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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGIONAL MEDICAL PROGRAM SERVICE

REVIEW COMMITTEE

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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REVIEW COMMITTEE

Conference Room E,
Parklawn Building,
Rockville, Maryland
Thursday, January 13, 1972

The meeting was reconvened at 9:50 a. m.,

Dr. William Mayer presiding.

C O N T E N T S

Walker 7/19

PROCEEDINGS

DR. MAYER: I think we better begin. We do have a major task ahead of us before we finish the day.

And to prove that old RMP review members never die, they just keeping coming back from Omaha -- Henry.

DR. LEMON: That's the only advantage I know living in Omaha, you are a thousand miles closer to anywhere you want to be.

I am substituting here for Dr. Spellman, very inadequately. He was the chairman of our site visit team which was composed of Mrs. Mars of Council; myself; Dr. Robert Toomey, Director of the Greenville Hospital System, who added a great deal to our capability, very perceptive; and Dr. Silverblatt, coordinator of the Arkansas program, who also was very helpful indeed. And I think in the course of the day and a half that we were at the headquarters of Western New York--

DR. MAYER: Henry, before we go on I just ought to really indicate for the record that Dr. Perry has left the room. Excuse me.

DR. LEMON: In the course of the day and a half we interviewed a total of 45 individuals -- more than this really, but there are 45 listed on the summary.

Now the general background, I would like to say something -- one of the difficulties we had at this site

visit, the site visit was structured probably improperly. They misgauged our needs, and we had great difficulties the first day in really finding out what the health needs of Buffalo and the seven counties of New York, Western New York and Pennsylvania that comprise this area. And then the second day when we began talking with the county health commissioners we got a very clear picture from them, and it is a very complex situation, and I think this is reflected in the history of grant applications from this area.

They have been characterized by extreme sophistication and concentration on things like renal disease and cancer of the skin, rather small facets of a very large health care problem that they have.

The State University of New York at Buffalo is one of the strengths there. But I note that in the American Federation for Clinical Research help wanted summary there are more vacant divisional positions at the State University of New York at Buffalo, every department is looking for divisional heads.

There is a very strong department there in community medicine headed by -- social and preventative medicine -- headed by Dr. Edward Merror. It is very well financed, and it has been a department of great strength; and Dr. Saltz, who has been chairman of the program committee for the RMP in Western New York for the last two years, has been a key

figure in the operations of this program, and I think this is one of the great strengths in this area. It is probably one of the strongest departments in that medical school.

Of course, there is the Roswell Park Memorial Institute which is an outstanding cancer center, and they have been extremely hard pressed financially during the last few years, and I think this is reflected in some of the special types of project applications which have surfaced in this area.

Now there are between 90 and 100 thousand under-served core minority groups, chiefly black. The population of Buffalo is 22 percent black at the present time. And one of the interesting manifestations is that most of the large hospital services are very close to or on the edge of this core area. And a number of these hospitals -- most of these hospitals have really no relationship to the care of the urban core community, and there is a great deal of antagonism, has been in the past, between the central community and several segments of the hospital community.

This was not helped by the fact that in 1969 the Western New York Regional Medical Program did develop an application which got up here to Washington in trial form for a community health center to begin to make some progress in health services for this minority group, and they did enlist the cooperation -- there are about 17 or 18 physicians, mostly

black, who work in this community, and they had a number of meetings under Dr. Ingall's direction, and this got up here and it received some kind of pocket veto. We don't know what went on. It never did surface as a formal application, but the Western New York Regional Medical Program lost credibility with the black community.

And I think this explains one of the problems that we saw, and it has been commented on by previous site visitors, the lack of minority representation on the Regional Advisory Group, on the core staff; and this was brought out rather frankly in our visits, that they have had problems in getting cooperation from a number of well identified leaders in the underserved group in their administrative activities.

Another thing which Mrs. Mars was particularly concerned about, and some of us, was that the Regional Medical Program really doesn't get all the credit that is due it for the many, many activities that do not even appear in the application here which have gone on under Dr. Ingall's very able direction because it's identified as the Health Organization of Western New York. And HOWNY has been the umbrella under which they have operated and to which the physicians and the county medical societies have gotten used to using, so that HOWNY gets credit where credit is due, and Regional Medical Programs do not.

Now this was essential in the initial planning

phases, but we had considerable question that this had anything except historical significance at the present time.

In addition to the hospital care activities being fragmented in the past and not serving many of the critical core areas the Regional Advisory Group has been very heavily provider oriented, chiefly by physicians; and while this is a very dedicated Regional Advisory Group, has some very able, hard working physicians, and they participate in every phase of planning, evluation, and supervision of projects together, even some of the members go on site visits, it is pretty limited in its outlook still, and this is one of the things we think has to be improved.

There are some very grave elements of instability. In the first place, Dr. Saltz has had the key position on the program committee, chairman of the program committee, which is a very powerful filter for all projects. All decisions are made by the program committee, and they have been very able decisions. He feels that it's a position that he has had this power too long, feels it should be turned over, so he is resigning. And then Dr. Ingall laid his resignation on the table of RMP as of October 1st. It has not been accepted yet, and he has indicated he felt that -- we got the impression that he will stay on until somebody can take over the reins. He will have been with the program for five years this spring. But he is a surgeon. There is a lid on

all ceilings, they are kept at the level of the other state institutions, the RMP, and with his children coming of college age he said he just can't afford any longer to take this on. He would like to stay with it, but it's an economic disaster as far as he is concerned.

I bring these out so that when we go to -- I will try to just excerpt portions of this site visit -- you will have a little better appreciation of some of the problems.

Now they have had a difficult time, as you can imagine, in turning around from categorical, and really highly specialized categorical interests, to the new guidelines And they had a conference in September, and they have done, I think, on paper a reasonably good job of reorienting their ideas. And as I have indicated already, they have not been unaware of the medical needs.

Dr. Ingalls actually after hours carries on a small surgical practice in the black community. He is on a first name basis with the physicians there. He is very conversant with the problems.

But they have had problems in getting the medical community reoriented. So they have identified -- turn to part 6 here of the site visit report -- they have identified goals, one, the promotion of preventive medical services, the development of improved primary care services, and to integrate rehabilitation services into the continuem of

medical services. Then they have two sets of objectives, and these relate quite definitely, and they are very articulate about these on page 7. I won't read over all of these. These are the fixed objectives.

But one of the things that concerned us when we came to the hard problem of which programs you are going to fund and which you are going to have to delay when there isn't enough money, they have floating objectives, and we spent some time with these floating objectives. They were frank about them; but these relate to political considerations, feasibility, and a variety of things which are not down on paper, and we felt this was a matter of some concern to us.

Possibly more concern -- and this is stated on page 9 here -- these objectives that they formulated in this September, '71 workshop as combined with these floating -- I should have said priorities. Now this takes into account the availability of leadership, the reliability of the applicant, the local political climate, the impact of the project on local vested interests. And we must realize here that in New York you have a special problem. There are such layers of institutionalization on the whole medical care picture because the state has been interested in public and has had very real concerns in public health for years preceding RMP. The medical community is pretty well

entrenched. It has been going a long time.

And so there are a lot of these subjective and intuitive factors, and we felt that these were probably used a lot by the Regional Advisory Group in their decisions, and probably in some cases were necessary ingredients. But they did provide some disturbance to us in terms of their proposal for use of a developmental component which was really quite unstructured administratively.

And then you will notice in their grant application on the sixth and seventh years, I believe, they are asking for something like $250,000, $60,000 of what amounts to additional development component.

And this relates to another interesting feature. This region does not have a large backlog of approved but unfunded grants. They have probably 15 to 20 projects that are being formulated. But because of the very tight way in which the Regional Advisory Group and its program commit run this, really they sort of take along each project they think is capable of being carried out and they get that funded. But they don't have a list of approved unfunded projects, so you can't really evaluate in terms of at least the paper what the future direction might be in terms of approvable programs or projects.

Now I think they have made very real accomplishments, and I don't in any way wish to deny that this is a very

valuable resource. And I think one of the things we would like to bring out, that Western New York could provide leadership for central New York and other areas in Pennsylvania, other areas with rural problems, because they have managed really initially to approach the rural health problem somewhat more capably perhaps than some of the other areas, and they have developed a very good model in their community health information profile system which they are applying county to county, and this has again worked. It's done under the direction of the Department of Social and Community Medicine by Dr. Ed Merror.

The outstanding new thing which has developed and which will be a very significant factor is the Lake area health education center in Erie, Pennsylvania, where they have pulled together five community colleges, a number of hospitals totalling 2400 beds, a variety of allied health training programs, and the V.A. hospital there is financing this to the tune of $40,000 for the first year for administrative help, and this is a real going planning concern that is going to be an area health education center, probably one of the first in the country. And I think we have to recognize that Dr. Roth from Erie, Pa. has probably been a pretty big catalytic agent in this. And this has required very little RMP money, but the outreach through the State University at Buffalo and the fact that there was a good core operation,

although understaffed, but that had input into all the medical care activities of the region, this has certainly gotten off the ground a lot faster.

Another interesting thing is there is more and more voluntary participation by various physicians, allied health professionals in the core activities. They estimate that as of last year 40 percent of total RMP activities were funded by voluntary contributions from the outside. I think this is a good example of their very real success of being able to act as a catalytic agent.

Now they have this telephone lecture network which has reached now over 30,000 allied health professionals and physicians. We saw that. It has been very useful as a tie in to some 50, 60 community hospitals. It is used probably more valuably, I think, by the smaller community hospitals, particularly for allied health continuing education than by physicians. But this is a very valuable resource, and it is going to be one of the things that will be continued.

Their evaluation has not been as strong as it should be. It is headed by a very capable girl. We feel definitely she needs more help. And I think their evaluation system is improving rapidly, and it feeds directly back to RAG and is participating in their evaluation activities. As a matter of fact, they cut off one of their projects a year in

advance because they felt it was not being productive.

They have given a lot of help to the CHP agencies, eleven, and the CHP and the OEO -- there is a $700,000 OEO grant to help in the care of the urban poor which was helped very materially by Dr. Ingalls and his group.

We come to page 12 here, this documents this a little more in terms of what I said, this 1969 project that they developed which didn't catch fire here in Washington for some reason. And I just cite this to emphasize that they have been aware of their responsibilities.

They have also carried out career ladder training for innercity girls. This has been assisted by their core staff. And they have been instrumental in getting the innercity hospitals to begin to look at the community adjacent to them, as we will bring out.

It's emphasized, however, they do have Mrs. Mary Northington, at the bottom of page 12 here, a new member of the RAG. She had worked as a research technologist, I believe, for years. This is part of the incredible medical background here, that they can get people to serve on their RAG who are very familiar with sophisticated medicine and who worked in research programs at Roswell Park. But they haven't fully utilized these people, as was apparent from Mrs. Northington's testimony. They need certainly to expand their RAG.

Now we felt that Dr. Ingalls had done a very good job. We don't feel that Dr. Ingalls is the world's best administrator. And I would just like to cite from this page in your summary. This gives a very good picture of the way their core staff operates. You notice there are no clearcut lines of relationship. Everybody is doing his job, and Ingalls has got his finger in every pie, and it is incredible that they submitted this, because this is a very frank statement in their organizational chart. We couldn't see that it was nearly as well organized as it might be.

Ingalls has to have a deputy coordinator if he is going to do more. This is getting so complex. They need to have additional staff and evaluation to help Miss Helberg, they need to have more liaison people for their innercity programs, and they need to have -- they just have one man now trying to serve eight rural counties, and it just can't be done in that area. So that these are some of their real needs.

The Regional Advisory Group, to come back to them, the preponderance of physicians, 20 out of 31 members -- there are no representatives of labor unions, teachers associations, no hospital representatives, although they have an excellent hospital network there, much better than many other places. And as a matter of fact, we got a strong sense of noncooperation from the testimony of the local head

of their hospital association. I don't think this reflects the attitude of individual hospitals.

The Regional Advisory Group does not have a functioning executive committee. It's extraordinary. They operate as an executive group, meeting monthly. They make their decisions. The program committee meets twice a year to decide which programs will be funded, which will be cut off, which obviously is not often enough for an active committee.

Proposals are disseminated among over 300 people because each county has its own county advisory group, so that any proposal goes to this 300 group, and it's obvious that the rural counties don't feel they are part of the show, that the urban RAG is running things, and it really is.

Furthermore the RAG -- there's no provision for turnover. Some of these people have been around six, seven years, and we were very critical of this.

We were also critical of the grantee organization, and I don't know what RMP can do about it, but there's a 58 percent indirect cost charge for on campus activities and 48.6 for off campus activities. So really the RMP dollars, for every dollar that you are putting into an RMP program there another 50 to 60 cents is going, siphoned off to Health Research, Inc., which is the grants obtaining arm for all the state agencies in New York like Roswell Park and the various public health research institutes, and so forth.

And I think this together with the fact that they are tied in with an antequated, absolutely antequated salary basis, which has prevented recruiting people into this, this is going to be more and more of a handicap.

Participation -- I have noted the lack of hospital and institutional involvement. But this is improving because the Meyer Hospital and two of the sections of this current application deal with assisting the Department of Medicine at the State University, at the Meyer Hospital, to develop a continuing care program with some continuity which would apply to the innercity underserved group.

And then the other outreach is a family practice program, which was one of the early ones to get going at the Deaconness Hospital, one of the first in the country, which is quite successful, and it is now serving -- this is also within the black community now, it is providing major service to the black community, and it is growing very fast.

We felt, however, the amount of money they wanted to aid in this was possibly a bit excessive since this is 70 percent paying practice of medicine.

Local planning -- the county rural health for the ambulatory care proposal which is sort of a mobile health education unit, it's a very valid concept, it's backed by all of the physicians in this one county, and has active participation from allied health. It's a very viable idea,

and we think that it will be an answer, at least one answer towards getting closer to the interface of the health care at the rural end of the scheme.

It wasn't our charge, of course, to look into projects, but I must say in terms of the million and a half dollars that were appropriated for respiratory care the testimony of Dr. Vance was kind of disastrous. He didn't even have letters of approval on extension of this program into the various rural hospitals for the next hundred thousand next two or three years. And we felt that obviously not all of the appropriated money had been spent, and we were very leary about any further allocation of funds. As you will note in our recommendations, we wanted to turn off the respiratory care program within 18 months.

The management, on page 16 -- as I have indicated, we feel that the project surveillance has been good, but they need to have a better management structure, and this would be aided by a deputy coordinator, and assistant evaluator, and also having field people to cover not -- at least two counties, two or three counties, and these will be in our recommendations.

I think that gives the general picture here. The details are pretty well spelled out in this very good summary that Mr. Kline developed. And we think there is considerable short term pay-off with continued activity in this

area.

In the first place, the Alleghany County mobile health unit is a pattern that can be applied to other counties, and it has the cooperation of the rural physicians.

Another interesting feature is that in another year they will have physicians that are trained in the family practice program in the Deaconness Hospital who have signed up to go out to the rural communities to continue family practice. So they are beginning to make a little headway into the deficit of physicians in their rural area.

The Lake area educational project should certainly get off the ground in the near fugure, and this will bring in a variety of colleges, which are resources that have not gotten involved, but which are very interested in getting more involved in allied health training.

One of the interesting facets here is that Dr. Perry has never been a member of their RAG group there and has always been in a peripheral position, although he has been extremely influential in developing the concepts of allied health training and in the Lake area educational concept in Erie County. He is certainly one that we were very, very strong in our recommendations that they are neglecting a very valuable resource by not having more allied health people on their RAG.

Now the recommendations. They are asking for the

05 level, coming to page 22, a total of $1,419,000 for the fifth year. And we made specific deletions on this. We cut back the respiratory disease project by $50,000 for the first year.

We felt that the comprehensive family health project -- that is the training program for family practitioners which is being run largely as a successful private practice residency program at the Deaconness Hospital -- in the first year would not need all of the funding that they had requested, and we felt this should be site visited because it is an important program, but we want to know, I think, how the money which we are putting in, how this is going to be utilized.

We also felt that this region probably should not have a developmental component until their Regional Advisory Group has been reorganized and until there is a better characterization of priorities and how they are going to utilize their developmental component. At the present time their broad strategy is to divide this developmental component half and half between the urban and rural communities and to put it out in $5,000 contracts here and there. Well, this may be a very good mechanism, and I am sure would have some impact, but we felt that they were still pretty much project oriented, until we could see more evidence of program development we should wait.

We felt that the mobile health unit which is going to cost $47,000, that RMP should not be in the position of putting the whole money down for a piece of equpment, that there should be matching funds. So we are only recommending 50 percent funding of this. So we deleted a total of $284,000 there from the grant, which would bring down the recommended level to close to what it is now, $1, 136,000.

But in the light that we feel their core staff needs enlargement by at least six members -- and this is recommend tion 4 -- deputy coordinator, an assistant for the present evaluator, two additional members to work with the county committees as liaison, and two specialists in health matters in innercity and rural health -- this might put back somewhere around 80 or 90 thousand dollars. And this is how we got at this figure, $1,219,000 for the first year, and then I think something on the order of ten percent increments for the subsequent two years.

We felt that the respiratory disease project should be cut back sharply.

And recommendation number 6, we felt there is a real need for the salaries of the staff members to be increased to levels consistent with people doing comparable jobs in other RMP's. Now here we are up against a problem with the Wage and Price Board.

Those were our principal recommendations.

The expansion of the minority groups representation, consumer representation, hospital representation on the RAG. And we felt that the coordinator should be congratulated on doing an excellent job, working 12, 18 hours a day many days. He has tried to carry too much of this on his own shoulders.

We felt that the leadership role in the creation of the Lake area health education concept in Erie is a tremendou forward step, and the fact that they are profiling the health needs of all of the county systematically with their Chip program, very good.

We think that their telephone network information dissemination -- their regionalization needs to be improved further, but with their telephone net they have got all the tools here.

So we feel strongly that they are ready for triennial support. But I think we have to recognize that these two major elements of instability -- we don't know who is going to be the new director of the program committee or chairman of the program committee -- this is a position appointed by RAG -- and the position of Dr. Ingalls here is tenuous. But I do want to emphasize he gave us the -- at least he gave me the feeling that he would stay until a replacement could be found.

DR. MAYER: Thank you very much, Henry.

Comments of staff before we go on? Any additional comments?

All right, questions? Jerry.

DR. BESSON: I am not sure, Henry, what your recommendation was for the diminution in support for the chronic respiratory disease program. It is requesting 93,000 and 17,000.

DR. LEMON: Well, this has been a large project which has concerned itself largely with training of respiratory care personnel in some of the innercity hospitals, and their projection w[illegible] -- they felt it was really a different project, but we didn't -- to move this out into the community hospitals. But they nad not taken any steps to really determine the need for this in the community hospitals or the cooperation. And we recommended here on number 3, this is page 22, the funding period for March 1st, '72 to February 28, '73 not exceed $60,000, and that this really be in the phase of tapering down their present training activities and evaluating what they have done. We felt it was very important to get maximum evaluation out of this for the benefit of other RMP's to see what they have really accomplished. And not more than $32,000 for the subsequent year.

So instead of putting in some 600 or 700 thousand dollars they wanted over the next triennium we recommended

only approximately $94,000 over the next two years.

We didn't really want to penalize them too much because we felt -- we didn't have time to go into all facets of this, but it was apparent that Dr. Vance was not well prepared to document his achievements or to indicate the directions in which they were going to go in the next triennium

DR. BESSON: The other question I have has to do with the function of the research foundation and their charges. What are included in those overhead costs that they pay?

DR. LEMON: Bert, I may need your help in this. But they process the c'arges. The Western New York RMP pays its own rent, does it not?

MR. KLINE: As I understood what they described, they provide recruiting services, attempt to locate personnel, they maintain all records of expenditures, provide these on a periodic basis. By and large I think they serve as a resource to Western New York, and they didn't get into a great deal of detail. But as I recall the conversation, the RMP staff felt they were getting a considerable number of services.

DR. LEMON: They get consultant services, too. They get a wide variety of health consulting services for free from the other state agencies andbureaus through this. And they came back several times -- the associate dean, I believe, testified -- or was in Ingalls -- testified that they

felt they were probably getting more for their money than RMP was putting in. But we were in no position -- you know, we weren't accountants -- we couldn't really get the dollar value of this.

DR. BESSON: What is the customary charge that a grantee organization makes for this kind of service? This is not really overhead. It isn't covered in the usual contract sense.

DR. LEMON: It is overhead because some of the grants or contracts that the state of New York accepts through the Health Research, Inc. have no overhead provision, or 8 or 10 or 20 percent; and the reason that they have to charge RMP this figure is to make up for these other low overheads so they come out with an average somewhere on the order of 25 percent overhead for all of their research grants, contracts and outside funds.

DR. BESSON: Of course, the aspect of your site visit comment that somewhat astounded me when I read it, that RMP is really bearing the brunt of the ceilings on overhead that the state of New York charges for entirely different programs, and this kind of penalty makes me wonder why you are chary about recommending a new grantee organization.

DR. LEMON: I think this involves administrative decisions involving several other RMP grants. All we could

do was to point out two things, that this seemed like a very high overhead figure, which, of course, is magnified in central New York and other areas in New York; and secondly, that operating as a part of Health Research, Inc. they are locked into the salary levels, but do have more flexibility than if they were funded via the state. This was one of the other reasons why Health Research was developed, because it provided more flexible utilization of funds than the very rigid restrictions which the state--

DR. MAYER: Henry, let me comment. I find it hard to believe, knowing how the audit of overhead costs goes, that they would accept RMP or anyone else carrying the load of someone else any more than Medicare would accept a hospital's indigent care component as part of cost. You know, costs are costs, and I assume they are being prorated on the cost relative to RMP or any other group being involved with that group as a group.

And I find that, you know, that last statement just almost impossible to believe. If it is going on that way, that is they are absorbing some of the other costs of other programs, then there is no question that it needs to be reviewed in detail. I just find that hard to believe.

DR. LEMON: I believe this came from the Vice President of the State University of New York.

MR. KLINE: Yes, in direct questioning this was

brought out.

DR. MAYER: Well, then my suggestion would be that that situation needs very strongly to be reviewed.

Yes, Mrs. Silsbee.

MRS. SILSBEE: Dr. Ingall is coming down to talk about the possibility of moving his Regional Medical Program to another grantee situation. He is exploring it and trying to move ahead.

DR. BESSON: Would it make it any easier administratively if we with fair play of turnabout put a ceiling on the overhead that the grantee--

DR. MAYER: No, you don't have that right.

MR. CHAMBLISS: May I comment?

DR. MAYER: Yes Go ahead.

MR. CHAMBLISS: Let me just say, please for the committee that the overhead rate, as you might know, is not negotiated by the individual programs of HSHMA or the individual programs of HEW. The overhead rates between the universities and their foundations, or what have you, is negotiated by HEW. So once the rate is established and negotiated wherever our funds are placed in a given RMP that grantee overhead negotiated rate will prevail, and that is the case in this RMP.

Now to speak with regard to the salary policies, it has always been our policy in RMPS that the salary

policies of the grantee institution prevail. So whatever salary policies are in the university system would automatically apply to the RMP.

