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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

National Advisory Council on Regional Medical Programs

Minutes of the Twenty-eighth Meeting 1/ 2/
October 16-17, 1972

The National Advisory Council on Regional Medical Programs convened for its twenty-eighth meeting at 8:30 a.m. on Monday, October 16, 1972, in Conference Room G/H of the Parklawn Building, Rockville, Maryland. Dr. Harold Margulies, Director, Regional Medical Programs Service, presided over the meeting.

The Council Members present were:

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

Drs. DeBakey, Millikan, Musser, and Roth were present on October 16 only. Dr. DeBakey was present only during the afternoon session. Dr. Merrill was present on October 17 only.

A listing of RMPS staff members and others attending is appended.

1/ Meetings are conducted in accordance with Executive Order 11671 and the Determination of the Secretary of Health, Education, and Welfare, thereunder, dated September 27, 1972. Proceedings of the closed portions of meetings, and materials submitted for discussion during such closed portions are restricted unless cleared by the Office of the Administrator, HSMHA.

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

I. CALL TO ORDER AND OPENING REMARKS

The meeting was called to order at 8:30 a.m. on October 16, 1972, by Dr. Harold Margulies. Dr. Margulies called attention to the conflict of interest and confidentiality of meetings statements in the Council books. Dr. Margulies specifically pointed out that the confidentiality statement applies only to the closed portion of the meeting involved with the review of applications. He also called attention to Executive Order 11671 and its requirements for announcement of meetings and provision for public attendance and observation.

II. REPORT BY DR. MARGULIES

1. Completion of Council Terms

Dr. Margulies noted that Dr. Millikan and Dr. DeBakey were both completing their maximum feasible terms on the Council. Both have served since the beginning of the Program.

2. Quality of Care Conference

A Quality of Care Conference has been set for St. Louis during the week of January 22. The meeting will deal with quality of care and quality assurance from a professional standpoint. It will consist of major presentations and panels, rather than a series of workshops. The meeting is designed to develop a common base of understanding on quality of care issues. Attendance will be kept limited to facilitate moving through the agenda effectively.

3. RAG/GRANTEE Policy Statement

The Regional Advisory Group/Grantee Relationships Policy, which the Council considered and endorsed at its June meeting, has been sent out to all Coordinators, RAG Chairmen and Grantees. While this has stimulated some further questions where grantees had not appreciated limitations on their actions, the policy has been generally accepted as reasonable. A March 1 target date has been set for Regions to make adjustments in accordance with the new policy. RMPS will provide advice as needed, but does not expect to approve interim drafts generated by the Regions.

4. Discretionary Funding Policy

Another policy statement which has been distributed is that on discretionary funding, which describes the freedoms with which RMPs can develop new activities without formalized review and indicates when RMPS approval is required. The Discretionary Funding Policy involves a transfer of responsibility and of judgment which is consistent with the

decentralization of RMP functions. Under the policy a Regional Medical Program, which has set out what it proposes to do, is given a degree of flexibility during the course of the year and the course of the triennium to pursue its interest without having to stop in every stage of the process for a pro forma endorsement of activities which have already been endorsed by a previous review.

In actual operation, the Discretionary Funding Policy will require discretion both on the part of RMPS and the individual Regional Medical Programs.

At this point one Council member suggested that discretionary funding authority possibly should be limited to a specific dollar amount. In response, Dr. Margulies indicated that the new policy provides adequate control over the kind of rebudgeting that occurs. He further indicated that any amounts rebudgeted inappropriately would be brought to the Council's attention. At a future meeting of the Council, there will be a report on how the Discretionary Funding Policy is being carried out, and the Council can decide then whether shifts being made under the policy are reasonable.

5. Kidney Guidelines

At the June 1972, meeting of the Council concern was expressed about the language in the RMPS Kidney Guidelines, specifically with respect to what it meant by a "full-time transplant surgeon." The Council directed RMPS to clarify the point by indicating that we were talking about a kind of commitment on the part of transplant surgeons, rather than something very tightly defined as "full-time." A clarification has been developed and sent to all the Regions.

6. San Francisco Kidney Meeting

At the June Council meeting some concern was also expressed over how kidney consultants were to be made available. The Review Committee had expressed some doubts about the use of a National Panel. These were not shared by the Council. The Council did, however, express a view that there should be a good level of understanding among the consultants as to how they were going to carry out their review functions--both from the technical point of view, and with respect to the overall principles of a network of dialysis and transplant centers to which RMP and the Council are committed.

