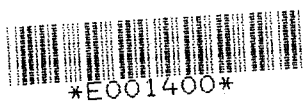
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Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

National Advisory Council on Regional Medical Programs

Rockville, Maryland
Tuesday, 8 February 1972

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Conference Room G/H
Parklawn Building
Rockville, Maryland
Tuesday, February 8, 1972

The meeting convened at 8:40 a.m., Dr. Harold Margulies presiding.

C O N T E N T S

P R O C E E D I N G S

DR. MARGULIES: Will the meeting please come to order?

I would like to call your attention once more to the items which you have in your agenda book on conflict of interest and the confidentiality of meetings.

We will defer for the moment, if you will allow, the consideration of the minutes of the last meeting because they were distributed very late, and you need an opportunity to take a look at them. And rather than get into any other business, I would prefer to turn the meeting over immediately to Dr. Wilson who has agreed to spend the first part of this meeting with you.

Dr. Wilson.

DR. WILSON: Good morning.

A good bit of water has gone over the dam since the last time we met, I think all of it encouraging, but a little of it perhaps confusing. And so it seems as though it might be worthwhile to spend at least a few minutes attempting to link what you have heard and what at least we know for usre at the moment to what is apt to happen.

I would guess that what you have heard will run such a wide gamut that we may need to share a little bit because I am never quite sure what people have heard. But I would like to get this as best we can on the board so that there is a full understanding between our office and this very

important council.

A few of you sat through the meeting in Chicago where we talked about the future of RMP. And for those of you who did, I might tell Harold I still have those tapes.

I think what we were trying to discuss in general principle at that meeting is now beginning to come into action for RMP. And it is that set of principles I would like to reiterate and then discuss as best we can from your point of view the implications.

You will recall that when we were trying to look at the Health Services and Mental Health Administration agency that we had spent a good bit of time saying that although it was at that time 11 different programs -- now, it is either 15 or 16, depending on how you count them -- it nevertheless was a single agency. Our performance up till that time had not really supported that kind of a statement. The various programs had been quite different in their origination and I think had even geographic separateness until roughly about two years before now. And for a number of reasons, we are finding it quite challenging to even live together in the same building, much less begin to work programs together.

A great deal of water has gone over the dam since that time. Much of what has occurred has occurred as a natural result of people working together in the same building, interchanging, meeting in the same meetings, and

undertaking the resolution of the same problems. It is sort of a natural process.

Part of what has taken place has taken place under the direction of Mr. Richardson who is a very vigorous person with interest in what he calls service integration or the combination of Federal resources in such a way that there is a minimum of confusion for the public or the person or group to be served.

His first talk, as some of you will recall, in Indianapolis emphasized, that he has continued to emphasize, this is not a passing fancy with him; it is something that absorbs a great deal of his time and effort. It is sort of a strange staff meeting if it lasts more than an hour where in one way or another he doesn't deal with that issue. We probably wouldn't have needed that much prodding to have had some substantial efforts of our own, but ours gets added impetus. You can't help it. He is a very persuasive as well as influential person in HEW. So both out of respect for his concerns as well as being part of an organization, we have tried to be responsive.

The reorganization we discussed which came in between at the last Council meeting, we won't go back through that or its rationale. One of the pieces that has not been as yet developed in that reorganization was the small advisory groups that we hoped ultimately to make available to each of

the deputy administrators. It is not a forgotten item, but each development needs to come into place at its appropriate time. And I think we have still a little bit of a ways to go in getting the job done.

That left us to sort of come up to the present with the fact that I said in Chicago that we expected this Council to be in a policy advisory group on issues that often would extend beyond RMP as such. And while the major mechanism for doing that probably will ultimately be the small advisory groups or however we work them, sort of inter-Council types of advisory groups, nevertheless this Council is beginning to pick up responsibility for advice and comment on things that go beyond your original charge for RMP in its initial form. These come out pretty clearly in the Emergency Medical Services, the Health Maintenance Organization and the Area Health Education Centers. This is where I think we begin to see these in pretty clear perspective. And I would like to deal with the relationship of those programs to the agency this morning. And hopefully in a way that will open it up for discussion and see if we can clarify what it is we have in mind and then be sure that the Council feels that it has its own appropriate role in each of them.

We had some options in how monies would be allocated for these three programs. The options were discussed with a variety of individuals as all program options are, including

the Office of Management Budget and the Office of the Secretary and Dr. DuVal's office. It was our considered opinion in that set of discussions that for some reasons which I will not even attempt to go all the way through here, but for others which we will, that we would be well served in RMP in the mission which we have been trying to describe for it if in fact we were to take on additional responsibilities that everyone would agree would make it advisable to release the monies that have been held in reserve. It was sort of a principle of approach of expending money appropriated in its full amount. And it turned out that was extraordinarily helpful in the two areas of Emergency Medical Services and the Health Maintenance Organization endeavor.

Now, you never get that kind of an agreement without also getting some stipulations with it. Nothing in this world comes totally for free, I have been led to believe. And, of course, with that came some stipulations that simply said that as we moved into these endeavors, we would in fact have extraordinary relationships with other programs with both of them.

With the Emergency Medical Services, and let me take that first, I think we probably have the most extraordinary. The others are simply by several degrees of magnitude. Emergency Medical Services have been a very peculiar field. And some of you have probably worked with these more over the

years even than I have, although I have had a substantial interest in them for the last ten years and have tried to work with it mostly on the State basis up to now. But if you take HSMHA as an agency, for instance, we have a program in health services under the Federal hospital, Federal health program services called Emergency Health Services, Item No. 1.

It has had an extraordinary and almost total involvement, however, in emergency preparedness. The monies for that program and the stipulations come primarily from OEP and in one of the peculiarities of transfer come on over to us. It is about a $4 million program, as I recall, $4 to $5 million a year.

Well, that only just kind of opens the package. Although they have had substantial interest in things external to their program, they have never had the resources or the staff really to do much other than emergency preparedness. And they have had the hospitals and the rest.

In NIMH there has been a developing program of support of what I called crises centers. And these have steadily expanded beyond just emotional crises to other types of crises. And with the development of drug use and the actual physiological crises that go with overuse of drugs, this turns out to be more important than it was even five years ago.

Maternal and Child Health has poison control centers,

and they have a fairly well-developed system of poison control centers. And they have set up a sort of clearinghouse function and a number of things that they do in the poison control.

Comprehensive Health Planning has had, of course, the whole business of design of systems for community and the approval of design. So there has been a spotted amount of capacity to respond to emergencies. But nevertheless, it has been there.

The National Institute of Occupational Safety and Health has a different interest in emergencies from an industrial point of view. And I won't go on down through the catalog list.

All I am trying to do is to say that when we picked up Emergency Medical Services as an agency activity, it is not a simple program that will be operated by a single one of our constituent programs. We truly are involved now in an agency-wide endeavor.

The money is lodged in the RMP program. And hopefully that is where we will keep it because I think there are a number of reasons for us to prefer to have the response to emergency needs be primarily provider oriented. And we use the RMP program as being primarily our arm for communication with the provider community. Nevertheless, we will be forming in the office of Mr. Riso, which is in the development area where RMP resides, an Associate Deputy for Emergency

Medical Services as the agency's national focal point for coordinating not just the RMP endeavors, but all of the rest.

Now, that complicates your life substantially. And I guess I apologize for that in one sense, but for another I guess it is the price of togetherness. It is what happens when you begin to look at problems from the community point of view instead of looking at them from a legislative entitlement or source of money point of view.

This says that while Harold and his staff will probably carry a fairly substantial burden for the staffing of what goes into this, any program that they develop under Emergency Medical Services is going to be subjected to the coordinating activities of the Associate Deputy for Development.

My hope is that at some point after we have gone through the development phase, we can once more look at this and determine whether we think it is still a development activity or whether it has gone far enough so we can put it over in the service activities. But that is probably four or five years away.

Let me discuss another part of the complication that goes with Emergency Medical Services. You recall it was in the President's Message cryptically, but nevertheless there. And we were asked I think part of this development to do extraordinary review of potential communities where Emergency Medical Services systems, model systems, might be established.