That may be the basis upon which Mrs. Silsbee makes the point that this RMP is contemplating moving out and moving into a nonprofit corporation. This would give an opportunity then for that nonprofit corporation to negotiate its own rate and for a restructuring of the salary levels.

DR. MAYER: Additional comments?

Yes, Len.

DR. SCHERLIS: Will you project as to whether or not you think the present coordinator will remain, or were you in effect granting funds really not knowing where the leadership will be derived as far as this area is concerned?

DR. LEMON: I can't say anything more than I think that Dr. Ingalls is emotionally very involved in the program. He has been the heart and soul of it for the last five years. I think he plans to stay in the Buffalo area, and I think that whether or not he is in the saddle that perceptive people would continue to build on what he has developed.

The other two stabilizing factors are that the Regional Advisory Group has some very dedicated people like Dr. Felsen, who is a very capable practitioner from one of the counties, very knowledgeable. And you have to bear

in mind this RAG has been functioning pretty much as a team for several years and working very closely with Ingalls.

The other thing is Ed Merror's Department of Social and Community Medicine, which has given extraordinarily good leadership, is a stable factor.

DR. SCHERLIS: I recall making a site visit there, it was a technical review, and one thing that impressed us was their number of project requests relating to what really amounted to central laboratory support at the university. And I note on page 7 of the yellow sheets that they now have an immunofluorescence service and training, and a regional coagulation laboratory that is to be supported through carry-over and rebudgeting funds.

I was wondering if there still is that emphasis on using the central laboratory, supporting its functions for the community. I think our technical review, as I recall it, was not too favorable, if I am not mistaken.

DR. LEMON: Right. I think I tried to indicate they were trying to phase this out, and this is definitely on the way out. They realize the new direction, and they are quite conscious of it.

DR. MAYER: John.

DR. KRAWLEWSKI: I was wondering if you would expand a little bit on the salary problem, because we are giving them a fair amount of increase for core budget here to hire some

ten new people, or something like that, isn't it, and are they going to be able to find these people, are they going to be able to hire them under this schedule, or is there a change imminent?

DR. LEMON: I think it was they had an assistant evaluator, didn't they, Burt, that they finally dropped from their table of organization because they couldn't find one under their present salary levels.

This is a very high cost area in terms of taxes and living expenses. The ceiling present on salaries is, I am sure, one of the reasons why the university medical school at Buffalo is in want of so many division directors. And I think Dr. Ingalls indicated he had great difficulty -- he was looking for a replacement, had been looking for several months, and there is no one in sight.

DR. KRAWLEWSKI: How much is he getting paid?

DR. LEMON: Thirty thousand.

DR. KRAWLEWSKI: We are recommending about $250,000 increase for core, is that correct?

DR. LEMON: No, about $80,000. Some of it could probably be rebudgeted, but the two most expensive things that -- Burt, you correct me, but the deputy coordinator and the assistant to the present evaluator, and then two additional members to work in liaison. But the increased core would be somewhere on the order of 80, 85 thousand which we would

recommend.

But, of course, under a triennial, as I understand it, this would be their option that they could make these salary adjustments if it could be done within the framework of the sponsoring institution.

DR. KRAWLEWSKI: I guess I don't understand that budget.

DR. MAYER: You need to go to the yellow sheet, page 5, which is where John is and where I am. I have got the same problem.

DR. LEMON: On the yellow sheet, page 5, okay.

DR. MAYER: Which, depending on your visual acuity, it says in effect that their current budget for core in the current fiscal year is $343,903, and what is being requested in the 05 year is 587. That's the point I think John is making.

DR. LEMON: I think we are looking -- at least the figure we were working on was this is awarded three one seventy-two twenty-eight seventy-one. That says 447 for core. But what we were working on was the awarded for the 05 year.

DR. MAYER: I see.

DR. LEMON: That's the 05 year, where they are requesting 587 thousand for core. So, see, they have already made an increase in their request for core to provide some of the things that they need in terms of better liaison

with the rural counties.

The community continuing education network of hospital -- that's their telephone network -- we didn't touch that, $82,000. The items 3 and 3A for chronic respiratory disease, we cut from 110 to 60 thousand for that year. They have already phased out the fluorescence. The tumor registry, there was some question about this. This supports four secretaries at Roswell Park, and it's just a local based tumor registry, you know. And in this day and age of nationwide programs like the pass map, and so forth, I just wondered, but we felt we would leave that in because this is one of the things that ties these divergent elements together, and it does cover the entire local region. And it's obviously well directed, I think. It is going to provide information. It is the only activity in cancer.

The model program for comprehensive family health, that is the family practice program, 171 thousand, we cut that back to 50,000 a year for two years until it can be site visited technically and until we see what the potentialities are.

DR. MAYER: I think, Henry, the only question that John is raising really relates to it would appear -- and I still don't understand -- what we are recommending is a $240,000 increase over their existing year as far as core is concerned. And he is raising, I gather, the question in

light of the other comments you made concerning recruitment, salary levels, et cetera, whether that was feasible.

DR. LEMON: I think this is a big question. We felt that their core staff was really much too small for an area with as complex medical interests as this. Dr. Ingalls, you see, has been trying to do all things, and it has just become apparent he can't knit the hospitals together into a better integrated program.

There is now one Lackawanna health clinic functioning that was developed by a medical student, who is now its director in an area of 7,000 underserved people imprisoned in this industrial cage of railroads and factories where they only had two physicians, one of whom was 80 years of age two years ago.

There are two other OEO health centers in the process of formulation which will serve another 30,000 people. There is a lot going on there funded through OEO, and it is supported by the State University, that he is going to have to try to keep tabs on.

So that whether he can find these people we don't know. Obviously there are good people there who are doing a job which aren't represented on the RAG or on the core or anywhere else.

DR. MAYER: Sister Ann.

SISTER ANN JOSEPHINE: Dr. Lemon, do you think that

when for a while Dr. Ingall has been coordinating all this effort himself and not letting anyone do it that under his direction it would be possible for someone else to function effectively and have satisfaction from his job? This is always a problem. You know, even if he brought in extra people, because of his tendency to do it all himself they might not stay.

DR. LEMON: I think he is interested in getting back to surgery. He is a board certified surgeon, and he indicated he has been trying to keep his hand in doing some after hours work in the community hospitals, but he would like to get back to his professional life. So I think he would gradually phase back into being a practicing surgeon. I don't have any real -- Bert, what would you say -- I think he was anxious to let go of this thing.

MR. KLINE: I don't know. I didn't come away with any real strong feelings. I came away vague, as may be reflected in the report. But I got the feeling that he would not leave, certainly until there was an adequate replacement. And he seemed a little bit vague as to whether or not his resignation he has officially submitted was still in effect. He made some indication that it was his hope that through this he might get some assistance from the grantee organization.

And I also possibly might just indicate a little

bit about what has happened in the interim period here. I know that they are giving consideration to change of grantee, or trying to give consideration to this, because this would, I think, ease Dr. Ingall's problems which are primarily salary based, and also relieve his recruiting problems where he recommended here six new people; if he were to get some higher salary levels I think he would feel he would be able to attract the kind of people he would like to have.

Then also they are working to expand the current RAG membership from 33 to 55, which is consistent with the kind of recommendation that is suggested here.

These are just some additional thoughts. But I really don't know the answer to the question posed, Dr. Lemon. I came away very vague on this.

DR. MAYER: I think Sister Ann is suggesting that even if you are able to change the grantee organization, even if you are able to produce salary levels that are recruitable, the question that is being raised is, you know, maybe because of his concerns and lack of ability, or whatever you want to call it, in administrative activity, that he may not even be able to do that job with those restraints removed.

Welcome, Robert.

DR. LEMON: I would like to say one other thing. Dr. Saltz, who is a dentist, but who has really been

functioning as the deputy director for the last two years, is chairman of the program committee with the power to appoint his own ad hoc evaluation group, his own membership to his committee, get any kind of technical advice he needs -- very able health planner, very good know-how, very good community relationships. And I think Dr. Saltz could step in and keep much of the program going if any crisis arose.

DR. MAYER: Phil.

DR. WHITE: Henry, on the one hand you tell me that you feel that this region is capable of managing its own affairs presumably, because you are recommending a triennial award, which to me suggests your consideration of their corporation is favorable. On the other than, you make recommendations for specific dollar reductions of specific projects. And subsequent to that we have these conversations now on these various points. These two sets of discussions seem inconsitent, paradoxical. I am reluctant to accept your recommendation for a triennial award in view of what subsequently you have said.

Can you clarify this for me?

DR. LEMON: Well, I think we felt we had misgivings about specific phases of this program. I think we came away quite aware that their awareness of the direction that they have to go is very good. I think our problems revolve around the fact that these are not spelled out in detail in

projects or programs that we can pinpoint. In other words, there are many good resources in this area, but as they have indicated in their application on the seventh and eighth years, the next two years, there is a large block of money that they are asking for for program which is not specifically allocated.

And as I indicated, we were not overly happy with the large sum of money that had been spent in the respiratory disease program. And obviously the site visit was partly tuned to the report of the various projects. We had to change the structure of the site visit. But we did not get a feedback as to how much accomplishment had been performed.

I think with the present set-up they have a good, hard working core group with lots of enthusiasm and excellent leadership. And they have some things going on I think that counterbalance some of the uncertainties, like the Lake area educational program in Erie. But it remains to be seen, you know, how well they can bring in the community college representations and all the power. There's enormous power here for manpower training and for development of better health programs. But the specifics have not been spelled out that we could see. They are being developed. I can't read the crystal ball any more than that.

DR. MAYER: Jerry.

DR. BESSON: Henry, I would like to return to this matter, even though I know that there's some constraints that Mr. Chambliss has indicated about that 60 percent rathole that we are working with in this region. If I understand correctly, the funding level that you are talking about, 1.13 million plus an extra 90,000 for core, 1.219, 60 percent of that, 58 percent of that is never going to reach the program?

DR. MAYER: That's a direct cost figure.

DR. LEMON: This is direct cost.

DR. BESSON: So that any way we slice it they will get a 60 percent gain if that hole is plugged.

DR. SCHERLIS: No. Mr. Chairman, don't I interpret our ground rules as not being concerned with overhead, that's an outside negotiated item?

DR. MAYER: Right. And I think we have suggested that it is certainly one that needs to be looked at from the evidence that has come back from the site visit, at least some evidence that I have just heard, and I think it ought to be pursued. But the figures that Henry is dealing with are direct cost figures, Jerry.

DR. LEMON: I am trying to justify the level. I know from previous discussions here this is where we have problems. And you look at their present funding level, which is $1,100,000 -- is this correct?

DR. MAYER: Yes.

DR. LEMON: Somewhere in this ball part. We wanted to try and hit a funding level that provided some level for growth of their activities. This is an area extraordinarily rich in medical resources, and on the basis of ground work they have done I think there will be considerable development in the next two or three years. So we didn't feel that we should really cut them back below their previous funding level. And we did feel that we wanted to give every inducement to have Dr. Ingalls stay on in an active capacity, and this consideration, if -- see, they do have -- under Health Organization of Western New York they do have a potential funding agency right there. This was the original reason for the creation of the Health Organization of Western New York, to have a funding agency for this program, and this is where the allegiance of the physicians of Western New York, is the Health Organization of Western New York.

So that if this could be taken out of the academic lid and put into an HMO, or something, where they could pay some realistic salaries -- you know, you have to pay a little extra to live in Buffalo. This is the other problem. They have probably got the world's worst climate. It isn't Southern California. These are some of the realities that people face in recruiting for Buffalo.

DR. MAYER: Sister Ann.

SISTER ANN JOSEPHINE: Dr. Lemon, did they give any indication of their plans for phasing out this tumor registry from their projects?

DR. LEMON: They have been careful to put down on paper with the other projects that they plan to phase this out, and right now I cannot recall any specific statement to this effect. Burt, will you correct me? I didn't hear of any.

MR. KLINE: They initiated this for five years and they have completed three years--

DR. MAYER: Can't hear you, Burt.

MR. KLINE: I'm sorry. They initiated this as a five year venture, they have completed three years, and their plan is to fund the fourth and fifth years as originally planned.

DR. MAYER: All right, other comments?

Would someone like to surface a recommendation?

DR. BRINDLEY: I move the approval of the funding level as suggested by Dr. Lemon.

MISS KERR: I second the motion.

DR. MAYER: All right, discussion?

The motion was that we approve the recommendation of the site visit team.

MISS KERR: Which is not to include a developmental component, but at the funding level by amounts that he

indicated.

DR. MAYER: All right, discussion of the motion? Philip.

DR. WHITE: I can't accept that recommendation. I just can't -- if you tell me you need a crystal ball to be sure what is going to happen in the future in this region then this region is not ready to manage its own affairs.

Further, as I understand the mechanism, Henry, if you do indeed award them triennial status with whatever amount of money is involved you can only recommend that pulmonary diseases, or so on, be restricted. They indeed then have the option of managing their own affairs. They may be in danger next time around if they have gone against your recommendations, but you can't actually control this. Is this not correct?

DR. MAYER: That is correct. Let me suggest a possible modification because I have the same kinds of concerns simply because the coordinator is up in the air, where the fiscal agent is really going to be is up in the air. Maybe what we need to do is throw in an amendment which says that the allocations of funds for the 02, 03 year of this triennium would be subject to review and site visit at the end of the 01 year, because by then my assumption is by then Ingalls is going to opt one way or the other, they are going to opt one way or the other by that time in terms

of where they are going to put their money, and whether they can recruit, et cetera, et cetera.

MRS. KYTTLE: Dr. Mayer, if you move to accord them triennial status on the one hand which accredits them with some decisionmaking authorities within the triennium, and then on the other hand say that at the time of their first anniversary application within the triennium you want prerogatives over the allocations of funding decisions, that's, I think, inconsistent.

DR. HESS: I wonder if maybe the way to deal with this is the way we dealt with two regions yesterday, two year funding with site visit, giving them some money to plan some basis for competence, but not going all the way as far as triennial status is concerned.

DR. MAYER: All right, that's another option.

DR. KRAWLEWSKI: A question of procedure. If we gave them two year funding now could they come in for a triennial application next year?

DR. MAYER: Yes.

MISS KERR: That sounds like a good alternative.

DR. MAYER: Would someone care to suggest a substitute motion? I know who the seconder was. Who made the original motion?

DR. BRINDLEY: I did, and I will remove it and Joe make his.

DR. HESS: I move two year funding at the level recommended by the site visit team, not granting triennial status, and with the provision of a site visit in one year and their option to submit another triennial application at that time.

DR. MAYER: All right. I assume there is a second to that.

DR. WHITE: I will second it.

DR. MAYER: All right, further discussion of that substitute motion?

Yes, Jerry.

DR. BESSON: I have a question of operational format. Once a region reaches triennial status they are then not subject to review committee action, but only staff anniversary review recommendation if there is request for an increase of funds, is that correct? Does the review committee then have any funding jurisdiction?

MRS. KYTTLE: If the requested increase of funds exceeds the level of approval it may well exceed its level of funding, but a region in a triennial status has the latitude of moving within its approved level. Staff anniversary review panel's action on an anniversary within a triennium will come, and indeed we have some today to look at, for basically information. But we also have one today that the SARP opted to send to the committee for action. But

the anniversary within the triennium, unless it requests funds that exceed the level approved, or three or four other reasons not having to do with the question you asked, would not necessarily come to this committee for action. It would come as information.

DR. BESSON: When does SARP take that option of asking the review committee to go over the funding request during a triennium?

DR. MAYER: Well, let me try, because I need to see if I have got it. If it exceeds that level that is approved by Council as the funding level in that second year of the triennium they would in all probability ask the review committee to look at it, number one.

Number two, if in their judgment there are some issues that are there that are different than the basis upon which the original triennium was granted and there are significant changes, they might ask. And that's why Northlands, for example, is coming back today.

DR. BESSON: But this is at the option of SARP?

DR. MAYER: Yes, that is correct. And that's why I think that Phil is a little chary about triennial status at this particular instance.

All right, further comments?

Henry, any comments?

DR. LEMON: I just might say I think it is obvious

that this region is in a state of transition between project programs, so I really wouldn't argue too strongly. As long as they get a durable commitment that will permit them to work on the Lake area health education center and support what they have ongoing in the rural and innercity I would think that a two year commitment would give them reasonable assurance.

DR. MAYER: All right. All those in favor of the motion say "aye."

(Chorus of "ayes.")

Opposed?

(No response.)

Henry, we thank you.

We will now take about whatever is necessary to register our votes, to remind you that we are still doing that.

We will now move on to the Florida project, with Dr. Perry as the chief reviewer.

The gentleman at the end of the table now, as most of you know is Dr. Robert Carpenter, coordinator of Western Pennsylvania Regional Medical Programs, who I didn't see flinch perceptibly when I heard all that talk about Erie, so I assume there is no conflict.

DR. CARPENTER: Just my poker face. Nice to be back with you.

DR. PERRY: From my standpoint I am especially happy to have Bob Carpenter here with us. I think Bob will share with me how sorry we are that Al Schmidt is not with us for the primary review, for Al was the continuity, having been at Florida RMP previously and returning to it.

We had quite a group on the review group. Three from the review panel -- as Al said, wasn't sure they didn't think he could handle it, or so damn many problems we better have a group down there, but it was Al Schmidt, Ed Lewis and myself from the review panel, Dr. Bland Cannon from the Council, and Dr. Bob Carpenter, as you have introduced, head of the Western Pennsylvania RMP.

DR. MAYER: With a crew like that I would have been a little shaky myself

DR. PERRY: Reinforced by a really excellent group here from RMPS, Jeanne Parks, Lymon Nostrand, and Abe Ringel.

We went to this region full of apprehension, and Dr. Lemon, who is here in the room, was certainly part of that apprehension from the standpoint of his having participated in Florida and the reports that some of us remember on Florida RMP.

The major difficulties, to review very quickly, as you recall, the problems as expressed and in all of our previous relationships with Florida, a great deal of dissent between

the RAG and the grantee agency, a lack of an executive committee, other subcommittee groups to do the job; full of in-house conflicts, to a point where the dean of one of the major medical programs was asking for the removal of the director of RMP; a move toward secession of the north Florida group area into its own RMP; an imbalance of the areas of Florida between the southern naturally headed by the University of Miami group, the central University of Florida. And thus we went to Florida.

Sometimes I think we can say miracles wrought by people can happen. I think we did find some major changes going on in Florida. And we were excited, first of all, by a very excellent triennial application.

Okay. To some of us going down let's find the reality on what has been written, for we knew some of the people that had gone to Florida recently and their capacity for writing. And so it was a test of reality to some of us of how much we could find that was in truth fact in terms of what had been written.

The triennial application was extremely honest in discussing the problems, but it was glowing with the changes that had taken place. It was not a duplication of national policies, but it was a selection of those national directions and recommendations that they felt might work in Florida. And I think that distinction was extremely

important to us as we looked at this.

What are some of these changes then that have taken place? The coordinator, Dr. Larimore, who had been under all kinds of fire, has certainly taken a major leadership role of coordination. I will discussion this in various way, through selection of new staff, through a relationship throughout the state, CHP relationships, and you will see this come out in many ways in this discussion.

The region has been successful in developing, perhaps forcing in some ways, cooperative relationships with the three medical schools in the region. The University of Miami, University of Florida have been the major programs in the past. But with the emergency of the University of South Florida in Tampa, and as many of us know that program, as it's strenghening with some really strong personnel that is going to it, this one in the middle has seemed to be a part of the major force of bringing three to talk together. So there has been a drawing together of the entire state of Florida into much more of a region than had been seen at any time before.

The close working relationships with the V.A., the State Medical Association, Hospital Association, Nursing Association, these were very strong.

The working relationship with CHP described and in action by the people appearing before us -- the chief of

Florida CHP serves as a member of the RAG and as chairman of RMP planning committee. The RMP director is on the CHP council working directly with the Health Services Committee. Okay. This relationship is in action and is functioning very, very well.

The core staff, though small, we found to be extremely effective. And to me one of the coups that has taken place in this region is the attracting of Dr. Herman Hilleboe to be head of their Planning Evaluation Committee. To some of us from the state of New York, we recognize that Dr. Larimore has brought down one of his former workers and one of the people that he worked very close with in the state of New York. Dr. Hilleboe was former commissioner of health in the state. He hasn't gone to Tampa to retire. He is intimately involved in the planning of this program and the evaluation of this program. And again I will speak to the way in which this committee has moved out in closing up some projects that have been in operation for quite some time, much needed things I think in many of the RMP's.

Additional staff in terms of a member out of the RMPS that many of us here around the table and certainly around the room have worked with, Spiro McSossacks(?) is joining the staff there in evaluation. He is looking forward to working close with the big boy, Dr. Hilleboe, that he knew in New York state also, and he will be a strength

to the program.

Sidney Froberg, the nurse coordinator on the staff, I found to be a very strong force in the total project.

Their monitoring and their financial system has been completely re-audited. The quarterly budget system that was explained to us in detail for rebudgeting of unused funds and the forces moving on that for efficiency and effective use of money we were impressed with.

I think in looking at the goals -- I am not going to take time, I know the amount of time you spent on the last one -- that I am going to go as quickly as I can in relation to some of these areas. But the important thing in looking at the new goals, which for the first time they have spelled out and are attempting to implement, the key word in the statement of goals is not just one of these motherhood kind of things. It starts out let's identify the gaps in our health delivery system rather than we are going to do the whole bit of health manpower and all, let's find the gaps and let's move in this direction.

They have come up with good data resources for planning to the RAG, and I am sure that John remembers some of the problems in relation to that group. There has been a broadening of membership. They are looking at taking on other people into the RAG. As I mentioned previously, CHP, etc. have been involved here.

The head of the RAG, the chairman of the RAG is Dr. Kyle E. Moore, Dean Emeritus of social work at Florida State. Haven't found a social worker involved in this role in any other regions that I have worked with. He is not only a politician, maybe he does a little role playing and all with some of them, but he is proving that age has very little to do with new ideas; and in this state in the way in which they are moving ahead, I think he has been a strong part of this.

Effective task forces have been set up, not only the categorical ones, but in addition to the categorical ones Council on Continuing Education, Committee on Health Services for new directions and to look at some of the broader issues; a new steering executive committee, and a very strong executive committee, has just been put together.

Okay, examples of strength as I am going on on this, the Planning and Evaluation Committee that Dr. Hilleboe is in charge of, began looking at ongoing projects, and as a result some of the projects were terminated early and others have been cut back.

I would like to speak specifically to this, and I think certainly Al Schmidt would have done this. At the time of the previous site visit the "ruler of the house" at that time was in many ways the University of Florida at Gainesville with the strength and the powers that be in that

situation. Some of the projects that were closed out and that were reduced are those projects from the University of Florida as the region has become strong through their Planing Evaluation Committee and through the total regional approach of a state.

The grantee agency, fiscal agent, has been changed from the Florida Medical Foundation to the Florida RMP Program, Inc.

These kinds of changes that have taken place through the direction, John, of -- you know, of a period of time, to Abe and to those of us who were there the first time were extremely significant, we thought, in terms of what had gone before.

Continuation of support. This has been built into the evaluation approval of each new project. And listen at this -- seven of the projects currently in the final year of RMP support will continue through non-RMP support next year. Seven projects. I was most impressed with that.