A two-day meeting was held early in September for over 70 kidney specialists who are on the RMPS Consultant list. The Conference

was also attended by Dr. Schreiner and Dr. Merrill, representing the Council. Dr. Schreiner indicated that a significant group of specialists attended the meeting and that it provided an opportunity for them to analyze the guidelines and get a common base of information at one time.

7. National Kidney Foundation Award

The Regional Medical Programs Service has been selected by the National Kidney Foundation to receive that group's Annual Health Achievements Award. The award will be presented in New Orleans on November 18.

8. Review Committee Functions

For the last several months the RMPS Review Committee has had extensive discussions about its functions, vis-a-vis the Council and Staff Anniversary Review Panel. These kinds of questions arise naturally in all review groups as changes occur both in their membership and the patterns of program operation.

In order to clarify the situation, RMPS staff has developed a paper on the role of the Review Group with respect to the other RMPS review bodies. The paper was discussed with the Review Committee, which found it acceptable. One Committee member felt that a chart of the RMPS Review Process would be helpful, but that is a mechanical feature rather than a substantive comment on the functions of the Committee.

The Committee does analyze applications in great depth and spends considerable time on site visits and subsequent discussions. In addition to the new functional statement, RMPS has done other things to make them feel more secure in their role. Communications has been improved markedly, for example, by feeding back actions of the Council to the Review Committee. This enables the members to know when there are differences, and understand why those differences occur.

9. Status of RMPS Policy Manual

It has been reported to the Council in the past that RMPS is in the process of preparing a looseleaf, cross-indexed policy manual. This has proven to be a rather arduous, time-consuming task, which has been frequently interrupted by the exigencies of day-to-day operations. The manual has now been completed. It will be circulated for comment to Coordinators, RAG Chairmen, grantees, members of the Council, and members of the Review Committee. It will also be announced as available for comment in the Federal Register.

Revised regulations for the program are under consideration. They will be redrafted, but they have been held back until the manual could be completed.

One of the items that will be included in the manual is a full discussion of Section 910 which, among other things, provides for activities of a National or interregional interest and otherwise broadens the scope of Regional Medical Programs in the fields of health manpower education delivery systems, etc. We have not developed a policy statement on Section 910, largely because this might create the illusion that there is a separate pot of money available for carrying out the authorized activities, which is not the case.

10. Progress on Section 907

Section 907 is that part of the Act which requires the Secretary to prepare a list of hospitals having the most advanced capacity for dealing with the categorical diseases.

RMPS is now in the process of developing a list of such hospitals through a contract with the Joint Commission on Accreditation of Hospitals. Under the contract a list of questions and a questionnaire has been developed by a group of experts. The questionnaire covers equipment, personnel, teaching programs and volumes of service deemed to be needed to assure quality of care. No final decision has been made on the nature of the list or its distribution when complete.

The final list will not be one that depends upon minimum standards, and this will make it unique. The nature of the final list, however, has not yet been determined. It conceivably could be restricted to an "unique" group of institutions. It could be a more extensive list associated with professional requirements for patient referral, or it could be a much larger list showing the characteristics of institutions.

It is anticipated that information in the questionnaire will also be useful for planning, allocation of resources, and attempts to achieve regionalization. The list, as put together, should be maintained, modified as needed, and made broadly available. As a consequence, RMPS expects to be working with other appropriate HSMHA offices to develop arrangements for the monitoring and continuity of the list.

There was considerable discussion by the Council with respect to the need for judgmental input by Regional Advisory Groups in the Section 907 activity.

It was moved, seconded and carried that:

> "After the list is received by this Council, it be distributed to the local Regional Advisory Groups for review and comment, and modification, and returned to this Council before the final list is passed on to the Secretary." (Transcript Vol. 1, page 34.)

In subsequent discussion it was made clear that the above action of the Council referred only to the list of facilities and not to the raw data from the questionnaires.

11. MIS and Evaluation Committees

Dr. Margulies called on Dr. Pahl to discuss two newly established internal RMPS staff committees--one concerned with Management Information and the other concerned with RMPS Evaluation activities. Both of these groups are composed of RMPS senior staff.

The establishment of the two steering committees indicates the very real interest of RMPS in setting a high priority on the better employment of the Management Information System and in improving the usefulness of RMPS Evaluation activities. The MIS group will look closely at the data being collected and its usefulness to site visitors, the Review Committee and the Council.

