of his own program and feels very strongly as to the direction it takes.

One of the things, of course, that we were very concerned about was the fact that with so strong a leader, just how much did he dominate the core and the RAG, but it was very interesting to find that he himself has surrounded himself with an entirely new core staff which is extremely capable and are not yes men at all in any way. He is 50 years old, and the core staff that he has surrounded himself with are mostly in the early 40's, and he has a great deal of youth as well. All these people seemed extremely loyal to him, and they respect and admire him tremendously.

They are asking for a very substantial increase in funding to support ten additional people, and these are very much needed. They asked for $595,673 to support core, and the site visit committee recommended $595,673. I think that we can certainly approve of that.

There are some criticisms, not very many of the program. I think that with any funding we should add a

directive that more minority groups be included in RAG as well as on the staff, and Dr. Silverblatt is very aware of this problem, and he is not remiss to change it in any way, but he felt that by doing so that there would be too many people in Little Rock, and he just simply didn't seem to know quite how to acquire more minority leaders, but we did give him several suggestions.

We felt that RAG was not being considered early enough in the project planning, and by the time the programs came to RAG, that they had been too finished, so that there was very little original thinking on the part of RAG. Also, another concern of ours was that responsibility had been abrogated to the executive committee of RAG for the approval of monies and funding for projects without any limitation, and this we highly recommended, and Dr. Silverblatt and all the core and RAG agreed that this would be corrected, and we hope that RAG will be more involved in the origination of programs.

The identification of needs of the region on the basis of health data has been very difficult, as their facilities for such collection have been extremely poor. They certainly have a great deal to accomplish in this area. We were pleased, however, to note that in the face of difficulties of getting the data, including the lack of cooperation from other institutions, that RMP has become a source

in sharing the data it has collected from the various community agencies. It's purchased computer tapes for census data and is working with the medical school, the state health department, and CHP to develop a health data base. The establishment of a better base and meaningful goal and objectives I think should overcome much of the weaknesses in their evaluation processes.

As you know, there are ten projects being terminated. Two of these it's much to their credit to say that they terminated them of their own accord since they were not meeting the goals.

Also I thought an admirable fact is that six of the programs that are being terminated, they have found continuing local funds for, and I think this is highly important.

The ARMP and their RAG have very definitely recognized that their chief impact is in the area of influence of health care delivery service, and this is illustrated, I think, by their training program for the care of coronary patients. They have had a dramatic success in shaping influence and improving care. Actually, from the initial base of eight CC units, the program has expanded to 45, and 20 more are in the planning process. They have over 200 nurses and 160 physicians that have already been trained.

The renal program, headed by Dr. Flanagan, has made remarkable headway, as a year ago there wasn't a single

hemodialysis unit in the State, and now there are twenty. The program has certainly brought expertise to all the subregions of the State. Dr. Flanagan, of course, is a very outstanding urologist -- nephrologist, I'm sorry -- and he has worked, I know, under Dr. Hume. I had met him there previously, because as you all know Dr. Hume is in Richmond, so he has certainly worked to make this program a success.

As to the cancer program, this has fallen down, but there is a new woman doctor who has taken this over, a very outstanding person, and she presented all her plans to us for the development and reactivation of cancer programs, and I think that under her direction some progress will be made in that field.

They have very definite programming for their developmental component, and they are increasing their cooperation with the State Health Department, and developing neighborhood centers in the two model cities, which are Little Rock and Texarkana. They are developing clinics in various Ozark and delta regions of the State. They are going to bring quality care into the rural pockets and lead to established centers and clinics throughout the State. I feel that the core must have great flexibility to take advantage of unseen opportunities that do offer the possibility of significant achievement for minimum expenditure of resources. Arkansas has certainly some very unique problems inasmuch as its

topography is very queer. The mountains run east and west rather than north and south, and there literally are no roads going north and south except two, which border on the edges of the State, so that everything goes east and west which makes it very difficult for transportation and communication. So this has been something that they have had to surmount.

Other than that, I think it's an exceptional program. I think the leadership is exceptional, and I certainly would recommend the acceptance of the review committee.

If there are any questions I'll be glad to answer them.

DR. PAHL: Thank you, Mrs. Mars.

Dr. Roth?

DR. ROTH: First, thank you for trying to get that plug in for the urologist. I appreciate the try.

But you mentioned that there was a reluctance or an inability to get background resource information from certain agencies, and I got the implication that there were outfits in the area that had information, and that so far nobody was getting it out of them very well, and since one of the roles of RMP that I think most of us agree on is its catalytic effect of trying to get reluctant people in, I was just wondering if you would want to comment.

MRS. MARS: This they are doing, and they have had trouble with the agency, actually with some of the

comprehensive health planning agencies. However, the VA, Veterans Administration hospitals, are working very closely with them, and there is very good rapport there, and I think that this is going to be overcome. Now agencies are turning to RMP for the information and beginning to appreciate what it can do.

DR. PAHL: Thank you. Is there further discussion from the Council?

DR. MERRILL: I have just a correction for the record. I hate to appear chauvinistic. But Dr. William Flanagan is a nephrologist who took his training with Dr. Merrill in Boston.

(Laughter.)

MRS. MARS: I said he worked under Dr. Hume. Did I say training? I'm sorry. I meant to say he worked with Dr. Hume.

DR. PAHL: Thank you, Mrs. Mars, for a very excellent report nonetheless.

The motion has been made. Is there a second to the motion?

DR. OCHSNER: I second it.

DR. PAHL: The motion has been made and seconded. Further discussion by Council or staff?

If not, all in favor of the motion, please signify by saying aye.

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

May we now turn to the Colorado/Wyoming triennial application. Mrs. Wyckoff is the principal reviewer. Dr. Watkins is back-up reviewer. Mr. Clanton is staff resource person.

Mrs. Wyckoff.

MRS. WYCKOFF: Briefly, this is a triennial application for a total of $3,384,030 for the fourth, fifth, and sixth year of operation, including a request for a developmental component of $288,000 total for all three years.

The review committee agreed with the site visit committee and recommended approval of the total request, and adjusted the amount to conform to the advice of the special team of site visitors who studied Project No. 29, pediatric hemodialysis, for the Rocky Mountain Region, at the request of the Ad Hoc Renal Disease Panel. This panel allowed $102,000 for the first year of the project, $91,800 for the second, and $71,400 for the third year of the renal project.

They also recommended $57,831 for one year only for Project No. 7, training program in radiation therapy and nuclear medicine technology, to allow time for local resources to assume total support of this project which is now assured

by the Denver Community College.

As a member of the site visit team which has made visits to this region each year for the past two years, I must say we were favorably impressed by the considerable progress made under Dr. Doan as coordinator and under the unusally gifted leadership of Dr. Nicholas as chairman of the Colorado/Wyoming RAG.

Dr. Doan is leaving, by the way, and a search committee is now working on a successor for him, and I believe they have several pretty good candidates in mind for him.

The RAG has moved vigorously in the direction of total program concept. It has developed goals, and objectives relevant to regional needs and resources, acceptable to health agencies and providers, and has established ad hoc task forces which have worked out authority arrangements based upon regional data collection.

A consumer health care data has been used to identify a number of health problems related to quality, quantity and accessibility. It is interesting to note that of the 13 projects supported during the 03 year, all but three are to be continued with funding assistance from other sources.

Staff is an extremely important catalyst for a broad range of activities in this, and has good relationship with all existing health agencies, providers, schools, and lay organizations.

Since there is no strong CHP activity in the region, core staff has stimulated consumer interest groups which might serve as nuclei for CHP B agencies, but if the B agencies fail to materialize these groups can become part of the local advisory bodies for RMP, which is essential for any outreach activity in this thinly populated mountain country.

There was a genuine concern for strengthening services to rural areas outside of Denver, deprived county, migrant workers, and remote subregions, strengthened by the hard data recently developed. There are a great number of specialists in Denver who are sort of underused, and there are general practitioners in the country who are terribly overworked, and this is one of their principal problems.

Core staff is working closely with community colleges on programs necessary to develop health manpower services outside of Denver. New approaches are being designed such as the planned utilization of returning medical corpsmen as ward managers, and possibly as assistant hospital administrators.

Other plans call for expanded role for nurses in various settings. County extension agents, for example, were found useful in deriving information about health needs and in initiating action immediately in remote rural areas.

The site visitors decision to recommend the total

amount requested was largely based upon the realization that the region has 20 RAG approved projects which were not included in the application package. This indicated to us that the RAG had established sound priorities and realistically faced its funding problems. This total request is only slightly more than its 03 year.

In recommending the developmental component, the site visitors felt that, first, the RAG was capable of mature decisions, two, that health resources of the region are very scarce, three, the new directions the region is taking showing the ability to respond to the needs of the peripheral areas. Therefore, I move approval of the recommendation of the review committee and the Ad Hoc Panel on Renal Disease, and I would like to ask Dr. Schreiner or someone to comment on the renal disease budget and say whatever they'd like about that recommendation.

DR. SCHREINER: Fine, if you want to wrap this up I did get a chance to go over this one.

DR. PAHL: Please proceed.

DR. SCHREINER: I think the comments of the site visitors and ad hoc panel are all very pertinent and I agree with them in general.

I am bothered by the notion of a two-bed unit. We, for example, using the same nurse technician ratio, are able to staff a four-bed home dialysis training program. I

think that there are optimal sizes for these kinds of things in terms of the relationship. You do have to have two nurses in the room if you have a number of people, but the two nurses can really operate with four beds most of the time, except when you are dealing with a very extremely ill patient, and I wonder if they shouldn't be encouraged either to share their facility by having it contiguous with an adult unit or nearby or else ask them why not go to a four-bed unit, because I don't think the personnel cost would be very much greater. This is an inefficient size for a chronic dialysis unit.

DR. PAHL: You would cast this in the form of a recommendation to them, however.

DR. SCHREINER: Yes. Otherwise I think it's fine.

DR. PAHL: Thank you.

MRS. WYCKOFF: That could be a suggestion to staff to negotiate with them.

DR. PAHL: Dr. Watkins, as backup.

DR. WATKINS: I concur with Mrs. Wyckoff's discussion.

DR. MERRILL: Mrs. Wyckoff, is this nephrology unit only pediatric?

MRS. WYCKOFF: Yes.

DR. MERRILL: And this is for transplantation and dialysis.

MRS. WYCKOFF: Yes.

DR. SCHREINER: They are proposing to go into a transplant program and have a peel-off by the fourth year.

MRS. WYCKOFF: It's covering a much larger area than just that one region, Colorado/Wyoming, but they are not getting any funds from the other regions except through payment by the patients.

DR. MERRILL: I notice representatives from the University of Colorado Medical School here do not include any surgical people.

DR. PAHL: Dr. Schreiner, with your permission perhaps we could defer this also until tomorrow until Dr. Merrill has had a chance to review this, and perhaps the Council therefore could consider the application with the deferral of the kidney proposal until tomorrow.

It has been moved and seconded, if I understand the principal and backup reviewers' comments, to accept the committee's recommendation, with, however, deferral of consideration of the kidney project until tomorrow.