There is effective planning at the local level. Eight district offices have been set up. I will talk--among the weaknesses of something that I think can be added there.

The process of application, the decisionmaking process and such, has been greatly strengthened in writing, in all kinds of effective communication systems throughout the state. I can mention some of the kinds of materials --

planning guides for applications, application materials, staff review checklists -- you know, in addition to the panels and such that we spoke of.

To give just a brief feel on the kinds of projects that they have moved into this regional scope I will mention just a few, but they do support their goals and priorities. For the distribution of health care services in the region, improving delivery; the children's cancer program has succeeded in developing a regional network of four centers in the areas of Miami, Tampa, Gainesville and Jacksonville. The cervical cytology project has also established a network of six centers for screening high risk women for cervical cancer, and these are in the target populations of Jacksonville, Miami and Tampa, where they will move ahead into other areas in the following year.

The health guides project was one of the exciting projects we saw down there. This is a new type of health worker that has been developed to improve the health care services of the model in the neighborhood area of Tampa. This is bringing the indigenous people into the area into the process of moving into the home, finding where the problems are, getting information of where you can get service on that very level. We suggested a replication of this in several other places.

The extended campus concept project, involving

large numbers of nurses and allied health workers in 15 county hospitals utilizing resources of a community junior college is also moving out in various ways.

There is a proposal among their new projects in the triennium, the region proposed developmental educational program designed to educate the black community, physicians, nurses, allied health personnel, regarding sickle cell disease. The leadership will come from the black community on this.

Not just in writing, we saw that they are indeed in the process of planning a health care delivery system for the poor, and this study is being conducted, will be for the medically indigent target groups, and they have got quite a few in Florida, including the aged, the migrant, the rural poor, and the suburban poor.

I would mention finally among the projects project number 44, which is an assessment of health manpower that will be done in their eight district offices for the assessment of physician, nursing, allied health manpower, which they are using as their assessment toward the viability of area health education centers in each of those areas.

In terms of the last area here that I want to really hit here on some of the materials that that region has developed -- and I feel a lot of this could be used as a

model other places -- these checklists for new operational proposals, the staff review checklist, the summary of comments and findings form, some of the things they have put together there for information to prospective people that are putting together grants. I think some of our projects that are in such need of how to develop and where to go, they have got some real strengths there going for them.

For the weaknesses: granted that they are doing a lot in the area of minorities, and such, we found no minority groups on the core staff, minimal representation on RAG. There is some evidence of minority representation on task force.

More important than anything, however -- this is not something they hid behind, they recognized the problem and discussed it quite openly.

They also discussed the difficulty they have found in implementing certain programs and projects because many other state agencies have moved out in this area in Florida to so implement. As an example, the Cuban population in Miami has money coming out of its ears from all other kinds of projects attempting to do something for the Cuban population.

We have recommended, however, possibly the Tampa health guides project is something they can move in here.

They are looking for some leadership people in the

minority groups to move with, for they have involved in the health guides program members from particularly the black community working in some of their training programs. They have got one key person that has just arrived there, as the dean of Allied Health, Florida International, Dr. Van White, who I had the privilege of bringing up from Louisiana and training in my own place as my assistant dean, has just taken the deanship in allied health in Florida International, where he he setting up programs for South America and for the blacks in that area. They already knew him. I didn't have to introduce him. They already knew him, and they are planning to get him involved in the program.

These then are the major strengths of the program as I saw it.

Before we go into any recommendation or I give any recommendations on the funding I would like to ask Bob to jump in here.

We do have a renal disease project to very briefly discuss because Ed Lewis was with us, as he mentioned to you. This project had not only his review while he was there, it has been brought back with representatives already from the Florida program meeting with the people on kidney here in the office. The recommendation is for a major cut from over $660,000 in the project to $250,000. We can get into that later.

Bob.

DR. CARPENTER: Thank you. I can't imagine what I could add to that fine description of the region--

DR. MAYER: Comma, but.

DR. CARPENTER: Beg your pardon?

DR. MAYER: Comma, but.

DR. CARPENTER: Yes. No, I am just going to highlight some of the points that Warren brought out.

I wanted to clarify that we did in fact the night before the meeting go and purchase guns, one apiece, and slipped them in our back pocket and went in, and I am happy to report also that at the end of the site visit I sold my gun at a five dollar profit.

We found, as Warren said, much support, in watching the interactions of people and hearing their detailed descriptions of projects, much support for the very well written application.

We were impressed, all of us, with the fact that they had arrived at a very logical arrangement to link CHP and RMP. They simply asked the state CHP chairman to set the objectives for the Regional Medical Program through an objectives committee, and this has been done.

The objectives are still somewhat broad, and they will have opportunities to refine their thinking about what should be done and what can be done in Florida. But

nevertheless they are well started in that direction.

The cast of characters is impressive. The staff are active and intelligent and alert and excited about their program. State health leaders visited us. The medical society leadership was actively involved, and the universities in Florida were becoming involved more evenly and I think in a very effective way in the program.

All of us were impressed with the management, and I think that such evaluation as has been accomplished has been largely from the management people, because Dr. Hilleboe has only recently joined the program. They have been very effective, and it was partly because of this and partly because of the great success in phasing out projects and achieving private support that we all came away with a feeling that you could trust these people with really a good bit of money.

I was impressed that the subdivisions of the program, the area advisory group, the subregional groups, were led by physicians, and not old retired physicians, and not young physicians that couldn't have their practice going well, but seasoned, active physicians. The one from Miami, for instance, was a past president of the Miami County Medical Society. And each of the eight regions is led in this way.

Organized medicine is also very much involved

through the offices of Dr. Philip Hampton, and he holds the grantee organization together and has been, I think, largely responsible for pulling the medical schools, the medical society, and the other elements of the health care system into some working order. And he is aided just magnificently by a social worker who is now -- social scientist who is leavin actually he is not, he is a southern gentleman and a very talented individual, and I want him for a RAG chairman in my region. He's really great. And the training in group dynamics that he lived with all those years is really, you know, just right for a RAG chairman.

Dr. Lamar Kravas at Gainesville has led the medical school involvement in the program, and he did it a little actively at the beginning; and I think until the understanding about an appropriate role for medical educators in the regional program came along perhaps there was some problem about that, but in the end this tremendous energy has been harnessed very well and has been working very hard for the program, and the other schools have followed that leadership from Gainesville.

I think Warren mentioned also their willingness to follow a good many federal initiates. As you see, their area advisory groups, subregional groups, are to move into the area of area health education centers and emergency medical service in the coming years.

The renal grant I think was a nice example of how well things are working. We were faced with talented people. They were hard working, knowledgeable, bright, and had been successful in the past, just the kind of health professional that one would like to have serving a region. The geographic distribution of the people talking about that renal grant was exactly what a master planner might have hoped for, and they really could work together.

But there were some discussions, you know, where things were not seen exactly the same right off the bat by people from Gainesville and people from Tampa and people from Miami, and in the site visit situation they very quickly handled this, and each person's leadership role became pretty evident.

So I think, as Warren said, they need to realize that there are other allied health professions other than nurses, and they do, and Warren helped them considerably to see the importance of that, and I think that they will broaden their representation on planning committees.

They need a little bit better objectives, little more active evaluation of the kind other than the fiscal evaluation.

But all of those things are under way, and it was, as Warren said, all our impressions that this was a regio that has the mechanism, has the leadership, and needs the

money.

DR. MAYER: Before you go on to the discussion I might make a couple of comments. I did have an opportunity to talk to Mac Schmidt in Chicago on Monday and Tuesday, and I would only indicate his real concern about not being able to be here, and I know that that concern was real because not only did he apologize to me, but his vice chancellor came up to me and said "I'm sorry that we are going to keep him from coming because I know how strongly he wants to come to be there with you."

I suspect he got to me because in one respect, not only because I was going to be here, but as some of you who may have better memories than others -- and I am surfacing this because there may be some of those of you who remember that when the discussion came of the possibility of turning the Florida region into two regions or three regions, I was one of the individuals that felt that that might be the appropriate direction that they might have to go in the state of Florida, and I was coming off of the base of having grown up in that area and with some continuing knowledge of what is going on in that area, and feeling that the direction we were going and trying to superimpose on the state of Florida might end to the destruct of the Florida RMP. I would have to say that what has come out of the site visit report and what has happened in the state

indicates to me that, by god, I am wrong once in a while. It is certainly clear from the enthusiasm of the site visit.

I might just read you the very brief note that Mac gave me, which said simply: "Bill, were I giving my report to the review committee I would enthusiastically describe the great strides made by that region in solving the messy problems they were faced with two years ago." And as Warren reminded you, he was on the site visit originally. "They have realistically and forthrightly come to grips with their problems and have solved a great many. Both Bland Cannon and I feel strongly that they should be approved at the level requested save for negotiation re the renal project and approval of the developmental component. It is now a B plus region. Mac."

Discussion. Yes, Leonard.

DR. SCHERLIS: Just a question. Perhaps I missed it. The grantee institution has Dr. Hampton listed as coordinator and Dr. Larimore as the director, and I notice that Dr. Hampton is listed as 20 percent effort. I was wondering what is the channel of command and what are Dr. Hampton's responsibilities in terms of Dr. Larimore.

DR. CARPENTER: My observation was that Dr. Hampton sat in the back of the room through the whole meeting, when he was asked by Dr. Larimore to comment he did so, and

very effectively. And when something needed to be done to put the polish on Dr. Hampton was right there to do it. I think he works as a long time respected member of the Florida community who can contact people and get things done, but that he is very ready to take advice from the technical people on the staff, the advisory committee, and so on.

DR. SCHERLIS: What does he do with his other time?

DR. CARPENTER: Practices medicine.

DR. HESS: Dr. Hampton is a well respected internist and formerly president of Florida State Medical, has been a director of AmPak. He is highly regarded in the American Medical Association. He is a good man to have on ther

DR. SCHERLIS: Gives them strength in the community. Dr. Larimore has the day to day operation, I assume.

DR. CARPENTER: Right. No question about that.

DR. MAYER: Dr. Brindley.

DR. BRINDLEY: May I ask you a question?

DR. MAYER: Could you use the mike, please?

DR. BRINDLEY: May I ask you a question on page 7 of the synopsis about one plan,"health care services for the underserved rural areas of the state whereby plans are to follow the Mayo, Florida experiment, whereby medical students are sent to Mayo for training and providing this

type of care." What are they talking about there?

DR. MAYER: Beautiful. By happenstance it turned out to be Mayo. Bob, do you want to try it? I would be glad to comment on that one because I have been involved.

DR. CARPENTER: Well, as you can see, the Chairman and I are both excited about this. Florida is excited, too. They feel that this is the new Mayo Clinic, the other one being somewhat old fashioned. And it is really an outreach program of one of the medical schools to a town called Mayo, Florida. They have introduced into this very small rural community physicians--

DR. BRINDLEY: Not Rochester we are talking about?

DR. CARPENTER: No. Everybody is very happy, and the people in the town are getting medical care they never got before.

DR. BRINDLEY: That's good. I just couldn't see how Rochester--

DR. MAYER: I might just comment that those of you who are interested in issues that relate to how can a medical center effectively relate to a community which has no health care and what are the impacts of that relationship, this is an absolutely magnificent experiment which is being well studied, and some of the even economic effects of that effort have been just remarkable because Mayo has now become somewhat of a referral center which has enhanced its

trade center, and they have literally doubled the tax base of the community from the sales tax receipts and the rest just in the period of time since they moved in. It is a fascinating experiment.

I bring it up only if some of you are interested in those things there is a good example to look at.

DR. SCHERLIS: Is there a motion on the floor?

DR. PERRY: I would like to make it more specific, if I can, because of the specific amounts to give you a feel of what it is. The current funding is for $1,355,718. The total request is $2,213,435 including the renal. We are recommending what they have requested from the $1,355 to $1,552,706, which is an increase, including the developmental of 135, of only $196,988; because they are reshifting so many of their priorities, they are phasing out seven projects, we are giving them this, and this is only an increase of $196,988 plus. And the renal project which has been recommended at at a 250,000 level, what was requested was 660,000. This has all been negotiated with Dr. Lewis and the other people.

So it is a total increase, if you include the renal, up to one million 802.

DR. MAYER: Including approval of the developmental--

DR. PERRY: Approval of the developmental of 135.

MISS KERR: And the triennial status?

DR. PERRY: Yes, full approval.

DR. MAYER: Is there a second to that?

MISS KERR: I would second it.

DR. MAYER: All right, discussion.

Yes, Dr. Hinman.

DR. HINMAN: Is there a level established for the second and third year, because the kidney level was not recommended the same for the second and third year.

DR. PERRY: In relation to this I believe Ed had suggested to the group that this would be negotiable as they went along. We did not establish that level for the total in relation to the kidney.

DR. MAYER: But you are recommending--

DR. PERRY: But we are recommending the movement ahead in their other triennial as far as the total amount.

DR. HINMAN: Have you talked to Ed since the discussions Monday that were held here with the Florida group, because there was a suggested figure of 187,000 for the second year and 150,000 for the third year for the kidney.

DR. PERRY: That would be excellent because, as you see, that is going downhill rather than uphill in relation to this, and they have many resources they are hoping to indeed put together in this. So this is very strong, and we would certainly as a sit visit group go right along with them.

DR. MAYER: Leonard.

DR. SCHERLIS: I was just going to say that perhaps we shouldn't be specific on the renal since that's really negotiated outside, and I would certainly second the motion that was made, leaving the renal item open for whatever negotiation--

DR. MAYER: Well, we are going to need to make a recommendation to Council relative to level of funding as far as the renal is concerned.

DR. SCHERLIS: What is the item, 240 or 187, or what has been the negotiated level?

DR. HINMAN: I'm sorry. I didn't hear.

DR. SCHERLIS: What has been the negotiated level at this point?

DR. HINMAN: The negotiated level at this point, my understanding it was not quite the 250; it was 223,500 for the first year, 187 for the second year, and 150 for the third year, which would be $660,500 over three years -- 560.

DR. MAYER: Bob.

DR. CARPENTER: If I hear this discussion right, I think I hear that because the renal disease grants will not be as expensive the second and third year that the region's approved level for the second and third year should be reduced, and I wouldn't offhand know if you would want to

go exactly that direction because this is a very strong region, and the reason they phase out activities is so they can phase in new ones. I have no doubt they will maintain their level of activity in the first year of the triennium and subsequent years.

MRS. KYTTLE: Dr. Carpenter, if you add the descending renal approval to the ascending programmatic apart from that approval you come up with a 1.776 for the first year of the triennium, 1.824 for the second year of the triennium, and 1.863. So the total does not descend because the rest ascends.

DR. MAYER: All right, further discussion or comments?

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

(Chorus of "ayes.")

Opposed?

(No response.)

Robert, we thank you.

DR. CARPENTER: Thank you.

DR. MAYER: It would be my thought since I gather that there are some lengthy components relative to the Metropolitan D. C. perhaps, that we try to catch Metropolitan D. C. before we break for lunch, and then after Metropolitan D. C. we break for lunch and come back and pick up those that are either anniversary before triennium or anniversary within triennium after lunch. So I think we would like to move on

then, John, if we could, to Metro D. C.

DR. KRALEWSKI: The Metropolitan D. C. program was site visited this past December by myself, Miss Anderson and Mr. Hilton from this committee, Dr. Ochsner from the Ochsner Clinic in New Orleans, and some consultants, Dr. Heustis, who is the former coordinator of Michigan, Dr. Shapiro and Dr. Kountz, looking a a renal dialysis, kidney disease program that they were proposing, plus staff from RMPS including Judy Silsbee and Jerry Stolov, and some assistance from Mr. Russell and Mr. Spear.

A little background about this program before we get into it. The area, for those of you who are not familiar with it, centered here in the District, with the counties, two counties of Maryland that are contiguous to the District, two in Virginia, Arlington and Fairfax Counties, and the city of Alexandria, Virginia.

The program was established in 1967 with a planning grant, and it went operational in 1968.

At the last review committee meeting -- well, last year at this time when it was reviewed the program was funded for a triennium with the recommended level for this operational year that they are in right now of a million six. That level was funded at somewhat over 900,000 by the RMPS staff here, Dr. Margulies and his staff, and then was cut back as a result of the cuts across the board to 887. So that is the

kind of funding they have at the present time.

But they do have a three year program approved by this committee and by Council, and they have levels of approved funding of one six for this year, one three for the coming year, and one one for the year after that.

This was an anniversary application then within the triennium and was referred to us for a site visit. And they are requesting in this anniversary a developmental component, a continuation of four projects, a renewal and slight expansion of core, and the activation of four previously approved nonfunded projects. It also included a review, as I mentioned, of the kidney project that had been developed, started to develop two years ago, and this past year was submitted in a tentative form, sent back for revision, and now is included in this review process.

The program was organized with the D. C. Medical Society as the grantee organization, and the Medical Society when they organized the program developed a board of directors as a steering committee out of the board of directors of the Medical Society, and they pretty much started out to run the program from a policy and fiscal and every other point of view.

Now the reason that we were asked to review this and to site visit was because of the fact that the program has had a very stormy history. They had a lot of problems

getting off the ground, and this application again asks for more money, including the kidney project, and therefore it was believed that it should be looked at again. I say again because they have been site visited every year for the past four years, and they are really getting to be good at site visits, if nothing else.

Now I just want to briefly review the history of some of those problems to put this in perspective so we can then go to our findings.

The problems were really in three general areas. First of all, their inability to get a viable program off the ground in terms of putting their projects together and developing an overall organizational thrust. In their first year of operation, for example, it was noted that many of their projects had a hard time getting started, and in the review that took place at that time by review committee they discovered that the program management for some reason or other was not able to get the information out to the project directors that their projects had been funded and they were able to start them off. So there was some undue delay in getting their projects going. Once the projects were going the program had a tendency to turn over all the funds to the project directors and then not monitor them sufficiently to be assured that they were getting anything back for it, so there was a problem of control.

The staff that Dr. Wentz, who is the director of the program, has was pretty much inherited from the previous director, and in many cases were not located in his organization. They were located in the medical societies, they were located in the hospital council, they were located in the health department. And these organizations in most cases appointed those staff members, so he really didn't select them. They were appointed by these other agencies, they are on his payroll, they were part of his organization, but they were operating in these decentralized units. So that again was a problem in terms of trying to get a viable program off the ground because they were each going their own separate direction.

With the mission change of RMP again there was an undue delay in their grasp of this new mission and getting the mission statement out to the Regional Advisory Group. As a matter of fact, they floundered around with that whole problem area for some nine or ten months, and finally Dr. Margulies met with them and went over the whole bit -- this past summer I gather is when this took place -- and as a result of that the RAG group now has a little better understanding of what is going on, but a real difficulty in changing over to the new mission.

They had developed a number of continuing education programs, but they were not tied in with universities, and

they were operating pretty much through a hospital council, and they were attempting to build the staff for these continuing education programs in their own organization rather than using the talents that were available from the three medical schools in the region.

They had a very difficult time developing any viable programs to meet the needs of the underserved in the area. And as you well know, there are many unmet needs in this region. Most of their programs, however, were still categorical in nature, and most of them really weren't serving the needs of the poor. And this again was a concern to RMPS here.

Well, that was the general problem in terms of trying to formulate a program that would meet the needs of the region.

They have not been able to develop a data base. Comprehensive Health Planning has not been terribly active in the region, and therfore they just haven't progressed very well in the whole program area.

The second area of concern was with administration. As I mentioned, the medical society was the grantee organization, and initially they took a very strong leadership role in running the program. When this was challenged during this past year they backed off completely and now are referring many decisions that they should be making in terms

of fiscal policy to the Regional Advisory Group. So it has been that kind of a fluctuating situation.

The medical society is a small organization and RMP dominates it. RMP has the larger staff, more money, more of everything than the medical society has, and it hasn't been a very profitable relationship.

The services that were supposed to be provided by the medical society have not been very useful, and even the limited fiscal services that were supposed to be provided have not come forth, and as a result the Regional Medical Program developed their own staff capabilities in handling fiscal management.

The leadership in the program has not been strong. Dr. Wentz is a nice guy, is well meaning, I think he has developed a lot of contacts in the region, he has developed a lot of rapport with the producers of services; but he is just not a strong administrative leader, and he has not over the past years appointed anyone on his staff to fill in that gap. So the organization lacks the strong leadership from the top.

The staff members, as I mentioned, were appointed by other agencies, at least in somecases, and they are busy doing eheir own thing, have been for the past two or three years, and he has just not been able to bring them into an organized group. At least that again was a problem that was

being presented to RMPS here. The staff members have pretty much their own personal interest in mind. They have personal projects that they would like to develop, and they have not been able to relate those to an overall organizational thrust. They have right now 31 core staff members on board, and they want to expand that by about five members.

The staff unfortunately, in addition to having individuals appointed by other agencies and individuals who have very personal kinds of things they want to accomplish, have another component made up of individuals who have retired from other jobs. And the whole administration of the program and whole complex of putting these talents together has been an ongoing problem.

Well, the third area was with RAG. The bylaws state that the RAG membership can consist of as high as 70 members. They now have 58 members with 53 alternate members that can attend meetings if these original members are not available. Most of these members of RAG are appointed again by interest group agencies. That's the way their bylaws read. They have some 70 members, as I mentioned, that can be appointed. Sixty-five of these are appointees of various producer agencies. So they have very little flexibility in terms of how they can change their RAG structure.

The RAG group appeared to be relatively inactive also. We noted in the past that while they may get a large turnout

for a morning meeting, by midafternoon there's very few, less than perhaps a third in some cases that are still there to deal with their problems.

They have not been able to really integrate minority groups into the RAG structure, and it is pretty much dominated, as I mentioned, by providers of services.

Well, okay, these were the major concerns, and these were the instructions that we had received from Dr. Margulies, to site visit the program and to explore these problem areas and see how the program was shaping up at the present time. And I will try to consolidate our findings under those three rubrics then, going on to some of the projects that they now have in mind and the program that seems to be developing.

First of all, under administration Dr. Wentz has been able to bring the staff into his parent organization. He brought them out of the medical society, the health department, what have you, and he has brought them now into his own organization. At least he has brought them into his own organization structurally. Philosophically they are still operating as individuals, and they are still operating in terms of what their own personal interests and desires are in terms of projects. So therefore what he has is a very diverse group of people with varied talents now brought into an organization -- and by the way, this caused him some space

problems that he didn't anticipate -- but brought into this organization, and what he is trying to do now is to solidify those talents to try to carry out some kind of a program role. And this has been very difficult.

He has appointed one of the members as his administrative assistant, or what I think he will probably call deputy director a little later, and I think this individual may offer him some help in bringing these talents together.

But his organizational chart is ill defined, people are not following the organizational structure, whatever. If they have a problem they bypass their supervisor and they go and see Wentz. He has not been able to get them to really appreciate how they fit into an organization structure and report up the ladder to supervisory personnel.

Again as I mentioned, we found at least part of the staff members, part of his staff were retired from other jobs, and he really doesn't have a good plan in mind as to how to phase them out of his operation. He hopes that they will retire. He is hoping this will occur this coming year for a couple of individuals. But yet he won't take the initiative to talk to them about their future role with him and to weed them out of his organization. He is taking the easy route again, and the human relations kind of approach that you would expect, if you would meet him and talk with

him five minutes you could appreciate totally, of how he is going to deal with these very, very difficult problems of putting that staff into some kind of order.