Early on, we had hoped that we would be able to identify maybe 25 communities and put those 25 communities out as forinstances and that we could then in a more deliberate fashion, working through our regional offices, come down on an agreement on which centers would be picked. We were given to understand that that was going to be too deliberate a process. As a matter of fact, this money we have is two-year money in its second year so the $8 million has to be expended by July 1.

One of the problems when they pulled the money out of the reserve was we were picking up money that had been put in reserve last year, so it is two-year money in the last six months of its second year. As of yesterday,we had that from that list of 20 cities a selection of 5 suggested cities or 5 suggested programs. And in that 5 programs, 4 were as they had been suggested on a sort of an inhouse, informal group who were working against the timing of the Health Message or the health initiative message. One of them has been changed somewhat, and we are going to have to go back.

The 4 by inhouse standards, as near as we can tell, are good candidates for site visiting and the next step. The fifth one, we need to know a little bit more about. And we are not quite sure how that got into the conversation, but it seems to be an expansion of what we had suggested. And we are not quite sure what warranted the expansion. And we will

have to know more about that one.

The others look bona fide, but they have been picked in a way that we do not ordinarily pick projects.

Now, I guess if we had our choice, we could play the game and get the pot that was on the table or we could have let it go to another large department which had a request in and which came very close to picking it up. I chose to play the game and to pay the price because it seemed to me that if we kept it in the health service delivery system, that over the long haul, we might lose a prerogative or so now, but next year we will have a $15 million instead of a $8 million allotment for this. That will be a part of this system. And by then we will be back in the business of prerogatives.

So I am not really apologizing. I am trying to tell you how we got here. And I guess you can take exception to how we did it. And that is your right, and I am perfectly willing to be criticized. I really in retrospect don't see how we could have done it much differently. end EM 5

Let me turn to HMO's for just a second because that will be simple and then to the Area Health Education Centers for which there are several answers we don't have.

The HMO is quite a different activity. That is a one-year activity on our part. There is a request before Congress which we had hoped would have been approved this year. And this would have been additive to that request.

Then, next year, the HSMHA or RMP budget would be reduced by that amount for HMOs, but we recapture all but -- In a program in the '73 request, we get all but $7 million back. So we have our lid on the budget up, and we keep most of it for planning.

Next year the HMO support would come from someplace else, about $18 million. And I think we get all but $7 million of it in program increase in the '73 budget request next year. That legislation has not yet passed.

We are working intensively with general counsel on how far we can go under the demonstration authorities that we have in RMP, and I think are pretty well agreed that we have to stop short of operational activities as such; that we are perfectly all right as long as we do planning and demonstrations but that we probably should not venture on into operational activities with these monies. So we will be dependent, I think, in the long haul for the next steps if the Federal Government is to assist in the founding of HMO's upon either new legislation or upon funding something like our 314(e) authority where we have service type money.

This is relatively uncomplicated. It did give us a chance to get that money released and get the ceiling up. We are at about $145 million which is an all-time high for us. That is better than that figure, about half, like that, we were looking at about 12 months ago. So all I can say of the

HMO's, I think it is appropriate within the limits of what we have done up to date, and we will be looking very carefully to make sure we stay within those limits. We will be varying back and forth a little bit in the HMO.

We would favor grants, as I think Harold talked to you -- at least part of you -- in St. Louis. We would favor grants whenever we can, using the HMO staff as sort of a review committee, but there will be a number of instances where the contracts will turn out, I think, to be the advisable procedure. And we are still trying to sort of move between the challenge of getting that initiative for planning and sort of development under way and the need for the new legislation. and HMO

Area Health Education Centers are quite different. This is one of the most intriguing things I think I have ever worked with. The Carnegie Commission rediscovered RMP as near as I can tell and put a new title on it. I have gone through what they said, and I don't see anything, at least, we weren't talking about in our RMP five years ago. Nevertheless, they discovered it, and OMB has said that they won't release either the money that we have that they have earmarked or the money that the Bureau of Health Manpower has that is earmarked until Dr. DuVal comes up with a definition of exactly what this is -- that is, a single definition -- and says who is going to run it.

And, of course, we have got a batch of money over in the Bureau of Health Manpower. We were just faced with all the problems of a new piece of legislation and basically no increase in their funding next year over this year. So they have got a set of priority considerations with which they have to struggle in addition to the specific programs they have -- the whole business of what do you do with the basically flat budget.

We have a lot of discussions, each of which seem to lead to an agreement in principle, but the last set of documents I saw still had some details yet to work out. I am sorry, I thought we would have it all worked out so that you would see it at this Council meeting. We thought we had it done about two weeks ago. My last review of documents indicated to me, and we have a meeting this afternoon, there is some chance before you leave tomorrow that we may be able to bring to you that final document. We are still trying.

Dr. Marston and Dr. Endicott and Dr. Stone and I will be meeting this afternoon, in fact, to have a look at it. So maybe we will get it done before tomorrow morning. I guess it is going to be the working arrangement that is apt to continue.

There is probably going to be continuing education money in the Bureau of Health Manpower as well as continuing education money within RMP or HSMHA. Dr. Endicott and I have

agreed and Dr. DuVal has agreed that one way to look at it is for us to look at it from the community point of view, the provider orientation and non-academic group and say that the responsibility of HSMHA is that responsibility where we are dealing with a system that is a semi-service responsibility, but on or with that service responsibility, it is providing educational endeavor. Or to put it in another way, we would be concerned with the programs where there was less likely to be a certificate or degree or formal program recognition of some kind while the Bureau of Health Manpower would deal more specifically with those things that lead to residency training, baccalaureate degrees, associate degrees, of the long-term training programs. Because they are putting a lot of money into the manpower base. That seemed logical to me, and everybody agreed in principle, but it is when you try to get that into words we seem to be having difficulties.

I submit it to you for at least the way in which the conversations have been held up to the moment and would solicit, I think, your comments upon it.

Well, that is a very fast, slightly kaleidoscopic view of what happened to RMP in its increment areas. I am delighted to see its budget going up. I think that is a mark of at least one thing.

I must say that the Secretary, due, I am sure, to some of your discussions and others with him -- I think

particularly that meeting, Harold, that you had downtown with him or Russ and Harold -- who else attended that? Russ was at that meeting and you were at this.

DR. MARGULIES: Only one from the Council.

DR. WILSON: I think since that meeting, the Secretary has shown an increasing interest in RMP. He is particularly sympathetic to the fact that the Federal Government has no formal way of communicating with the provider community and that this does give the Federal Government a way to talk to providers in a sort of official manner.

I think that is all the formal comments or at least opening comments, rather informal comments, I want to make. I would be interested in sort of your reaction to any or all of the things that have occurred.

MRS. WYCKOFF: When you talked about emergency medical service and you said the money was with RMP, what money did you mean when you spoke of all those different programs, each of which has money? What money is the money that we are responsible for?

DR. WILSON: The $8 million that is here will be used to establish five model centers or systems plus some subsystems. When we do that, we will be in each area capturing the additional money that is being expended by the other programs.

MRS. WYCKOFF: It is to coordinate it?

DR. WILSON: Yes. One of the techniques that we have used in recent programs -- for instance, the Family Health Center Program, the Family Health Center Program or the Experimental Health Service Delivery Program, one's in Community Health Services, and the other is in the National Center for Health R&D -- both when the community applies and accepts them takes precedence of any HSMHA money in that area. If a community buys one of these, then that community has to agree to the maximum extent possible it will coordinate the use of funds and will be doing the same thing with the Emergency Medical Services in the five selected communities. We will simply be saying these other activities are going on, and the community competes and gets the money. We expect within the limits of reasonable operation, we will integrate them all.

Russ.

DR. ROTH: Vern, has anybody undertaken a precise defintiion of the scope of the word "emergency" in this context? To explain the dichotomy here, we have, I believe, two kinds of major problems that come under the heading of emergency medical service. And one is the actual medical emergency which happens to somebody on the highways, remotely, in the center of town, and so on, getting service to it, to that particular problem.

The other, however, is this subversion of the use of

emergency rooms which are becoming about 20 percent or less concerned with true emergencies and are becoming community health centers or people's family practitioners.