With respect to evaluation, the Council has from time to time been advised of evaluation contracts that have been let and has periodically been informed of results. As the program matures, however, it becomes more and more important to develop an understanding of the accomplishments both of headquarters staff and the individual Regional Medical Programs.

The establishment of the evaluation committee is designed to give the evaluation function a considerably higher priority in the future than it has had in the past. It is hoped that increased emphasis on the evaluation function will enable RMPS to involve both the Review Committee and the Council more fully in the formulation of plans. The stepped up evaluation effort is expected to improve the understanding of the program within the Department, and HSMHA, and among the general public.

12. Review Committee Membership

Dr. Margulies also called upon Dr. Pahl to discuss changes in the composition of the Review Committee.

Three new members have been appointed to the RMP Review Committee. They are: Dr. William Luginbuhl, Mrs. Maria Flood, and

Dr. Grace James. In addition, there have been three recent resignations from the Review Committee: Mr. Jeanus Parks, Sister Ann Josephine and Dr. Edmund Lewis.

At this point there was considerable discussion by various members of the Council, principally Dr. Brennan, with respect to the need for greater representation of the categorical disciplines on the Review Committee. As a result of the discussion it was moved, seconded and carried that:

> "The Council expresses, through the Administrator, its conviction that authoritative scholars, qualified in neurology, oncology, and cardiology be included in the membership of the Review Committee." (Transcript Vol. 1, pages 55 and 57.)

III. STATEMENT BY DR. STONE

Dr. Margulies introduced Dr. Frederick L. Stone, Interim Deputy Administrator, HSMHA, who read a statement for the Administrator. The statement primarily concerned two subjects: (a) developments relating to categorical disease control programs within the Department, and (b) the desirability of continued funding by RMPS of certain types of activities. A copy of Dr. Stone's statement is attached.

Dr. Margulies asked Mr. Peterson, Director, Office of Program Planning and Evaluation, RMPS, to discuss recently developed statistical data relating to the matters discussed by Dr. Stone. Mr. Peterson stated that roughly two-thirds of the project activities for which RMP support has been discontinued are being picked up at a reduced level by other local funding sources. In addition, many discontinued projects have been phased out for thoroughly valid reasons. Such projects (1) may have been time limited, (2) may have proved to be undesirable, or (3) may have been determined to be of low priority in relation to available funds.

With respect to the funding of categorical activities, there has been a marked percentage decrease in single categorical disease activities and a slight increase in dollars devoted to these, largely as a result of the increase of total funds available to RMPS from 1971 to 1972. In addition, many activities related to the categorical diseases in general are submerged in the "multi-categorical" classification.

There was extensive discussion of Dr. Stone's remarks by various members of the Council. The following key points were brought out:

1. Firmness in phasing out RMPS funding for particular activities has largely resulted from limitation on the amounts of funds available.

2. RMP staffs need to develop capabilities for economic planning, argument, and presentation to funding bodies.

3. If NIH controlled programs do not work along with the RMP structure, a new organization similar to RMP will have to be invented.

4. Earmarking of funds for specific categories of activities can be detrimental to the administration of the total program of an RMP.

Dr. John R. F. Ingall, Chairman of the National Steering Committee of Regional Medical Program Coordinators, was recognized by the chairman. Dr. Ingall endorsed the Council's comments concerning the need for assistance of RAG and RMPs in the development of control programs. He also stated that Regional Advisory Groups had strong categorical protection built in, and indicated that the problem of many RMPs is relating categorical interests to the general delivery of health care. He stated that many projects have been continued by other agencies and requested (re: EMS) that HSMHA keep RMPs informed on relevant contracts.

In closing, Dr. Stone indicated that he would advise the Administrator of the Council's and others' comments. He also stated that NIH clearly would not try to stimulate another set of networks--that the creation of "control" programs would be a HSMHA-wide activity in which the Council could expect to take the principal load. Finally, he pointed out that other HSMHA programs have a certain experience in dealing with the third party payment problem and can furnish technical assistance to RMPs and other organizations where required.

IV. SPECIAL REPORTS

1. RMP Relationships with Health Care Institutions

Dr. Margulies called on Mr. Sam O. Gilmer, Jr. to discuss RMP Relationships with Health Care Institutions.

Mr. Gilmer pointed out that recently a number of small and informal conferences have been held with hospital oriented RMP/program staff and with individual hospital administrators. These indicate, as in the past, that there is little institutional commitment to RMP on the part of hospitals. There are exceptions, however.