They have some good people on board, and I think they have a lot of talent there if they can put it into some kind of order. The good people, as you would expect, of course, are getting very upset with the organization because of the way it is kind of floating along and with their inability to even get their employees or their people that he wants to report to them to be able to follow that channel and stop bypassing them.

Okay. Well, the next thing is the question of the medical society, and this has been at least partly resolved. There is now a committee been formed between the RMP staff and the medical society. They meet weekly to try to iron out some of their differences. They are trying to iron out now exactly what the role should be in terms of a grantee organization in fiscal management, and I am fairly confident that that is going to improve, that relationship will improve over this coming year.

The newly elected president of the medical society assured us that he is going to tive them his fullest cooperation to expand RMP, and that in his estimation it was perfectly agreeable to let RAG be the policymaking body and for the medical society to act in a different capacity.

They have a tentative agreement at least that the program will probably move out of the building that the medical society is operating in and get into a different building which will give them more space, and probably also a little more freedom from organizational constraints.

The Regional Advisory Group has been totally reorganized, and they have organized it now into a number of working committees, and Dr. Wentz believes that these working committees will involve RAG more actively in the decision-making, and therefore will be helpful in getting them to come to meetings and take ar active role in the program.

They have been only minimally effective in involving minority groups into this decisionmaking structure, although they have added one black woman -- her name is Mrs. Bullock -- to the group, and she was very impressive to us. Unfortunately, they didn't invite her to the site visit meeting, but we did; and we brought her in and sat down and chatted with her in the afternoon, and the plain fact is that she had been invited to join RAG some six months ago. They have not, unfortunately, done a good job of bringing her up to date on what RAG is all about or about the program. They have not involved her in the decisionmaking process as of yet. But she has attended the meetings, she has made herself heard, and we think in the long run she is going to be an extremely beneficial influence to the program.

The chairman of the RAG group, that is now chairman of the group, and he wasn't last year, as I understand it, assured us that he fully intends to integrate all interest groups into the decisionmaking of the Regional Advisory Group. And through their reorganization and their formation of working committees he believes that he can do that. Yet, every one of his working committees are headed by physicians, and they are pretty much representing interest group agencies, and I think it's yet to be tested as to whether people like Mrs. Bullock, who I think will be very influential on the program, will be able to alter those committees or be alter the decisions that come out of those committees. We think that she might, but yet it's untested.

The RAG group during the past year have only met three times. They have an executive committee that is supposed to handle decisions between meetings, and the executive committee only met once. Again this RAG chairman assured us that this was not going to be the case in the future. And he did come across as an aggressive kind of guy who will make changes. Again it is of yet untested.

Twenty-three out of the 110 RAG members and alternates are minority members. But with the exception of about three of them they are a relatively passive group, and it would appear to us that they were handpicked -- maybe that's being a little too unkind, but they were brought in there with

the idea that they weren't going to cause any waves. Mrs. Bullock, on the other hand, will cause waves, and again we pin a lot of hopes on this gal.

All right, the program in itself, they have broadly stated goals and objectives that kind of go along with what everyone else thinks should be done and reflect the national interest. Their projects that they have developed, however, don't really fall into these general areas, although the areas are so broad that you could fit everything into them, I suppose. They have few new projects. As a matter of fact, the application we have in front of us here, all of the projects have been previously approved. So there's no new projects in it whatsoever.

They have asked for money for a number of contracts. In fact they have asked for $700,000 in this application for contracts. And they hope through those contracts for small studies to give advice to different groups to be able to implement some new strategies dealing with HMO's, dealing with manpower development -- for example, the geriatric nurse program, this kind of a thrust.

Their priorities again have not been well developed. And as a matter of fact, in loooking at the projects that they are requesting funds for here, with the RAG group that was in front of us that day we were asking them what they thought of these projects and the priorities, and they

essentially reversed many of the priorities as opposed to what we have seen in our application.

Now we were both dismayed, and on the other hand somewhat appreciative that this might be effective in the long run. Number one, we were dismayed because of the fact that it appeared that the priorities as they were spelled out here in terms of projects probably hadn't been effective; but number two, RAG had been reorganized, the reorganized RAG had not had an opportunity to look at these projects, and it appeared to us as we were dealing with RAG in that meeting the day we site visited them that probably they were going to be effective in reallocating those priorities in a more meaningful manner. So we did get a glimpse of the fact that RAG may be shaping up and may be willing to really take this program and turn it around.

Of course, in terms of a program they have had a difficult time getting a thrust from the core staff because of the fact that they are all operating in their separate ways. This isn't exactly true, but still we see programs such as the continuing education program for nurses being developed by itself, continuing education program for physicians being again a separate entity. And when we raised the issue of trying to put these together into some kind of a continuing education thrust it was really a new thought, and they really had not done that at all in the past.

They have totally reorganized their review procedure, and they have an office that they call an Office of Program Appraisal which will be evaluating the projects once they are funded and will be reviewing the projects, and again on paper it looks as though it might be pretty functional; again, however, it is untested.

In terms of projects they have some few that we feel had some real merit. For example, one of the projects they are asking for is a nurse midwife project that would train nurses to work in the poverty areas.

Through their contracts they are asking for money to involve medical students and nursing students and other health students into a program in the poverty areas for two purposes, one, to get them to appreciate the problems; and number two, to get them to start working together as a team. And it seems as though this has somemerit.

The training of nurses to work with the aged seemed to have some real merit to us.

The HMO projects that they have in mind in terms of giving groups of physicians some help, providing them information with the HMO concept, to help them get the organizations off the ground, seemed to have merit.

Again, however, we felt that their program was still at the embryonic stage of development. Their organization was certainly minimal in terms of its capabilities at

the moment. It looked as though RAG had some promise in terms of decisionmaking. But yet this all might be for the future, and when you are dealing with $700,000 in contracts you have got to have, of course, a much stronger organization than that to be able to handle that kind of money.

Now with all of those -- oh, one other project, of course, that I should mention in that context was the kidney disease project. This was reviewed separately by Dr. Shapiro and Dr. Kountz in a separate meeting, and they found that project to be very worth while. And as a matter of fact, maybe at this time I can get you to comment on it since you sat in on the meeting with them, Mr. Spear.

MR. SPEAR: My naturally poor enunciation is further burdened by some oral surgery yesterday, so if you don't understand me, holler and I will go back.

The renal project has a history that in many ways parallels the history Dr. Kralewski described for the region. The history is one burdened with poor organization, poor planning, selfish interests expressed. And at the last Council meeting, one of the last projects in hand, Council said let's take one more look, one more attempt to get these boys to sit down and work together, and that's what the kidney deal is all about.

It was not the first time this had been attempted, and I think that had some flavor in what happened.

There was another element I think that was important to the flavor of what happened, and that was that a young doctor by the name of Argie on the Georgetown nephrology staff who had been talking with us for some years and recognized what we were trying to say and recognized, or at least agreed with the kinds of activities and directions we were suggesting, had in the past had to admit to us that he was not in a position to come forward with any strength with his recommendation to this regional group. As of the meeting in December he was the spokesman and was the central force, I think, that brought the group finally together.

It was a very quiet meeting, one that pretty clearly through Dr. Argie's efforts as well as the RMP, had done its work and gotten its marbles lined up pretty well. There was a good sense of cooperation. There was an admission of the need in the area, and the fact that they had resources to build on, and promised to come forward with something more realistic to meet the needs in the renal disease area for the MWRP.

Shall I go ahead and say what came up later, Dr. Kralewski?

DR. KRALEWSKI: Yes.

MR. SPEAR: The plan that came forward was for a total request of $524,000, a little more, about 525, including the indirect. This is a reduction from the

application we were seeing last fall of about $384,000. It incorporates a strong or certainly a stronger transplatation program which was an element about which we had been hung up previously. They had not pursued this as deeply as we thought they should.

It reiterated three elements that were in the original application; one, a neighborhood dialysis center at the -- I have got this listed backward, I think -- yes, at an Upshur Street clinic to be installed by Howard University, and a community home dialysis unit at the D. C. General Hospital, and an outer center home dialysis center to be placed in Northern Virginia.

Let's talk about these separately.

The transplantation component was a request for $183,000, and is focused on Georgetown University, and includes an appropriate number of staff and some very minimal other cost elements that need to go into this. And rather than detail it for you, let me give you the reviewer's comments. These are comments from Dr. Kountz and Dr. Shapiro.

"The transplantation program now appears to be well structured with two exceptions. The nephrologist, which was one of the positions listed, is already on duty at Georgetown, and should not be charged against RMP. The concept of the administrative coordinator is an error. The proposal places this individual in the RMP offices to keep

records on available organs and recipients, to assist patient referral, and to compile and act on third party sources of payments. This position should be located at Georgetown with the surgeon, and to work closely with him. There will not be a large recordkeeping activity, but there will be or should be an intensive activity in developing organ sources which will involve a large public relations burden on both the surgeon and his assistant. It is recommended that these and the other responsibilities indicated be under the close control of the surgeon."

So the upshot in terms of money was out of 133,000 requested for this component the reviewers are recommending 106,000, a reduction of the salary of the nephrologist.

The transplant program is in the plan and was accepted by the reviewers as a phased development of three transplant sites. The initial one I have just spoken to is Georgetown.

There are two ways to go in the second year, and obviously the last one to go in the third year. The second year could be either Howard University, who will have a trained surgeon coming on duty this coming July, a young doctor who I am told is quite capable and has been receiving a year's training in Minnesota. George Washington wants to get a transplant and get going.

So that in looking to the future what the reviewers

are suggesting, they found no difficulty with this, given the kinds of problems that exist in the metropolitan region and given the nature of the three institutions involved. They accept that premise. And so they have recommended that 106 of that be given to Georgetown for its kick-off activity, and during this first year the other institutions will refer their patients, and have agreed to do so, to Georgetown; that in the second year whoever picks up the ball and goes, we give $100,000, and in the third year we provide on the order of 30,000, which is very close to the final year requested by the region.

The neighborhood dialysis center at the Upshur clinic was essentially a reiteration of the plan we saw in the request that we were looking at last fall.

It is worth while to insert here perhaps that in this review by the ad hoc committee and the comments which this review group made to the Council it was stated that if the region had only shown a definite focus on transplantation and had demonstrated the desire to get transplantation going then some of the dialysis request could have been approved.

So in the review two reviewers, Dr. Kountz and Dr. Shapiro, with the transplantation that has been described are now quite willing to pick up these other three dialysis activities and think they are quite appropriate for the needs of the community.

The region suggests that there are on the order of 150 patients -- this was the 1970 figure -- on dialysis in the region being treated through seven centers. The gap lies in the innercity where there is little, if any, resource for the innercity residents. These dialysis centers, essentially the Upshur clinic and the one at D. C. General, would start moving on that need.

The Upshur clinic would establish a satellite center to which could be referred home patients whose home environment does not permit self dialysis. This would be what we call a satellite center that would have beds or reclining chairs with several dialysis machines. It would be staffed essentially by perhaps a nurse and a technician. There are certain requirements that are unique to the District that require a physician in attendance for two reasons: one, Upshur clinic is made available through the Department of Human Resources, and they don't want it used this way without a physician in attendance; and secondly, Medicaid requires it for reimbursement. So they intend to employ probably resident physicians to be there during the evening and be in attendance for this dialysis. But those people being dialyzed or using the machines would have been trained to use them themselves, but would be people whose home environment would not permit them to perform this at home.

Secondly, they want to train community physicians to maintain primary responsibility for the patients. They want to train people in the Northwest, central D. C. area to fill the technician jobs that would be open in the center. They want to provide general renal training to other physicians. They want to augment the city's dialysis capabilities, and they want to integrate this with the other activities that are or will be coming forth within the region.

It is worth while noting that a home training unit in Howard University will be in operation next month. And they would hope with the RMP support to have the Upshur clinic in operation by about July, and through their own center operation have the patients trained to start putting this unit into operation immediately.

The reviewers' comments were: "The reviewers felt it would be unrealistic to train community physicians and to follow up on home trained patients. University physicians or center physicians should retain this responsibility. If having a physician in attendance will meet Medicaid requirements then it should be possible to obtain reimbursement for evening physicians and the technician services. Since the Upshur patients will be trained in self dialysis supplies should not be reflected in the budget. The reviewers believe the remodeling cost to be wholly out of line." They were

$30,000, and they had not receded from the earlier application. And they believe essentially all that is needed if you have a room is a source of tap water and you put the machines in and go to work.

The reviewers recommended that only minimal support should be necessary to get the Upshur Street satellite center into operation.

The requested amount, direct requested was 78,000 plus a bit. The proposed amount for approval from the reviewers is 30,000, a reduction of a little over 48,000.

This level of support, given the budget that was presented, would provide half of the personnel costs that were requested, all of the proposed equipment, a minimal $1,000 to initiate supplies in the unit, and just under $2,000 for basic alteration cost.

The center proposed on the grounds and in the buildings of the D. C. General Hospital--

DR. MAYER: Mr. Spear, I think we are going to need to abbreviate the last two components of this.

MR. SPEAR: All right, very good. Let me go right to the comments. I think they are almost self-explanatory.

The reviewers found the D. C. General proposal to be unnecessarily lavish for the patient output that was being proposed, and they raised question that the output levels given by the applicant was wholly underutilizing the

center, and they say even though at that level there is a question whether enough patients could be found who would have the financial support back of them to fill this unit. They think some rather extraordinarily rich ... aides are completely unnecessary, they see no reason for the computer data bank that was proposed, no reason for some intensive kinds of almost research activities that are proposed.

So from $175,000 requested they proposed that only $41,000 be recommended for approval. This would provide for a nurse, half a social worker, half a secretary, two machines and related build-in, and a basic 1600 for alterations.

The Georgetown unit which is proposed to be placed in North Virginia serves essentially two purposes. Georgetown presently cannot expand on its present site. It is estimated that the earliest expansion of its renal unit could not occur before five years. In this context they are being burdened by West Virginia patients who are being literally put on the bus and shipped in and dropped at their doorstep. And they urged two things. Let's help solve the Georgetown patient problem. They can't expand to take on any more patients at this time. And let's put a center in North Virginia where there are no facilities, but where there will be enough supported, financially supported patients to help cover the West Virginia load,

which is estimated to be about 25 percent of the predicted load.

The request is for two part time doctors, and the reviewers said we are surprised that you asked for that, you have doctors coming out of your ears, perhaps you need a nurse. But they didn't go ahead and specify. All they said, all right, you ask 35,000, almost 36,000 for this, we will recommend approval for 25,000, which would give the three dialyzer machines requested, and one or more personnel depending on how it was laid out.

The total request as recommended by the reviewers: year 1, 202,265; year 2, 144,000; year 3, 30,000.

DR. MAYER: Thank you. And just point out that the 202,000 in the first year was comparable to a request of theirs which was 423, which was a deletion from about 700,000 from previous request, which in turn had been a deletion from a million five or some such thing as that sequential.

DR. KRALEWSKI: Okay, want me to continue on here then just briefly with some of the accomplishments, and one of the major accomplishments--

DR. SCHERLIS: Can we ask questions about the renal study while it is still fresh in our minds?

DR. KRALEWSKI: All right, if you wish. That's fine.

DR. MAYER: Go ahead, Leonard.

DR. SCHERLIS: I was just scanning the available

application, and no mention was made in the discussion of the facilities at the V.A. hospital or at Bethesda Naval Medical Center, and I gather there are already going on active transplant units there. Are we thinking in terms eventually of six transplant centers?

MR. SPEAR: Yes and no. We are thinking of getting the three nonmilitary hospitals started. The military hospitals are going right now at developing transplant. And there was considerable discussion about sharing facilities, and this is hopefully down the line. But there are legal problems involved for the military. So rather than deal with that it was pushed aside.

DR. SCHERLIS: Lots of problems with the military?

MR. SPEAR: Yes. It simply was not addressed. It was discussed, the desire to get together, the desire to work together and to utilize facilities where necessary. And I didn't mention that the site for the tissue typing -- the group did agree to have a single tissue typing site. It may be a military hospital or it may be George Washington or it may be Georgetown. It has not yet been decided. They simply agreed they will determine on one site. And the V.A. could do it, Walter Reed is willing if they can overcome their problems, or these other hospitals. If RMP support is given there will be one transplant site.

DR. SCHERLIS: One transplant site?

MR. SPEAR: I'm sorry, one tissue typing site.

DR. SCHERLIS: And probably five transplant sites?

MR. SPEAR: Very likely.

DR. SCHERLIS: Since we have been subjected to the discussion I feel that we have a right to participate in response, and I must register a strong feeling that if we are talking about regional cooperative ventures as being, I assume, still one of the hallmarks of RMP, I must express a great deal of concern about having five transplant centers unless I can have some explanation from Dr. Hinman possibly, or one of his staff, as far as what they really project the needs for transplants in this area.

I equate in many areas of medicine, particularly in such areas as this, the fact that you have to do a certain number to maintain competency and low morbidity and mortality. Maybe we shouldn't discuss this since it has already been passed upon, but since we have been subjected to the information at one end I think we can respond at the other.

MR. SPEAR: May I comment on this, Doctor?

The Bethesda Naval Hospital has been designated by the Navy as its transplant center for the Navy. Walter Reed has been designated by the Army to be its transplant center for the Army. The representatives of these groups who were there said we want to be with you fellows, and the fact that you get organ procurement going we will have to use your

services, but until we have met our needs with the military we can't do much in the community.

DR. SCHERLIS: But the V.A. hospital works with which of the medical schools?

MR. SPEAR: George Washington, I believe. Am I correct?

DR. SCHERLIS: Aren't there shared facilities there in many of the areas? I would assume if this is the usual V.A. organization it is dependent on medical school affiliation, and usually one would not choose to develop two transplant centers, one at the affiliated medical school and the other the affiliated -- isn't this the usual--

DR. MAYER: Is the V.A. currently involved in transplantation?

MR. SPEAR: Yes, they have done a little bit. Only eight were done in 1970, and the total for the past five years in the D. C. area is only 20 or 30 transplants, and most of those are line related, including military and nonmilitary.

DR. BRINDLEY: How many are there in Baltimore and Richmond and the areas around?

MR. SPEAR: I only know by hearsay. I don't know of any immediate teams, none we have supported immediately other than Richmond, with whom Georgetown has become affiliated. There are two transplant sites or renal sites in

Baltimore.

DR. MAYER: Dr. Thurman.

DR. THURMAN: The point Dr. Scherlis has raised is a good one, because do we really need three transplant teams in the city of Washington other than those that are already established? And we asked the same question yesterday about Philadelphia because we are also going to have them coming out of our ears up there.

MR. SPEAR: I can only answer that, our own wish in this building is that there be one good one, big one, active one.

Dr. Kountz, who is a very active transplanter, does over 100 a year personally in San Francisco, when posed this very question said yes, given the Metro D. C. difficulties, complexities and population, and the nature of the institutions, he would agree to it in this instance.

DR.THURMAN: Dont you think the last part is the most important part, because one hospital could do all you are projecting, so the nature of the difficulties is the important--

MR. SPEAR: Dr. Shapiro made the point that three institutions of this size and this independence must maintain their service, have transplants. Whether we should pay for it may be another question.

DR. SCHERLIS: I think we have to separate from

this what is clearly our involvement to make sure there is an adequate delivery of such a need as distinguished from the need of a teaching institution to be involved with certain programs as far as teaching needs are concerned. I think there is the probability of there being a strong distinction in this regard.

DR. MAYER: Let me just make sure that I am clear and the committee is clear, the recommendation vis-a-vis transplantation was 106,000 in the first year in order to get -- I gather it was Georgetown moving -- 100,000 in the second year to move the second one, with presumably the 106,000 being pulled out of the Georgetown program, it is one year funding; and then 30,000 in the third year toget the third one moving.

I guess the question that you are raising, Leonard, is in the transplant area the appropriateness of our suggesting funding of more than one center.

DR. SCHERLIS: Yes, and the way that we are using these funds is really as a direct means of getting three additional centers, one I guess primed further, and the other two off center. And I really question the decision of the task force that looked at the renal problem.

DR. HESS: I can see some real practical problems in trying to lump the military in with the civilian. I think there is a justification for separating those. But if

we take the civilian as a separate category and the one with which we are primarily concerned, which could include the V.A. -- I don't know what the problems are in terms of cooperation between the V.A. and let's say D. C. General, but if we separate out the military and look at that and say that is our primary focus of concern as RMP then I don't think it makes sense to promote and facilitate unnecessary duplication.

DR. MAYER: All right. Further discussion on the renal? We will come back to it when we come to the recommendations specifically within the whole recommendation of the project.

DR. KRALEWSKI: Let me comment just briefly on your response of why you were subjected to this information. We were directed by Dr. Margulies when we went on this site visit to review this project and to bring it to this committee in the form of a recommendation one way or the other for this region in terms of their total program. He, or his staff, had selected site visitors to take a look at the renal program which, as I mentioned, were Dr. Kountz and Dr. Shapiro and Mr. Spear, and they met with this group in the afternoon while we were carrying on the rest of the site visit. And Dr. Shapiro believes that the program was a good one and that we should bring up in this form in front of the group, and that was in accordance with the instructions from

Dr. Margulies. So that's why the information was being presented.

DR. THURMAN: He survived it.

DR. KRALEWSKI: He did, yes.

Okay, let me go on here just briefly with a few other of the accomplishments that we have noted.

They have made progress in reorganizing their program. Of course, they have brought some of their staff together. They have reorganized RAG, they have reorganized their review of the projects, they have reorganized the evaluation of the projects and monitoring of the projects. All of this, though, has been accomplished recently and will be in effect only for the future.

They have voiced some interest in putting their continuing education programs together into more of a thrust after some discussion with us, but they have made progress in continuing education, and particularly in terms of regionalizing their efforts with the hospitals, because they have been working pretty closely with the hospital medical staff members in the region for a continuing education project.

They have made progress in a patient education project through the outpatient services in the hospitals; and they have a young gal who is a nurse on their core staff working on that, and she is fairly effective.

They have been pretty successful in finding other

funds for their projects once they have phased them. With the cutback in funds during this past year they have transferred many of their projects over to other funds. In fact there were six or seven of them that they found other funds to support, six or seven projects.

Now the reason they could do some of this, of course, is again through the relationship with these many, many agencies that are locked in with them on their RAG committee. So locking in with those agencies, of course, works both ways. It has been a limiting factor to them in terms of their flexibility, but they have been able to get the support from those agencies when they needed the dough to pick up some projects that were being phased out from RMP funds.

They have, of course, good relationships with many of the provider agencies, again through the RAG members being part of those agencies.

They have worked to try to develop a Comp planning B agency, not too successfully, but they have made a little progress on it. And they have a good relationship with the developing A agency.

Their short term pay-offs I suppose in our estimation were few, with the exception of promise again from these contracts where they could probably realize quite a few benefits in a short period of time by allocating that money through a contract method.

They have been able to develop some fairly explicit kinds of operating objectives for their core staff. They are spelling out fairly precisely what kinds of activities they are going to be involved with this coming year. Again they haven't got this back down through the staff members yet so they are tuned with it, but they are developing these instructions, and they are developing it also in terms of these contracts that they hope to let in terms of how that will fit in with their core staff activity. So there is a glimmer there of hope in terms of control of the allocation of funds through contracts to be able to get specific things done that they need to further their program.