Is there further Council discussion?

Is there discussion from any of the staff?

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

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

The next application is the triennial application from "Connecticut," with Dr. Millikan as principal reviewer, Dr. Cannon as backup reviewer, and Mr. Colburn as our staff representative.

Dr. Millikan.

DR. MILLIKAN: When I received the blue sheets, my first reaction, I guess, was amazement, and then when I re-read a paragraph on page 3, it says, "In the discussion, committee endorsed the concept of CRMP but expressed skepticism as reflected through these questions that were asked: Is it real? Is it unique?" and there are a series of questions there.

I had to conclude that somewhere in the process of overall review the project site visit participants had somehow failed to communicate adequately to the review committee. On September 23 and 24 there was a project site visit and I happened to be on that visit.

This failure of communication is so significant that I feel I need to review a bit some of the design and some of the issues at stake in this application, because the review committee has recommended a very significant decrease in budgetary allocations from that recommended by the site visitors.

One question asked: Is this unique? As far as I am concerned, the answer to that is yes, it's extraordinarily unique.

As one reconstructs the conceptualization of this particular RMP, you get to the opinion reading between the lines and looking at the action that there was a starting point with the original legislation for cooperative arrangements between institutions of excellence and the providers of medical care, but that the design was so skillfully put together, that there was a potential in the very design itself for producing ultimately a fundamental change in the delivery system by a series of steps, and these steps were so designed that they would hopefully be palatable and logical to the physicians of the State, so that they not only would be accepted but would actually gradually be generated by the physicians of the State. And as the designers of the scheme looked at what they had in the way of basic building blocks, they of course saw Yale University and they saw the developing school of the State of Connecticut Medical School, they saw a variety of agencies around the State, they saw several thousand physicians, 95 percent of whom are staff members of 33 community hospitals, and they zeroed in on the possibility of making the real fundamental contact point with the physicians of Connecticut via these hospitals; then went almost immediately to the idea of, well, should we try to get these

physicians to come from their hospitals to Hartford and to New Haven, to Yale, or wouldn't it be wiser to get them sort of womped up in their enthusiasm by doing something locally by assisting them in the design of a changing system in their own locale.

So starting with the entry point of these 33 community hospitals, there evolved the concept of developing physicians of full-time chiefs of service.

Now, at the time when all this business got started there were four such chiefs in the State of Connecticut, and now, as of this date, there are approximately 42 and some 16 other appointments are available.

The concept of the full-term chief included three subdivisions of responsibility. First was an inhouse responsibility to education, organization, and quality of care. In three of the hospitals now, where there are full-time chiefs, there is a local internal medical audit going on.

The concept of education was much more than the idea of simple refresher or review courses, but it had to do with the interrelationships between what we call formal education and how it might impact on patient care.

For instance, in one of these hospitals a full-time chief was designed to study -- it involves the records there of patients simply known to be hypertensive because high blood pressures are recorded in the records. Then there was a

follow-up on these records to see whether anything had been done about high blood pressure, and in 40 percent of them there was no evidence that anything had been done. So then there was an intensive series of interrelated education activities between the staff of that hospital and personnel from Yale, and now they are in the process of doing another audit to see whether that educational experience about high blood pressure has made any impact on the behavior of the physicians in that area.

The third responsibility of the full-time chief is called an outreach responsibility. Now, it's pretty obvious that if you look at his beginnings in a hospital he must make his way there on the basis of how he can get on with the staff and what alterations he can convince them to make, and so forth. But then comes the point in time when he begins to look out into the community. This is part of the design.

Well, an interesting example of how this has worked is in Danbury. The full-time chief of medicine there convinced the staff that they should really inspect their emergency room service. So they looked at their emergency room service over a period of three months with a team of their own selection, including people from the University Center, but selected by folk at the local level, and they found that two percent of the people going through that emergency room were categorized as emergency problems, 46

percent were categorized as urgent, and 52 percent were categorized as non-urgent, that is, could be handled any time from three weeks to three months hence without hurting the health of the individual. This was their own judgment.

Now, the point of that was that when the staff there saw these figures, they were convinced that some alterations in the pattern of practice of that emergency room as a portion of that hospital was indicated. So they then began to develop the idea of an outpatient facility which would be available at the hours of the day appropriate to siphon off a large number of the 52 percent who were categorized as non-urgent patient problems.

Well, I just cite that as an example of the continuing kind of activity of the full-time chief. Now the question has been brought up about how responsive CCRMP is to the needs of a variety of kinds of people.

Well, one of the things that they have built into their system, I think, is an unusual degree of flexibility and elasticity, not only in searching out the problems but in responding to the problems. For instance, in Hartford, there is an area of some 19,000 underprivileged, low income individuals, so a series of three organizations were put together by RMP to get going a clinic in that area, and this was done with $30,000 of RMP money. The place opened July 1, 1970, and in its first year became responsible for the health care

needs of 6,000 of the 19,000 people. Well, they immediately identified that that isn't by far enough, but what I am talking about is the response to need. There is some 170,000 Puerto Ricans collected in one portion of the State, and the handle here, or the vehicle, George, was diabetes, and they found that 3500 of these people had diabetes. So some diabetic clinics were put into operation with Spanish translations of the literature, Spanish-speaking people making the contacts, et cetera, to try to get these folk into a better health care system, in this instance the vehicle being that of diabetes.

There have been queries raised about the small size of the core staff. Well, this depends on how you define core staff. There are very, very few people in the Connecticut Regional Medical Program sitting behind desks making no contact with anybody outside of their offices. And the reason I put it in that frame of reference is that in a sense the full-time chief and the "university-based faculty" -- and that probably is a poor term as far as public relations are concerned -- constitute a real basic portion of core staff energy and activity.

The question has been raised by several: Well, how do you monitor somebody who is on the staff of Yale if you are sitting in an RMP program office across town?

Well, they had an example of an individual at Yale

who, according to the RMP literal core staff, was not subserving the function that he was supposed to be doing, and they went to the dean and a couple of other people at Yale and they got that incumbent changed. So there was evidence at that level that they could impact on the staff at Yale.

The query has been raised about the funding of these full-time chiefs. Well, they start with the idea that they will provide a maximum of $15,000 per annum to a hospital for a full-time chief for a period of three years. Now, in actuality, they've got several full-time chiefs short of that figure, the rest of that money to be contributed by the hospital, and the facilities and all the backup, physical activities and other personnel, to be put in the hopper by the hospital. There are a couple of full-time chiefs that are getting $11,000 per annum through the Regional Medical Program.

The query has been raised about the activities of the faculty-based staff. We had an opportunity to interview some of these people. One of them was a pediatrician who had replaced another individual because the other individual hadn't apparently been much interested in the RMP concept. The man we talked to gets 40 percent of his salary from RMP. It was estimated by him and by others that he spends about 60 percent of his time on RMP activities. Now, "time" is not further defined.

Well, what I am trying to display here is that

many, it seems to me, of the fundamental things that we have been talking about for a long time have been achieved. Regionalization is beautifully displayed, the ability to ferret out local problems and interact to them. For instance, there is an estuary area along the coast that has a summer population of 120,000 and a winter-time population of about 30,000, and the Middlesex Hospital adjacent to this, through its full-time chief, was spending $20,000 of RMP money, has got a clinic going in the estuary area which last summer took care of 13,000 people, subserving the needs of, in this instance, a transient population. And that was done with a relatively small amount of money.

I neglected to say that the Hartford experiment, where the 6,000 of the 19,000 were taken care of last year by this local clinic group, is now self-supporting. It's getting no RMP money at all. But I'm using it as an example of what can be generated by proper planning. So regionalization I think has been adequately taken care of.

The query comes about the position of the Connecticut State Medical Society and the interaction and the reaction of formal medicine to CCRMP.

I suppose that the simplest way to display what has happened, and is continuing to happen, is to point out that at the last review of this CCRMP "problem," there was a formal request to this Council from the State of Connecticut

Medical Society, that we disapprove the application. This time you have seen no such request.

Now, that's one way of identifying progress, and I know it creates kind of a smile, but I am displaying it as an indication of a gradual changing attitude.

Now, the interesting thing about that Connecticut Medical Society business is that we heard all kinds of testimoney from individuals who are members of that society attesting to the validity of the concept of the CCRMP. We had one man get up from the audience and identify himself by name as the President of a county medical society and said that their compendium of opinion in that county disagreed 100 percent with the unexpressed statement of the Connecticut Medical Society, and Russ can tell you about the presentation made at the recent AMA House of Delegates meeting, once again representing the Connecticut Medical Society as firmly opposed to the CCRMP. Is that too strong a statement?

DR. ROTH: Yes, that's too strong. This was in reference committee hearings, a couple of resolutions introduced from other States in support of the RMP, wishing to reaffirm official policy position of the AMA, backing the RMP concept, and this obviously occasioned considerable discussion.

One of the most vocal memberparticipants in the discussion was a physician from Connecticut. He did not make the mistake of representing himself as the spokesman for the

State Medical Society; however, he attempted to take RMP apart. Other people from Connecticut, however, stood up and said nay, and I'm happy to report that the upshot was that indeed the American Medical Association support goes for it. But when Clark came in with his glowing report, after recovering from the initial surprise, I think it's a beautiful manifestation of accomplishment in an area which is one of RMP's most important roles in my opinion.

DR. MILLIKAN: Incidentally, the gentleman that we've been talking about is not anonymous at all. He happens to be -- and he's not been excluded from the deliberations of the CCRMP -- on the executive committee of the Regional Advisory Group. So that his opinion is a part of the mix, but he's outvoted when it comes to certain action items, but it's not as though he had been deliberately excluded because of his adverse opinions concerning RMP.

One of the fascinating things about what I think of as the uniqueness of the total design is the way it's now beginning to accommodate itself to such items as Area Health Education Centers, because they could come close to writing the definition of this in a variety of settings, whether it were to be in Hartford or at Yale or at Stanford or wherever; they have the whole concept in mind of the Area Health Education Center and are really moving in this direction.

Now, as far as the HMO business is concerned, once

again they are so flexible in their design and their ability to get into these hospitals and make contact with the doctors has been so significant that the HMO business is now very, very much on their agenda, and there are four of these in the design process right in the New Haven area itself. So the totality of the design for this Regional Medical Program has been so well put together and so well-worked-out that they are able to alter, if you will, or maybe lead, if you will, in the construct of new ideas and the implementation of those ideas.

It says: Is the core staff large enough to monitor the university's activities? Well, I mentioned a few moments ago two examples where the university had changed the personnel involved in RMP activity as a request of the RMP central office staff.

I think the word "monitor" is in a sense unfortunate because the University of Connecticut Medical School and Yale really represent in this RMP local arrangements, and they are all working together with a whole host of other agents rather than one literally monitoring the other, or one being directly subservient to another. It really is an example of interrelationships.

Now, the question here is raised: Are the universities really committed to the concept and what is their real interest?