There is a real need to strengthen RMP and RMPS relationships with hospitals. Hospital governing bodies generally have not adopted policies clearly stating the relationship of the hospital's service program to the activities of the RMP serving the area. Likewise, there is no commitment

on the part of hospital administrators, as a whole, with respect to the importance of RMP or commitment to working with RMPs even though a number of hospital administrators are involved with the programs as individuals.

In addition to the informal conferences, a survey of hospital administrative competence within RMPs is now being conducted. Returns indicate that about two-thirds of the RMPs have designated a staff person to handle hospital liaison functions. In closing, Mr. Gilmer cited a number of activities in which hospitals and Regional Medical Programs could profitably participate and particularly called attention to the TAP program of the Joint Commission on the Accreditation of Hospitals.

2. Management Survey Activities

Dr. Margulies called on Mr. Thomas Simonds, of the RMPS Grants Management Branch, to discuss Management Survey activities.

Mr. Simonds stated that the Management Survey Program was first organized in 1969. At that time surveys were only conducted at the request of the Coordinator or with his agreement. Approximately two years ago the Management Survey Program was reorganized so that all Regions are surveyed by staff on a regular basis.

Management surveys cover such items as the adequacy of a Region's written policies, payroll and leave procedures, the adequacy of financial management and records procurement and inventory control, as well as personnel policies and procedures.

On completion of each survey, preliminary findings are discussed orally with the Region and the final written report includes only material which has been discussed in advance. Survey reports are distributed internally to appropriate units of RMPS, HSMHA and HEW, including the HEW Audit Agency. Copies are furnished to the coordinator, RAG Chairman and grantee institutions.

Recommendations of Management Survey reports are used to correct identified deficiences, to assist the operations desk and the Director, and to provide information for consideration by site visitors and other reviewers.

By the end of November 1972, management survey visits will have been conducted in 35 Regions. Eighteen additional surveys have been scheduled for the 1973 calendar year.

RMPS has considerable information in the Management Information System as well as extensive institutional memory on the part of staff and older Committee and Council members. Membership in these groups changes, however, and the visual materials were developed in an attempt to bring background information to reviewers in a matter that can be quickly grasped without slowing down the review process.

After viewing the visual charts at the September 1972, Committee meeting, Committee members expressed the view that the presentation had been helpful. They suggested, however, that the information in the charts would be even more useful if made available to site visit team members prior to site visits. Committee members also expressed the opinion that canned visuals could be misleading and that information should be tailored to individual applications to bring out the salient points.

Council discussion following Mrs. Silsbee's presentation likewise sounded a note of caution. The Council members expressed the opinion that such material might be presented in a capsulated form which could be misinterpreted by the uninitiated. Several examples were cited of how data accumulated in broad categories could mask important details. Program staff functions, for example, include both administrative activities and activities of a professional and program nature.

IX. REPORT ON MOUNTAIN STATES, INTERMOUNTAIN AND COLORADO

Dr. Margulies called on Dr. Milliken, who had participated in a site visit addressed to the question of territorial overlap between the Mountain States, Intermountain and Colorado/Wyoming RMPs.

Dr. Milliken stated that the purpose of the site visit was to decrease the friction that had apparently developed between the RMPs. The three Regions decided to create an interregional Executive Council designed to reach joint decisions regarding programming in overlapped areas. In addition, a policy and procedures document has been developed for coordinating the activities of the three programs.

X. REPORT ON DEVELOPMENTAL COMPONENT

Mrs. Silsbee was called upon to report the results of a staff study concerning the developmental component and proposed action.

At the present time, 35 Regions have been approved for a developmental component; twenty-one have not been approved.

Of the latter group, eight Regions have not applied. Two of these are still in the planning stage. Thirteen Regions have applied and have been disapproved--eight of them twice.

The Developmental Component was initiated at a time when RMPS was shifting from a focus on "project" to emphasis on "program." Among other things, the developmental component appears to have been useful in helping many Regions to strengthen the RAG, program staff activities, forward planning, budget control, and the project monitoring function. At the same time, there may have been a detrimental effect upon those regions that were not approved. Some disapproved applicants misinterpreted the denial of a developmental component as signifying disenchantment with specific activities proposed, rather than with their goals or processes. In addition, and most important, those Regions that needed the developmental component most were those that did not meet the standards for approval.