They helped develop an allied health forum, bringing together the various educational institutions in the region to discuss the whole problem of allied health education and how they could cooperate, and this is making some progress, and I think it was a useful contribution.

They formed an HMO subcommittee. They are meeting with physicians, with hospitals, they are putting out literature on it, and they are holding informational meetings. Whether that will develop to any great extent is still an unknown factor.

They have been successful, as I mentioned, in adding at least some minority groups to RAG, one of them being Mrs. Bullock, who we think will probably have a good influence

on the program in the future.

Well, in my summary then, we see here an organization that unfortunately has not lived up to the expectations, I suppose, of our last review. They were awarded a triennium grant at fairly high level. The performance is certainly below that level. We see, though, that they have made some real strides in reorganizing their program and bringing their staff closer together.

They have been visited by the staff here in terms of the management review, and they have taken the suggestions from that review and attempted to integrate them into their organization by changing some of their organizational structure and by developing written job descriptions, et cetera. So they are making progress.

And I think at the moment our question, at least in my estimation, is how we can help them further strengthen that organization and to bring it in to some kind of an appropriate level of performance.

And that brings us again back to the kidney project because we felt, and Dr. Shaprio and Dr. Kountz felt, that the kidney project offered a great deal in this regard. It, first of all, offered a concrete kind of activity that they were going to be able to get off the ground and would give them some visibility and credibility.

Number two, they felt that the project in terms of

the overall program of RMP offered a great deal of potential in terms of bringing these universities together to start thinking about the development of programs to meet the needs of the region, and this would be one of the first major efforts, and they felt it would lead to other efforts. They felt that it would be a project that would bring many of the hospitals into a regionalized kind of arrrangement, and that therefore it might be really a center pinning kindof activity that many other things could develop off of that would be very useful for the program.

They felt, however, that at the moment -- and we all felt after our review -- that perhaps the RMP program should not run the kidney project if it was funded because of again the problems that they have in their organizational structure, but it probably should be run by someone who is project director in one of the hospitals.

With that I will ask you, Miss Anderson, to comment on this.

DR. MAYER: Dorothy.

MISS ANDERSON: I can only add a few things to what John has said because he has covered the situation very well. But I think some of his key words that you probably heard was that most all these things are on paper and untested and whenever we asked questions about their organization and what their plans were for the future or who was involved

in various committees, what was the broad approach, we would always get a flood of papers. In fact everybody had to look up on the sheet of paper just what the situation was because they had not been so involved in really operating or implementing any of these plans.

I had an opportunity to meet with two groups, one a group of professionals and volunteers who were representing various organizations, and I asked them what do you feel the RMP contributed to the community. And there was a Dr. Gins, who was chairman of the Department of Health Care Administration from George Washington University, and he was very positive in his feelings of relationship with RMP. He felt like his students had an opportunity to have contact with RMP staff, and that the RMP staff lectured to his students.

The woman from the Cancer Society said what they felt was the accomplishment was that they are able to publish a catalogue of professional films that were available to the community. And I asked if this was used, but they weren't sure about the answer.

Dr. Finertu(?), who is responsible for a hypertension clinic, said that the reason that he developed his clinic was because of problems in the community in regard to other hypertension clinics, and so his clinic now was set up according to appointment so that patients wouldn't have to

wait all day. They were playing follow-up for patients with hypertension, and also that they are giving patients humane treatment, and are utilizing allied health professionals in this clinic. And he feels that this plan, which is similar to a plan in Detroit, will be very effective here.

In talking to the staff in regard to the developmental component Dr. Woodside, who is responsible for the community program aspect in this new organization, felt, too, that they needed to have a thrust as far as their direction was concerned. It was interesting, I thought, that some of the staff members asked us "what is a thrust." So we had to be somewhat basic. She felt like the new plan of organization was very good, but she had questions in her mind if someone came in with an idea with the community programs whether it would really go to her or to the coordinator first.

I had a chance also to talk to Miss Bullock, and I was impressed by her also. She said that the community had been studied to death, and that what the problems were were well known, and she spelled them out, about the needs for funds for education of health professionals, the need for a ladder for health professionals to grow and develop in their jobs, the need for satellite clinics in the community, and she really spelled out all what they needed whereby -- she felt the RMP staff had not been out in the community, but that the community had been invited in to RMP, and she was

the example of how the community was invited in.

DR. MAYER: Other comments?

DR. KRALEWSKI: I would like to make the recommendations for funding them, because again as I mentioned, what I hoped to do is somehow strengthen this organization and give this relatively weak program director some opportuniities to further strengthen his staff. And maybe you can't see this, it is pretty small, so I will just flip this over and write these figures up here.

This past year they had $575,626 for core, and they have had $312,055 for projects. Now what they are asking for here in this application was for core at $638,766. They are asking for projects, $496,700. They are asking for contracts at $772,061. And then they are asking for developmental, $88,768.

We believe it would be useful -- then there was the kidney project in addition to that where they were asking for, as I mentioned--

DR. MAYER: 423.

DR. KRALEWSKI: It was over a million, and it came down to 423. We think that it would be useful if we would further cut back their core budget. This has been reduced the past year over what it had been before because of the normal cutbacks across the board. We feel if we cut it back again it will give Dr. Wentz the boost that he needs

to go through there and cut out the core positions that would strengthen that organization. So we are recommending that the core be cut back to 477, and that when we do that he is going to have to discharge some people and he will have to take a hard look at that organization and come to grips with the problem or resign.

We are recommending as far as the projects that we give them $205,000 so that they can continue on with some of them that they have going now, and specifically also will have a chance to deal with that nurse midwife project and a couple of projects such as that that seem to be worth while.

We recommend inthe contract area -- although as I previously said, there is real concern over the ability of this organization to handle that kind of activity, but we feel, on the other hand, it would be important for Dr. Wentz if we cut back his core to have the opportunity to build some kinds of services through a contract group, and we feel that he probably will be able to do that, both because of the fact that RAG is becoming stronger and will be able to deal with these, and because he has a little different make up on RAG, therefore should be able to strengthen his organization and possibly develop the kinds of things that he needs to be able to develop a program thrust through allocation of core. Now we are recommending $125,000,

a substantial cutback from what he has asked for. And this area in here, I think it might be worthy of some discussion as to whether we should drop that a little more or keep it in that general area.

Now we are recommending along with that the funding of this kidney project at about the $200,000 level, as was mentioned in this review, again because we were told to review that kidney project in this total program context, and to look at it and to see how it fit into this and if it made a contribution. The general conclusion of our site team was that it would make a contribution, that it would help them get that program off the ground, and that it was a reasonably priced kind of investment in terms of allocation of that money. And that would add up to a sum of just slightly over a million dollars, as opposed to their request for 2.1 million or as opposed to their funding level that has already been approved at 1.6.

MISS KERR: Are we to assume, John, that you were suggesting nine, the developmental component?

DR. KRALEWSKI: Yes.

DR. WHITE: A point of information. Once a triennial status has been awarded can it be retracted?

DR. MAYER: Let me comment on that. Let me remind you of how we got into, or of what went on that led us to approving the triennium, at least as I view it. As you may

recall, that was early on in the triennial review processes, number one.

Number two, we had a site visit report that recommended a level of funding significantly above the level which we as a committee finally recommended, that recommended the triennium and recommended the awarding of the developmental component.

What this committee did then in the course of discussion of that site visit information that was provided was of those three things they took away the developmental component they signifi antly reduced the dollars, but we never got around to saying, you know, no triennium.

Now I have to say that my guess is from John's comments here, and having remembered the comments about the last site visit report, is that they are further ahead now than they were when we awarded the triennium in the first place, Phil. And if we are going to take it away I would have to say it was our error in the first place, you know, rather than any deterioration.

Now I would guess if we got into a situation in which there were significant alteration in a program we may want to do that, but I don't think we would have a very good data base in this instance to do it on that basis. That's all I am saying.

DR. WHITE: I wasn't suggesting directly that this

be done. I am just questioning whether it could be done.

MRS. KYTTLE: Dr. White, from my memory one slight modification, when the three year funding was awarded developmental component approval was withheld because of RAG worries. It was the promise last year, and so we would not be withdrawing an approval for developmental component this year because it was not granted in the beginning.

DR. MAYER: Other staff comments?

All right, you have a recommendation before you.

DR. KRALEWSKI: I will put it in the form of a motion, if you would like. One year funding at $1,007,000, site visited next year again, and then the level of funds for the following year to be determined at that time.

DR. MAYER: Is there a second to that?

MISS ANDERSON: I second it.

DR. MAYER: All right, discussion.

Joe.

DR. HESS: Yes. It seems to me that if we go with that recommendation as is we have removed triennium.

DR. KRALEWSKI: We have what?

DR. HESS: We have removed them from triennial status. And the only thing that -- well, we also need to look at that in light of three other actions we have taken. And if we do not remove them from triennial status it seems to me we have to recommend a budget for the second year or the

third year in the triennium, because what we are talking about now is the second year of the triennial budget, is that not correct?

DR. MAYER: Yes. They already have an approved level of funding for that third year by our previous action and Council's action of a million one roughly.

DR. HESS: So that that's already taken care of, the third year.

DR. MAYER: In a sense it is, Joe.

DR. HESS: This just doesn't abrogate, that's the point I wanted to make.

DR. MAYER: I would just like to make one additional comment, and I would have to say that in the discussion we had yesterday of minority group involvement that to me this is one of the most appalling examples, because if there were ever a region in the country where there are some unbelievable competencies existing, you know, it's this particular region. And the fact that they have not accessed those competencies to me is a major concern, simply because of the obvious gap between -- you know, the strengths are really there and they simply just need to be accessed.

DR. SCHERLIS: I'm back on the renal bit, and also having looked at some of the projects -- they have this exercise project, is that ongoing, at about $75,000 a year, exercise testing?

DR. KRALEWSKI: That's right.

DR. SCHERLIS: That's an interesting definition of priorities. I am all for exercise, mind you, but I just want to mention that.

The other thing is looking at even the projections given by Howard University and by George Washington University in response to a direct questionnaire, each responded that the number of transplants projected for each of the next three years is in the order of ten. And how much money was planned to be given to either Howard or G.W., $100,000?

MR. SPEAR: The second year figure was $100,000.

DR. SCHERLIS: That seems rather expensive just as the basis of operation, not even including the direct cost of the procedures, namely would be $10,000 for each of the procedures done there in the next three years. And I assume that there were some Brownie points given to the renal project because it appeared to be a unified effort, but -- I guess they all agreed to sit down and ask for funds, but I don't know how much pooling they have done of their needs in terms of being able to accomplish what has to be done.

I have a great deal of reservation not on the other recommendations, although I do want to ask you want contracts they are proposing. Was that clear?

DR. KRALEWSKI: The contracts that they are proposing? Well, they have an array of about 45 activities listed that

they were going to become involved in, and they ranged considerably, from helping hospitals to establish PAS procedure in the hospital by talking to their medical staff, and so forth, helping distribute some kind of a calendar of the continuing education events that are going to take place.

DR. SCHERLIS: Do they have the ability to decide which of these contracts should be given the highest priority or the lowest priority?

DR. KRALEWSKI: Well, it's a risk. There is no question about it. But on the other hand, it gives them something to decide with this new organization that they have, and it is a risk that we thought might be worth taking to the tune of this much money at least.

Some of the things that they are listing are very exciting, the medical student, nursing student thing, you know, things such as that.

DR. SCHERLIS: Do you think they will choose the ones that to you are most exciting?

DR. KRALEWSKI: That's what we will find out next year. I'm sorry to be that evasive.

DR. SCHERLIS: I'm not too concerned about the contracts. I think this may be just what they need to get moving. But I wonder what some of the reaction of others

that if I am the only one who is concerned about it.

DR. MAYER: I have the concern about the renal project only in the sense of the funding in the second and third year for two subsequent transplantation centers, the very point that you raised, Leonard. And I think when we get to a specific recommendation what I would move, or would suggest that somebody move, is an amendment to it, would be $200,000 the first year, but take that $144,000 in the second year and reduce it by the 100,000, specifically the second transplant component, which would bring that down to 44,000, and then no funding in the third year, because the third year funding of 30,000 that was recommended by the group was totally for that third transplant unit.

DR. THURMAN: But you realize you are going to destroy their only hope of a continuing cooperative effort?

DR. MAYER: Well, I think we need to know that.

DR. THURMAN: I am being facetious, Bill.

DR. MAYER: I think it may present an interesting challenge to them. They may relook where they want to do that transplantation under those circumstances.

DR. KRALEWSKI: Mr. Spear, maybe you would like to comment on that because I think it is an important issue, is whether there is a willingness to cooperate on this, because this is much of the basis of our willingness to go along, because of the fact that it seemed as though this brought about

a great deal of cooperation.

DR. THURMAN: But, John, they are talking together only because they are going to each get what they want if they wait long enough. Judy disagrees.

DR. MAYER: Mrs. Silsbee.

MRS. SILSBEE: I would like to ask a question here because at the time that Dr. Shapiro reported to the team at the site visit it sounded to me just from your description that their proposal now is different from what they agreed to at the site visit in terms of the transplantation situation, because he was excited about the fact that Howard and George Washington had decided to get together at D. C. General and would let Howard use its facilities, and so forth.

MR. SPEAR: I was less surprised, I guess, by his reaction to the question than I was by Dr. Kountz's, who I thought was wholly on one side. I can only suggest that in retrospection as they looked at it they thought well, this is workable and if they can do it, if they mean it, then it's fair to go alongwith it.

I would like to state one other thing. The matter you were discussing, Dr. Kralewski -- I should think we would feel here in the RMPS that if they really mean to do business and get a good transplant operation going there is no reason one can't do it, and in the first year while they are doing one they all say they will refer their patients. And I think if

they get one going that is efficient and effective and does the job they will have many more patients than they suggest, because the figures I have are similar to yours, only indicate those dialysis patients now waiting for transplant. It does not get into this whole unknown universe of people out there who are not financially able to be dialyzed, but will be transplanted.

DR. SCHERLIS: I only have the data for each of the next three years--

MR. SPEAR: That's all I have. But there is more than I am speaking to, and there's no reason one can't satisfy.

DR. MAYER: Would someone care to make an amendment relative to, or to extend the motion as it relates to transplantation in the second and third year?

DR. SCHERLIS: I would father the amendment you refused to recognize as your own.

DR. MAYER: All right, thank you.

DR. HESS: I will second it.

DR. MAYER: The amendment was that we would agree to the 202,000 recommended by the group for the kidney project in the first year, we would recommend only 44,000 for the second year, which deletes the second transplantation center, and no dollars in the third year which deletes the third transplantation center, but does permit support in

the first and second years of the dialysis units.

DR. BRINDLEY: If experience were to show that they needed to have more they could reapply for some extra funding, could they not?

DR. MAYER: Yes. They have that option in the anniversary sequence that is here.

DR. SCHERLIS: With which medical school is the V.A. more closely affiliated?

MR. CHAMBLISS: I believe it is George Washington University.

DR. SCHERLIS: So they could really share these facilities, I assume, and that is permissable in the V.A. regulations, isn't it, that if you have an affiliation of this sort your patients--

MR. CHAMBLISS: There is a sharing provision in the V.A. regulations, yes.

DR. MAYER: Shall we vote on the amendment first?

All those in favor of the amendment?

(Chorus of "ayes.")

Opposed?

DR. KRALEWSKI: No.

DR. BESSON: Will instructions go to the region about this level of funding with advice about this amendment?

DR. MAYER: Oh, I would think so.

Now the discussion of the motion as amended, further

discussion or comments.

Yes, Jerry.

DR. BESSON: Well, I wonder whether it isn't also appropriate, in spite of the fact that granted the military lives in a different universe than the real world, for the Council to see about some kind of coordinative effort with the kind of facilities that are available currently at Walter Reed and whatever the other hospital is, the Naval Center. And I think it would be perfectly appropriate for some kind of coordinative effort to take place between HSHMA and the Department of Defense. So I would like that our motion also include a request of Council that some kind of coordinative effort be initiated as far as this transplant program in this area be concerned.

DR. MAYER: All right. You understand that?

MR. CHAMBLISS: That could be very easily covered in the post Council advice letter.

DR. MAYER: I guess my only -- I couldn't agree more that they need to look at those resources and that HSHMA ought to use its strengths, whatever they may be on the federal scene, to be helpful since they are right here to do that job. If in fact it turns out that both Walter Reed and the Naval Medical Center acting as the centers respectively for the Army and the Navy are not in fact overloaded by their own activities, then I think it's one that ought to be

encouraged to be pursued.

Yes, Phil, you had a comment.

DR. WHITE: May I move from the concrete to the abstract, because I think in my mind if this action that we are contemplating occurs we are indeed jeopardizing the whole concept of a triennial review. What we have said to this region or are saying to regions is we agree that for the next three years you are capable of managing your affairs. But our action belies that in this case. And if we can do it in this case then presumably we can do it in any case, and the meaning of a triennial award is zero. No region will trust us.

I think we either have to say you are no longer meritorious and we are withdrawing it and this is why, or we have to say okay, we made an error in judgment, but we will live with it for the next two years.

MRS. KYTTLE: There are several items that staff is charged with the responsibility of monitoring within the triennium, and should any of these be breached it is a flag that staff is required to call these things to the attention for full review insofar as Council is concerned within a triennium. And failure to -- well, I think the words are substantial failure to achieve what was funded and the intent of what was funded is one of them.

Judy will probably be able to give you much better

background on what generated the decisions this round on Metro D. C. than I, but just by our procedural regulations they themselves would bring any region in a triennium that is thought to be not meeting the goals that it was funded for.

DR. WHITE: I agree, I think that's quite appropriate that there should be some mechanism for it. And I can understand that there may be within a region certain elements of the programs that would need flagging, but I think when we look at a region in which all elements of the program are flagged and where we are making substantial budgetary revisions, substantial suggestions to them about changing their personnel pattern that this is a farce.

DR. MAYER: Well, Phil, my assumption is if we say in this situation a million dollars, of which 200,000 is to go to the renal project, that the only restraining force on that region is the 200,000 for the renal project, that they would then have freedom to expend the remainder of those funds in a way which they think is appropriate for the region within the confines of things that we have approved in the past. Now I think we are laying on them some pretty strong suggestions, which I think is appropriate, but I think within that triennium they have that freedom. Is that not right, Mr. Chambliss?

MR. CHAMBLISS: Yes, that is correct. They have

that freedom.

MRS. KYTTLE: Although along those lines, Dr. White, this afternoon you will be looking at anniversaries within a triennium that were not site visited, did come through the staff anniversary review panel, and are being brought to you for information purposes, but nevertheless include staff anniversary review's recommendation that words go back to the region about suggestions they have within the triennium.

DR. BESSON: I share your concern, Phil, but on the other hand I think when the anniversary review program was first developed it really was an untested idea, and if RMPS is anything it is an evolutionary program. I think the notion of remanding to the regions full authority has really been untested, and we are in the process of testing that now.

I do have one of the programs, Alabama, to review where this very question comes up. So I think that there are several aspects of that anniversary review that are being changed as we go along.

For example, we had originally spoke of anniversary review as precluding project review, but that has become patently impossible. We can't review program without looking at the matrix of the program which is project, and if we are candid about how we reach a dollar figure, which, after all, is the only leverage that review committee has, we reach that dollar figure by careful scrutiny of the projects,

the leading projects here and there, which gives us a final figure. Now that is appropriate, I think, because we are looking at the substance of the program in terms of project.

The second thing that has changed since anniversary review has developed has been the emergency of SARP, the Staff Anniversary Review Panel, which I think gives staff a very substantial function in the review process. And in my particular region that I will be reviewing it will be for review committee's function alone. We have no action to take on it, and staff I think has been very close to the problem, nas appropriately, I think, recommended a change in funding level. But they retain, as I understood your comments a little while ago, Mrs. Kittle, the option of bringing it to review committee for action.

I think it would be well for the review committee to have some clearcut idea of standard operating procedure vis-a-vis the entire anniversary review process. But I don't share your concern that we are going back on our original intent. I think the intent is that we do have an obligation to monitor the region and make sure that they are accountable.

DR. MAYER: Phil.

DR. WHITE I have no problem with the concept of surveillance, and I have no problem with the concept of a close scrutiny of the application, including all elements

MRS. SLOAN: Could I make just one comment that may be helpful in the kidney disease area? The National Kidney Foundation has brought together a committee to develop guidelines in the field of kidney disease, in stage kidney disease, comparable to those which we have been developing for the Secretary's list under section 907. They have made the recommendation that unless a proposed transplant facility could project a volume of transplants of 50 cases per year that it was not an appropriate place to have a transplant program in terms of the safety of the patients and keeping the team sharp and active.

But rather than saying that neither G.W. nor Howard could hope to have a transplant program in the future, if you could tie this in some way to the projected load as this would increase within the District you might eventually be able to justify three transplant facilities. I think the hope of having one eventually as part of the medical school's program of all three medical schools has been a very important part of bringing this amount of cooperation together.

SISTER ANN JOSEPHINE: May I ask just one question relative to this and maybe relative to Dr. Margulies' remarks this morning? I recognize that a significant sum of money has been appropriated at the present time for treatment of renal disease and that there is going to be a

of the application which incorporates project, at the time we come to these decisions. That doesn't bother me. What bothers me is that by our actions here in reference to Metro D. C. we are saying we didn't really mean to give you triennial status last year and therefore we are going to be meddling in your affairs, we are not going to tell you you are no longer triennial, but indeed we are not going to let you behave in that fashion. And I think this is ridiculous, that we either say you don't or you do, and I think thing this precludes the staff raising flags about certain kinds of program elements. But when you have this substantial amount of concern it's a totally different kind of picture.

DR. BESSON: Well, the other aspect of this, Phil, is that we make decisions very often on promise, and there is a very obvious gulf between promise and performance, as is manifest here. Well, I think it is appropriate for regions to know that they are accountable for their promises, and I think it is perfectly appropriate for RMPS to hold them accountable with performance, so that if this is going to be interpreted by regions peripherally that they have to measure up, well, that's fine. Thre's nothing wrong with that. I can live with that very easily.

DR. MAYER: I guess what I was trying to say earlier, Phil -- maybe I wasn't communicating clearly

enough -- is that what we are doing is arriving at a suggested funding level as it relates to the second year of the triennium. What they do is still a matter of significant judgment on their part about that.

Yes, Sister.

SISTER ANN JOSEPHINE: Let me ask a question I think is related to this. I would like to ask what has happened to the management audit that was inaugurated?

MR. CHAMBLISS: That's a good question, Sister. Those are going forward and the pace is being intensified. This region has already had a management audit of its activities.

SISTER ANN JOSEPHINE: Has the management audit prepared them for possibly recommendations that will indicate they are not living up to their commitment?

MR. CHAMBLISS: The management audit did in fact point out their weaknesses, which some of the areas you discussed broadly were touched on.

DR. KRALEWSKI: And as I mentioned in the accomplishments section here, they have implemented some of those suggestions, particularly the ones dealing with personnel policies and the ones dealing with their organizational chart.

MR. CHAMBLISS: And pulling the core back in.