And they are two quite separate problems.

DR. WILSON: We have been very clear, the meetings that led to the Emergency Medical Services activity were combined meetings. The VA sat in on them, Jim Musser sat in. In fact, DOT sat in, Dick Wilbur sat in from DOD. And HSMHA sat in. I think NIH had a representative because of the Institute. We were very clear from the beginning that here we are talking about incidence where time is a factor, where you know there can be proven to be a direct relationship between the timing of what happens and the possibility of prolonged disability or death.

Now, there is with that a substantial interest in looking at the ambulatory, the walk-in, clinic, ambulatory problems which have created the burden for Emergency Medical Services. But these experiments are intended to deal with the time related part of this where time is really a factor.

Now, we will try obviously in any of those systems to see what you can do about the other walk-in problem, but we would not be attempting to demonstrate that as part of the Emergency Medical Services activity itself because that is a big one. And I think we probably, before we moved in and said to a community, "Before we will give you money, we will

probably say, 'How did you plan to handle the problem of the walk-in patient as a part of handing over the money?'"

DR. ROTH: I don't think it is worth taking any time of the Council to discuss it. And with the people that are worrying about it, I am sure it is in view. But probably the single striking thing about Russian medicine that we came back with from our group over there was their emergency care system which has a reverse philosophy from ours. They are geared to carry the expertise to the emergency, and we are more geared to bring the emergency to the expertise.

And one of our recommendations was an in-depth evaluation. And I understand that through the Fogarty Center, they are purusing this with the idea of setting up perhaps a joint or an international study of the end results in respect to six specific disease entities handled by these two alternative groups.

DR. WILSON: So-called tracer diseases. They have had the other. As you well know, Russ, I was much intrigued with the fact that because this service was free, they have had to put a deterrent charge on using it in Russia. You know, for quite a while you just picked up the phone and called the number, and people would come on an emergency basis. They have now placed a nuisance charge on it because it apparently was getting overused, something that apparently everybody could have told them.

It is a little interesting to see Russia putting nuisance charge on it. The more they work, the more they find out all people are alike.

DR. ROTH: It always did cost 10 rubles if you turned out to be drunk.

DR. WILSON: That might be an emergency, Russ.

DR. KOMAROFF: One area we didn't talk about today and was after much anticipation cryptically absent from the President's Message was dollars for advanced technology and HSMHA's possible role or RMP's possible role. Can you give us an updated report?

DR. WILSON: The Dollars for Advance in Technology, if you recall the President's talk, he said he was going to come out with a later program. And that is in the making at the moment. In the inimitable ways for preparing for such things, all kinds of people are running around writing pieces. And you never know which one of them will survive if at all. So anybody who tells you they ever wrote one of those messages, they are smoking opium because everybody writes them and nobody writes them. Finally, they collect all of this paper in some interesting place in an unknown dungeon, and they write up the Message.

But that work is all going on at the present time. We have not made a heavy pitch for RMP in that particular instance. I had the feeling it was a calculated risk, and

this may be right or wrong. I had the feeling it was a calculated risk that might slip us a little further to the sort of impersonal provider relationship. And because we are working so hard on the provider image of RMP, if I may use that type of word, we obviously would be accepting, but I have not personally made a heavy pitch to get a lot of the money into RMP.

RMP has worked very hard on some of the initiatives that went through, though, on the other side. You worked with the blood.

DR. MARGULIES: Particularly with the kidney.

DR. WILSON: So there is an initiative in kidney. We didn't exclude this, but if you look at the ones we went for in RMP, they are people oriented kinds of programs where technology would be an assist rather than the reverse, the highly technological orientation.

The kidney program, and didn't you have one other one that went down there?

DR. MARGULIES: We worked on two or three in fact, but that was the one that was most. Blood bank we were involved with also.

DR. WILSON: Blood bank and kidney, those are two that went to other echelons of discussions. But whether they will turn up in the final thing, we don't know at this stage of the game.

I have either totally confused everybody or totally discouraged them.

DR. McPHEDRAN: I just wondered if you could say something more about these remarks on the Area Health Education Center, what your discussions have turned on and which agency should take responsibility for which kinds of AHEC activities. I really didn't understand what have been the differences of opinion that have made it so difficult to get this thing out.

DR. WILSON: As a matter of fact, I haven't quite understood what made the differences of opinion either. So I am not going to be all that much help.

Let me deal with the mechanisms of it first. It is agreed the applications for Area Health Education Centers will all come to RMP and be distributed. So we will staff the reception of these and distribute them.

It is also agreed still processing that all applications formally for Area Health Education Centers will be jointly reviewed regardless of who the dominant funder might turn out to be. So we have had agreement these are not independent.

It has further been agreed we might well jointly fund an Area Health Education Center. They might decide 20 percent was one kind of program and 80 percent another kind of program. Maybe it was 70 percent and cut them back again. That is another technique. We would share one way or

another a mutual agreement how we would fund them.

Now, the principle I am trying to set forth on how you would determine which percentage went where was basically working off the assumption, number one, we are only funding education and training. We are not paying for health care as a part of this. That is something that the Bureau of Health Manpower has had to struggle with. We are only funding education and training.

Then, the second, and it becomes a little tougher to get defined, is that we would then only support from RMP the costs that were attendant upon the post-graduate education type endeavors, short course training, people who are primarily practitioners at one level or another in the profession and who are being refurbished or updated or whatever. But we would not be looking at the funding to any extent out of RMP of residency training or associate degree people or formal degrees.

Now, the cloudy area is the certification. And that is not totally thrashed out and I think is not a bone of contention. And I suspect it would vary from place to place if we threw it in gear.

The Bureau of Health Manpower would be the other way around. You see, they would be funding residency training, the various candidates for degrees. And then we would be looking at the problem of certification together, depending

on the length of training. In a sense, it says that we will be funding programs that have a heavier community component in them, and they will tend to be funding programs that have a heavier university or academic institution component in them. But neither would be funding, I think, exclusively one or the other because the programs won't come that way.

DR. ROTH: That would be coordinated either in RMP or BHM office, I would hope, because it would cause havoc in the field being in the midst of one of these emerging experiments, working with Jack Chase's money at the moment. If you had these different components, you were trying to balance in something, you were just trying to create, it would be impossible.

DR. WILSON: It is a single application, and it will be a single award as far as we are concerned. But it might be composed of amounts of money from both agencies. But it will be a single application, single processes as far as the applicant is concerned and then a single award.

DR. ROTH: The bookkeeping all gets done here.

DR. WILSON: The bookkeeping gets done here, that's right.

Mr. Milliken.

MR. MILLIKEN: Has there been any rationale or term for locating these according to population in existing resources?

DR. WILSON: Only in theory. One of the debates right now that I think may be clobbering this up a little bit, and I hope to learn a little bit more about it this afternoon, is what do you do about the Bronx? That is a good question. They don't have enough health manpower in substantial areas in the Bronx. But if you take the New York metropolitan area, it is pretty hard to make a case for the fact there is a shortage of manpower in the New York metropolitan area.

What should be our relationship to the Bronx? Should there be an Area Health Education Center in one of those community hospitals in the Bronx when you know it is a streetcar ride away to places that they have got a pretty big supply of health manpower?

Now, I have sort of prejudiced the conversation, you see, by the way I have posed the question. And that probably is one of the issues that will be up this afternoon. You know, I am not sure that the AHEC is the device to deal with that kind of an issue, but there is a substantial argument being made for using the AHEC for that kind of process.

So when you start to say you have got your finger right on them, you say what is the definition, our definition to date has been slightly different. You have said there has to be a real manpower shortage in some kind of a reasonable geographic area with which you are dealing and not simply a training program that renders its only byproduct as the help

it gives at the moment. The guy is in training, he gives help while he is in training, but then he disappears. And it seems to me thatisn't the way I have understood the AHEC endeavor, but that is very much under discussion.

MR. MILLIKEN: It might be split down according to the difference in approach between the manpower and RMP.

DR. WILSON: That's right. And finally, they have a right to form whatever policies I guess their advisory groups determine. We won't try to mandate it, but I think we were careful about how we participate. It makes it very interesting with OMB saying to Dr. DuVal that they want a single program for AHEC with a single focal point and single set of principles. And that is probably why we have had a little delay.