Since the developmental component was initiated, RMPS has decentralized project review, initiated the triennial system, introduced the review criteria and rating system, and announced the discretionary funding policy. These changes provide Regions with flexibility and recognition, and do other things that the developmental component was originally designed to accomplish.

RMPS is currently thinking about phasing out the developmental component in an orderly manner and will be seeking the Council's advice on this at the next meeting.

XI. MISSOURI SITE VISIT

Dr. McPhedran reported on a special site visit to the Missouri RMP which took place on September 18, 1972. The site visit had been recommended previously, by Council, to relay Council concerns relating to the value of some expensive computer projects and the organization of both the program staff and Regional Advisory Group. Dr. McPhedran reported the following:

1. Program staff is beginning to seek solutions to problems in the Region, rather than waiting for project proposals to be initiated by other groups.

2. Program staff is beginning to work on priorities, goals and objectives.

3. The Director of the program has assumed another responsibility, on a part-time basis, and is spending currently only 54% of his time with the RMP.

4. The Regional Advisory Group needs to add Veterans Administration, CHP and minority representation.

5. The Region needs to create an evaluation section and simplify its review process.

At the conclusion of Dr. McPhedran's report there was some discussion of the relationship between the Missouri RMP and the Bi-State RMP in St. Louis. The consensus was that while there were unsettled jurisdictional issues between Bi-State and Illinois, there is no problem between Bi-State and Missouri.

XII. REVIEW OF APPLICATIONS

A. Albany

Moved: Dr. Ochsner
Seconded: Mr. Ogden

Accept the Review Committee's recommendations for three-year funding in the amounts of $1,618,000; $1,783,090; and $1,940,723. (Transcript, Vol. 1, Page 165.)

B. Bi-State

Moved: Dr. McPhedran
Seconded: Mrs. Curry

Award triennial status, but no developmental component in the amount of $1, 150, 000 for the 04 year with 7% increases for the 05 and 06 years, and conduct a site visit after the next year of operation to review RAG effectiveness, staff relationships, and boundary problems with Illinois. Amounts approved include $50,000 in discretionary funds to make it possible to hire a Deputy Coordinator. (Transcript, Volume 1, Page 171.)

C. Wisconsin

Moved: Dr. Millikan
Seconded: Mrs. Wyckoff

Accept the recommendation of the Staff Anniversary Review Panel to increase the approved level for the 06 year to $2,153,624, including $312,881 for kidney activities and a $177,907 developmental component. (Transcript, Vol. 1, Page 173.)

D. West Virginia

Moved: Dr. Cannon
Seconded: Dr. Roth

Accept the Committee's recommendation for $1.5, $1.6, and $1.7 million for the first, second and third years. (Transcript, Vol. 1, Page 178.)

E. Central New York

Moved: Dr. Schreiner
Seconded: Dr. Musser

Approval in the amount of $889,000. (Transcript, Vol. 1, Page 185.)

F. Michigan

Moved: Dr. DeBakey
Seconded: Dr. McPhedran

Approval in the amount of $2.25 million. (Transcript, Vol. 1, Page 189.)

G. Hawaii

Moved: Mr. Hiroto
Seconded: Dr. Komaroff

Accept the recommendations of the Review Committee in the amounts of $1,805,488, $1,839,213, and $1,820,577 for the 05,06, and 07 years, respectively, including kidney and earmarked funds for the Pacific Basin. Kidney funds are subject to satisfactory definition of relationships between Kuakini and St. Francis Hospitals. The request for a developmental component was not approved. (Transcript, Vol. 1, Page 194.)

H. New Mexico*

Moved: Dr. Komaroff
Seconded: Dr. Watkins

Approve for triennial status in the amounts of $1.25, $1.30, and $1.35 million for the 05, 06, and 07 years, respectively. A site visit is to be conducted next year, and no funds are to be allowed for basic training in allied health professions. (Transcript, Vol. 1, Page 206.)

The Council increased the amount recommended by the Review Committee because of the Region's success in obtaining alternative funding for six of thirteen projects.

* Mrs. Morgan not present in meeting room.

I. Northern New England

Moved: Mrs. Wyckoff
Seconded: Dr. McPhedran

Approved in the amount of $850,000 for the 04 and 05 years, including a developmental component and $ 37,500 and $25,400, respectively, for continuation of kidney activities. Triennial status is denied, but should be granted if the Region seems ready for this after a site visit at the end of the 04 year. (Transcript, Vol. 1, Pages 209 and 213.)