DR. KRALEWSKI: Pulling the core back in.

SISTER ANN JOSEPHINE: Pursuing this a little further,

are there capabilities in the staff review that unsatisfactory performance can be flagged early enough so that a management audit could be made and be helpful, be supportive maybe to the recommendations of a site visit team and prepare the region for the recommendations that will be made? It would seem to me if these things occurred simultaneously then it would begin to be effective in the total process.

MR. CHAMBLISS: The management audits are now on a schedule for covering all the regions. It so happens we have passed this one already. But certainly if there are elements in the program that need management audit attention at any point in the program I think the management audit team would get back in.

DR. BESSON: Was the management audit available to the site visit team prior to its--

MR. CHAMBLISS: In fact it was.

DR. BESSON: Is it available here in the books?

MR. CHAMBLISS: It may not be in your books, but it was made available to all the members of the site visit team prior to the site visit.

DR. BESSON: I have never seen one. I wonder whether we could see one.

MR. CHAMBLISS: No problem at all.

DR. MAYER: Any further questions on the motion?

push for transplant and renal dialysis. However, it may well be that when we find out how many candidates do exist if the program is expanded and the fantastic cost of the program, we will find that we won't be so energetic in pursuing this whole thing. In fact I have real fears that we will move in the area of a philosophy comparable to euthanasia as we begin to look at these candidates. And I wonder if we shouldn't take into thinking -- there isn't anything we can do about the policy, I know; but even as we develop our own philosophy here, that we may not always be this enthusiastic about developing all these centers, and maybe need to look realistically at what is a realistic case load to support a center, and this would be of great concern to me.

DR. MAYER: All right, further comments?

Everyone understand the motion?

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

(Chorus of "ayes.")

Opposed?

DR. WHITE: Aye.

DR. MAYER: All right. It will be duly recorded.

Let me suggest that we make every effort to be back here by about a quarter of 2:00 if we possibly can in order to get through the remainder.

(Whereupon, at 1:15 p.m., the meeting recessed, to reconvene at 1:45 p.m.)

AFTERNOON SESSION

(1:45 p.m.)

DR. MAYER: We are going to make one small modification in the schedule and move to Susquehanna Valley and honor the plane J. Warren has to make to Buffalo this evening.

DR. PERRY: Thank you, Bill, and special thanks to Miss Kerr for permitting me to go ahead first.

Susquehanna Valley RMP is currently in its 03 operational year. It is functioning at $480,405, and they submitted an 04 request for a million four.

DR. SCHERLIS: May I interrupt you just a moment? Do you want us to fill out for the others coming up the same forms, or are they only necessary for the ones we have the regular review of?

MRS. KYTTLE: The rating sheets should be filled out for your anniversary prior to the triennium.

DR. SCHERLIS: Intermountain and Susquehanna?

MRS. KYTTLE: No, Intermountain and Susquehanna are regions that are anniversaries prior to their triennium. They have not received a prior rating from this committee. SARP rated, and I have the ways in which the SARP members arrived at that rating, and I was trying to get back before you started to talk this over with you a bit. This is what we were kicking around.

For anniversaries prior to triennium they need to go to Council with a firm recommendation of a rating.

We were wondering what the committee's assessment would be of a procedure whereby SARP would rate; if you would wish, we would show you how SARP arrived incrementally at the total rating on the pink sheet you have before you. If you would want to affirm the rating that SARP has given, or if you would want to change it; we are not trying to color your thoughts in that line.

MISS KERR: I would have only one comment relative to your question, Lorraine, and that is that I personally on Intermountain have no handle other than the written word which the staff review and SARP has given me, plus this, plus their application, and my interpretation may not be a fair one. Now I will be asking for imput from the staff members involved, but since I have never been to this region on a site visit I have to depend largely on the written word. And I just want to throw that in as a potential for perhaps not a fair evaluation or interpretation from me to this group.

MR. CHAMBLISS: Well, we would certainly hope that an overview of the region could be augmented by knowledge that resides either on the committee or in the staff on which you could base some rating.

MISS KERR: And so you are suggesting then that we

do rate?

MRS. KYTTLE: Well, now this is what I want to ask you then. Therefore just thinking of Intermountain at this time rather than the larger question, would the specific ratings of the Staff Anniversary Review Panel assist you? Would you like to see them.

MISS KERR: I would like to -- after the presentation and after the discussion if there are discrepancies maybe, if there are some major questions or gaps.

MRS. KYTTLE: That's a good base. All of the anniversaries have been reviewed, even those within the triennium, and have been assigned ratings.

MISS KERR: Could you report to us afterwards what the average was or what the number assigned to that was, and then we can--

MRS. KYTTLE: Individually?

MISS KERR: No, as a group.

MRS. KYTTLE: I can do both.

DR. MAYER: Let me try a suggestion, that since SARP will have arrived at some ratings on the anniversaries prior to triennium, and I assume -- will they have done anything on anniversaries within the triennium?

MRS. KYTTLE: Both.

DR. MAYER: All right, they have done both. I guess, just to throw it out for discussion, that perhaps if

this group had those ratings available to them to look at while we are going through the review process that we might want to raise some discussions about particular areas which we may have some feelings of gross discrepancy, but that we would not attempt to evolve a separate rating for those that are anniversaries or anniversaries within triennium.

Now how does that grab the committee? Is it appropriate?

MRS. KYTTLE: Could I add something to that? In an effort to get your feeling of -- you know, this is only our second, and really the first full time that we have seen anniversaries in this light -- in our effort to get to you materials that would help you in your reviews of anniversaries that had this prior review, these ratings come in two forms individually, both raw and weighted. And I would like to get your feeling about whether both documents or either document sent to you at the time the other papers are sent to you would be of assistance to you.

DR. PERRY: I think I would have been happy to have seen them. I have th total that came in -- you know, on the pink sheet. I would have been very pleased to have seen the other.

Again as Billy has said here, I have been to that region, but I am responding at this point to the printed

word, and that kind of review from those people that have been much closer I think would be of assistance to us.

MRS. KYTTLE: Mr. Chambliss, in an effort to assist the discussion may I pass them out now, so it would perhaps generate--

MR. CHAMBLISS: Indeed so. I should think so. And we would like to say that the SARP ratings are in no wise--

MISS KERR: Are binding?

MR. CHAMBLISS: Beg your pardon?

MISS KERR: Are binding?

MR. CHAMBLISS: No, indeed, they are not.

MISS KERR: In no wise are binding?

MR. CHAMBLISS: Yes, they are simply for your augmentation if you choose to use them. What we are trying to do is to get as many regions rated as we can; as we can get them through the process, then our basis for comparison will be much greater.

MISS KERR: Well, in essence then unless we have any glaring opposition to this we are really supporting SARP's rating which will then be its official rating for the moment?

MR. CHAMBLISS: If that is your pleasure, all right. But again that is left to this committee.

MISS KERR: That's what I mean, unless there is.

MR. CHAMBLISS: Yes.

MRS. KYTTLE: It would constitute either your modification or your affirmation of a rating that would hold until the next anniversary.

DR. BESSON: But that would be for the raw data rather than the final figure? We would have an opportunity to inspect the raw data rather than just the single weighted score?

DR. MAYER: Right. Yes. I gather that's what they were saying.

All right, why don't we just move along and try it and see how it works, and I guess it's like everything else in here, policy finally evolves out of dealing with the real world.

DR. PERRY: Susquehanna Valley, as I started to say, is currently on its 03 operational year.

Geographically this is the central Pennsylvania area, with Harrisburg, Hershey as the focal point.

I did have the opportunity of participating in the last site visit here at this region. At that time -- and Susquehanna has quite a history of problems -- there was, the site visit group believed, a lack of strong leadership anywhere, the coordinator, RAG, medical school relationship, and so forth.

There were some major questions asked about the relationship between the region, if you recall, andthe grantee,

the Pennsylvania Medical Society.

The weakness of the RAG was emphasized time and again. Continuing emphasis in the region had been placed on categorical and what appeared to be quite separate projects with no evidence of program planning.

The noninvolvement of the Hershey Medical School -- although repeatedly requested liaison had been requested and had been looked at, was noticeably consistently missing.

The absence of nursing and allied health imput, and although their continuing education program in that area emphasized this, there was no voice and little relationship in any decisionmaking or committee relationship.

There was a concentration on subregional development. And although there was recognition of this strong relationship of individuals throughout the region in various sections, there was little, if any, regional direction.

There were questions raised about how decisions were made by the RAG because there was evidence that practically nothing had been turned down in the history of the program.

Okay, that's a pretty dark and bleak picture that I painted here. But at this point there seems to be some light on the horizon, and in terms of these kinds of negative statements I would like to attempt to indicate what in the written report Susquehanna has moved on so far to remedy some of these weaknesses.

Number one, and of primary importance -- and all of us, I guess, recognize the importance of leadership in a program -- the replacement of the lay coordinator with a physician who will assume this post January 1st, just a week or so ago, is of major impact here and major import. We hope impact.

At the time of the site visit great concern -- and it has been expressed for several times -- at the capacity of the past coordinator, recently past, to speak up and to be heard in any way with the Pennsylvania Medical Society. He had formerly functioned as the executive director of the Pennsylvania Medical Society. When he moved to the other position they were not sure in any way that he had a really major leadership role and voice to make.

As of January 1 Dr. Joseph T. Ichter will be taking -- I'm not sure I pronounced the name right, I-c-h-t-e-r a pediatrician, attended the University of North Carolina, got his M.D. at the University of Pennsylvania, has accepted the position and is on staff in the region.

There is a vacancy on the core staff for the position of Assistant Director for Program Services. The nursing staff position is still open, has not been filled. So there is a capacity, an opportunity for the new man to make some appointments that should strengthen core and give him a working relationship there in the program.

The core staff, those of us that met them -- and I recall several of them very well -- and this is in the report of the staff review, the staff anniversary review that has been handed to me -- great confidence in a competent though small core staff. This core has carried on in the past few years, and some of us wonder how, with some of the lack of leadership that I think some of us feel has been present there. Even during this last matter of months I am sure it has been core and such that has developed the application, that has put some of this together. There are some strong evidences there of change.

Number two, in relation to RAG, RAG has also appointed a new chairman. In the staff report, those who have known him and met him and seen him in action -- and again I recall who he is -- another member that I had lunch with today indicated she remembered him also -- the new chairman of the RAG, again showing change in response to some new actions there.

RAG for the first time has appointed a planning committee. This had been recommended at our last site visit. So a planning committee for the first time has come up.

The new RAG chairman has expressed the desire which -- you know, this goes back to the early statement I made -- but to spell out the specific relationship between the grantee

agency and the RAG.

Okay, how many years did it take to get to that? But they are willing to spell that relationship out.

In relation to the approval of programs and the assigning of priorities and such, we still have major questions, and I believe these are some of the things that the new RAG and certainly the new director of the program must get involved in at once.

The report indicates that RAG is studying its composition. This is another positive. Many of us were concerned about the composition of that RAG.

Although the nonwhite population is six percent, there are none on the core, none on the project staff, one of 34 on the RAG, two of 493 on other groups and committees. There are some opportunities certainly for action there.

There is still a major question of relationship that has not been spelled out yet with Hershey Medical School, although we have the first evidence indicated here that they will consider -- and I am sure this is true since indeed a position has been found for this physician, a faculty appointment for the physician coordinator. We hope this moves ahead so there is a definite relationship there. We will have to wait and see if this indeed does happen. But again this indication from Hershey that they are willing to look this way is strong.

If you recall from our past review, it has not been statements of negativism from Hershey, for they have been the location for quite a few continuing education programs -- I remember specifically a physician assistant, well attended conference that they have had, programs of this kind. It has been the great involvement that Hershey has been involved in in getting started itself, and their unwillingness to commit meager resources and such to anything else at this period of time. They have not looked at it as a unit where could strengthen each other together, which, of course, would have been ideal.

Although regionwide planning is badly needed -- and I spoke of the disparate projects and the problems in terms of putting a region together -- the new coordinator -- and I am sure he will find this out very soon -- has available some very excellent resources in the very active local advisory groups. They speak quite openly about -- they are a grass roots group, everything happens in their program and has in the past in the grass roots.

Many of us were extremely impressed with the young physicians that we met from the various district committees. Here is a resource that the new director, the RAG needs to bring in spelling out a role, a leadership role, the ways in which these men can become a much more positive influence. In the past they had very little relationship to the region other

than what they could do out in their district, and in that case it was a separate kind of approach. These people need to be brought into a total relationship. But there's strength and there's resources there to work with.

At the last meeting there was no data base of any kind, the last site visit, there was no data base of any kind; reported in the proceedings here and in the application, and it is a bright spot certainly, in cooperation with a social epidemiologist from Hersey a data base for the region has been developed and published.

What is needed certainly, I believe, is a major commitment of assistance from RMPS here. This has been spelled out in the recommendations made. I see a comment here that Harold has put on the outside of these, "let's get in touch with this man immediately and work with him as closely as we can," and from comments that were made yesterday the approach has already been made. I notice someone, they said, fr the staff is there today. He is willing, eager to come in and work with RMPS. He wants to take a little more time to assess his own resources, his own region, before he starts to move.

In terms of recommendations -- and to go down the line of all of these I think in the period of time that we have, it is going to be a repeat of what we found in that region before. I think the important thing to make of the

recommendations -- and here I am leaning very heavily on the staff review recommendations, and I do concur certainly with them.

Number one, to provide an initial award for the 04 year of $480,405. This was the commitment for the 04 year as well as the current level of funding, the exact amount.

I think it needs to be made clear, as the staff has recommended, and looks like an excellent way of doing this -- made clear to the region and to this new coordinator and to the RAG that's trying to make all kinds of changes that this amount can be allocated by the region in the most effective way possible to chart this new course for the region.

Number two, to recommend that the director of RMPS be given the authority to allocate up to 100,000 to this region during the 04 year if it is determined by staff that this can be effectively used for regional and program development. That total, were it to be given, would be up to an amount then of about $580,000. Regional and program development certainly deserves this. They have the programs, the staff -- and those of us who recall the projects that are already in operation, we are not too impressed with some of them, some of them have had minimal effectiveness in various ways, but this would put the RAG and the director on the basis of an opportunity to move ahead and change.

I feel that it is absolutely crucial that RMPS

move with this individual in every way possible in terms of whatever assistance can be given.

We would also disapprove the developmental component.

And I would like to have Judy, any of the other people who are familiar with the region, to respond to this since there was not a site visit, anything that I might have missed in the recommendation.

MRS. SILSBEE: You didn't miss anything. Dr. Ichter is on board. I understand he does have a Hershey faculty appointment, and as soon as he gets his feet wet and goes to St. Louis he wants to talk to Dr. Margulies.

DR. MAYER: All right, comments?

I have one to make. I would just like to suggest that in recommendation number two, that is the availability of 100,000 in the 04 year, that it be clear that in making those dollars available there is no implied commitment in the 05 year above and beyond the $580,000 issue. Because what I am saying is if they commit that, all that 100,000 in the last quarter, you know, in theory one could be caught in the begining of the 05 year with an $880,000 kind of commitment, and I just think care needs to be given in dealing with that.

DR. SCHERLIS: For my own information would Dr. White comment on project number 28?

DR. WHITE: Later.

DR. SCHERLIS: What's that?

DR. WHITE: Later. I haven't looked at it.

DR. SCHERLIS: It's just a small paragraph.

DR. WHITE: I don't even see it.

DR. MAYER: What page are you on?

DR. SCHERLIS: Last page of the orange sheets.

DR. WHITE: Ridiculous.

DR. SCHERLIS: What?

DR. WHITE: Ridiculous.

DR. SCHERLIS: Thank you.

DR. PERRY: These are the recommendations that have been made also by -- an I recall this specifically -- by the last program. This was the project, if you go back into this region, that concentrated completely on coronary and all these various -- and we have been criticizing them right down the line. This is one of the reasons why in the committing of the money we are saying for god's sake, let's look at new objectives, new goals, in terms of what you are coming up with.

DR. SCHERLIS: In view of Dr. White's rather prolonged discussion, would it be incumbent upon us to say since we are attaching no strings to the funds, we nevertheless do not think that project number 28 should be funded under any circumstances?

DR. PERRY: I would be happy to have that included.

DR. SCHERLIS: I gather this is Dr. White's

reaction. Is that correct?

DR. WHITE: I think it is.

DR. PERRY: A footnote, "ridiculous."

DR. MAYER: All right, additional comments?

I gather you are moving then the recommendations of SARP.

DR. PERRY: (Nods.) So move.

DR. MAYER: All right. Further discussion?

All those in favor?

(Chorus of "ayes.")

Opposed?

(No response.)

MRS. KYTTLE: This includes affirmation of the rating?

DR. PERRY: I have not had a chance to look at the rating. That was 244, if we look at this on the scale this places them in the two and a half C category. Unless there's some recommendation for change I would certain reaffirm that rating.

DR. MAYER: All right, are you willing to accept then the rating, overall rating granted by SARP?

DR. PERRY: I am.

DR. MAYER: I see heads going up and down instead of sideways, so we will assume that we have consensus.

I would like to then move to Intermountain,

Elizabeth.

MISS KERR: I would again make it clear I have not visited Intermountain, nor have I before reviewed any of their materials. The secondary reporter is not here, Mr. Spellman. I don't know whether he had or not. But I would like to have--

DR. MAYER: Just document in the record that Sister Ann is leaving.

MISS KERR: So I would hope that Harold O'Flaherty and Dick Clanton, who are familiar with the area, or any others around this table who have made visits, will feel free to put in anything that they would desire when I get through.

The Intermountain Regional Medical Program, the grantee institution is the University of Utah. The Regional Medical Program consists of a geographical area of Utah, parts of Nevada, Montana, Idaho, Wyoming, Colorado, which covers 546,000 miles, and I think we must keep this in mind when we look at the core and a few other things that seem to be quite sizeable.

There are two and a quarter million people, about fifty percent of whom live in urban areas, and therefore the greater portion is arid, mountainous, sparsely populated.

The Intermountain Regional Medical Program is presently in its fifth operational year. It is not within

a triennium. It is presently funded at direct cost of $2,478,645, with an indirect cost of $904,419, which kind of startled me. And they are funded through March 31st of '72.

This particular anniversary application requests continued support for core and 21 projects ongoing, support for initiation of seven new projects, a developmental component, totalling $3,025,219.

This anniversary proposal had a staff review on the 14th of December and was reviewed by Staff Anniversary Review Panel on the 20th of December, and recommended approval.

As far as the goals, objectives and priorities of this region are concerned, they certainly used the right words, and are therefore in writing compatible with national priorities. But the relationship of the operational projects to the goals and objectives are rather fuzzy at this time.

It appears that the goals, objectives and priorities speak to such factors as improving health care delivery, accessability, and so forth, but on closer speculation most of the projects are still basically oriented to continuing education.

Apparently Intermountain Regional Medical Program continues to demonstrate outstanding progress. Each of the projects that have been funded appear to be accomplish their stated objectives.

It is felt that the present coordinator, Dr. Satovick, has really done an outstanding job in terms of filling the position of the former coordinator and in terms of preserving and even strengthening the autonomy of the Regional Medical Program. There have been a minimum of problems in the transition and in the program as it is ongoing.

Apparently they have a very strong staff. There has been considerable improvement in involving the outside organizations in planning and in carrying out program components.

I go to the core staff, which consists of 30 people, most of whom are full time, but all of whom are at least 60 percent time or more. Twenty-four of core staff are men, and their are three Orientals.

Then in looking at RAG, let me say first that RAG consists of 30 people. Now they still have 30 people on their RAG, although the representation has been changed to involve more consumer input, and just a slight token, I should say, of minority representation, in that on the RAG they have at the moment 28 active appointments, 23 of whom are men and two with Spanish surnames. But I think we need to say here that in this particular area we do not find as many blacks and we do not find as many chicanos, and so forth, so perhaps we have to take this in consideration, too, when we are looking at the minority representation. But it does look a little low.

The RAG membership, though it has become more representative of the community at large and is seemingly better informed about the role and the program of the Regional Medical Program, there is still concern that the RAG is not as active as it would like to be seen. The comment here was made that this is due primarily to the fact that there is difficulty in the RAG membership relating with core staff. This was not enlarged upon, and somebody may want to speak to this. I assumed that because the core is active, is aggressive, is able, that perhaps the RAG sits back and isn't quite as prominent in decisionmaking as perhaps we would like to see them.

The education planning and evaluation section appears to have a great deal of visibility. Their major contribution has been to assist those people directing educational projects, and they have been particularly helpful in the specifications of educational objectives and in evaluating educational programs.

However, when we look at the total evaluation program it seems that the majority of their work has been done in the area of educational programs, and little in total program evaluation.

Though they do have some hard data, it appears that the region has established a systematic process for painnin proposals or developing proposal objectives -- it does not

appear that they have used these data to establish their priorities.

The region has made considerable progress in the development of subregional centers despite budgetary cutbacks, and they at the present momemt have apparently what individuals they title coordinators in Grand Junction, Colorado, Pocatello, Idaho, and Provo, Utah. In these three areas it is foreseen that there is great potential for area health education center development, and they are looking in this direction.

Apparently the Regional Medical Program is directly involved with many activities of other health planning agencies in the region, though it seems that again CHP perhaps because of the visibility and the action and the positive movement of the core staff of RMP seems not to be as active as one would hope that the CHP might be.

The ongoing projects, of which there are 21, two of which are to be phased out at the end of March, are indeed quite categorically oriented and continuing education oriented.

The new projects, the seven new proposed projects seem to fall more in line with the new direction that RMP is taking and is encouraging.

In looking at the strengths of this region, certainly this new coordinator is leaving his mark at the

present time, and it is predicted that he will continue to. It is felt he has good administrative ability. It was felt that the core staff is one with a high level of competency and hard working, with broad vision.

The development of subregional centers which may lead to AHEC's, at least there is activity out in these centers that is active and has visibility, and this, too, would be considered a strength.

The Regional Medical Program has had an impact on the improvement of care of the people in the region. There are a few areas, however, that need to be strengthened.

As I mentioned before, at the present moment it still appears that their overall program is still pretty much project oriented.

If some of you caught my early remarks, you will note that the indirect costs of $904,419, recognizing that we have nothing to do about this, but it is a sizeable amount of indirect cost, and it is up to sixty some percent -- I have forgotten just the exact amount.

Again they need to strengthen the relationships and show them more clearly between their goals, objectives and priorities as they have written them in light of the new mission and what really actually exists at the moment.

Evaluation procedures need to be improved in other areas than that in which they are doing an acceptable job,

which is the educational evaluation.

The region has not done too well to seek out other sources of support for the continuation of its projects.

The staff group in its review -- and I concur with this -- is that rather than the 3,025,000 which was requested for the sixth operational year, because of the area's needs to strengthen their activities in those areas identified, and yet to give them an opportunity to do so, it was felt that the funding allocation be kept at the same level as it was last year rather than to increase it to the $3,025,000, which would remain then at $2,478,650. This was the recommendation of the staff. It also was the recommendation of SARP, and I would go along with this.