Well, if you go back to the history of the Yale participation, you find that the Yale interest in going outside its own walls antedates the RMP original legislation. They were beginning to get interested in community medicine, were assigning medical students and graduate students in economics and sociology and political philosophy to looking at the nature of the provider-consumer interrelationship in health affairs as early as the early '60's.

I think that there is good evidence that the Yale and University of Connecticut commitment to this concept is a firm one and a permanent one.

Well, you can get the gist, I think, of my comments. I think this is a unique program. I think it has fine leadership. I think the cooperative arrangements between a whole group of agencies -- I didn't mention the blood bank program, for instance. This has been a beauty. They have got some real evaluation data, for instance. They have changed the loss of blood, that is from outdating, et cetera, from 50 percent in the State of Connecticut to 12 percent in the last 18 months, via the computerization, and changed the availability scheme as far as getting the blood out in the State where it's needed. This has been done with RMP leadership.

So there is a host of bits of evidence about the wide ranging nature of the activity, and with these very brief comments I am going to move that we fund this program at the

level identified by the project site visit group which, incidentally is considerably under the original request from the Connecticut Regional Medical Program, that we do concur with certain of the questions about possibly enlarging the core staff. The question was asked of personnel: Why don't you have a larger core staff? They have some positions empty. I think one of the things we came away with is that they have tried to develop a core staff as well as inhouse chiefs and Yale and Connecticut University personnel who really believe in the total program and they are willing to work in a dedicated fashion for it, and they are reluctant simply to fill positions just for the sake of filling them until they can get the personnel they really want.

But I move that we go back to the level recommended by the project site visitors with these ideas about some additions to the Regional Advisory Group, some additions to the Board staff, and so forth.

DR. PAHL: Thank you, Dr. Millikan.

Dr. Cannon.

DR. CANNON: You don't think I'll add anything to that, do you?

(Laughter.)

DR. PAHL: No, sir, I was just asking.

DR. CANNON: No icing on that cake.

I think that Dr. Millikan was there, and I think

he has given you a pretty good rundown. I believe the review committee should hear his entire rebuttal. We've got it recorded.

DR. MILLIKAN: It's really just a part of it.

DR. PAHL: Dr. Schreiner.

DR. SCHREINER: I don't know whether you want a completely total comment here or not.

DR. PAHL: On the kidney proposal aspect?

DR. SCHREINER: Yes.

DR. MERRILL: I have looked at that so I can comment on that, too.

DR. PAHL: Fine, let's do the kidney one on this then.

DR. SCHREINER: I was curious as to what Dr. Millikan's response was. I looked these over and I don't know all of the people who are on the Ad Hoc Panel on Renal Disease. There is a lot of expertise on surgery and organ profusion, and I think their critique of the organ and tissue transfer program is generally correct, but I don't see any sign of very much expertise in the realm of immunoflorescent and electronmicroscopy, because there are some statements made in the criticism here that are just plain not true, such as ten percent of kidney patient cases require EM or FM biopsy analysis. There is no such data in existence. It depends on whether you do prospective or retrospective analysis, and it

depends on what kind of patient material you are dealing with, if you are dealing with a loaded pediatric census with lymphonephrosis, then maybe you don't need it in a large percentage of cases. But if you are dealing with adult hypersensitivity diseases which, for example, we encounter in a general hospital, you may need it in as much as a half or two-thirds.

And I've seen some other comments by the panel to suggest there are some deep prejudices in this area, and I have looked over this scheme and it's an excellent one. This is one of the problems that falls through the cracks, and it's like any other technical achievement. You can't get research support for utilizing these new techniques on larger groups of people because it's not considered a pure research project, and you can't get third-party payment because they don't consider it absolutely proven practice, and it's precisely the kind of thing that RMP ought to be addressing itself to, how you move it from the bench to the bedside. And to do this in any significant number of people, to find its place, you are going to find three kinds of groups of people, one, in which you do it to discover that it's not going to be useful -- in other words, that group of people can then be phased out but we really don't have that information now. You are going to find that there are a group of people in which it does add something, and you are going to find a group of people in which it is absolutely necessary for proper treatment.

And if it's not available and a medical school simply can't do this because of the expense involved, then there are some people that are going to be misdiagnosed and there are going to be some people that are going to be mistreated. It's like a lot of other technical things. You don't need it very often, but when you do you need it a hundred percent.

I think it's a very well-thought-out program. It has the strengths Dr. Millikan mentioned in that the material can actually get around from the various community hospitals to a center where it's going to be read because of the interchange of personnel that they have, and I would disagree with the Ad Hoc Renal Panel on that diagnostic one, and I would agree with them on the criticism of the organ and tissue transfer program.

DR. PAHL: Dr. Merrill, do you have a comment?

DR. MERRILL: Well, I certainly agree the organ and tissue transfer program has very little merit. I don't think we ought to get into any technological discussion here, but my own opinion is that the renal regional diagnostic program is a very valuable one, but I must confess that if I were running such a program myself -- and this is essentially what we do on almost all the patients we have; the yield in terms of making a difference between curing such a patient and not curing such a patient is almost minuscule, which is very

disappointing, I think, to most of us. Perhaps Dr. Schreiner is an exception. So, for different reasons I would agree that the application be deferred. I don't think the yield in terms of number of people who might be helped, applying this generally, at the present time is going to be worthwhile. However, eventually, in a prospective study over a period of five or ten years, we are going to learn something from this. If this can be interpreted as a function of RMP, then I would agree with Dr. Schreiner, but it's my impression that this is probably not the function of RMP.

DR. PAHL: Is there further discussion before we phrase a motion?

DR. OGDEN: I'd like to ask a question for purposes of information. If the site visitors had recommended $2 million, I assume that that includes $34,640 for the organ and tissue transfer program, which you have now said you don't approve of. I also assume that it includes the $133,533 for the kinetic kidney disease program, which you now tell us you do approve of.

If we look at the recommendation of our own review committee of $1.7 million, and add to it the $133,533 for the kinetic kidney disease program, we are up to $1,833,000.

So I would like to know what figures are we dealing with, if we are dealing with the $2 million from the site visitors committee, $1.7 million that has been recommended,

and then these other two kidney programs. I assume the kidney programs are not in the $1.7 million.

DR. PAHL: They are not in the $1.7 million.

MR. COLBURN: The strategy for the $1.7 million was to not allow for additional funding for the new requested activity and to keep the funding level of the regional faculty at the present level and not at the requested increase. That came to $1.7 million. That was the strategy of the committee.

MR. COLBURN: What you are really talking about here is $1.7 million, plus $133,533, if this regional kidney disease proposal is approved.

MR. COLBURN: No.

DR. EVERIST: No.

DR. MARGULIES: The thing is there is a difference, which is the issue that Clark is getting at, between what the site visitors recommended and what the review committee recommended, and he is preferring the figure of the site visitors which would come to what figure?

DR. CANNON: $2.25 million on the second year and $2.50 on the third year.

MR. OGDEN: He's talking about the $2 million. What I'm talking about is the $1.7 million that our committee proposes, plus the $133,533 for this kinetic kidney disease program, which would come to $1,833,533.

MRS. KYTTLE: Connecticut has an approved but

unfunded kidney activity which is the $133,000 that you see on this chart. It's $97,000 that is the proposed plan that Dr. Schreiner mentioned.

MR. OGDEN: I stand corrected. Then what we are talking about here is $1.7 million plus $97,000.

MRS. KYTTLE: Right.

DR. MILLIKAN: What I was really discussing was without the inclusion of the kidney proposal, since those were not really gone into by this site visit team. Since we do have expert opinion about them here, I simply did not include them in my discussion.

MR. OGDEN: Dr. Millikan suggested $2 million plus $97,000.

DR. MILLIKAN: I am not making any suggestions about the kidney proposals at all. I think we should listen to our experts on the subject.

DR. PAHL: May the chair hear a motion, please.

DR. MILLIKAN: I move that we go on record as approving their application, the first year $2 million -- this is not including funding of the kidney activity -- second year, $2,250,000, the third year $2,500,000.

MR. OGDEN: Do you then recommend on top of that there would be --

DR. MILLIKAN: The way I'm phrasing my motion, that would be a separate motion.

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

DR. CANNON: Second.

DR. PAHL: The motion has been made and seconded to accept the site visitors' recommended levels of support, with the kidney consideration to be the subject of a second motion.

Is there further discussion on this motion?

If not, all in favor please say aye.

(Chorus of ayes.)

Opposed?

MR. OGDEN: No.

DR. PAHL: The motion is carried.

MRS. KYTTLE: Dr. Millikan, can I ask a staff question right in front of you?

DR. MILLIKAN: Sure.

MRS. KYTTLE: Spence, do you feel that you have some material here that you could give committee feedback on the specifics for the reasons that Council overturned their recommendation? I don't feel I do, but if you feel you do, then I will be comfortable with that.

DR. MILLIKAN: I can draft them. It may be a ten-page document.

DR. MARGULIES: I think that would help.

DR. PAHL: The concern here is that review committee has expressed an interest at its last meeting in all

those instances where their recommendations are not accepted, to have as clear as possible an understanding of the basis on which the recommendations have been modified, and this is the basis for this request that we as staff can convey the information back to them.

DR. MILLIKAN: I think that's entirely fair. I'll be happy to draft it.

DR. MARGULIES: I wonder if I could just shed a little light on this peculiar chain of events, because obviously something did alter the view of this program, Clark, as you saw. It was a most peculiar discussion by the review committee. Those who presented it, who had been on the site visit, did it extremely well and with considerable enthusiasm, and in this particular case there was the additional support of one of the site visitors, Dr. Hirschboeck, who is the coordinator of the Wisconsin program and was equally enthusiastic.

Then the whole discussion sort of wound up in a lot of other issues, some of which were related and some of which were not related, and there were some strong positions of advocacy and antagonism, and I'm not sure that by the time we got through with it the Connecticut Regional Medical Program was what we were talking about.

DR. MILLIKAN: I think that came through.

DR. MARGULIES: There was even a very strong motion

at one point, in a manner which surprised me, which would suggest that what this program should do is conduct a plebiscite of all the doctors in this State to find out if they liked what they were doing. Now, since this has hardly been a custom in the Regional Medical Program to have inhouse plebiscites on how well they like what's happening, it gave you some sense of the fact that the general review was not as objective at all times as it needed to be. And I would add to the reasons for that excepting that I don't understand them. But there was something more afoot in that whole review process in looking at the Connecticut RMP, at least in my judgment.

MISS SILSBEE: Dr. Margulies, nevertheless, the review committee's expression reflected the continuing concerns that have been felt about the Connecticut program since its inception, and they felt like the site team did not come back with an adequate appreciation of those continuing concerns. The amount of money that they were requesting for the university faculty which was rising over the three-year period with no notion of how the universities were going to take over some of this, if indeed they were -- these were questions that have been inherent in the Connecticut program since its beginning, and I think that also was reflected in the committee discussion.

DR. MARGULIES: Yes.

MRS. WYCKOFF: What do we do about the principle of phasing out programs after three years? We are supposed to recycle them. How do you get to that?