It has shifted so because they got so much less money in the Bureau of Health Manpower than they had originally anticipated for the program. What is it they have -- $8 million or $10 million?

DR. MARGULIES: About $10 million.

DR. WILSON: About $10 million. And they had anticipated $25 million with a fairly rapidly expanding program. They have $10 million and a flat budget for next year which has caused them to relook, I think, part of the program.

DR. KOMAROFF: I thought I heard you say this Council might look at HMO developmental proposals at least

until there is a separate funded law. Did I hear correctly?

DR. WILSON: You heard correctly. You heard me say I never prefer to use the HMO review group as a review committee for this Council and to run grants through Council. That is not a totally resolved issue, but that was the direction we were trying to work.

I am sorry Mr. Riso is out today. I think he got called out, but that was my preference, and it was in the last set of discussions I had with him. If it turns out to be contracts, obviously we would keep you informed, but we would not run it through the Council.

Harold, I believe they have had about all the administrator they need for the morning.

DR. CANNON: I am just asking about the paper you said might be ready on AHEC. Will we have a chance to look that over before it is initiated? There are some things, you know, if you try to focus in on these programs you have, one I see is the target on emergencies. If you really take care of the true emergencies, this takes probably the pressure off of the health care system because I think the public is more concerned about their emergencies being taken care of.

And then I see the AHEC. Is this effort in increasing the manpower pool? Russ expressed some concerns about the emergency. And I have some concerns about AHEC and its relationship to the university health centers and to ongoing

programs in education in the States, collateral mobility of personnel, whether it would enhance, decrease, the opportunities that we have been working hard to improve.

And then I see the HMO as an effort to improve delivery of health care, more comprehensive delivery of health care.

But in focusing in on those three areas, you see the program, just like HMO's, all at once is out, and we really didn't have the opportunity to discuss this before you got the program going. And I think if you have got something going on AHEC, the Council, if they are going to be involved in it ought to see the papers before you say this is the way it is going to be. Maybe we are not going to change it the way you have decided it is going to be, and I don't mean you personally.

DR. WILSON: HEW.

DR. CANNON: I think we ought to have the opportunity. What is the value of having us, you see, if you only use us after the fact and not in the formulation of the program? I may be wrong about this. I think the other Council members ought to speak to that.

DR. WILSON: It was our intent. With AHEC, of course, we have been working for a month trying to get that gearing toward this Council's meeting so you could have had it. So we really worked in every way we knew how. We just

ran into the fact that the paper we were bringing by direction had to be in a paper agreed upon, and we couldn't bring you an agreed-upon paper in that kind of negotiating. It is part of the place of togetherness. It is one of the things that is going to happen to the Council system.

The more you combine efforts from different legislative entitlements into a single activity, the more you get caught up in the fact that there are in-between decisions that get made because there has to be a negotiating point between the two groups. And that is why I said at the beginning, sometime we are going to have this sort of inter-Council group, a small group, who could sit in on and be a part of it. I just don't think it is feasible to bring all the Council members in for every one of the discussions where you have an unpredictable number of discussions. That was the reason for the Chicago suggestion and subsequent suggestions.

I buy immediately the plan that this is not the way one should relate program to the Council. I think that is self-evident. I wouldn't be down here really trying to explain how we got there if I thought we would have spent the morning on something else. Our choices were not all that good in this, however. And it seems to me we could reject the role, but that is about the only thing. We had the opportunity to be in the game or not in the game. We didn't have the opportunity to launch it on the slow mounting base.

Now, that leaves us with the obligation of keeping you informed on what got started, but I don't think you are by any means hooked with that in perpetuity. I think what we are trying to present you is a starting base to get the thing open. And the Council then from a policy point of view can continue to revise this because I don't see anything that we are doing with this that is going to hook us in that deeply.

I wish we had intended for you to have the AHEC thing. EMS, there weren't no way -- no way. There were just too many players in that game. And that was the condition. The AHEC thing, we have been doing this for five years. The Council has been in this business. And you have to go at it this way, I view as quite the reverse.

HMO's, you were simply a repository. You wouldn't up sort of by accident in the HMO business. And you will be out of it again pretty soon. So I don't view it quite the same as I do the other two which are your business.

I would be glad to hear other comments.

DR. McPHEDRAN: I really thought that this meeting in St. Louis, while it wasn't formally perhaps set up particularly for getting Council's views about it, nevertheless afforded an opportunity for this kind of discussion. And that is the way I took my own participation in it. I thought that was really quite worthwhile, particularly with the emphasis on the responsibility of the individual regions in Regional

Medical Programs for assisting in making policy. I think that this was a kind of meeting that was very good for this kind of discussion.

The issues were heard, and one could have spent a lot more time on each one of them. But nevertheless, I thought it was a good kind of arrangement for us to give you input on what we thought about these matters.

MRS. WYCKOFF: It was very good to test it against their local problems in a way, to have an opportunity through a meeting that was an excellent idea.

DR. CANNON: We can't hear you.

DR. WILSON: Florence was saying it was an excellent way to test it against the local problems, to take it out into the real world at leastin theory.

It seems to me it would be very, very helpful to Harold and to our office if in the course of this meeting you were to spend some time talking about the way in which you think we can improve your involvement discussionwise. We will have to decide. I guess you could say to Wilson, "Don't go out and drag in any more of those squirrels on my back porch." I have been sort of anxious to get this program on an upward swing in terms of resources. And maybe we have given you a gift or two that as a Council you would rather not have had. And if that is the case, you know there are other ways to approach it.

Right now, I kind of like that new ceiling myself. It seemed to me that gave us more running room for subsequent times. But if you have any kind of direct or indirect comment you need to do officially here, if you would send me a note or drop me a letter, if you feel it would be easier to do it that way, or send it to Harold, we would be glad to have either personal or official comment.

MRS. WYCKOFF: Would it be any help to have a small subcommittee of this group to sort of work on a more frequent and intense basis with you?

DR. WILSON: Yes, it would be. And while I have never made any formal suggestion, as you know, I have suggested several times that there ought to be some small group with whom we could spend time who might keep us a little more sensitive to what it is we ought to be saying to the Council.

It turns out, though, the days are fairly long, just like yours are at home. And you wind up with sort of a succession of crises that keep coming through. And I think sometimes we are not as thoughtful as we ought to be about getting the word out. And that is where a small group who worked with us would be very helpful.

MRS. WYCKOFF: Some group focus on the AHEC problems and specifically concerned with that.

DR. WILSON: Yes.

O.K., Harold, I think that is all the contribution

I can make for the morning. I have two other crises upstairs, one of which almost literally threatens to lift my scalp. Maybe I better go.

DR. MARGULIES: O.K., thank you very much.

I would like to pick up just a little bit more on the current budget and what it means and make sure that we all understand what the figures are and refer in the next few minutes to some of the non-identified -- that is, especially identified -- programs about which we have been talking so far this morning.

As you heard, the full appropriation was released so that our total budget this year is $145 million. A part of that, as you know, is involved in operational costs. And there are some specific items which have been identified administratively for special action.

Just to make sure that you understand what those figures are, once more, the understanding from OMB was that the Area Health Education Center would be $7.5 million, Emergency Medical Services Systems $8 million -- we had carried over from the prior year $5 million for construction which will be discussed today, construction of a cancer center in the Northwest -- and approximately $16.2 million for HMO planning and development.

Now, by HMO, we include the broad definition which is currently being used which includes both foundations and the

narrower definition of HMO -- that is, the medical foundation concept. The remainder for grant support is approximately $98 million which is in interesting contrast with a figure which would be the relevant figure for the last fiscal year of $70 million.

When that was identified, we did develop a spending plan which we have begun to move ahead with and with which you will be concerned during the course of this meeting in the next two days. We felt that the first thing which ought to be done within the general framework of relative ranking of programs with appropriate funding was to restore to programs funds which had been removed as a consequence of a prior reduction in allocation.