The staff review recommended $75,000 for the developmental component. The SARP group -- and this was the only area in which there was any marked difference of opinion relative to their reviews-- the SARP group recommends that this region perhaps if it had more flexibility with more developmental funds could be a little bit more effective in moving ahead to accomplish the strengthening of those areas identified as needing this, and recommended ten percent of the former level of direct funding, which comes then to $247,864.

As a reviewer with no more familiarity than I have with this area, I agree they have many strengths. I

think they have to take a hard look at turning the corner further and looking at their projects and relating them to their new priorities.

And perhaps I am getting just a little bit squeamish, because as I sit on this committee at times I think -- and I use the word "hard-nosed," but I don't really mean it that derogatorily, but I think sometimes we get a little generous and then a litttle bit later wonder if we really did the right thing.

So what I am saying is I personally would rather myself recommend the developmental component which would be a part of the total level of funding at $150,000 rather than the $247,00. But I do recommend the developmental component. I recommend it at that level.

I would be glad to hear from the rest of you, and I would be willing to consider changing my mind.

DR. MAYER: Comments from staff?

VOICE: I would only comment that the rationale for holding the developmental component at $75,000 was to maintain the existing level across the board. That was the only rationale.

MISS KERR: Yes, and I think this is what I assumed. Yet I also gathered from the SARP report that that review group felt that it might give them opportunity to move out faster to do things if they had more.

MRS. KYTTLE: I'm sorry. I was involved in something else and missed part of your conversation. Are you on item 2 of the things that require committee action? Says Council approval at a $75,000 limit, staff recommended that that limit be maintained, but the staff anniversary review panel recommended that the allowable ten percent be approved within the 2.4 recommended. Are you saying -- and I missed it -- that you do go along with recommendation number two or you do not?

DR. MAYER: N , she is saying--

MISS KERR: I compromise.

DR. MAYER: She is saying a third proposal, which is to limit it to 150,000.

MISS KERR: I believe that the 75,000 may keep them down a little bit too much. I believe the 247,000 is probably more than is necessary to get them to move until such time as we can look at it again.

MRS. KYTTLE: Mike Posta, who isn't here today because of illness, and who is chief of the desk under which this region falls, had a conversation with the region, part of which I participated in, because the region was calling to ask what latitude it had to redesign and put monies into different places that had generated since this application had been developed, and part of their concern was that they had opportunities to move in developmental component

kinds of ways. And, curiously, this region has funded a great deal of its development component through grant generated income. One large component that has generated this income has generated so much that it is phasing out and it is continuing most of its activities under its own steam and others. And when that component went they were going to have to redesign some of their monies to fund even up to the $75,000 approval that they had been given, because the grant generated income that had substantiated the fund was going around 58-60,000 dollars.

Mike Posta tells me that they were talking about activities that would more than double the $58,000 that they had. Now whether they would double the 75,000 I don't know.

Did he have a chance to get into that with you, Dick?

VOICE: No, he didn't.

MRS. KYTTLE: So apparently the region at this time stands ready to use about 125,000.

DR. MAYER: Which would be within the $150,000 restraint that is being suggested.

MISS KERR: I guess I had the feeling we have gone on promises so long, but you know -- I'm really questioning whether we should do that as much as we have. And this gives them more latitude than they would have had with the

75,000.

DR. MAYER: Yes, Leonard.

DR. SCHERLIS: I hate to bring up individual projects, but there is a small bookkeeping item of $333,000 for multiphasic screening with a comment made in the SARP review that the slowness of the multiphasic screening activity raised doubt about the relationships between the medical school, county and community it was designed to serve, and the IRMP.

I was wondering do you have any comments upon how well that program is moving or what it means in terms of the present attitudes toward multiphasic screening? I know it is only a small item in their total budget.

DR. MAYER: Dick, would you care to comment?

MR. CLAMPTON: This was also a concern of staff.

DR. SCHERLIS: Could staff tell us a little bit about it?

MR. CLAMPTON: The indication is they hope to begin operations in this project as of this month, January of '72. However--

DR. SCHERLIS: This is the third year, isn't it?

DR. MAYER: No.

MR. CLAMPTON: Well, they have been tooling up during that period, but they will be going operationally supposedly this month. This has all been a tooling up process.

DR. SCHERLIS: Have they already spent two times 333 prior to this third year? What kinds of tools are they tooling up? I don't mean to be facetious on this, but it's obvious that we are talking about an expenditure that is going to run a million dollars by the time it is completed, I hate to hear at this point in time that they are tooling up.

MRS. KYTTLE: This is part of the Intermountain program that has generated carryover every year. They money was awarded, and I believe historically they had troubles with the county on zoning exceptions, and that carried over one year because they needed to rennovate and weren't very successful with exceptions that they needed.

I know the charts show that monies were awarded, but they were not expended. They were carried over. Some of the money reinvested in this project is the same money that was awarded the year before. Not all; some.

DR. SCHERLIS: I would suggest as a logistical ploy that this be a device that every RMP follow; namely, to have an expensive project funded, because it then gives a utilizable source of funds to be used for developmental component.

MRS. KYTTLE: I think it was a model cities joint endeavor.

MR. CHAMBLISS: Yes, I think the committee should

know that, as Mrs. Kyttle points out, this was a model cities project.

We have undergone some concern about this project not getting moving before now. It relates very directly to the same kind of problem that was encountered at Meharry of multiphasic screening, And here again, if you recall, there is a policy determination on the multiphasic screening to see how they are going to move before we get much further into this, and we are beginning, I believe, to see some of these answers fall out now.

DR. MAYER: A you recall, Leonard, when we approved that one we approved it with really that thought in mind, and it looked like one of the better multiphasic screening proposals that we had, and it also was involved in a joint effort with model cities in terms of the population served, et cetera, et cetera. But your point is well taken about the built in developmental component.

DR. SCHERLIS: I am just wondering what should we do at this point in time about the third year coming up, let it go at 333? What was SARP's reaction to this? Aside from having some negative gut reaction, what logistical--

MR. CHAMBLISS: Maybe I can share our reaction with you. That sentence that you read does encapsulate our feeling here, and we raised a further policy issue about the interface between technology and service. That was

encompassed in that discussion.

DR. SCHERLIS: I guess the real meaning of my question more directly is do you translate that into your final dollar and cents recommendation for the region. Was that part of your consideration or not? Or did you just say we will keep that at 333,000? I was curious.

MRS. KYTTLE: With a funding level recommended of 2.4 something is going to have to give. I don't know whether it will give out of multiphasic screening or not.

MISS KERR: This is their prerogative to decide, isn't it?

DR. HESS: But I wonder if something shouldn't be said about this in the advice letter, because again if you look at everything else this seems to be funded disproportionately high.

DR. MAYER: The question that I had is what are the implications of the recommendation, and I am asking it vis-a-vis the comments that Dr. Margulies made yesterday relative to potential add on dollars going in. If we took no action the region's request for the 06 year -- well, the region's approved level for the 06 year by Council as it now exists on a previous action in the triennium was 2,687,000, and we are now recommending 2,478,000 as a funding level. What does that mean in terms of recommendation that goes to Council, and is this really a suggestion that you lower the

previous Council approval of the 06 year by approximately 200,000 or not? I just need to understand the implications of the motion.

MRS. KYTTLE: It's a funding level, not an approved level that we are making.

DR. MAYER: All right, fine. Did you hear the response, that it was a funding level we are talking about and not--

DR. BESSON: I think the point of this question really revolves about how these figures were arrived at, and it really takes a little bit of scrutiny to determine how 3.025 is cut down to 2.478. But it seems to me that that figure is arrived at not arbitrarily, but by looking over each individual project and saying this is not appropriate and this is.

Am I incorrect in that, Lorraine?

MRS. KYTTLE: Well, I'm not chairman of SARP. I'm Exec Sec of SARP, but this is how I recall the figure was arrived at. Some calculations were instituted, and when you started adding this and subtracting that the members of SARP concluded finally that if you sent them the message that two projects that have been criticized before stand criticized again, and if you send them the message that they have turned off one that we wanted turned off, and if you send them the message that some of the new activities that they are

proposing are looked upon much more favorably than some of the continuations like, I believe it was project 18, and say you get the same amount of money next year as you had last year, and within that framework to make your decisions, that they felt they were coming to about the same amount of money.

DR. BESSON: Well, it would be very heopful if we could have the basis on which SARP arrives at its funding level because this is really the way we operate here, too. We start with a number and then add and subtract to it. Now as I look over the items requiring committee action, I see that there are suggestions based on approval or disapproval of individual projects, and as I have looked over some of the new projects that you say are more in keeping with the new missions I may disagree with some of those. But I think in the light of the question raised about multiphasic screening it would be important for review committee to know whether that was "deleted" or whether that was allowed to stand.

MR. CHAMBLISS: It was allowed to stand.

DR. BESSON: Well, then it might be appropriate for us to know a little bit more detail as to how SARP arrived at its funding level recommended. Maybe that's a loss to us now, but in the future I think it would be helpful.

DR. MAYER: I think the point you are making is a

valid one, Jerry, and I would like to suggest that it really would be helpful to this committee that when SARP does arrive at recommendations concerning funding level that -- you know, we went through this process just now, we have been going through that process for six years now, and we would hope that something akin to -- if SARP is going to replace our activities, that something akin to the procedures being used here are also being used there, and that that information be brought to us.

Yes, Harold, do you want to comment?

MR. O'FLAHERTY: I was going to say in response to the question there has been a concern, particularly over the last year, with the Intermountain RMP that they have shown a very lack of being able to make any hard funding decisions. A lot of their ideas -- as has been pointed out, they have come up with new ideas that are valid, they have a lot of palatability in the region, but nevertheless we have activities that have been going on out there for up to five years, and we felt that to increase the funding level over this past year would in some ways put a commendation to this process.

The group did not feel that they were ready, the Regional Advisory Group was ready to make some of these hard decisions that had to be made in this region and to turn off some of these old activities that should have demonstrated

their utility or nonutility to the system at this juncture. So we felt it would be a disservice almost to aggrandize them in this capacity to add to the past year's level.

DR. MAYER: I think one can just look at the fact that the dollars are precisely the same as last year and assume that. I think the issue is we would hope that SARP is arriving at those conclusions on a more exploicit basis by looking at projects and finding out what projects they think ought to be phased out, et cetera, et cetera, and then adding on those that need to be approved, and that level may not be 2.4, that level might bel.9 million or 2.39 million or some other such figure. And it is that explicitness that I think we would like to see incorporated into the SARP process as well as our own.

Is that, Jerry, adequate paraphrasing?

DR. BESSON: Well, I know it is incorporated in the SARP thinking, but I think it should be made available to review committee. I'm asking that it be made explicit.

DR. MAYER: Well, I was taking it one step further, assuming that the level came out exactly right, they didn't go through the process that we have gone through. Now that's just putting two and two together. That may not be right. So I think there's a second component to it, not only should we know about it, we think it should be done.

Yes, Elizabeth.

MISS KERR: I would like to also make two more comments.

In looking at the mean weights given by the review panel they are strikingly similar to what I would have felt was reasonable, and you all can make your own decisions, having read the material. But I think they point out very well where the weaknesses are. And it shows it a little bit above satisfactory, and that's about where I would, as a reviewer on paper, put it.

I also want to make one other comment; since this is our first go through after having a SARP procedure, to me it was very helpful. I do agree with what you are saying, however, Jerry, that some of these details maybe if shared with us would be good. But I do want to say it does appear to me that the SARP procedure is helpful to the reviewers.

DR. MAYER: All right, further comments?

DR. THURMAN: I second the motion for 150,000.

DR. MAYER: So what we are suggesting is the SARP recommendations with the exception that instead of not to exceed ten percent under item 2 of the recommendation we are saying not to exceed $150,000 in the 05 year vis-a-vis the developmental component.

All right, further comments?

Yes, Jerry.

DR. BESSON: I also wonder a little bit about the

letters of transmittal of our decisions here. If the area is to have a litle bit of a sense of what the messages are that we are transmitting they have to be something less than cryptic, and I think they may be quite cryptic if we just give them a number without backing up how we arrived at the number. The region may take refuge in considering that these are just funding constraints because RMPS doesn't have enough money this year and say "well, we are doing exactly what's expected of us, and if only RMPS had a little more money we could have some more," but that may not be what we intend.

Is there any way that review committee can have some feedback as to exactly what's told the region after we come to sort of very theorial decision here and say well, somebody is going to let the region know what the messages are that we are transmitting.

MRS. KYTTLE: Dr. Besson, we had copies of all the advice letters from the last review cycle ready, and I had hoped we would get them ready to give them to you today, and it is only that the same people are involved in all of this are the same people that were involved in all that that we didn't get them to you. If you don't catch a very fast train going home it will be there waiting for you, copies of the advice letters that generated from the last cycle.

MR. CHAMBLISS: If I may add on to that, that is now a matter of policy, that the members of the Advisory

Council, the members of the site visit team, and the consultants, along with the chairman of the RAG and the grantee institution, will get copies of the post Council advice letters. So this information will be widely disseminated.

DR. BESSON: Will those letters of advice incorporate the kinds of specific comments that we make about projects, that project number 28 for Susquehanna Valley is ridiculous?

MR. CHAMBLISS: Yes, indeed.

DR. BESSON: I mean maybe dressed up a little bit.

MR. CHAMBLISS: We won't say it in that way, but we will make it very clear to them, your concerns.

DR. MAYER: It will also say if you have any questions about what that word means just write Dr. Philip White, Marquette University.

(Laughter.)

MISS KERR: One of the things we haven't discussed at all is the mini report of the mini-SARP review committee on renal disease application which is incorporated in the total amount, but I don't want to let it pass by without any reference to it. And that is that on 25B you will notice in the peach colored sheets -- 25A, rather, is control of chroni renal disease, and the part of this in the application is an ongoing program, but the committee wished to point out -- it says "the directions the regions appears to be going

appear to be nonproductive, and would give a low rating if so asked regarding this activity." Furthermore, the progress report is not satisfactory because of its incompleteness and brevity. Relative to 25B in the ALG portion, it would have to be deferred pending the RMPS policy decision on this."

Relative to section 25B, again it indicates that there has been some new information fed into RMPS as of December 9th relative to the activities for the renal control, and I do not have this information.

MR. GROSS: The new information related only to supplemental activities, namely, 25B. It was basically a more detailed description of what they were applying for and the reasons for it. If you would like, at the present time I can give you what my reactions were as a staff reviewer in more detail of the supplemental activity.

My recommendations were that this not be approved as well because of the following reasons. First of all, it appeared -- first of all, what was requested was the funds for hiring an organ profusion technician as well as an organ procurement technician, and thirdly, the ALG aspects of the program. The ALG might be mentioned first because the decision there is a little simpler. RMPS has yet to make a policy decision on that. I think any decision regarding funding of that has to be deferred.

The objections that I had to the first two portions, the profusion technician and the organ procurement technician, were not that such a need is probably not justified in an absolute sense, but that poor planning I think was demonstrated in the fact that these profusion machines had already been purchased, and it has been clearly demonstrated that the ancillary personnel for such a profusion approach to organ procurement are also a necessary part and should have been employed initially, and why they would have purchased the machine and now are requesting the necessary personnel is beyond me.

And secondly, that this sort of piecemeal support of a program -- I mean asking for supplemental activity and just wanting, you know, a couple of desks sort of thing, a couple of technicians here and there, without clear evidence of how they are going to be utilized, was lacking.

Thirdly, it has been demonstrated in many areas that third party support can be generated for organ procurement if a single cost is identified. Many insurance carriers are now in several areas willing to pick up the tab for this. The precedent has been set. So I am not sure the actual fiscal need for this is there.

And fourthly, in their application they did not make any mention of why RMPS specifically was needed for support of these individuals. In other words, why other

sources of funding, of which there are many potential ones, weren't available.

So for all of these reasons, primarily poor planning reasons and poor justification reasons, I didn't think that 25B was worthy of approval.

DR. MAYER: Thank you, Dr. Gross.

MISS KERR: Thank you. This is helpful. I don't think this alters the level of funding we are recommending, but I am wondering if we don't want to in the advice letter, or least include in this some of our discussion relative to this.

DR. MAYER: Well, I assume that -- my assumption is that advice letter comes not only from information surfaced here, but in these instances by SARP and elsewhere.

Yes, Joe.

DR. HESS: I had a question that may have relevance for the advice letter. Did you as you reviewed the application have the feeling that they are really reaching out into some of the far areas away from Salt Lake City to address some of the problems in Wyoming, Montana, et cetera? The majority of these projects are University of Utah based and Salt Lake City focused, many of them are, although they have established some regional offices apparently in two or three other locations--

MISS KERR: Urban areas again.

DR. HESS: Yes. But in this area some of the real

problems are rural problems. And my question is are they really making an honest to good ness attempt to cover the problems in the total region for which they are responsible.

MISS KERR: If you are asking for my reaction, I feel they are not getting to the rural areas. There is not the evidence that they are.

DR. HESS: What about the staff reviewers?

DR. MAYER: Someone from staff want to make a comment?

The question is to what degree are they relating to the rural component of Intermountain region.

MR. CHAMBLISS: Out of SARP came the view that you hold, that there needs to be much more outreach in terms of their program.

DR. HESS: If that is indeed true I would suggest a recommendation to that effect be incorporated in the advice letter.

DR. MAYER: All right, everyone understand the motion?

All those in favor?

(Chorus of "ayes.")

Opposed?

(No response.)

Thank you, Elizabeth.

We move on then to Alabama.

DR. BESSON: We should be able to complete Alabama in five minutes. It doesn't require any committee action.

DR. MAYER: It didn't take the big eight much longer either, Jerry.

(Laughter.)

DR. BESSON: But I will just give the committee a bird's eye view of the Alabama program, and I am interested in knowing why SARP felt that -- it took the option that this didn't review review committee action and others in the same general category did, not that I don't share SARP's view, but in just elucidating the modus operandi of Anniversary Review Committee.

This is Alabama's first anniversary application in the triennium. The region is requesting some two million. The Council has previously approved at the time of the triennium application for the upcoming year 1.6 million, and the Staff Anniversary Review Panel recommends 1.15 million.

I won't detail the -- oh, the 1.15 million is made up -- the request is made up of continuation of core for the fourth year, six ongoing projects, two approved and unfunded projects, and eight new unfunded projects. They are not new, they had previously been approved.

The major concern that staff has with the Alabama region is that in spite of the fact that there is a strong RAG and that their priorities are well ordered, they have

great difficulty in relating projects to priorities, and the director feels that a staff tactical review of the Alabama region is necessary.

In looking over the program I concur with SARP's recommendation that the committee has no need for action.

DR. MAYER: Further comments from those that participated in the SARP review on the staff?

Anyone want to comment on Dr. Margulies' comments, which was simply that that letter of advice was very important and that some of these issues needed to get incorporated in it, perhaps even some direct staff discussion.

Comments from the committee?

Jerry, would you phrase your question again for staff, or I can try to paraphrase it.

DR. BESSON: I have no question.

DR. MAYER: Well, I thought the question -- at least I heard you ask a question which said--

DR. BESSON: Oh, yes, the question I have is -- and this came up before -- whether staff could outline for review committee exactly what its modus operandi is vis-a-vis anniversary review, which ones they choose the option to present to review committee and which not.

MRS. KYTTLE: With respect to procedures any anniversary in its triennium need only get Council approval by regulation. By agreement -- and Dr. Pahl outlined this

at the last committee -- anniversaries within the triennium that are going on their way to Council still stop off at committee prior to going to Council , so that if committee has something before it for information only that nevertheless jars it, it can make noises at that time.

With respect to Alabama, though, Dr. Besson, the secretary of SARP asked the specific question on Alabama as to whether SARP would want to refer Alabama to committee for action, and SARP decided it did not.

Anniversaries prior to the triennium do come to commi for action, as our agreement that Dr. Pahl outlined. This is an anniversary within a triennium, and it comes to you as information on its way to Council.

DR. MAYER: I gather they -- perhaps need to clarify the question of what Jerry was saying, was on what basis do you make this decision that you pop some here for action and some for information.

MRS. KYTTLE: Changes in program direction or methods of operation, such as what brings Northlands to you for action even though it's an anniversary within a triennium; failures in staff's view to meet the standards that the region set for itself in the first place, which brought Metro D. C. to you with a site visit. Those are the two primary reasons.

MR. CHAMBLISS: Or they are asking for funds in

addition to--

MRS. KYTTLE: They go to Council, by regulation stop off at committee.

DR. MAYER: You mean those that are requesting -- no, wait a minute. I think what Mr. Chambliss was suggesting was that those that were asking for dollars in the anniversary within the triennium, for dollars above those previously approved by Council, don't those come here?

MRS. KYTTLE: No, sir. An anniversary within its triennium that doesn't ask for any more money than its approved level Council has delegated to staff.

DR. MAYER: No, you missed the question. The question was those that are asking for more money than was approved by Council do they not come here?

MRS. KYTTLE: Within a triennium?

DR. MAYER: Within a triennium an anniversary request that asks for more dollars than approved by Council.

VOICE: Funded level or Council approved level?

DR. MAYER: Council approved level.

MRS. KYTTLE: No, not within the triennium.

DR. MAYER: Well, by George, I think it ought to. You know, if I were a Council member I would sure want the advice of this committee on those.

DR. BESSON: It would be nice if we could have these all spelled out for our next review committee meeting so we

would know exactly what we are supposed to do.

MRS. KYTTLE: They are spelled out insofar as Council is concerned. Council has delegated to the Director to make continuation awards within the triennium and just advise Council unless the region asks for more money than its approved level.

DR. BESSON: Well, that's what he just described.

MRS. KYTTLE: Yes. Now in setting up the procedures to operate under that delegation -- and this is what I understood Dr. Pahl to present to committee last time -- anniversaries prior to the triennium, in an effort to keep your workload on trienniums the point of action primarily, under Council's delegation we would deal only with Council and advise committee after the fact of what Council had recommended within the triennium. It was at the last committee meeting that Dr. Pahl agreed to advise you prior to the Council rather than after the Council.

Did I get that wrong?

MR. CHAMBLISS: No, I think that--

DR . MAYER: You got that right, but I can assure you that if Dr. Pahl suggested that those that were above the funding level already approved by this committee and Council were going to pass by this committee without even a blip I would have come out of my seat. So I suspect he didn't communicate that to us, or I was gathering wool when

he did. And I think that's an issue that needs to be clarified because I think it's important.

DR. THURMAN: Bill, he did speak to that when those of us who wer new were indoctrinated. He said exactly as Mrs. Kyttle has said, but we did not know enough to say anything back. I am speaking of those of us who were new to this committee.

DR. MAYER: I see.

DR. THURMAN: Because as she has phrased it is exactly as it was phrased in that indoctrination session, and Dr. Pahl conducted that.

DR. MAYER: I guess then what I would like to request, if the committee concurs, that further staff discussion occur about that one particular issue, because otherwise, you know, a region could request two mil in the second year of its thing and it wouldn't fly by here at all. You know. And I suspect that you might like to know how that two mil is being spent.

Okay, further comments on Alabama?

New Jersey. Dorothy.

MISS ANDERSON: Yes, New Jersey -- this again is for your information. No action is required.

This is a review that was done by staff. I was not there, and so I am just reporting to you the result of their findings.

Apparently this program triennial review came through with awards for funding for only one year, and somehow the second and third year fundings were overlooked. So consequently this is the main purpose for it coming in at this time.