DR. MARGULIES: As I understand it, the basic plan, so far as this additional staffing is concerned, is to have this become the responsibility of the hospitals in which the additional personnel are located, and they seem to have moved in that direction. There was some question about the validity of that, but that appeared to be their purpose.

And there was confusion, although there was a discussion, about the status of the faculty at the universities, and I think valid discussion. There was also considerable confusion about what figures we were talking about, and the review committee kept bouncing back and forth between two levels of analysis, and it finally came down to a lower figure than they had anticipated.

I think the questions they raised were valid, but the environment of the discussion became a little distorted.

DR. MILLIKAN: If you look at the issue, for instance, of the full-time chief, there is one hospital that has now opened up positions of surgery and psychiatry and in pediatrics requesting zero funds from RMP for those three new full-time chiefs. Why? They are so convinced via their experience from the RMP sequenting of the validity of the concept that they are willing to fund it themselves. I think

this is a fundamental idea of the whole RMP phenomenon.

Now, if one were to ask the question: Is the portion of this core staff, using the phrase in the large sense, at the University of Connecticut and at Yale, is it ever going to be completely self-supporting, I would venture a guess on that that the answer is no. Now, where the support will come from remains for time to determine, but I think that's the problem of any core staff.

MR. OGDEN: I would like to ask some questions and also to make a comment. And I will preface this by saying I am not a great believer in this body or any Regional Advisory Group abdicating its responsibilities to its staff, but at the same time I think we owe it to the staff to answer the questions that they present to us.

Now, we have adopted a budget here a moment ago without actually addressing ourselves to some associated questions which the staff has asked the Advisory Council to answer, and I think this is the first of the triennial applications, looking back through them quickly that we have gone through today, on which specific questions have been asked by the staff, and I really feel we should address ourselves to those.

We also have left unanswered in adopting this budget the question of whether this $2,250,000 and $2.5 million also includes this kidney disease proposal, or whether that will now be voted on as a separate amount to be added to

those which have already been authorized.

I should like to ask Dr. Pahl to lead a discussion about the three questions that appear on the blue sheet which the staff has asked, the first of these being that CRMP at the end of its fourth year provide a statement on how Yale and the University of Connecticut intend to eventually absorb the cost of the university-based faculty; the second that CRMP at the end of its fourth year provide a precise statement of the relationship to organized medicine in the State and what has been accomplished toward their improvement; and third, that the NAC render a policy guideline depending on the matter of support of faculty physicians.

This is the reason I voted no a moment ago because I don't think these things have been discussed, and I don't feel that adopting the budget is appropriate until they have been.

DR. PAHL: Thank you, Mr. Ogden. Let me open these questions for discussion. Perhaps we might turn to Dr. Millikan for initial response beyond his previous comments.

DR. MILLIKAN: I think it's entirely appropriate to ask any funding group to tell us at a given point in time what their intent is as far as the future. That's number one, what about Yale and Connecticut in the 04 year, what are their plans for absorbing these costs. I think it's entirely legitimate to ask them that.

The second item had to do with the business of relationship to organized medicine, and I tried, without going into a great deal of detail, to give the summated reaction that the project site visitors had to this.

Now, nowhere in the yellow sheets or in the past history of this thing did I see any details of a certain consultation visit. It wasn't a project site visit. It was called a consultation visit to the Connecticut Regional Medical Program which was made a couple of years ago after this Council received a formal request from the Connecticut State Medical Society to disapprove that application. There was a visit at that point in time where there was testimony from a wide variety of people about the Connecticut Regional Medical Program design, its impact on organized medicine, its impact on individual physicians, and on other health agencies in the State, and it seemed apparent that there was a relatively small group of individuals who were vehement in their opinion that CCRMP was not a good thing.

Now, I was simply trying to identify at least a change in their willingness to formally express that by pointing out that at this time we do not have a statement from the Connecticut State Medical Society asking that we disapprove this application, nor do we have a statement supporting the application, and I was trying to use that as evidence of some modification of their position.

MR. OGDEN: May I interrupt you just for a moment and say that I think perhaps asking CRMP at the end of its 04 year to provide a precise statement of the relationships with organized medicine is perhaps asking them to do something that nobody knows exactly what you want. What's a precise statement? I don't know who drafted that phrase, but I find that as a lawyer rather difficult to interpret.

I think perhaps what we are looking for is some better feeling of relationship, but I'm not sure that's a very good phrase for the staff to have used as a precise requirement.

I think what I'm getting at, Clark, is really numbers one and three, and I think here we do have an unusual situation of the support of faculty physicians. And this is something that perhaps a policy guideline ought to be rendered on.

DR. MILLIKAN: Well, it might be difficult to write a firm policy about this particular one. A good many of us have been convinced that it's a more effective mechanism to get cooperative arrangements established to have part-time support for a person who is a member of a university faculty, presuming that he is really going to contribute to the RMP activity, than it is to try to base a physician or a non-physician in a distant office and get him into effective daily intercommunication inside the university.

MR. OGDEN: Let me ask you a question here. Is part of the lack of relationship with organized medicine in Connecticut involved with the fact that there is some hostility toward the medical school faculty members and the medical school itself?

DR. MILLIKAN: I don't know the answer to that.

MR. OGDEN: We have this from place to place.

DR. MARGULIES: I think that may be a factor. There may also be some tension over the difference between those who are concerned with hospital function and those who are concerned with non-hospital function.

But let me just place this in what kind of light we can. The problem in Connecticut has been to determine who it is that we are talking about -- and this was the review committee's language, not the staff's -- when we say to get some interpretation of the attitude of organized medicine in Connecticut. Because what has happened is that there has been an executive committee of the State Medical Society which has had primarily one individual, and to some extent another, who have spoken frequently and loudly about their relationships with the RMP, and nobody has been able to determine what the rest of the executive committee feels about it or what the organized segments of the remainder of the Connecticut Medical Society feel or the rest of the State. Since we have one voice speaking loudly, and the rest of them

apparently going along in what appears to be a happy arrangement, it is difficult to know to whom we address that kind of a question.

DR. EVERIST: It has been small in number but large in power, that have been the dissidents there.

Another thing about the Connecticut Regional Medical Program, the first planning grant that came along that we thought was outstanding in this Council was from Connecticut, and for the first year or so of that planning period we thought it was outstanding. So their problems date not from the very beginning, as you may have thought from Mrs. Silsbee's comments, but rather they developed after the State Medical Society became upset about some of the things that were happening in RMP.

DR. MILLIKAN: One more comment about this relationship to physicians, the most articulate and visible of these individuals is Dr. Granoff. Dr. Granoff is a generalist who practices in a private office seeing many patients every day. He was asked in a friendly fashion, how should RMP go about making cooperative arrangements with the physicians in the State? And he said, "It should be done at the level of the doctor's office."

Well, Russ, and everybody here, I haven't seen any real successes down through the years that is getting into the MD's office, period. Now, this is a fundamental difference

of opinion about the way you go at constructing cooperative arrangements, and this was the very reason I gave a bit of history about why the community hospital -- and Connecticut is a bit unique in regard to the fact that there are 33 significent community hospitals, and only 33, in the entire State.

MR. OGDEN: I would hope, though, that many of the preceptorship programs around the nation are getting into the doctor's office.

DR. MILLIKAN: Well, there are so many things about this that I didn't mention. For instance, I didn't mention anything about the affiliation agreements that are being contrived between the two medical centers and a variety of these hospitals, and these have been interesting steps. The first one is a very loose one, and ultimately it becomes a much closer, a much more commiting kind of affiliation agreement, in which only eleven hospitals have signed up at this point in time. Now, in those eleven hospitals, there is complete interchange of house staff, intern, resident, and including undergraduate students, between the center and the community hospital, and in three of those hospitals there is now a program for getting medical students into physician's offices. So there is a distant attempt in that regard.

But what I was addressing myself to was the inability of the medical educator and cooperative arrangement type guy to get into offices of physicians across the nation.

DR. BRENNAN: I would like to respond to two of the points that have been raised. First of all, I would much dislike to see us make any general guidelines about paying salaries to people who are on university staffs. The relationship between the practicing profession, the hospitals, the delivery of medical care on the part of the university in various parts of the country differs widely, and I don't think we could make a valid guideline on this.

The same thing I would say about this application is that it seems to me that it's the review committee that always has an explanation for the position it took. It is very unusual to find the review committee recommendation go this degree contrary in a negative direction to a site visit recommendation, and I think that our practice has generally been to figure that the site visit brings back information for all of us that no amount of examination of documents can produce. I think that the inconsistency here lies not in Council voting on Dr. Millikan's motion, but in the review committee opposing the recommendation of the site visit group.

DR. MARGULIES: I do think we need to talk a bit further about the point that they raised, although I would not be deeply concerned about whether the Council reached any policy decision. But I think all of you who have had extensive experience with Regional Medical Programs have a sense of the meaning of a policy statement which would say that no

part of RMP money can go to pay a part of the faculty of someone who is in a university health science center because this arrangement is pervasive in the Regional Medical Programs. It does produce problems, obviously. You have a divided loyalty and all the difficulties that are inherent in that kind of an arrangement, the question of how well one can control the individual who is placed at some distance, et cetera. Yet, to involve salaried time of university faculty people in a Regional Medical Program on a voluntary basis is most unlikely, so this arrangement is commonly practiced. It requires careful supervision. It has to be guarded very well. But I don't know whether the Council has ever made any policy statement covering that kind of an arrangement and whether it wishes to.

MR. HINES: I feel very strongly on one point. Speaking as a layman it's probably much easier to come to this conclusion. I do not think it's incumbent upon this Council to pass judgment on approval of Regional Medical Programs because the State Medical Association leadership does or does not approve, or does or does not relate perfectly to the Regional Medical Program.

I feel implicit in the question is some concept that elements of organized medicine must approve before we approve, and I don't think that's the purpose of our work. I feel this very strongly. This program, obviously, according to Dr. Millikan's opinion I respect and whose presentation was

most articulate, is extremely effective. If there are elements of the State Medical Association in Connecticut that are not supportive of what is happening, that's too bad, but we should go ahead and approve it anyhow. Otherwise we are going to find ourselves trapped by an inertia that will mitigate against progress. Am I right, Dr. Millikan?

DR. MILLIKAN: Yes, I think that's correct. I was trying to point out the basic dichotomy here in the formal past position of the Connecticut Medical Society, in contrast to the behavior of its members. Now, I neglected to say, for instance, as far as this chief of service business is concerned, has that been forced into any hospital by RMP? Well, the answer to that is no. A hospital staff must vote in favor of a chief of service before the position can be created. That's an integral portion of the whole plan, and has been right from moment one. Those are practicing physicians, most of whom are members of the Connecticut State Medical Society, and so forth.

MR. OGDEN: Well, maybe I can wind it up this way just with one comment. I think we have had two occasions this afternoon, just with respect to one comment which was made down here, where we have approved budgets below those of the site visitors.

Now, in connection with these three questions that are asked here, unless Dr. Millikan wants to make some specific comment about it, maybe I ought to just make a motion since I

brought them up.