J. Virginia*

Moved: Dr. Watkins
Seconded: Dr. DeBakey

Triennial status approved in the amount of $1.8 million, including Developmental component for each of three years. (Transcript, Vol. 1, Page 218.)

K. Indiana

Moved: Dr. Brennan
Seconded: Dr. Ochsner

Approve the Review Committee's recommendation for $1.2 million for one year. (Transcript, Vol. 1, Page 220.)

L. Rochester

Moved: Mr. Milliken
Seconded: Dr. Brennan

Accept the Review Committee's recommendation for $935,000, including $35,000 for kidney, and noting specifically the Committee's requirement that the bylaws be completed.
It was also recommended that the Region be revisited in within six to nine months. (Transcript, Vol. 1, Pages 225-226.)

M. Texas**

Moved : Mrs. Morgan
Seconded: Dr. Schreiner

Accept the Review Committee's recommendation for $1,900,000, $2,100,000 and $2,300,000, including the following amounts for kidney: $337,157, $309,640, and $294,640, for the next three years (with the funding for the second and third years contingent upon greater minority involvement in staff and RAG as determined by further review in nine months. (Transcript, Vol. 2, Page 6.)

* Mrs. Mars not present in meeting room.
** Dr. Meyer not present in meeting room. Dr. DeBakey absent.

There were no Council comments with respect to these continuation applications, or the proposed actions by the Director. (Transcript. Vol. 2, Page 80.)

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

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

ATTENDANCE AT THE NATIONAL ADVISORY COUNCIL MEETING

October 16-17, 1972

RMPS STAFF

Mr. Norman Anderson
Mr. Waddell Avery
Mr. Charles Barnes
Mr. Kenneth Baum
Ms. Marilyn Buell
Mr. Richard Clanton
Mr. Spencer Colburn
Ms. Cecilia Conrath
Mr. Joseph De La Puente
Ms. Annie Dicks
Mr. Alex Dobson
Ms. Eileen Faatz
Ms. Myrtle Flythe
Mr. Gerald Gardell
Mr. Sam O. Gilmer, Jr.
Ms. Eva M. Handal
Mr. Charles Henson
Mr. Charles Hilsenroth
Mr. George Hinkle
Dr. Edward J. Hinman
Ms. Dona Houseal
Mr. Francis C. J. Ichniowski
Mr. Joseph Jewell
Mr. A. Burt Kline
Ms. Lorraine Kyttle
Mr. Walter Levi
Dr. Joseph Linehan
Dr. Harold Margulies
Mr. Rodney Mercker
Dr. Bruce Miller
Mr. Roger Miller
Mr. Ted Moore
Mr. Bob Morales
Ms. Marjorie Morrill
Ms. Mary E. Murphy
Mr. Frank Nash
Mr. Eugene Nelson
Ms. Peggy Noble
Mr. Harold O'Flaherty
Mr. Joseph Ott
Mr. Chris Ottenweller
Dr. Herbert B. Pahl
Ms. Jeannie L. Parks
Mr. Roland Peterson
Mr. Michael Posta
Mr. Laurence Pullen
Dr. Richard M. Reese
Mr. William Reist
Ms. Leah Resnick
Mr. Abraham Ringel
Dr. Jimmy L. Roberts
Mr. Richard Russell
Ms. Rebecca Sadin
Mr. Luther Says
Ms. Patricia Q. Schoeni
Dr. Richard Schrot
Ms. Kathryn M. Sievers
Ms. Sarah J. Silsbee
Ms. Shirley Simon
Mr. Thomas Simonds
Dr. Margaret Sloan
Mr. James Smith
Mr. Mathew Spear
Ms. Doris Staton
Mr. Jerome Stolov
Mr. Calvin Sullivan
Mr. William Torbert
Dr. Clarence Washington
Mr. Lee Van Winkle
Ms. Glenna Wilcom
Ms. Constance Woody
Mr. Frank Zizlavsky

OTHERS ATTENDING

Mr. Edward Bridgforth, Public, Jackson, Mississippi
Dr. Margaret H. Edwards, NCI-NIH
Dr. John R. F. Ingall, Public, Lakes Area RMP, Buffalo, New York
Ms. Frances Howard, NLM-NIH
Dr. Frederick L. Stone, OA-HSMHA
Mr. Donald N. Young, OGC-HSMHA
Dr. William J. Zukel, NHLI-NIH

Presentation by Dr. F. L. Stone
to
National Advisory Council, RMPS

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

Before proceeding further, I would like to emphasize those specific attributes of the Regional Medical Programs that signalize its progress:

1. Its decision-making powers have been decentralized to the final level in most cases; i.e., to the states or sub-regions of states.
2. In a special sense it demonstrates revenue-sharing at its best.
3. It has evolved, nationally speaking, into the only reliable tool we have which relates to the professional at the community level.
4. In these Programs we have, regionally disbursed, the largest pool of talent addressed to health care in our Nation.