In reviewing the original request for this program I was very much impressed upon the action within this RAG organization. The New Jersey RAG is really a group of core people and active committee members who are involved in changing and improving the health care delivery system in their community.

New Jersey, as you know, is one of the most densely populated states in the United States, and it faces intensification of the problems that other urban areas have.

Their greatest problem they found was basic health care, and in recognizing this they designed their goals in this direction.

Their first priority of the region revolves around improving accessibility, quality, quantity of health services for the urban disadvantaged.

You will be interested to know that 80 percent of the money requested in the past has gone for community programs.

For two years the urban health component of this RMP has had staff active in the model city programs in the

state, and the accomplishments of the urban health coordinators are impressive. I think there's 17 urban health coordinators at 17 different locations.

A hospital based family health service in New Brunswick has been developed, and a consumer health radio series has begun this year. It was interesting they surviewed and found that people really learn more from the radio than they do from the T.V., and the people in the underserved areas had their radios on most of the time.

Next year they would like to see the initiation of a comprehensive family health service in Newark, and a community health improvement project.

This latter activity is requesting $50,000 to $100,000 to be divided among the 17 cooperating cities on a matching basis according to size, need, and available resources to support the development of primary ambulatory care centers.

What's interesting is the fact that this RMP is really working with many of the local, federal and state agencies in cooperation in developing these various programs and resources.

Now in reviewing this in the past the staff was cautious about their approach, and thought maybe they should try it in only one or two cities. But because of the good background activity that has taken place and enthusiasm of

the staff they feel like they don't hesitate to recommend the go signal for all 17 locations that are being discussed.

The core staff is made up of 15 people and six clerks, but the project core has 53 people and 40 clerks.

Some of the concerns the panel had were, one, what is the rationale behind assigning project status to the urban health component rather than including it as part of core where this function would seem to lie logically. The staff also felt that in a project as limited, and whereby if you had core activities it could go on for a much longer period of time, and I think many other RMP's are utilizing their core in a smiliar method.

It was noticed with some condern that this massive effort in urban health has an entirely white professional core staff. And I could not find any indication of any plans for hiring minority members. On the urban health component staf there are three blacks and three Spanish surname professional personnel.

The New Jersey program was commended by the review panel for the success it has shown in garnering funds from other sources, particularly the large amounts of federal and state money which had been funneled into the model cities area and the considerable support which had been received from the State Health Department.

Their RAG -- as I go down the line, their RAG and

their grantee organization are identical bodies, and it seemed like this might be a possible conflict, but they assured the staff there is no conflict of interest in this set-up.

There are 27 members of RAG, and five of these members are black minority members.

The overall panel assessment of the New Jersey Regional Medical Program was that it is an excellent program which has become a potent force in medicine in New Jersey. The goals and activities of the program are geared to the unique requirements of the area, with a primary emphasis on improving health care for the urban disadvantaged. There are too numerous less expensive efforts directed toward increasing the effectiveness and efficiency of existing facilities and services and increasing the skills and knowledge of health practitioners.

They had a program that I was looking at in more detail which I thought might be combined, the one -- oh dear, where is that -- one in regard to medical audit in hospitals, and they discussed the possibility of expanding this, and I think it would be very worth while to expand it beyond just the medical physician component, but also to the other allied health members who are involved in medical care.

In terms of arriving at reasonable funding level for the next year based on the success of the program to

date and the bright prospects it holds for the future, the panel thought that the current level of $1,087,904 was entirely inadequate, and they are consequently recommending $2,990,000 for this, the third and fourth year.

DR. MAYER: All right, let me see if I am clear. I guess I need to have a better feeling. In other words, this committee recommended, I gather, with Council approval, that they be funded in the 03 year, the first year of their triennium, for 2.9 million.

MISS ANDERSON: Yes.

MRS. KYTTLE: 2.99.

DR. MAYER: 2.99? That was our previous recommendation, too? All right. And then by a decrease in the funding process by staff or some other device it was cut back to the million 225?

Eileen, you want to tell us -- you know, I'm just trying -- what the action that we are saying on the surface would look like we are saying okay, SARP has just said throw in another 1.7 mil, and that, you know, on the surface gives me a little trouble, so I gather the story has to be a little more complicated than that.

VOICE: There are two problems. When the region came in with the triennial application it was at a point where core was in its third year of continuation, had one year's commitment remaining. And the region as well requested only

on year for its developmental component. And we weren't operating then nearly as cleverly as we are now, and the region didn't pick it up either. So when the committee made a recommendation as to an approved level core, the developmental component, and certain continuing parts of the program were not taken into consideration in arriving at a dollar amount for the second and third years of the triennium.

Now for the 03 year, although the committee recommended 2.99 million the region was actually funded at just a couple of dollars over a million.

So what SARP is suggesting is that Council restore for the second and third years of the triennium the approved level that was given for the first year, the rationale being that that is the intent of the previous reviewers, and recommending as well that the region be given lots of extra money in terms of actual funding, actually 2.9 million which is what is requested in the application.

One thing I did want to comment when you were describing the community health improvement program, that request -- the entire request is for $900,000. It is to be utilized in lumps of betweeen $50,000 and $100,000 to each of 17 model cities. But the total request is for $900,000.

DR. MAYER: Yes, Len.

DR. SCHERLIS: How did the decrease from 2.9 to 1.2 actually take place. I'm curious. That's a tremendous

drop, and--

MRS. SILSBEE: That was the level at which they were, and there was no more money; had to keep it at the same level and actually cut it back.

DR. SCHERLIS: In other words, that was just keeping it where they were. Funds were not available at that time.

DR. MAYER: I gather they came through here with a triennial request before we were establishing priority ranking.

VOICE: Yes.

DR. MAYER: What is the impression of staff, going back through our minutes, of where we would have put that, A, B or C?

DR. KRALEWSKI: I wonder if I might comment on this since I site visited last time.

DR. MAYER: All right.

DR. KRALEWSKI: I think it is a very good program. There is some of the best leadership there that I have seen in a corporation. Dr. Florin was a good guy. Dr. Hartman is a good administrator, and he really keeps track of what's going on in that place. So I think, from my estimation at least, we probably would have rated this thing one of the top programs.

Now on this funding, though, it seems to me that they

were operating at a higher level than that 1.1 or 2 or whatever it was, and I suspect that that was a cutback, as a matter of fact, in their operational level, because as I recall, I don't believe that our recommended level of funding was twice as much as what they were getting at the present time, going from one to three. I might be wrong on that.

MRS. SILSBEE: It was 1.3.

DR. KRALEWSKI: They had a lot of programs going when I visited them, and particularly a lot of exciting programs going with the core city. They were making a good contribution, there was no question about it.

They had a number of good staff people on board, and I don't know if they still have them or not. Maybe because of the cutback they have had to--

DR. HESS: According to the sheet here, when you visited them, John, they were operating their funding level at 1.3, and then they were cut back to 1.2 for budgetary reasons.

VOICE: The cut brought them back to about $1,087,000, and then at the end of fiscal '71 we gave them a supplemental award to bring them up to 1.2.

DR. MAYER: We actually recommended a 120 percent increase?

DR. SCHERLIS: You must be a good salesman.

DR. MAYER: You're powerful, John.

(laughter.)

DR. KRALEWSKI: As I said, I don't recall recommending an increase of that magnitude, but perhaps we did. But the impressions that I again give to the group were that we did rate the program very highly. They really had been able to switch over to the new RMP mission very rapidly; they had a good staff, they were involved in the real gut issues of that region, and they were producing. And so we recommeded a substantial increase, and I gather that the group here -- I don't remember just all the discussion that took place, but anyway it was roughly--

DR. SCHERLIS: I was on a site visit with Dr. Florin and I was very impressed with his ability.

DR. MAYER: The rating by SARP at least is 412, which is off of the scale, you know, of the sheet here.

So all right, I feel better about all that.

Other comments that anyone has?

DR. KRALEWSKI: If we are going to give them roughly a million nine -- a million seven increase?

VOICE: That's what we recommended.

DR. KRALEWSKI: You have been in touch with them, I am sure, in between. Are they capable of handling that influx of money all of a sudden? What I am worried about is if they have lost some of their staff--

VOICE: No, the largest chunk of this money, 80 percent--

DR. KRALEWSKI: The model cities?

VOICE: Eighty percent of the request is for urban health, and they do have lots of people.

DR. KRALEWSKI: Do they still have those individuals on their staff yet, the guys who were operating in the model cities program and were funded part by--

VOICE: Yes.

MRS. SILSBEE: They also have some that were used as staff that were put in [illegible] the state.

DR. SCHERLIS: I think it should be emphasized that this was the level of your original request anyway.

DR. MAYER: Sorry, Len, I missed that.

DR. SCHERLIS: It was the level of the original request of the site visit and of this committee, is that right.

DR. KRALEWSKI: That's right. But my question is whether it's the same organization now that it was during that visit.

DR. SCHERLIS: And they reassure us that it is.

MR. CHAMBLISS: Doctor, you raised the question about whether that staff that has been working in urban health is still there, and I think the answer is yes.

Furthermore, that staff, as you probably recognize --

it's called an urban state. The whole state itself is just like one big -- I won't say a ghetto, but it's just one big rundown state. And the idea coming out of the staff was to the effect that that urban core group would be made a part of the core, and that they would no longer be supported under a project as they had been, and that was one of the recommendations coming out of SARP.

DR. MAYER: Okay, further comments relative to New Jersey?

All right, I will move on then to Northlands RMP. The Northlands RMP is a euthemism for the state of Minnesota. It started out originally as being more than that, but they finally retracted it back and put it in the state border, with 3.8 million people. It has been operational since March of 1969.

The triennium was approved at our last January, February review cycle a year ago. I participated in the triennial review site visit along with Al Putman in December of 1970, just a little over a year ago. There has been no site visit since that point in time, but there has been a management assessment team from staff in there within the last month or so.

We approved, as well as did Council, the triennial application and the developmental component, with a budget of $1,157,000. They were approved by the Council in the 04

year, that is this next coming year, which is the second year of the triennium which we are reviewing, a level of $1,450,000, with committed funds for that year the same as the existing year, that is $1,157,000.

They are requesting in the 04 year, that is this coming year or the second year of the triennium, two million on in direct cost, including 309,000 for a kidney project, or roughly a million eight plus the kidney project, that million eight being roughly about 700,000 above the current funding level.

From an organizational standpoint this is one of the regions that has a board of trustees and a RAG which have had problems initially on who's on first, the board of trustees or the RAG. It looked like we were resolving when we were there in favor of the RAG assuming the responsibility. The subsequent year seems to have proved this out in terms of responsibility, and they now are in the process of merging the two groups, with a meeting at the end of this month to finalize that.

As far as the coordinator and staff, we were impressed when we were out there with Dr. Winston Miller, the coordinator, and his key staff. They were very strong and effective. And we were particularly impressed with the system that they had evolved of monitoring the achievement of staff and accounting for the time and expenditure of staff

in light of preestablished goals for each of those individuals. That is one of the most effective management tools that I have seen actually functioning for quite a while.

As far as their goals and priorities, one of the key issues when we were out there expressed by the Northlands staff and the RAG is the difficulty they may have in turning this region around towards new goals in light of the existing commitment they had for some fairly effective ongoing projects established under the earlier goals.

They have accomplished this in a rather interesting way, which I suspect, Jerry, is the reason why this one is brought to our attention for action when the others were not, rather than simply for information as was the case in Alabama and New Jersey.

What they evidently did is as follows: The RAG charged their three planning, review and management committees, which are the education, health manpower and health services development, to develop essentially what were prospecti for the next year's activity. What they did essentially was develop 29 contract offerings of about $25,000 each which were sent out on a mailing list of over 7,000 people in the state of Minnesota. From that they got back 68 applications from 38 different organizations. Forty-three of these were approved and, if you will forgive me, prioritized, and were included in the application.

This somewhat unusual approach on the surface looked like that what they were doing was really creating contracts, but as you really look at it, essentially what they have done is decided what it is they want to do in the region and they have just simply developed a communications device that has been more effective than some in getting projects back into the region to work on.

They did provide some freedoms in that they suggested that there might be some variations on the prospecti that they sent out that could be accepted, as well as a few came in which addressed themselves to the goal but were different than the original 29.

These projects or contracts have been reviewed in detail by staff, by SARP, and by the kidney review panel.

I might comment first on the kidney proposal which they had which was divided into three components, a professional and public education component, a hypertension screening component, and a transplantation, tissue typing, dialysis, blood bank component. The kidney review panel recommended not only disapproval of the entire kidney project, but actually recommended disapproval of each of the individual components of it. And I see no reason to disagree, and it would save me some major problems as well.

SARP recommended that they be funded at the 1.450 level, which is equal to the level already approved by us

and approved by Council for the 04 year. This is roughly $300,000 above the current level of funding, but significantly below that which they have requested. This would enable them to continue their core operation at approximately the existing level of funding at the developmental component of $115,000 which we have previously approved, both ourselves and Council, but which had not been funded by Northlands due to the previous commitments they had on ongoing projects.

It would also enable them to continue some of their ongoing projects and studies, and at the same time add 15 of their top priority rank projects that came out of the prospecti as well as eight in the second priority.

All of this is possible with the addition of only $300,000 because they are phasing out eight ongoing projects this current year.

I have some of the same concerns that SARP mentioned as they went through it, that it may be difficult to manage as many as 23 small contracts or projects as a problem. The only feeling I had of a positive nature was that if they can apply the same techniques that they have used for the internal management of their staff to managing those projects then I think they will be able to handle them.

I also concur with the comments of SARP that they need to place emphasis on initiating fairly early on in those individual contracts emphasis to pick up support for

them at the completion of their funding.

So I especially concur with the SARP recommendations that they be approved for funding at the 1.45 level, and that there be no kidney proposal accepted at this time.

John is the second reviewer.

DR. KRALEWSKI: I can't add a great deal to that. In looking over these projects and not having site visited this region, it appears that these projects would make a contribution to achieving their goals.

It looks as though the RAG is active in the decision-making process, and therefore would apparently help formulate this list in the order that it is in.

I think the critical issue is whether the organization is capable administratively of handling this kind of activity, and I think if we look at the fact that at least the reports that came from the site visitors, the reports that we have had in writing and verbal, indicate that this is a strong area. The administrative staff is well organized, and they have done a good job in running their project so far.

So I think on that basis probably we could conclude that they will be able to handle this kind of decentralized activity, particularly since they have been able to develop some pretty good control mechanisms on staff activity and core activity.

So I would concur with the recommendations you have

just made, and would put that in the form of a motion if you wish.

DR.THURMAN: Second.

DR. MAYER: Len.

DR. SCHERLIS: I only have one comment, and that is they must be blessed with a great gift of wisdom to be able to give a priority rating to 43 projects and assign ranks to each of them. I think that that is a very, very difficult feat, and it would be very interesting to see how they arrived at it. I would concur with what you said, but I think it is amazing to have a group be able to assign priorities to 43 discrete items and quite diversified projects like this in that manner.

MRS. KYTTLE: I think it is interesting because I think the committees did the first ranking and then they were interdigitated.

DR. MAYER: There weren't just 43, there were really 68, because there were 25 of them that they bounced out as saying no go, they are not good enough.

DR. BESSON: I'm fascinated by this approach, and I think that the idea of setting priorities first and then having people devise projects that you say yes or no, whether they meet with your priorities, is the very reverse of the way we have been seeing the whole thing operate right along, and I think is a very interesting approach. That's really

what we're doing vis-a-vis the region. And while we say yes or no to funding, they just have the same kind of decision to make, yes or no, to awarding a contract. I think it is a very interesting approach, and it will be interesting to see how they develop.

DR. MAYER: Additional comments from staff who were at the SARP review?

All right, the motion then is to accept the recommendations of SARP at 1.45 level with no kidney effort included in it.

All those in favor?

(Chorus of "ayes.")

Opposed?

(No response.)

I would like to take a couple of minutes to see if there are any further comments about the Connecticut activity. As we indicated to you yesterday, there were some materials that were incorporated in the back of your book which we suggested that you might want to take a look at for further discussion.

Yes, Joe.

DR. HESS: I read with some interest the comment here that Council believes the question concerning investing heavily in a state so wealthy in resources is completely irrelevant, and I wonder if that is an overstatement oftheir

views or if they really believe that, because it is hard for me to accept that as being valid from an advisory body of a federal governmental agency.

Now to say that we should look purely at the merits, or let's say the RMP should look purely and only at the merits of the program and have a system where the excellent programs get more and more money, and by and large the areas that have excellent programs have already got more resources to begin with, this only tends to increase the disparity between the upper and lower ends of the scale of health care around the country. And it seems to me that that is in a sense going contrary to one of the basic purposes of the federal government in this country, and I just have a great deal of difficulty in understanding or accepting what I read into that kind of a comment.

DR. MAYER: Would someone at the Council meeting care to elaborate on what they thought the intent of that statement, whether that was a fair statement of how they felt about it? Is there someone here on staff who was at the Council meeting?

MR. CHAMBLISS: Judy.

DR. MAYER: Judy, the question that is being raised is the issue that on the Connecticut proposal in which the Council altered the recommendations of this group, was that one sentence statement that said "the Council believes that the

question concerning investing heavily in a state so wealthy in resources is completely irrelevant," and Joe has raised some questions about did they really say that, and if they did, did they really mean it.

MRS. SILSBEE: I think they did really say that.

DR. SCHERLIS: My reaction to that might be that it was posed to us that one of the reasons we were interested in the approach of New Jersey was because that is such a rundown state, and I would suggest that we can't do both of these things as approaches in a logical manner simultaneously. Either we exclude -- and I would call for a revision of my New Jersey vote if that approach is not to be relevant.

I think just as we can look at a have-not state and feel very strongly that we might apply other standards, we have a right to look at a have state and have certain standards. Is my point of view is out of line with Council program? If so, all my votes should be reconsidered.

Would you care to respond to that interesting point, Judy?

MRS. SILSBEE: I think perhaps the Council and committee should get together on the subject of Connecticut because we can't act as go-betweens.

DR. SCHERLIS: We have been told to emphasize urban problems and dense populations.

MRS. SILSBEE: Council is looking at the Connecticut

program as a different type of program and they feel that it needs support as a different type of program.

DR. SCHERLIS: I guess the statement is what troubles me.

DR. MAYER: Yes, Jerry.

DR. BESSON: Well, I think there may be a source of confusion here as to what deserves support. I think RMPS has continually from the beginning awarded a meritorious program. Now whether a program that is meritorious involves a have-not area or a have area is what I think they considered to be irrelevant, and I can live with that.

DR. SCHERLIS: I can live with that.

DR. BESSON: And I think that's all they are saying, that Connecticut is a very meritorious program, and if that's the case the fact that they have a higher per capita income and a higher dollar amount from RMPS and everything else, that is irrelevant. That's the only way I interpret it.

DR. SCHERLIS: Is that the way you interpret it?

DR. MAYER: Joe has some problems with that, I think, if I heard him clearly.

DR. HESS: That's right, I certainly do, because I fully concur with the need for a meritorious program for funding, but I think there comes a point where some regions -- you know, we have got to anticipate some leveling off as we try to -- let's say the have regions in terms of funding, and

not a continual escalation of funding just because they are meritorious, because there's only X number of dollars in any one year to spend, and I think that sure, we would like to see excellent RMP's in every region of the country and we are working toward getting that by a variety of mechanisms which we use here. But I think that there will need to come a point where there needs to be kind of a damper on the have regions who are excellent; otherwise you sort of say the sky is the limit and you end up spending proportionately more money on the have regions than the have-not even though the have-nots may be on the way to developing better programs.

DR. BESSON: Okay, Joe, but this is the first time we are beginning to speak of a rational way of comparing regions. Up until now our decisions were completely dependent on the time of day and how tired we were and who had more money, and it was all very haphazard. But now that we have an order of relative ranking for the first time we are being able to use them -- I notice that the use of PPBS in New Jersey is commended, as though that's something that was discovered yesterday. Well, that has been around for a long time, and why RMPS has never used it I will never understand.

But there we are, we are just -- RMP is being dragged clutching and screaming into the current era. Unfortunately,

the kind of thing that you are asking for, we are just beginning to do it.

DR. MAYER: Comments?

VOICE: Yes, I think the comment about the relevancy in relationship to the state developing resources is due to the fact that possibly the state that is wealthy in resources may very well be the best place to demonstrate or experiment with some of this. I think this is part of the reason for the statement, justification for the statement.

DR. BESSON: I have difficulty living with that Connecticut decision for an entirely different reason, and that is the big concern that we had here was yes, they were asking for a lot of money, but if this was a surreptitious way of supporting medical schools that was a bottomless pit, and if we were going to get into that then we really wouldn't have any money for health care delivery changes. And for the Council to consider that the only notion that apparently made them reverse our decision was that this was an innovative program, I think Connecticut has been extremely clever in using cliches in just the right way to push the right button here in RMPS, and that's unfortunate because I think the emphasis in Connecticut for the amount of money that is being spent is somewhat misdirected.

DR. MAYER: I'm delighted that we made as strong a point of the two or three issues which we made on this one,

namely the concerns about support of faculty and the need to revolve that, and where do those medical schools stand in terms of picking up their responsibilities, number one, at some time in the future; and the second issue which relates to the longstanding concerns relative to organized medicine in that state, and then the issue that Joe has raised that we discussed at some length previously.

I just hope that since I won't be here beyond the next meeting, that that has gotten so well documented in people's thinking that three years from now somebody will be looking at how much of the federal dollar through RMP is going into facilities of those medical schools, and somebody will also be looking at the time of the next triennium beyond the surface about how are they really relating to organized medicine in that state.

Other comments?

I would just like to make one other additional comment on something that would be helpful at least to me as an individual. I asked the question initially when we started on these priority rankings were they the summation of the weighted, and the answer was yes, they were the summation of the weighted. I would like to see a correlation between the summation of the weighted and the overall assessments and how that works out, and I hope somebody is looking at that because I sure would like a report of that

to find out how high that correlation really is. And I would like to have some of that data so I could look back and think, you know, maybe that overall assessment component is meaningful. And I hope some further detailed analysis of this interms of what weights ought to go and are they related to overall assessment or not by factor and subfactor is going on.

But I think for now what I would like to know is the sums of all of the above, plus the overall weighting and how that looks at the next meeting.

DR. SCHERLIS: Maybe we will find one of the members of this committee always is right at that average point and we can let him cast all our votes.

(Laughter.)

DR. MAYER: Right. You know, Harris and Gallup, they learned that a long time ago.

Any other items of business to come before the group?

Yes, Mr. Chambliss.

MR. CHAMBLISS: The question was raised initially at the beginning of the review about travel and about your reimbursement, and I simply would like to say that we have checked with our travel office. All of the payments from October forward are now at the Treasury, and you should be getting them within two weeks.

I know you have heard that before, but I do

understand that they are in fact there. And perhaps but for the holidays you would have heard from them.

DR. SCHERLIS: Which Treasury is that?

(Laughter.)

DR. MAYER: Of the United States, that is.

MR. CHAMBLISS: The disbursement office of the Treasury.

DR. MAYER: Any other items of business?

Thank you very much.

(Whereupon, at 3:50 o'clock p.m., the meeting was adjourned.)