You remember that in April of last year, there was an across-the-board cut which was mandated by the reduction in funding which appeared at about that time. And we did reach an agreement that those funds which were cut at the April moment would be restored. And we are now moving toward that restoration. We have only in the last couple of weeks had freedom to act on a spending plan.

We also agreed as a consequence of that that we would look at the relative ranking of programs and give them additional awards according to how well they had fared in the review process and in accordance with their capacity as we saw it to effetively utilize increased funds at this time in

their fiscal year.

In some cases, this may require some additional Council action, and we will be bringing that to your attention in the manner in which I think you will clearly understand when we bring the papers before you.

This left some other major considerations, one of which I have spoken about to some of you. The kidney activity should be expanded with the expanded resource which we have. And we propose to do that so the total amount of investment in kidney activities will be approximately 50 percent above where it was during the last fiscal year. This will bring us somewhere in the range of $8 or perhaps a little more million for total investment in kidney activities combining contracts and grants. This was also a very propitious time for us to consider what we had talked about rather broadly before -- the change in the review cycle from four a year to three a year.

Now, there are some special advantages to that which I won't go through in too great detail because part of the advantage this year is fiscal, but in the long run, the advantage is primarily one of better staff management and one of better timing for the regions themselves. And one of the reasons we have not brought to your attention today the new meeting dates for the rest of the year is because they haven't all been laid out, but you do already know that we

have asked to change the next meeting from May to June.

Now, one of the purposes involved in this is the concentration of staff efforts on the very demanding review cycle three times a year rather than four. In order to achieve the best possible results, we will also have to try to further weed out any work which is being done which need not be done, any extra papers which are being developed which can be deleted, and so on, so that the work load of the staff involved in the operations activity can be cut down as much as possible and the efficiency of production raised to the highest point. If this can be done, if we can use the triennial system with increasing frequency, and if there is no delay in the period of time from submission of application to the completion of the review cycle and report out of an advice letter and award, it will provide time which we have not had at all at an adequate level for the staff to do the kind of technical assistance which they need to do outside of the review cycle itself.

Tech asst

We would then raise to the highest priority for technical assistance attention to those programs which had rated poorly in the review process and be able to begin or to move more rapidly toward a rectification of the differences between those that come out very well and those that come out very poorly. There is really no alternative to doing it with the present staff. We can't look toward a greatly amplified

staff. That isn't in the cards. And so we are going to have to do it by increasing our efficiency.

The other reason we want to do it at this time, -- I think we might have done it in any case -- is that the short period between the release of the budget to RMPS and the end of the fiscal year makes it mandatory that we either release funds to the Regional Medical Programs at a rate which may be greater than make sense at this point in our history, or utilize the funds in some other fashion. It is perfectly possible by going on the triennial cycle for us to award grants over a longer period of time, thereby utilizing in this fiscal year a larger sum of money for basic RMP growth.

It also means that as our budget is maintained over the next fiscal year, it will be a more manageable rate of increase of RMP activity spread out over time so that there isn't a sudden pouring in of resources at a time when the programs have sort of gotten adjusted to the fact that it is going to be very lean. I won't go into all the intense details of how we are going to manage that, but it turns out to be an extremely convenient way of handling our activities. And I think it will work out quite well.

Another feature of it which we hope to be able to stick with is that we will give the Regional Medical Program a longer period of time from the release of the advice letter and release of the action of the Council until their next

fiscal year. As it is now, very frequently a regional medical program hears only a week or ten days before their fiscal year is to begin -- that may be a slight exaggeration -- what the actual level of funding will be. And then there is a great scramble to readjust their budget, to reset their priorities, to renegotiate activities. We can extend that out so there is a longer period of opportunity in there. And I think they will find it much more agreeable.

Now, once this has been launched, it means we will in fact have three review cycles a year. This does not reduce the total work load, but it concentrates at around those particular times.

I think I ought to say a little bit more also at the risk of amplifying unnecessarily what Vern said about the Area Health Education Center activities. I was not sure during the course of the discussion if it came through clearly that what has been agreed on is a common set of guidelines. There will be a single document describing what the Bureau of Education and Manpower Training, the Bureau of Health, whatever it is, and the RMPS -- I know what that is -- there will be a single document describing what an Area Health Education Center is. And in practice, the difference between what comes through RMPS funds most of the time and what comes through NIH funds most of the time will be reflective of the differences in those two agencies in their

constituencies and in the people with whom they do business. They have some different concepts of how one works with a contract, of how one works with a university health science center. And we have enough latitude so that we can operate in a somewhat separate fashion and so we can also combine some activities.

As Vern has indicated, the meeting we will have this afternoon is another attempt to reach a full agreement on how this will actually be worked out.

The definition of the Area Health Education Center as you know from your own experience will be made sharper as we begin to look at some of the applications. And we will be asking you for some special action on how we want to meet with the AHEC issue so that we do not have too long a delay in the period of time between now and the time when we next meet in June so that the Area Health Education Center activities can actually get established.

The budget for next year does, indeed, indicate $15 million for Emergency Medical Systems in the RMP, another gain, $7.5 million, for Area Health Education Centers, and the basic grant support is going to be maintained at approximately the level which it has been in this new budget for fiscal '72. That is the President's submission. Dropped out of it will be the funds for construction which were in just one time, I hope the only time, and funds for

the HMO's which were really an internal administrative decision as you have already heard.

Now, I think probably while we are at it, we may as well get a little bit more explicit about what we are talking about with the HMO. And I just want to lay this out, and I think maybe some of these questions you might want to explore later in the morning in further detail. When the money was released, and it included an understanding on the part of OMB that we would be supporting activities like HMO and so on, it did have the interesting effect of putting our total obligational authority and our total spending capacity at a higher level. And whether this went this particular year directly into usual RMPS activities or not, it produced that change of level which has continued in prospect anyway throughout the next fiscal year.

What we will be asking you to consider is a choice, really, in HMO funds between doing it all by contract and doing it through the RMP mechanism with a clear understanding that it would not follow the usual pattern of RMP review and grant. What we would anticipate in order to keep the HMO development consistent within the HMO service which is a parallel structure to RMPS and HSMHA is the effective identification of HOM applicants, the review of their eligibility and suitability by the HMO service, saying, "These are the HMO's that fit with our program whether they are medical foundations

or HMOs developed by consumer groups or whatever, these have been reviewed, these are appropriate, they meet our standards, and we would like to see them get the necessary funding."

It would then require if we used the grant route that the Council agree to that kind of a review process, empower us to give grant awards to the Regional Medical Program, the appropriate ones, so that that RMP can provide the support for the HMO within its region.

And there is no question that the role of the Regional Medical Program under those circumstances would be relatively passive. The coordinators would vastly prefer that to the alternative route which is a contract kind of a mechanism through the national headquarters to HMO candidates, to HMO applicants. They have two reasons for preferring it that way.

One of them is because they are in many cases already involved with the HMO development, and they want to be close to the activity as it continues.

And the second is because it is quite clear and becoming progressively clearer that the RMPs will have a major role in theprofessional development of HMOs, that they will have a responsibility for establishing methods for monitoring the quality of medical care, that they will very likely be developing specialized programs like Emergency Medical Services, Health Manpower Training, and so forth, in

conjunction with HMOs. And it is better that they have at least if nothing more than a relatively banker-like relationship with them, better that way than to pull the whole thing out of the region and make it a national issue.

I will not ask you to consider that formally at this time, but I will ask you before this particular Council has finished with its meetings to do that because it is obviously of great importance.

I will also be talking with you, as I indicated, about some case in which we could get the Area Health Education Center activity on its way. There was some comment earlier, and I think I need only give you a kind of perfunctory report unless you would like to go into it, on the fact there was a national coordinators meeting. A number of you were there. It did go well. There was an opportunity for people to raise some issues which they thought were of importance. It identified, and I have already begun to act on this, some barriers which RMPs felt they could not surmount which required further understanding, probably R&D type of understanding, which we have begun to talk with the National Center for Health Services R&D about so we can begin to get on with the kinds of things we were concerned with. There was a vigorous, an effective, and critical discussion of our paper on Area Health Education Centers with some changes coming out of it because the input that

they gave was good and proved to be highly acceptable. And we modified internally the document which we produced at that time.