There are several things he has asked me to discuss with you--and the first is

I. Priorities:

We are well aware of the many pressures which have buffeted the Regional Medical Programs ever since they became a part of HSMHA in 1968--and never has the strain been greater than in the last two years. Under your guidance, they have made the best of very difficult situations, and their contribution to solving the problems of access to primary comprehensive health care has been remarkable. Their flexibility, imagination, and resourcefulness have been most impressive. They have found it possible to adjust to new priorities identified by HSMHA when these came along--the medically underserved, Indians,

migrant workers, urban and rural poor, young children, and the elderly--and they have been able to place emphasis on ambulant care facilities and the more effective use of allied health personnel. Their ability to enlist the cooperation of the providers and all concerned groups in the regions was most notably displayed in the recent crash program to set up emergency medical

services, and I believe no other organizations in the country could possibly have done this so rapidly and so well.

However, our priorities are also set by the Congress, which in general reflects the will of the people, and it has been inescapably clear that many members of Congress are just as interested today in improving the care of patients with heart disease, cancer, stroke, and kidney disease as they were when the RMP legislation passed in 1965. As a matter of fact, the National Cancer Act of 1971 was passed in part because the RMP's had not fulfilled the expectations of those who pled for the RMP legislation in '65 and those members of Congress who overwhelmingly supported it; so they decided to try again. Those members of the health professions concerned with heart disease were not quite so frustrated because they had been deeply involved in the RMPS effort to develop guidelines for optimal care through the Inter-Society Commission for Heart Disease Resources. Nevertheless, they also were deeply distressed as the RMPs withdrew sharply from support in the field of heart disease and urged equal time with cancer on the Hill. Congress expressed its continuing commitment to improving the lot o people with cardiovascular, respiratory and blood diseases by passi the National Heart, Respiratory and Blood Disease Bill of 1972. It is no accident that increasing amounts of $20, 30, and 40 M were authorized in both bills for control activities in cooperation with other Government agencies.

When Appropriation Hearings came around last spring, members of Congress were hearing bitter complaints from their constituents--doctors and patients concerned about heart disease, cancer, and stroke--who found that many RMP programs in these disease areas were being terminated. They pointed out that the legislation on the books still makes heart disease, cancer, stroke, and kidney disease the major responsibility of the RMP's. And they are right; it does!

Of course, itis perfectly true that if people do not have access to health care at all, they will not have access to care for heart disease, cancer, stroke, and kidney disease either, and therefore the recent emphasis on access to primary care is totally commendable. What the RMP's have been able to accomplish in that direction has served to strengthen the base for all medical care across the country.

Now, however, Congress has made it crystal clear that it wants the national effort in the control of heart disease, cancer, stroke, and kidney disease greatly intensified and that it will no longer tolerate diversion of funds appropriated for those purposes. This time it has authorized special funding for control efforts in the budgets of the NCI and NHLI and in both cases it has directed that these activities be

carried out in the closest possible cooperation with other Government agencies. The appropriation committees have been generous with the control portion of the NCI and NHLI budgets, but at this point we cannot tell what funds will eventually be released.

Partly as a result of Congressional pressure, partly because of the need to achieve better coordination between the various parts of DHEW, and because of the crushing magnitude of the problems of heart disease, cancer, stroke, and kidney disease which constitute at least 70 percent of the content of comprehensive health care, the Secretary has agreed that HSMHA will work closely with the Institutes in the area of disease control--and specifically in the fields of heart disease, cancer, stroke, and kidney disease.