I will start with the bottom, in which it would be my motion that this National Advisory Council not render a policy guideline on the matter of support of faculty physicians, because I doubt that there are very many Regional Medical Programs around the country that don't have some faculty physicians involved in them someplace.

Secondly, as far as CRMP providing a precise statement on relationships of organized medicine, I just don't see that this is possible. I think they have got to come to some grips with the thing. I think asking them in a year to come up with some precise statement is really asking for something Olympian, which isn't likely to happen. It sounds to me as if there are some people up there who are pretty firm in their opposition, and they are not going to change their minds in a year.

So I would move that we vote no on those two.

The first one maybe we ought to take up separately because that is the one I just don't have an opinion on. So I will move no on two and three. Can we take them up in that order?

DR. PAHL: Yes, sir. The motion has been made to give an answer of no to points two and three. Is there a second to that motion?

MRS. WYCKOFF: I second it.

DR. PAHL: The motion has been seconded. Is there further discussion on the motion?

DR. MERRILL: I think the point raised by point number three is a critically important one. I myself have been given to understand that there was a policy already on the matter of support of faculty physicians, and that it was no, that we did not support them. I disagree with this, but in evaluating a grant and in looking at the evaluation by the renal committee of the grant that I had to evaluate, I know that they, too, felt that it was the policy not to support faculty physicians.

DR. MARGULIES: John, I think the distinction here is partial support of faculty for giving service to the Regional Medical Program versus partial support of faculty to carry out some kind of distantly RMP-related activity. It's really a question of adding RMP competence by the partial support.

DR. MERRILL: Am I to understand then that if one adds RMP competency by partial support this is justifiable?

DR. MARGULIES: That's what Woody is saying, yes.

MR. OGDEN: I will accept that as the motion.

DR. MERRILL: I second it very strongly.

DR. PAHL: Is there further discussion of the motion?

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

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

Mr. Ogden, would you like to discuss point one now?

MR. OGDEN: Well, I would really have to defer to Dr. Millikan on this. It seems to me, I don't know how related this is to item three. I really feel somewhat like the late Will Rogers, all I know is what I read in the papers, and this is the material that is in front of me, and I don't know how Yale and the University of Connecticut currently to what extent they are paying for university-based faculty and how CRMP is paying for it, and whether Yale and the University of Connecticut can absorb these things.

DR. MILLIKAN: I think the question is a little bit selective. I don't see the review committee, for instance, asking us to approach 56 Regional Medical Programs with the request that they define for us how that Regional Medical Program is going to replace the funding of a given category of personnel in each of the 56 Regional Medical Programs. Now, this is in essence what we are talking about. These people are doing RMP work.

MR. OGDEN: Let me ask you if you feel that it is desirable that Yale and the University of Connecticut eventually absorb the cost of the university-based faculty in this program.

DR. MILLIKAN: I think it depends on what these people are doing.

DR. BRENNAN: I think that probably the university-based faculty here spoken about will become employees of the hospitals concerned insofar as they are acting as chiefs of service in them. Now, I am happy to see that all these chiefs of service have appeared in Connecticut, but I am not prepared to believe that this is entirely the result of the CRMP effort. That is a widespread tendency across the country, and it's related to residency recruiting in a number of specialties, and I think there are strong motives for the hospitals to move towards chiefs of service for this and other regions, and that one could reasonably expect that if they were given a time ahead when support for this function was to be removed, that ways would be found to compensate for it, not necessarily in the university.

DR. MARGULIES: Now, there is a distinction and that caused some of the confusion during the review committee, between the support of people who are in the hospitals and the support of that portion of the program which is the responsibility of faculty people in the universities themselves, and it's the latter that caused most of the concern, because this appears to be a way, and it may be in some circumstances, of providing faculty for the university which the university doesn't have to pay for. And I think that's what concerns you,

isn't it, Bob?

MR. OGDEN: Yes, it does, because we have had this come up in Seattle.

DR. MILLIKAN: There's a neat little item here that the CCRMP boys missed out on originally, if they had called these people part-time core staff, the question might never have been raised.

MR. OGDEN: I think it depends on what they do.

DR. MILLIKAN: That's the point, and incidentally we inspected that by going to representatives of the hospitals, the project site visitors -- actually they came to us -- and we queried them about the time devoted by the university-based faculty to the activities identified in the application. We got affirmatives all the way down the line. We got time schedules on some of these people.

MR. OGDEN: I think perhaps what we are talking about is something that can't be resolved at the end of the 04 year, the statement particularly, and in connection with a comment that was made down here, perhaps what we are suggesting is that we would like CRMP to make an effort to get the university-based faculty, to get their costs absorbed by the university or the hospitals, whenever it's possible, and as a means of phasing out this kind of activity from CRMP support.

DR. SCHREINER: Isn't that concept self-defeating to what we are trying to do? Let's just take a defined situatio

like the stroke situation. If you have a university that's handling its service and requires one neurosurgeon and you now want to reach out into the community and support the backup of the training or in specialized care for a group of community hospitals, the university's answer is, "We need one more neurosurgeon to do that," and simply because he's based in the university hospital if he's serving that purpose, I don't think you can expect that the university is going to absorb this, because that's fine for a state university but it's not fine for a private university. What are they going to absorb it with?

DR. MILLIKAN: Well, George, you've just picked a real dandy. There has been no collusion here. The weak part in the Connecticut Regional Medical Program is the stroke portion of it, and the interesting thing about that and the analysis of why it's so weak is reasonably simple. Yale has a neurology department, for instance, that is not interested in stroke, and there has been no ability to go into Yale and get 10 percent time or 12 percent time from somebody knowledgeable about stroke at that level. The University of Connecticut emerging medical school has not yet developed any kind of expertness in this particular area, so they have gone elsewhere. The question was raised, you see, about support, and they have gotten very, very poor talent but it's all they could get at this point in time, and your question is, of

course, a dandy.

DR. MARGULIES: We are dealing with an issue which actually rises above the details of this particular discussion but one which is of tremendous importance, and that is the definition of what is the responsibility of the medical school with relationship to the community? One would hope -- I would hope at least -- that it would become almost an "of course" kind of thing that the university would absorb this kind of individual, because that's how it meets its community commitments, and I think that institutions like Yale and the University of Connecticut and many others are attempting to do so. I don't think they are trying terribly hard, and I think they are facing issues which they are allowing to defeat their efforts more readily than is absolutely necessary. On the other hand, they do have some tough fiscal problems. They have the constant tensions of their academic interests and their internal commitments of another kind.

So that what we could well do, and I think what you were saying expresses that intent, is to push things in that direction. My own feeling is -- and I have tried to propose this concept wherever possible -- that RMP may serve as one of its best efforts, that linkage between the medical schools, which will make it more natural for it to be a part of the community, and not find it a strange place but a rather natural place for it to teach, and for it to serve, rather

than defining it to the hospital.

DR. SCHREINER: The point I was making, though, was that the way to do that might be to put the man in the university. So if you take a doctor and they understand you are not going to support a man within the university, you might be defeating the best technique you may have for getting that connection.

DR. MARGULES: The question always is, which swallows which? And what we are hoping is that the medical school will be pulled out rather than the RMP being pulled in, but you can't govern that at all times.

DR. SCHREINER: You have to be realistic, that there are a couple of private schools that are on the verge of bankruptcy because they've been involved in community activities. So it's not really fair to say they are all that negative.

DR. BRENNAN: I'd like to make a point relevant to the future of financing for this kind of thing. I think when RMP demonstrates that a relationship with the university that brings consultants and teachers to update a hospital practice, when RMP succeeds in showing the way to this, that there exists resources for making various kinds of arrangements to allow this action to continue.

For example, hospitals all over the country are collecting substantial amounts of Medicare and Medicaid

monies that they didn't collect before and throwing these funds, insofar as the patients or staff cases, into what they call educational funds or development and research funds.

Now, much of this money is poorly spent. You will have the paradox that side by side with the university that is pinched on being able to hire enough faculty to discharge its responsibility, large-sized hospitals in the immediate area will be building up substantial bodies of money in reserve for educational programs which may consist of lecture series and other such or locally sponsored research projects, and so forth.

So the funding is there. Once the hospital staff and the hospital administrator begins to realize that this kind of a relationship with the university is valuable, there is nothing to stop an association of hospitals or a group of hospitals from contracting with the university to pay part or all of the faculty staff member's salary. Let him work from the university base and serve his function.

So I don't think we have to fall back from the idea that we want our monies to turn over, that we are basically in the business of starting things, and we shouldn't be frightened about the lack of resources. The resources are there. They are simply not being put to these purposes.

I think the Connecticut program will teach the Connecticut people the value of this, and if it is really

worthwhile and it's having a genuine impact in the community, they will see to it that it goes on.

MR. HINES: I'd like to speak to the funding aspect of the problem, not out of my personal attachment to Yale but as a matter of principle.

It seems to me that as a matter of principle we should not look to universities to absorb these costs, but as a matter of principle we should be very sensitive to the economic difficulties of the universities, and try to support them whenever we can, because they are so bereft of funds, and the work that we are trying to stimulate is so much related to patient care. It's impossible to separate the function as I see it of medical education from medical care, that I feel strongly as a matter of principle that we ought to take a position that we want to try to support these programs whenever we can and not ask them to absorb the costs. I don't know whether there is general agreement on that point of view but I feel quite strongly about it.

DR. MERRILL: I would certainly agree with that statement. I think the point is perhaps we have already passed a resolution which affirmed partial support for faculty physicians when it's justified if it adds to RMP competence. I think the problem is what happens to a man, let's say, who is funded for three years as an assistant professor, and then the university cannot pick up the tab, and I can tell you from

experience as the chairman of the committee on resources for the Harvard Medical School, there are many, many instances, in spite of Medicaid and Medicare, in which the hospital or the medical school cannot pick up the tab. However, I still affirm the principle which you have stated, because at least it gives them three years to look around and do something else in that time, and it seems to me he can be of tremendous assistance to the spread of medical care or to the facilitation of medical care. And, of course, in my own specific area of competence, of course this includes the transplantation and dialysis area. He can be there to train people and to take care of sick people and to help outside physicians accomplish this same end.

So I would agree that support is necessary but I can't see that the university is able or willing to pick up the tab after that, and that this support should depend on their being able to do it.

DR. EVERIST: This statement says that all they are asking for is a statement from these two universities at the end of the fourth year to say when they are eventually going to do it. It doesn't mean that they want it done at that time. As a matter of fact, they have funds to go three years. So that eventually might be twenty years hence, and they are not concerned about time at all here. It says eventually.

DR. BRENNAN: They are not even asking the

university necessarily to do it. All they are asking is that it be phased out of RMP.

DR. EVERIST: No, they are asking to make a statement of whether they intend eventually to do it.

DR. MARGULIES: If I get the sense of the Council up to the present time, it is that this particular arrangement, if well-handled, can work for the benefit of the university and the benefit of the Regional Medical Program, and I think we can express that concept.