The physician paper which we developed on Emergency Medical Services went well, and there was little dissent from it. And for the most part, I think the coordinators came away convinced that the kinds of directions which they have decided to pursue have jelled and that there is some idea of where we will want to go.

I thought one of the points that was particularly useful for me, and it is still a surprisingly live issue, was the better definition of the relationships between Regional Medical Programs and Comprehensive Health Planning which Monty laid out very well. In fact, I think the talk which he gave was very much to the point. He particularly stressed the responsibility of RMPs in monitoring the quality of medical care, not in the HMO context so much as it was in the context of the great likelihood of national health insurance.

Now, we do have copies of the DuVal paper which we had not previously distributed. They are here, and we will make them available to you because I think you will find them of value. In fact, we will be distributing all of those papers in a very short time, including the plenary sessions where the total of the discussions was summarized

by the participants.

Now, I wonder if there are any questions about any of these issues which I have raised up to this point.

DR. DeBAKEY: Harold, may I clarify something in my mind in regard to the HMO's? As I understand from what you said, this decision to put the HMO in RMP was made at some executive level and a certain amount of money which had been appropriated for Regional Medical Programs by Congress was released and specified to be used for RMP. That decision was made at some levels of the Administration.

I just wanted to get it clarified in my mind how this was done.

DR. MILLIKAN: You mean used for HMO?

DR. DeBAKEY: Yes. Isn't that right?

DR. MARGULIES: The way it came out, you didn't say it quite the way you intended. You repeated RMP when you meant to say HMO. I find myself doing that.

The money was appropriated -- let there be great clarity about this -- the money was appropriated for RMP. When it was released, it was released with the executive understanding a portion of it would be used for HMO development. This was an executive decision made by the Office of Management Budget and HEW with the argument this was appropriate to RMP activities.

This is the point of clarification you wanted?

DR. DeBAKEY: Yes, that is exactly the point.

MRS. WYCKOFF: How much money was involved in restoring the April cuts approximately? You said you were going to use some of the money to restore those cuts. Would this be a substantial amount?

DR. MARGULIES: We have not completed all of the work because it is not only restoring.

Mrs. Wyckoff has asked how much money was involved in restoring the cuts. In restoration of the cuts alone, -- that is, just bringing it back to the level of prior commitment -- the amount was not very great. I would guess it would not be for all the programs in excess of $4 million, $4.5 million. But when you add to that the increased funding for programs which are well below Council approval or which have moved very rapidly since the Council last took action, then the total amount goes up quite rapidly. And it approaches a level fairly near the limit that we had set for ourselves which is not the total $98 million.

Now, let me just expand on that one for only one purpose. When we are told that there is $7.5 million for Area Health Education Centers and so much for Emergency Medical Assistance and so on, that merely means we are obligated to spend that amount of money for those purposes. That does not mean that if RMPs request funds and the Council agrees that we cannot exceed that kind of investment in any

of these programs. So that if the Area Health Education Center as a partial or total concept appears to be attractive enough and consistent enough with RMP development to exceed that kind of a figure and we have the funds available, there is no reason why it should not do it. That is not a limited figure. That is an obligation we have. And so far as I can tell, whether I can say that with as much ease on the Emergency Medical System, I don't know, but I don't see why not because in some degree, and in a considerable degree, RMPs have been dealing with portions of emergency medical systems for a good long time, and some of their better activities have been in that field. Certainly in the categorical areas, this has been a very generous activity within the RMP. So there is no restriction on it in those terms.

DR. KOMAROFF: Does it also mean if money can be identified out of the currently funded $70 million pot that is already going into AHEC and HMO planning that that in fact frees up more of this additional money within the level of $145 million?

DR. MARGULIES: It is conceivable. It would not be true of HMOs because we don't have any real RMP money going that way into HMOs. It could conceivably be true in the Area Health Education Center or the Emergency Medical System, but less in the last one because we don't really have any total

system going on. We have some segments of them. And wherever an Emergency Medical System is to be established, there will already be many segments present. Obviously, we are dealing with something which has a partial development.

John.

DR. MERRILL: Harold, could you enlarge a little bit on your ideas about how you intend to expand the kidney activities? Does this simply mean increased funding or are you looking for new approaches?

DR. MARGULIES: This gets a little bit into this whole question -- and Vern brought it up so I will expand on it a little bit -- of what we have been doing in our discussions in the new technical initiatives. We have been trying to promote interest in the concept that certainly the dialysis and transplant aspect of kidney disease management involves a great deal of technical skill. I think it is self-evident. Dialysis itself is a technical activity and a remarkable one with a great amount of new development and with a remarkable transfer from very compoicated environments to the home. There are technical activities involved in typing, in development of banks, in the transmission of information.

We have proposed very broadly stated that there be made available money enough and a mechanism which works well enough to support a limited number -- and "limited"

meaning adeqaute for the total country -- of centers for transplant, identifying kidney as the primary target to begin with, so that at the end of five years, the facilities available would meet all of the predictable needs for dialysis and transplant for everyone in the country and to do this in such a fashion that there is a method of influencing, if not controlling, the placement and the rate of development of these centers to keep them somewhere within the range of a total of a minimum of 50, probably something closer to 75 or 80, in the country, depending upon their distribution, to beuild into this national computer system the necessary methods for identifying transplantation and for maintaining a collateral development of associated research so that at the end of that period of time this would indeed be the state of affairs.

Now, we have talked about this extensively with a number of people from the National Kidney Foundation and elsewhere. The paper which was developed, I think, is pretty sound. In the absence of some official action on that concept, but with the feeling that the idea is good and isone that we ought to try to support, we would like to believe that as we increase our investments in kidney disease, they will be leaning in that direction so that whatever we can do would be perfectly compatible with that kind of a systematic approach. This will be important, not only for

the kidney transplant area, but for the general concept of developing transplant potential. Because this should not be confined, and it should be a multiple potential setting.

I think the same kind of an activity is one that the Council ought to be thinking about more and more when we are talking about what kind of control and management is necessary for all to be sharing highly developed medical activity.

Well, Congress made a point, and we are trying to be responsive, in the last session about the multiplicity of centers for open heart surgery and the fact there are too many some place and too few somewhere else. If one can begin this kind of thinking for the establishment of transplant capacity in major centers, one can begin to think about it in terms of other highly sophisticated, expense activities which really do best when they are limited in settings and have a total sophistication around them, an idea which is hardly unfamiliar to you, Dr. DeBakey.

DR. DeBAKEY: I am determined to get some of the original concepts of the Regional Medical Programs.

DR. MARGULIES: But it takes time, and I think what is interesting to me is that some of the ideas for doing this in the field of open heart surgery are now being generated outside of government by people who are suddenly realizing, not only do you have a problem with too many centers,

but you increase the problem by having to train people in those centers, by now having to go out and establish more centers. And the multiplier effect is fantastic.

But this in response to your question, John, is the way we would really like to go.

Are there any other questions about these general issues which I have raised?

(No response.)

So far as the appropriations themselves are concerned, I understand that the appropriations hearings will probably take place beginning in March and probably move quite rapidly this year. It is the intent of the chairmen of the Appropriations Committees to get the hearings over with rapidly. They did very well last year, and they will be even more interested in it in an election year.

I wonder if this might not be an appropriate time to bring up a couple of other issues before we have the coffee break which we would like to pick up on. Because one of the things we would like to get to quite soon after that is the Northwest Cancer Center application. But there are a few special reports and a few special actions, and I would like to pick up on the kidney one now.

Ed, if you want to extend that at this point, I think it is pretty appropriate we do.

DR.HINMAN: Mr. Baum is getting ready to give

to you the document we are getting ready to talk about.

At the last meeting of Council, I outlined in a brief fashion the method we thought we would pursue in kidney review in attempts to have it become a little bit closer to the usual Regional Medical Program activity, but yet enable there to be some special attention because of the desire to achieve a goal as Dr. Margulies has just outlined. And we have for your comment a proposal that is being passed out now which in essence states the following:

The first step will be as soon as there is a potential applicant identified, the appropriate RMPS desk would be contacted to see if it fits in with the national priority so the local investigator, the local applicant, would have the knowledge of where it sits in rank order of priority.