As a forerunner of the kind of intense cooperative effort which will henceforth be coordinated by the Institutes, the Secretary launched the National Hypertension Program on July 25. Aimed initially at professional education in the field of hypertension, it will later move on to public education and to the preparation of the health services delivery system to respond to an increased demand for screening, diagnosis, treatment, and follow-up. This activity is being served by a National Advisory Committee, an Inter-Agency Working Group, and four task forces made up of members of the National Advisory Committee and representatives of the NHLI, VA, FDA, and HSMHA. The first will determine the content of the educational program, define the level above which

treatment is indicated, and recommend what that treatment should be; the second will plan the professional educational program; the third will plan the public education program; and the fourth, chaired by HSMHA, will evaluate the impact on the health services delivery system and determine the resources needed to respond to the professional and public education programs. Dr. W. McFate Smith, Regional Health Director for Region IX, is serving as the chairman of Task Force IV.

This has been a very intensive effort since July, and has engaged a large amount of the time of Dr. Margulies, and of Drs. Hinman, Sloan, and Greenfield. Eventually, it must engage the time and attention of this Council and of all the Regional Medical Programs.

Dr. Wilson has made a firm commitment that every HSMHA program which can increase its attention to measures affecting the control of heart disease, cancer, and stroke within the limits of present funding and personnel will do so. Depending on the level of funds eventually released, additional contributions will be made by HSMHA programs to the control of these diseases in cooperation with the NCI, the NHLI, and the NINDS. The area of hypertension will take precedence in this cooperative effort, but the others will not be far behind.

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

of comprehensive health care. We wish to protect the gains they have made in the last two years and to reintroduce some of the categorical disease activities in a very special way which will not adversely affect the current noncategorical program efforts. We therefore wish to seek your reaction to the following proposals:

1) That the RMP's be encouraged to retain or redirect a part of their regular grant program to support those activities which seem most important at the local level in relation to heart disease, cancer, and stroke.

2) That a special fund be designated for control activities--the exact amount to be determined by the level of funds finally released to RMPS by OMB and DHEW--at least a portion of which would be held centrally. Emphasis would remain on getting this to the RAG's as rapidly as possible but with more specific guidelines than has held for some of our past programs.

3) Some part of these central funds may be awarded to the regions by contract after review by appropriate committees of expert consultants for activities which will follow guidelines developed by RMPS in close cooperation with NCI, NHLI, and NINDS.

4) Quality assurance has been discussed with this council before but the issue has never been more urgent. Some of these central funds may also be used to support contracts (a) with national professional organizations for the development of criteria for quality assurance in relation to heart disease, cancer, and stroke; (b) with individual institutions or to groups of institutions to demonstrate various alternatives for the delivery of high quality services to patients with these diseases; and (c) with Regional Medical Programs or

national professional organizations to promote the regionalization of specialized facilities and services.

Review mechanisms would have to be worked out; staff would have to be assigned (any additional positions possible?); and methods of communication of these changes to the regions would have to be developed.

In short, RMP's have some new priorities which are really some of the ones they started with, but which now should be integrated into comprehensive health care as much as possible and represent a partnership effort with the NHLI, and NCI, and NINDS.

II. Council Policy on Duration of Funding and Phasing Out of Projects

The other subject I wanted to discuss with you concerns your Council policy of decremental funding and phaseout at the end of three years. We all know the dangers of getting trapped in demonstration projects for which it proves impossible to find other sources of support. Obviously, if these are allowed to become fixed charges and continue to proliferate, the situation would resemble Medicare and Medicaid, soaking up an ever-increasing share of the RMPS budget. The Program would then cease to be a developmental one and lose the marvelous, innovative, catalytic role it has played so well. But it was this 3-year termination policy also that gave us special trouble in the Congress last spring. Programs were being terminated rigidly because they had had 3-year funding. In some cases little effort was made to help the project directors find other sources of financial support. In some, allegedly promising projects were terminated abruptly when one or two more years at reduced funding might have enabled them to become self-supporting. Some of these were successful

programs or just beginning to fulfill their promise, and it appeared that the reward for success was annihilation. What we should like to have you consider are some modifications of your policy which would put emphasis on the following:

1) Continue, as I know you do now, requiring new applicants to indicate how funding will be covered from other sources in 3-5 years.

2) Make awards with decremental funding when possible.

3) Ask the RMP's to take greater responsibility in helping applicants find other sources of funds.

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

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

It has been a keen pleasure for me to participate in your discussions this morning. I trust you have found my remarks interesting and thought provoking. Their general thrust will be to add materially to this Council's present responsibilities and scope of activity. I will be pleased to try to answer any questions that arise the ensuing discussions.

Frederick L. Stone-OA-10-16-72