On the other hand, it can be mishandled and be used as a cheap method of getting help that the university is not contributing to community resources.

I think we can transmit to the Connecticut RMP in generally that sense.

MR. OGDEN: I think we are dealing with a subjective as well as an objective discussion here. In a subjective sense I think this item one makes sense, within a year let's see what they can do. From an objective standpoint I agree with Dr. Merrill.

DR. MARGULIES: I'd like to add just in passing that I think this is another one of the areas of general concern in RMP's around the country which we must continue to evaluate, because the issue has not come up before. It's a little more striking here. We have begun to collect some data on this kind of arrangement and we will continue to do so and

keep you current on how much this kind of process is being pursued and what it seems to mean.

MR. OGDEN: We haven't completed the kidney portion.

DR. PAHL: If it's the pleasure of the Council, I would suggest that we break for a few minutes for coffee before it gets too cold and I lose my secretary who has been frowning at me for fifteen minutes, and that we then proceed on with Dr. Roth's application so we do justice to those regions, unless you feel we can come to a very quick resolution of the kidney aspect of the Connecticut proposal, and perhaps over coffee Dr. Schreiner and Dr. Merrill can chat with me to know how to proceed after coffee.

(Whereupon, a short recess was taken.)

DR. PAHL: May we get started again, please.

I'd like to take one minute more at the request of Dr. Brennan to call on him for a specific statement relative to the discussion which we just completed, and then we will move on to the kidney proposal with Dr. Schreiner and Dr. Merrill.

Dr. Brennan.

DR. BRENNAN: In inspecting the yellow sheets here that give the projected budget, I am led to a feeling of caution with respect to the bottom of page 3 in the yellow sheets on the Connecticut application, which shows the cost

for university-based Regional Medical faculty growing from $180,000 in the first year of that program to $819,000 in the sixth year of the program.

It seems to me that in the motion that we have just passed, the approval of the grant we have given, that we have laid before our staff, which will have the problem of looking at the second and third year of this application, a difficult job if we don't give them some guidelines.

Therefore, I should like to move that the CRMP be notified that it is the desire of the Council that ways of reducing the RMP share of these expenditures, these projected expenditures, be found.

I am not calling for the university to pay these expenditures. It's all right with me if they get it from the Hartford Trust, or something like that, but simply that they explore ways in conjunction with the hospitals and other funding sources, for seeing to it that this exemplary program is continued without quite so large a rate of growth as is projected at the bottom of this page.

DR. EVERIST: Do you want to give that same admonition for the community base?

DR. BRENNAN: No, because I understand the community-based program is one which I -- all right, I will give it for the community-based program, the whole works as a matter of fact. The only problem is it's a little more difficult to

handle this one.

DR. PAHL: Is there a second?

DR. SCHREINER: Second.

DR. PAHL: The motion has been made and seconded. Is there further discussion by the Council?

Mr. Colburn.

MR. COLBURN: This could be confusing about the community based, because the community-based physicians do have a built-in phase-out mechanism, and it provides for only three years to a maximum of $15,000 per year.

DR. SCHREINER: The numbers still keep going up.

MR. COLBURN: If you want to make some type of judgment of what the saturation point is on the number of full-time chiefs in the State of Connecticut.

DR. BRENNAN: All I want to do is put a shot across their bow, that's all. I don't intend to knock them down.

DR. PAHL: The motion, however, includes a statement as to the expectations of the total growth of the program which would relate therefore to the community-based activity, I would assume. Is there further discussion?

All in favor of the motion please say aye.

(Chorus of ayes.)

Opposed?

(No response.)

Motion is carried.

DR. PAHL: Now, if we may turn to Dr. Schreiner or Dr. Merrill for a motion relative to the kidney aspects of the Connecticut triennial application.

DR. MERRILL: Dr. Schreiner and I have had a little discussion during the coffee break, and I think we are essentially of the same opinion, although I think the implementation of that opinion is probably a matter for the board to decide.

First of all, we both agree that the organ and tissue transfer program is probably not worth funding. We agree also that one should do renal biopsies, and that certainly more than 10 percent of these do require EM or FM biopsies.

Where we perhaps disagree slightly is in whether or not this is critically important to the medical treatment of a large number of patients. I do not feel so from our own experience. If, however, diagnosis as an end to itself is something the Regional Medical Program should fund, then I think we are in total agreement that this is a good procedure.

Is that a fair statement, George?

DR. SCHREINER: Yes. I think part of our differencesof opinion as we chatted were that we see a little different kind of material. John's conclusions on glomerulonephritis, for example, are completely valid as far as our experience goes, but our material apparently is a little bit different. I think it has a little more utility than he does,

but I also think that we did cardiac catheterizations long before there was cardiac surgery, and I think about three-quarters of what we do in medicine to establish diagnoses is done without necessarily assuming that we are going to follow immediately with successful treatment. There is always a point in making an accurate diagnosis even if successful treatment doesn't exist, and I think this is a valid thing. After all, what's the successful treatment for cancer if you want to get down to it. We can do all kinds of diagnostic procedures, and rightly so, in order to characterize so that when the developments come along we will be able to put them in the right slots at the right time.

DR. MARGULIES: Really, the issue is not so much a technical one at this point as whether this represents the kind of an activity which RMP should reasonably support and which it is a segment of a health delivery system which at the present time ends at the point of diagnosis with no definitive treatment following, and I think we probably had enough experience that we could probably get a motion one way or another on whether this is worth supporting with RMP funds.

DR. SCHREINER: Well, I would move that it be supported for a three-year period, and I think it has some interesting lessons to be learned from applying this. There aren't very many communities in which you can actually get

this material moved from the places where the tissue is being taken to the place where it can be adequately studied, and I think a small State with a big community hospital is a unique kind of situation.

DR. PAHL: Mrs. Kyttle reminds me that this is a two-year proposal in which $97,037 is required for the first year, and $82,820 for the second year.

DR. SCHREINER: I haven't critically gone over all aspects of the budget. If the staff feels that this project can be done with a little bit less, I think that would be satisfactory as far as I am concerned, but I would like to move that the two-year project be approved.

DR. PAHL: The motion has been made. Is there a second?

DR. BRENNAN: Second.

DR. PAHL: The motion has been made and seconded for approval of the two-year period of project 39. Is there further discussion?

DR. MERRILL: Could we have just a comment, perhaps, from staff, those two gentlemen at the head table, as to whether there is any policy with regard to funding this kind of approach?

DR. MARGULIES: Well, so far as kidney activities are concerned -- and we are now talking in categorical terms -- as you know, the previous policy of this Council has been to

concentrate the expenditure of funds in the development of complete centers for the management of patients with terminal kidney disease, and since this is a separate kind of activity, my interpretation would be that it falls outside of that previously established policy, and it will, of course, if passed, be in competition for other funds which we would elect to grant as a part of our general kidney effort. So one of the issues is: What else might be done with the same funds as a part of the total dialysis transplant facility?

Now, I don't think we have any previous policy regarding this kind of expiration of diagnostic skills, but I do not believe that it has been a regular part of RMPS, or for the most part we have tried to concentrate on practice ready activities which are part of a continuum of diagnosis and treatment.

DR. BRENNAN: Is this practice ready from that standpoint?

DR. SCHREINER: Yes, but it falls between the cracks, and this is the problem; at least in most areas you can't fund it with NIH funds and you can't fund it with Blue Cross or Blue Shield. One of them says it's research and the other one says it's care.

DR. BRENNAN: So this is developmental rather than research. There's a nice distinction but I think it's real.

DR. PAHL: Is there further discussion by the

Council or staff?

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

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

In the interest of time, and since we have an executive session which we perhaps might schedule at 4:30 or a quarter to 5:00, I think it would be well if we would turn to the "Ohio Valley RMP," with Dr. Roth as principal reviewer, Mr. Ogden as backup reviewer, and Miss Parks as staff resource person.

DR. ROTH: Thank you very much. I'm sorry to throw the time schedule out of kilter. I appreciate this.

This is a triennial request, triennial review. I had the privilege of participating in the site visit, the report of which I believe is available to you at least in draft form.

The site visit team and the review committee recommendations are in virtually complete agreement, so I am spared dealing with any dichotomy on that score.

It might be entirely appropriate, since this is true, to shorten the procedure by simply moving the recommendations that have been agreed upon by the two bodies. However, I very briefly want to comment on two philosophical matters,

two problems that are of concern to the Council, that were manifest in this area. They are discussed at least briefly in the site visit report, and one relates to a problem which I suspect will be cropping up in other regions in respect to the subject of Health Maintenance Organizations.

It was interesting to have recently read Dr. Hinman's recapitulation of the HMO definition very much as Mr. Riso repeated it for us this morning, and find that when we got to Kentucky that there had been evidence of exercise of supreme grantsmanship in constructing the material which they forward on to Rockville, with a substantial emphasis on HMO's in support of HMO's.

It was a little bit surprising in testing out the sentiments about HMO's from individual physicians, representatives of State Medical Society and so on, to find that they took a much more free-wheeling view of what an HMO might be even to the point of including within the definition things that were not prepaid or financed on a capitation basis.

I don't think that I want to base any Council action on this except to alert the Council to this peculiar problem which we are going to have to face up to, and it's probably not at all surprising at this stage in the development of the concept, but I think we have to recognize that sometime when we get grant applications involving support of HMO that the people at the other end of that application aren't really

talking about HMO's as they may be defined in our language, and on the other hand, there is the very real, not only possibility but fact, that in some areas illustrated by part of this region, where making a great deal of fuss and furor about supporting HMO's turns off some of the groups of providers involved, and this I think is unfortunate because it represents a lack of communication. I think the people who understand HMO's, as Mr. Riso presented them to us today and as we can hopefully educate the provider public to understand them, will not automatically assume that this is some kind of compulsory governmental intervention with their business, that it is a developmental, experimental innovative and flexible approach.

I want to make no more of an issue of it than to point out that in this peculiar area that parts of three States -- parts of four States -- West Virginia, practically all of Kentucky, a southern part of Ohio, and some of Indiana, that you are involving medical societies and county medical societies of broad diversity of opinion from some pockets of ultraconservatism to some fairly liberal groups. These are simply considerations that I think we need to bear in mind, and it may be worth substantial thought here at RMPS to try to make the communications crystal clear and forceful when we are dealing with a confusing matter, at least confusing in the public's mind and many of the physicians' minds with

this HMO subject.

The only other thing that I would like to point out is that in this area when the committees, the site visit committee and the review committee, speak of minority group representation, in this area, certainly, and in probably others, the truly underserved of the area are not encompassed in the ordinary definition of minority groups, by which I imply that the real need for provision of medical service in this particular area extends to a group not normally considered among the minorities because most of them are white Anglo-Saxon protestants without shoes on back in the hills, and therefore, when we are concerned for minority representation, I think we need to think of it in a different context in this particular area.

Having said those things, I would like to move approval of the recommended funding at 90 percent of requested levels, which includes -- well, perhaps I'd better isolate this renal project again.

DR. PAHL: Yes.