This would not preclude their submitting an application if they so desired, but at least would give them some indication whether it is worth pursuing.

Secondly, each RMP would be required to establish a local technical review of at least three recognized kidney experts from outside the region who had not participated in the development of the program. They would perform a local technical review which would be submitted to the regional advisory group and through them to us. We would maintain a list of consultants who would agree to participate in this type of activity. And it would be up to the region

to select them from the list.

When there was a favorable local technical review, the RAG would consider the proposal, would look at it, whether the region could administer the program without hindering its development, and would look at whether they thought the budget was adequate and reasonable.

Now, the RAG would not be asked to rank order it in priority with other RMP funding since we are talking about keeping the money essentially separately. This would be forwarded to RMPS, RAG reviewed, of course a CHP review is necessary, and the technical review.

Staff here would take these, look at where this would fit in with national priority, look at whether under preferred method of funding, under 4C, whether this would potentially fit an interregional approach, whether this would be a single region, or we are talking about a potential contract versus a grant. This would be made available to the review committee at their request. If not, it would come straight to you all for handling in the same fashion that you handle other RMP requests.

You would review the findings that we would have summarized for you and then approve or disapprove and recommend a level of funding to the director. And it would then be handled as any other grant request.

Concomitant with this, we are updating the

guidelines that go out to the region to be a little bit more program oriented and a little less application oriented, such as this sheet is. This is the review process, the application review process. The guidelines portion of it would be essentially as Harold has outlined to you.

DR. MARGULIES: The reasons for making this final determination were really hewed out of experience. The central technical review committee did provide some assistance, but it was running into difficulties because of its separateness and because we were putting on too many layers of technical review which in general we have tried to avoid in the RMP.

The reason for outside consultants in the kidney thing is quite simple because in most cases with the limited number of people in dialysis and transplant, the proponents in a given region are likely to be the only ones available to do the review. And that is not a highly satisfactory arrangement except for them. So that we felt that this additional consultant role from the outside in giving us information we needed would be quite adequate.

We also found that when we tried to mingle this very categorical approach and particularly as we are looking at a national system with a review of the regional medical program that the review committee in particular found it almost impossible to do. They would rather look at them

separately. And only when there is a problem as the Council sees it, then is there some special consideration in view of the RMP and the kidney activity itself. So we have tried to keep them separately.

They will also enhance our capacity to develop a true national network without the limitations we have previously placed on it.

Now, if you find this particular proposal acceptable, we will proceed with it or if you would like a little further time to consider it, we will come back to it later on during the course of the Council.

DR. SCHREINER: ARe the RAGs being very carefully instructed about the separate funding? I still hear the old rumors that we are afraid of this one cutting in on our budget and all this kind of thing.

DR. HINMAN: When this goes out, there will be fairly clear instruction -- at least we hope fairly clear instructions -- to the coordinators of the RAGs and potential applicants.

DR. SCHREINER: The whole purpose of asking for earmarked funding legislation was to avoid this natural human instinct of territoriality so it would be an add-on rather than a competitive situation, the whole sense of it.

DR. MARGULIES: I think we have done this, George, less because of the implication of funds being earmarked and

more because of the difference in the character of the program, one of them being categorical, and the other not. But we also want to avoid assiduously a return from the categorical activities to the enhancement of the professional environment of some institution without adequate concern for the delivery of services within a region.

DR. SCHREINER: We always t-ought it was the best situation as well, and that is why it was worked in that direction. And I think you have done a nice job in framing this up, but I think it is very important because somehow the old budget is to stay on.

DR. MARGULIES: I think that will get straightened out because one of the things that draws attention constantly is how we handle the money. This has not been widely distributed because we want to bring it to your attention first.

Tony.

DR. KOMAROFF: Does the additional grant money open up the question of 9-10 interregional grant funding mechanism?

DR. MARGULIES: Yes. We will in fact be proposing some 9-10 activities, particularly in the Southeast area. I think we will be utilizing 9-10 and bringing it up for your action during the meeting of the Council.

DR. HINMAN: The Southeast and Oregon procurement group would be an ideal 9-10 activity. The option would be

a contract, but it certainly would fulfill the type of 9-10 criteria.

The one problem with 9-10, as I see it, if you are going to talk about a large number of regions, is the fact each region and each RAG would have to act upon it. And this would get to be a very cumbersome activity. So there are considerations on both sides, Tony.

DR.MARGULIES: Well, if there is no further discussion on this, let's have a coffee break for a few minutes. And then the first item after that will be the consideration of the application for the Northwest Cancer Center which is a special kind of action.

(Whereupon, a recess was taken.)

DR. MARGULIES: I was going to come back to the proposed kidney review and ask for some action on it, but in the absence of both Dr. Schreiner and Dr. Merrill, I will wait until they return.

That still leaves us a third kidney specialist, but I don't want you to carry the full brunt of this thing.

Under the circumstances, then, rather than getting back to that, if we can delay that a little bit, I would like to have the Council consider the application from Seattle for a cancer center. We were fortunate in having Dr. Henry Lemon available to not only participate in the site visit, but act as chairman of it. There were two members of the

Council also part of that particular site visit. Dr. Brennan is ill and can't be here. Mrs. Mars was present. She is not ill, and she is here.

So what we will do is ask for Mrs. Mars and Dr. Lemon to share the presentation of the results of the site visit after which there will be whatever discussion is necessary.

Mrs. Mars.

MRS. MARS: May I ask Dr. Lemon to come to the council table?

Oh, he is there. Good.

On January 24 and 25, a site team visited the Fred Hutchinson Cancer Research Center or prospective, shall we say. Dr. Henry Lemon; Dr. Brennan who unfortunately could not come until the last day; myself; Dr. Richardson Hill from Alabama; Mr. Harry Malm who is an executive director of the Lutheran Hospitals and Homes in Fargo, North Dakota; Mr. Schmehl; and Mr. Grady R. Smith who is director of the Office of Architecture and Engineering of the Health Care Facilities Service.

Since Dr. Margulies wants to get this out of his hair, we will do our best to facilitate the matter.

I might say to begin with everything was against us. We were there in a blizzard. It was one of the worst blizzards that Seattle has, I believe, had in many, many

years. And this was unfortunate inasmuch as on the second day some of the people who had anticipated coming before the site visit team were simply unable to get there. They were literally snowed in. So that a few brave souls managed to get through and to wind it up and give Dr. Brennan some sort of a summary. However, fortunately, on Monday, we were able to see a goodly number of people.

The first part of the site visit, we all met together. And after that, we divided it into three separate groups which were organized as education and public interest and research in patient care. I chaired the first, Dr. Lemon chaired the second. And then health research construction and operating support with appropriate consultants assigned to each group by the chairman. So we all reported on very separate sections.

In the general session before all of us, the Lt. Governor of Washington, the dean of the School of Medicine and the Vice President for Health Affairs of the University of Washington appeared before us. Unfortunately, the dean of the Oregon University School of Medicine was not able to be there. However, two of our team members did speak to him by long distance. And then, as I said, the second day of the visit took place in the regional offices.

Under organization and education and public interest which was the section that I chaired, I had a variety of

people come before me. I had people from the American Cancer Society, the Associate Dean for Continuing Education of the University of Washington, the President of the King County Medical Society. A rather interesting and colorful character was a man by the name of Ed Donohoe who is editor of the Washington Teamster Board of Trustees, and it was very interesting as a sidelight that labor apparently is supporting this center wholeheartedly. They have even taken their paper which is published and charged for now so that the remuneration could go to the center, to the proposed cancer research center. And he spoke at great length and with great enthusiasm as to the need of it.

We also had Dr. Hartmann, we had several lawyers on our group. Of course, Dr. Sparkman who is the coordinator of the Washington-Alaska RMP. We had Dr. Reinschmidt who is director of the Oregon RMP, Dr. Sidney Pratt who is from the Mountain States RMP, Dr. Taylor who was from the Therapeutic Radiation Center of the Virginia Mason Medical School and David Johnson, Dr. David Johnson, from Region X who is a regional health director. So that we had a great variety of people from all walks of life.