DR. ROTH: I will move approval of all except the renal project, which includes a continuation of a multiphasic health screening project, and this has been run through staff here recognizing that it is a Council position that we have a freeze on new multiphasic health screening projects, but since this is a continuing request it is apparently, in the

opinion of staff, at any rate, with which I would concur, that it would be inapt to cut them off now, that if they are running a good program, and since this is a continuation project, I would interpret for the Council, unless it wishes to object, that this falls outside the proscription of funding of multiphasic health screening, and it includes a normal developmental component.

I move approval with the exception of the renal segment.

DR. PAHL: Thank you, Dr. Roth.

Mr. Ogden, would you care to comment before we ask for a second?

MR. OGDEN: The only comment I would make is that I was impressed with this project, with this Regional Medical Program, with the way that it's been written up. I think they have met their problems in a very imaginative and a very straightforward way. It seems to me that they are moving rapidly to the kind of a way from the categorical areas into the kinds of changes in health care delivery which the area obviously needs.

I have one question, and that is, Doctor, I believe that the 90 percent that is recommended includes the renal project.

DR. ROTH: Yes, this is correct.

DR. PAHL: The motion is excluding that.

DR. ROTH: It's hard to sort out but if it creates a fiscal problem that will be a staff problem, not ours.

DR. PAHL: The motion as made is for acceptance of the review committee's recommendations, exclusive of those sums which can be related to the kidney project.

MR. OGDEN: So the figures that appear here are not those that we are approving.

DR. PAHL: That's correct. May I have a second for the motion?

DR. MERRILL: Second.

DR. PAHL: The motion has been moved and seconded. Is there further discussion?

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

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

If we may now turn back of the yellow tab to the "Tri-State" anniversary application, again Dr. Roth is principal reviewer, Dr. Ochsner is backup reviewer, and Mr. Colburn is the staff person.

DR. ROTH: It's been a pleasure to go over this because although I have not been there currently, I was involved in the site visit for the triennial review of this area, and it's very encouraging to see that things are working

out as well as the site visit team at that time expected they might.

This is a very sophisticated RMP with an excellent core staff. I can't help but point out that the reports of the staff anniversary review panel make a couple of entertaining comments, which I'm sure are completely true as evidence of grantsmanship out of Tri-State RMP, where they say in one place that it was the conclusion of the staff review that Tri-State RMP is trying to present itself as being a program that is all things to all people, and in another place it comments that this is probably ingenuity at its greatest.

It's an excellent presentation, and those of us who have been there know that it is based on factual operations.

The matter before you obviously now, under the new system, is really essentially the recommendations of the staff anniversary review panel, and they have been crystalized into two sets of items. I don't know whether everyone has the white sheet, the anniversary application within the triennium for Tri-State.

DR. PAHL: Yes, they do.

DR. ROTH: I think we should briefly take these in reverse order, the items submitted for Council's information.

Proposed activities for which funding is requested

appear to be within the scope of the region's three-year plan. However, staff has specific concerns regarding projects 4, 11 and 17. The region has been notified of these, and the recommended reductions in funding are really reflections of what might in the old days have been denials of these projects since it seems obvious that the region will be persuaded to adjust itself to the budgetary circumscriptions if this Council approves the recommendations by shorting those three projects, and there is mention of the region's extensive use of the contract mechanism. This was examined with the resultant recommendation that RMPS consider the need for developing policies to govern this method of funding. This is probably a more practical recommendation than that made by the site visit team a year ago where we suggested that since they practically invented this business, they might come up with some proposed guidelines. In any event, there is a need for some ground rules on how you run these little contracts of relatively small amounts, recognizing that they can be immensely productive, that it's a mechanism that probably ought to be used by other RMP's, but that there needs to be some definition of limits beyond which you cannot use individual innovation and ingenuity.

Having given those items for the Council's information, I would then proceed to the items requiring Council action which are listed first, and I would move approval of

the intent of these two items, recognizing that the region has requested $3.5 million for its fourth operational year, that the staff anniversary review panel has recommended that the approved level of $2.3 million be raised to $2.5 million for each of the 04 and 05 years, and that there be an increase in the developmental level which would be included in the $2.5 million.

DR. PAHL: Thank you, Dr. Roth.

Dr. Ochsner, do you have any comments?

DR. OCHSNER: I have nothing more. I was tremendously impressed by the presentation here. I haven't had the opportunity of visiting the area so I can't speak to that.

DR. PAHL: All right. A motion has been made.

DR. OCHSNER: I'll second it.

DR. PAHL: Is there further discussion by Council?

MRS. MARS: In the raising of the sum, where will this money specifically apply in taking it from the $2.3 million to the $2.5 million.

DR. PAHL: Mr. Colburn, could you perhaps answer?

MR. COLBURN: I'm not sure I understood the question.

MRS. MARS: Well, it was recommended that we raise the sum of funding from what the approved Council level of $2,323,591 is, to raise it to $2,500,000. Where will this difference of money, from the $2,323,591 to $2,500,000, be

applied?

MR. COLBURN: That would be the decision of the Regional Medical Program as determined through their own decision-making process, but it would have to be applied to --

MRS. MARS: So there was no specific project that you were thinking of in raising the sum.

MR. COLBURN: That's correct.

DR. EVERIST: That $2.5 million does include the developmental component.

MR. COLBURN: Yes, it does. You have limits on the developmental component.

DR. PAHL: Dr. Roth, did you have a further comment?

DR. ROTH: No, if Mrs. Mars is satisfied with that answer, the $2.5 million is mathematically arrived at by taking the $2.3 million and the increase in a kidney component which is not really under debate at this time; it was a grant request which was submitted and approved subsequent to the triennial appropriation that created the $2.3 million.

DR. PAHL: Is there further discussion by Council?

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

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

DR. PAHL: I should like at this moment to take care of one or two housekeeping chores.

First, I think the record should show that Mr. Milliken was absent when the Council discussed and voted on the Ohio Valley application, and Dr. Komaroff and Dr. Merrill were absent during the discussion of the Tri-State application.

Also, I would like to make a statement to the Council. I'm afraid we left you in a bit of confusion, or at least some of you, earlier today when we distributed to you the revised rating sheet form. This is for information purposes only, and we are not asking you in any sense to use it for the applications under discussion. It was merely to show you what our present system is and how it has changed from the earlier one.

We will be distributing to you at the end of this meeting a sheet which will display the review committee's ranking of the regions and the priority ranges as we did at the last Council meeting, and ask you before you disband to either endorse or modify those ratings as a group.

Subsequent to this Council meeting, and with the formalization of the rating procedure, we will be bringing to you on the review committee and staff anniversary review panel sheets, the ratings given by those bodies, so that at the time of Council review, presumably starting with the next Council, you will see the ratings that have been given and

will have an opportunity to comment on them at your leisure.

Perhaps we might go on to another application, and so that we won't shorten Mr. Hines' time tomorrow, since he does have to leave early, perhaps we might take up the North Dakota application, which is under the anniversary tab. Mr. Ogden is the principal reviewer, Mr. Hines the backup reviewer, and Mr. Ashby our staff person on this application.

MR. OGDEN: In reviewing this application I felt myself at a disadvantage in not having had the opportunity to visit this Regional Medical Program and to experience somewhat first-hand the problems that they so obviously seem to have, and I think I should like to preface my entire comments with the thought that I think we need to be careful not to kill a Regional Medical Program by action that perhaps is unintended in the hope that we are being helpful.

That is a rather mixed statement, but I think you will see what I mean as we get into this.

This is a Regional Medical Program which admittedly has good provider support, but as I understand it, the North Dakota situation once upon a time it was hoped that this would be a part of the Northlands RMP; the North Dakota people elected to go it on their own. They have a group of relatively unimpressive projects, most of them related to nurses and to types of hospital inservice training.

I think I thoroughly agree that this is not a

triennial application. Funding for one year is all that is warranted, and that a developmental component is not in order.

I thought the staff anniversary review's critical comments were well summarized. It seems to me that more stress needed to be laid throughout the entire proposal on the evaluation of what is being done and what has been accomplished, and considerably better coordination with CHP in North Dakota is necessary.

Under Tab 3 you will find that they are indicating -- I think page 17 under that -- hopefully that they are going to be working -- it's under Tab 3.

DR. PAHL: Mr. Ogden, only you have that, the two principal reviewers.

MR. OGDEN: All right. In any event, they have indicated an intent to work more closely with CHP but this strikes me as something that perhaps has been included for the purposes of an application, and nobody has thought through precisely how that should be done.

This Regional Medical Program has a director who is not full time. It obviously needs some additional staffing, and it's my thought here that if this is approved at the figure of $293,301, that perhaps to that should be added sufficient monies to hire a full-time deputy director, and a full-time program development and evaluation individual, and I'm not certain and would like to ask staff whether they feel

that the $293,301 should include those two new people.

I also felt that Project No. 10, which is mentioned on your summary sheet for the items requiring Council action, was worth supporting. There is another project of about $8,600, which I gather I apparently am the only one who has it, that in reading through their material appealed to me. I don't know whether it would be numbered Project 44 or precisely what it is. This is a very difficult document to go through. I agree with somebody's comment that the grantsmanship could stand some improvement. But it's called Community Health Care Aid Demonstration Project that involves a nurse providing health care services insome rather remote areas in the State, a sum of $8,600 involved in that.

It would be my suggestion that on the items requiring Council action, first of all, that this be treated as a one-year application only, that the funding of $293,301, if it does not include the full-time deputy director and a program development and evaluation man, that the cost of those two people be added to this, and I would like to have staff advise me as to whether they feel their recommendation on item No. 4 on this Educational Center for Respiratory Care is included in the $293,301, because I am simply not able to tell whether it is or not, and I agree that the developmental component certainly is not appropriate for this.

This Educational Center for Respiratory Care

strikes me as being one mechanism on a regional basis toward changes in health care delivery in the State of North Dakota, and I think it's well worth supporting because it has in it that seed of something very necessary for this Regional Medical Program.

DR. PAHL: Thank you, Mr. Ogden.

Let me also understand, you do agree with the recommendation that the developmental component be disapproved?

MR. OGDEN: Yes, I do. I don't believe that the developmental component would be spent in a useful fashion in this Regional Medical Program at this time.

DR. PAHL: All right. Now, before we move on to the comments from Mr. Hines, perhaps we could ask Mr. Ashby and Mr. Webster to comment on the points raised by Mr. Ogden.

MR. WEBBER: This is a very interesting RMP and it's sort of at the crossroads. As you may not know, last week, because of the fact that the written page does not always carry all the information which is vital to a decision, Mr. Ashby and Mr. O'Flaherty made a site visit from here, and they uncovered some things about which I knew some, not completely. For example, the situation at the moment is that the dean of the medical school spends 30 percent of his time and receives 30 percent of his salary as the coordinator. There is a full-time and very capable director, Dr. Wright,

somewhat of a conservative, I would say, but he let me know last week that he now plans to retire, or he hinted to this extent that he plans to retire this coming year.

Meanwhile, there is a very capable physician who is heading up the Medex program at the university, being paid 100 percent by the university, and spending 10 percent of his time in the RMP program, part of whose arrangements for coming to the university were that he would take over the directorship of the RMP upon Dr. Wright's retirement.

The one fallacy or shortcoming in this approach is that in view of the apparent intent of Dr. Wright to retire, it will be well to get a deputy director on board without any more delay than possible so that this transition can be made smoothly, and that there might be some young new blood put into that program.

Now, the program is not completely conservative. They are doing some innovative things. Some things are kind of tied down and I am going to ask Mr. Ashby to comment on these. For example, they have an interest in fostering and helping in the development of an HMO. Well, you can do this in North Dakota; this is pretty good. We have the application in the regional office. It has been approved, and we suspect it will be funded. So they are changing some directions.

I will just turn it over to Mr. Ashby at this point, but we think the main thing is we need to get new leadership

in there. First, let me just mention that the $293,000 would not be adequate to do these things, to put on these two additional personnel full-time, which are badly needed, and to include any activity in these new projects which will not be able to be covered as far as we can see in the $293,000.

MR. ASHBY: The last site visit was made in December 1970 which was almost a year ago, and during this visit -- actually it was a get-acquainted visit for me because I had never been in the State of North Dakota at all. They do have a system now set up, and it's the same as Inter-Mountain, for evaluation and planning, and are utilizing it for evaluation, as far as I know now no planning. They have excellent visibility throughout the State. They work closely with four B agencies in the State. They have full cooperation of the medical community.

In each one of the records that I have read there has been concern that this program was oriented towards continued education for nurses, and to a certain extent this is true, but I found out one thing while I was there, any hospital in the State of North Dakota has to have a coronary care unit, and it doesn't matter if it's 20 bed or 28 bed or what, and a lot of this had been in coronary care, a lot of the nursing training, and I think this included about 80 hospitals.

I think after talking to each member of the staff, they have a competence and they have a dedication. I think

that they are certainly doing something towards upgrading the quality of care in North Dakota, and I'm sure they are doing some towards accessibility.

This doctor that he was referring to that heads the Medex program is a Dr. Bassett, and this class I think graduates in January, and we talked with this fellow for I guess two hours. He's a young physician, very innovative, and I think would probably fit in well, but anybody that takes over for Dr. Wright up there is going to have to be somebody that supported Dr. Wright. He is a powerhouse in North Dakota. There's no two ways about it, this guy has the power, and when Dr. Basset came in on the Medex program he was promised Dr. Wright's job when Medex was over.

I don't know, most of the projects are poor projects. They have no problem whatsoever getting volunteer people to work, and they put on their seminars and so forth, and I just think with the $293,000 we're just killing them. That's all there is to it. I think there's more there. I think the foundation is there for a good RMP, and I think we have to have a deputy director for that, and I think we definitely have to have a full-time director for planning and evaluation. Actually, Council had approved to go on the 03 year $371,325.

DR. PAHL: Thank you. Let me ask Mr. HInes to comment, and then we could come back to possibly what

additional sums are required for those salaries and the projects that Mr. Ogden referred to.

MR. HINES: I have nothing to add to Mr. Ogden's comments except the hope that Dr. Wright keeps the faith.

(Laughter.)

MRS. WYCKOFF: Can you get someone to take a job on a one-year basis? Don't you have to have a little more base than that.

DR. EVERIST: Keep the faith.

MRS. KYTTLE: In arriving at the $293,000, the staff anniversary review panel thought it would force the region to make certain funding decisions that we thought must be made at this point. Approximately $90,000 of the dollars in this program are earmarked to continue beyond their period of support programs that we were rather hoping would be turned off. Another $97,000 were to activate previously approved projects which we rather thought were no longer as relevant to national priority as they are now, and moving back from those points, we felt that $293,000 would be close but it would require funding decisions and still provide enough room to add the two full-time positions that we felt were more critical than keeping programs ongoing that we were rather hoping would be turned off and not initiating these new programs that he proposes.

DR. PAHL: Mr. Ogden, would you like to specify

the motion with respect to Project 10 and the other project whose number I don't recall, so that we could have it.

MR. OGDEN: I'm not sure I've got a number for it. It turned up in my book -- it's under Tab 13 on page 101. It's called Community Health Care Aide Demonstration Project, 44-5-M-0.

DR. BRENNAN: I've got a little question about one of the projects here. They've got a cancer registry going for a substantial amount of money here. They can't add more than about 1200 or 1500 cancer patients in the whole State a year. The reality and value of a cancer registry in a population of half a million people -- a little more than that, 600,000 -- can be questioned. It seems to me that this program is a twisting of the things which medical societies group will probably find acceptable, helpful in one way or another, but that the program isn't probably moving things very substantially there, and won't.

MR. WEBSTER: Could I make a brief comment? Whatever the funding level is agreed upon by the Council, the most important aspect is the personnel, leadership changeover. And I would hope that this is appropriate, that the condition of the award provide that the first thing that must be done, with whatever money is provided,this new leadership and direction be brought in as a condition of funding.

MR. OGDEN: Mrs. Kyttle, I understand your comment

to include that the $293,301 was to include Project No. 10 also?

MRS. KYTTLE: That is a demonstration feasibility study type thing which was to be undertaken as a part of core, was it not?

MR. WEBSTER: Yes.

MRS. KYTTLE: That's a core activity.

MR. OGDEN: So it would be in the $293,301.

MRS. KYTTLE: Yes.

MR. OGDEN: Well, I think on that basis, since I did not understand that, I am going to recommend that this project be approved for just the $293,301, with no additions.

DR. SCHREINER: Does your motion specify the salary of the people to be brought on?

MR. OGDEN: Yes, and that included a full-time deputy director and a full-time development and evaluation man.

MR. ASHBY: The money is not there. It can't include it.

DR. MARGULIES: Well, you know, that depends upon what programmatic decisions they make. I think the point Mrs. Kyttle was raising was exactly that. If you are talking, as she was suggesting, as I understand this motion to be, about a sum of money which is to be used in a specific fashion, and if you are going to develop new leadership and if you are

going to bring the new leadership into a program which is given enough money to initiate some activities they should have initiated in the first place, you're going to saddle that new leadership with some things they never should have been saddled with. This program actually is at the point where with the right kind of people that it has to go back to something like a planning level and decide what it needs to be, and if it continues what it's been doing and adds more of the same, the leadership that comes in is going to be stuck with what they have already started, and it's going to take another year or two to undo it, at which point that leadership might decide they'd like to go somewhere else.

DR. BRENNAN: For example, they could hire an assistant project director for $25,000 just by dropping that cancer register.

MR. OGDEN: I agree with that and I think on their Project No. 2 for training nurses and rehabilitation of nursing techniques, this again is a project that perhaps could be phased out, and some effort could be made to find support for this with hospitals and with nursing homes, and I would frankly say that this kind of project is one which I think needs evaluation because in so many cases the people who attend these are people from nursing homes and they go back to where they come from, and for budgetary and other reasons simply are not able to carry out what they have learned, and

I think that project may very well when it's evaluated prove to be less worthy of support than it appears.

DR. PAHL: The motion has been made to accept the recommendations of the staff anniversary review panel, specifically including the salary of a deputy program director and an assistant director for management planning and evaluation in the recommended level of support for the one year. Is there a second to that motion?

DR. BRENNAN: Second.

DR. PAHL: The motion has been made and seconded.

Dr. Roth.

DR. ROTH: I think it's important for the Council to recognize that here you are dealing with a rather peculiar region. For example, North Dakota has the lowest infant mortality of any State in the union, if this is the thing that everybody sort of judges medical care efficiency by. I don't know the precise figure, but they are about 41 to 47 percent below the national average in terms of ratio of physicians to population -- I'm not equating these two things.

(Laughter.)

One of the first studies that North Dakota RMP did was an extraordinarily interesting study of physician movement from their small towns;fifty years ago there were physicians in all these little towns scattered throughout North Dakota. Some of them would have three or four physicians

The ones that had only one now have none. The ones that had three and four are lucky if they are holding on to one. Their problems in meaningful projects for North Dakota are, I think, a very different sort of problem than most of the regions we have to deal with. Perhaps the site visit teams and the review teams sitting here are taking all of these factors into consideration. Their problem, for example, is not a matter of getting distribution or delivery of care to people in any ordinary sense of the term. It's a geographic problem that will probably never be solved, except by the development of trade-offs, improved transportation, perhaps even air transportation, the use of two-way television, the development of new kinds of allied health personnel. I think we need to be very careful not to downgrade a program in an area like this because it hasn't shown performance like other areas that are more stereotyped in their demands.

I have not been in North Dakota to look at the RMP program. I know a number of physicians out there and have discussed what RMP is doing and, as has been said here, there is no problem with the fact that the program has established good rapport with the providers of service, not only the M.D.'s but the other areas.

But I think to summarily cut them down to the bone because they haven't got some kind of a dramatic program may be short-sighted, because this is an area with deficiencies

that are shared by some other areas, perhaps Alaska has got them worse, but not too many other places have them, and what is innovative and constructive in North Dakota I think wouldn't be given a second thought in any of our metropolitan areas or any of our more populous regions. This is all gratuitous information. I haven't studied the program. I mostly know about it from the fact that the first grant application I had to present when I came on the Council happened to be North Dakota, and I have continued an interested in their problems.

DR. PAHL: Thank you, Dr. Roth.

MR. ASHBY: Their two major industries, believe it or not, are farming, and the second is hospitals.

DR. ROTH: The Air Force base.

DR. BRENNAN: They've got very good bird shooting there, too.

I would say that one of the things that troubles me about this program, though, is drawn exactly from what Dr. Roth has talked about, namely, that the problem up there is a radical problem in medical care, just as it is in northern Michigan, and the extension of funding and efforts along what I would call the stereotyped lines represented by this application has no hope of making an impact on that problem.

Now, one doesn't want to destroy the morale of these people utterly, but on the other hand, he has to face

up to it. An RMP in a region like that with those problems comes up with this list of projects, he really does need some more core staff, a lot better than it's got at the present time, and it's going to have to do the things you're talking about, and it hasn't begun to think about doing them.

So I don't think they are going to be injured in their fundamental interest by the withdrawal of some of the support for some of these projects and the requirement to put it into staff effort, although I'm sure that they may be discouraged, and it will be a hard bump for them to take, and I regret that, but I have no hope that the pursuit of this kind of thing or the encouragement of this kind of thing is going to gain anything for them.

DR. EVERIST: If George Moore were here he would note that they are getting 50 cents per person in this area, so it's not a small amount of money relative to population.

DR. PAHL: Are there further comments or discussion by Council?

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

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

Since it's now 20 of 5:00, I think we will conclude the review of the applications for today and go into executive

session, and starting tomorrow we would like to have the Virginia application first, since Mr. Hines will have to depart, and then we will take up the other applications and the kidney proposals which we did not on those applications which were reviewed today.

Let's just take a three- or four-minute break and then we will reconvene in executive session.

(Whereupon, at 4:45 p.m., a short recess was taken, and the meeting was continued in executive session.)