I think that the management of the Fred Hutchinson Cancer Research Center has been very well planned. They have a committee of three currently who are, (a) building, (b) finance, and (c) public relations. There will be a director

selected after it gets going.

Dr. Hutchinson will be acting as the executive officer. Dr. Hutchinson is still engaged in private practice. However, he does intend once the center is organized to entirely give up private practice and devote his entire time to it.

The Board of Trustees very definitely implied to us that they do feel morally committed to raising funds for this center. They also expect direct grant support for the center. And it was very obvious that a medical center in the area has developed and the team believes that it can become the focus needed to coordinate research efforts.

I know in all those that we interviewed, this was the one point that was brought up that this would become a focal center for cancer research. There is, as you well know, I am sure, a great deal of cancer research being done in the area by outstanding people. And this was the one thing that was emphasized that a focus was needed, a focal point was needed, and that the center would comply and supply such a need.

A Mr. Wyckoff and a Mr. Richmond indicated to Dr. Hill and myself -- I might say that Dr. Hill supported me in this organization education and public interest section and also our staff, Mr. Ted Moore .

Two members of the board of trustees, Mr. Wyckoff

and Mr. Richmond indicated that they would assume the responsibility for generating necessary funds for operation and the construction for the Fred Hutchinson Cancer Research Center. They all emphasized the fact that many of the board have known Dr. Hutchinson and his late brother Fred Hutchinson. And the whole community -- it really was quite extraordinary because, as I said, people from all walks of life -- the entire community supported this. Apparently Fred Hutchinson was really revered.

I don't know very much about baseball, but I gather he was an outstanding individual in the baseball world, but also a person who was highly respected and very much of a civic community leader.

The president of the Washington State Division of the American Cancer Society was unable to be present, but their executive director, Mr. Evans, substituted for him. And he indicated that the American Cancer Society is fully backing the FHCR and would cooperate in every way possible. Of course, he could not pledge any definite funds. However, the ACS is supporting a good many grants in the area, and I would say that to a certain degree, he indicated that some of these grants could possibly in the end ultimately be given directly to the center.

The Oregon Division of the American Cancer Society gentleman was unable to be present, but he also sent a letter

indicating the full cooperation from the Oregon Division of the American Cancer Society.

Dr. Robertson who was president of the King County Medical Society, Seattle, then King County for those of you who do not realize that fact, stated that he hoped that the expertise in oncology of the area would be brought together via the FHCRC and felt this was very probable.

There was a letter of support from the King County Medical Society. In fact, the relationships with all the medical societies seemed to appear very good, and we also heard Dr. Tanaka who was head of all the combination medical societies.

And then we had a Dr. Wright, a radiotherapist of Anchorage, who has been in Alaska for seven years who reported to us on the needs of Alaska and emphasized the need for immediate communication in cases of emergency and also for the education of physicians in recent advances in diagnosis and treatment. And he felt that consultative visits from FHCR to assist with the solution of Alaska's problems would be a very great boon.

Continuing education was stressed, and Dr. Wright felt that the outreach by the center to the, as he called it, boondocks is essential and certainly can be achieved for in his case, a continuing evaluation of treatment is one of the greatest needs. And he felt that the center could provide

physicians in Alaska with the needed help which this was one of to him the most important things to be able to carry on.

Dr. Morgan, the Assistant Dean of the University of Washington Medical School for Curriculum, substituted for Dr. Lein. We saw Dr. Lein the next morning, as a matter of fact, and Dr. Morgan discussed the student education and the great focus on cancer.

Dr. Thomas' oncology program is more than filled to capacity, and cancer education has, of course, been one of the highest electives. He indicated that there is simply no teaching space available in the Public Health Service Hospital.

The University there, has, I believe it was, 8 beds. Is that correct, Dr. Lemon?

DR. LEMON: Yes.

MRS. MARS: And these men have to teach in the hallways. So that here is a very important role that the FHCRC can create as a focus for the medical education program and for better cancer management which is simply not possible by the University of Washington at present.

In addition, 600 students are anticipated which will result in a greater demand for teaching facilities, and the cancer center can fulfill this need. There is great need, apparently, for cancer education in the Seattle area. And

one good example was cited in kidney disease. Dr. Wright is very hopeful that similar experience will eventually result in the cancer field.

Then, we had a Mr. Gerald Oppenheimer who is Director of the Pacific Northwest Regional Medical Library who spoke to the necessity of having sufficient library resources for the FHCRC. He indicated the willingness of the Regional Medical Library to cooperate with the proposed center and made a plea for funds for such a cooperative effort.

Incidentally, the Regional Medical Library is phasing out of the MEDLARS system, and it does have an online communication with the National Library of Medicine. So the proposed center will play a very important role in this by developing a similar system either through the Regional Medical Library or directly with the National Library of Medicine which is based on an evaluation to be made by Dr. Lighter when he visits there soon.

They also are going to do a collaborative effort with the Lister Hill Center of Biomedical Communication. And all this can be integrated and very definitely will be with the proposed Fred Hutchinson Cancer Research Center.

I spoke of Labor's support of the FHCRC. And incidentally, this is a considerable financial support. They have a dinner which was shortly to be held which they contribute anywhere from $7,000 to $10,000 to the Center funds.

And I think one of the other interesting things about Labor's supporting this is that their health benefit program has a plan which provides for catastrophic disease through contributions of $35 per member per month. And this takes care of 85 percent of the cost of such illnesses. So that, of course, if there were any patients going into the center, this money would be channeled into that.

So besides the money from the paper which I gather is building up to a considerable amount, they will still contribute $10,000 approximately per year. So there really seems to be no question about the cancer center being able to be funded.

The moral commitment, I think, of the members of the board of trustees makes this very obvious. And all these people were outstanding citizens, reliable citizens, of the Seattle area.

Dr. Hartmann who is a member of the National Advisory Cancer Council spoke to my group on patient care and naturally emphasized that the center could not be designed for all patients in the region. After all, they plan to only begin with 20 beds. However, they hope that this can be increased very shortly up to 50 beds and that it will grow. They have a 3-man protocol committee set up who would presently decide on the assignment of the available beds.

We brought up the question of what sort of quarrels

were going to result out of who was going to occupy the 20 beds. And Dr. Hartmann acknowledged the possibilities of this problem. But he believes that he can certainly work it out.

One of the things that was important, he emphasized the fact that the center is not set up to interrupt the regular pattern of cancer health care. The public's idea that any cancer patient can be admitted will require proper public education and communication on this subject. And this, they are prepared to do.

Dr. Hartmann also discussed with us the proposed therapy -- we brought up this question -- for outpatients as well as appropriate referrals. And the center expects to handle 10 to 15 outpatients a day on 200 working days a year.

Then, we had a Mr. Sullivan from the Alaskan CHP Agency who also really reiterated what Dr. Wright had said and stressed again the need for continuing education to help inpatient diagnosis. And this, of course, is because of the great distances involved. Naturally, patients cannot be moved 2000 miles very easily. A great deal of telephone consultation takes place in Alaska. Also, they are using some satellite communications for education, diagnosis, even for such things as monitoring -- what do you call the heart, the ticker thing -- pacemakers. I couldn't think of the proper word. So there is ample opportunity for the center, proposed center, to play a part in this.

We heard about the consumers' interest in the FHCRC. Mr. Breskin, the attorney for the EEO Board and a member of the Washington/Alaska RMP Cancer Research Center Task Force talked to us on this subject.

The Model City program shows good outreach into the community health pattern. There is a very good interdigitation among the public sector, also the health programs in Seattle, and the guidelines that have been developed by the Cancer Task Force.

The Washington/Alaska RMP has been able to amalgamate the thinking of many diverse groups. It was very interesting that in 1971, there were, I think, was it 5 or 6 groups, Dr. Lemon, that had planned to build new cancer facilities, and they all have withdrawn their applications and have deferred this to the proposed FHCRC application. So that the community is very much in back of it.

I think that it is very much to the credit of the Washington/Alaska RMP that it has been able to amalgamate the thinking of all these diverse groups. And Mr. Breskin, and I think all of us, saw this as a great accomplishment.

Dr. Sparkman, the coordinator of the program, spoke about the relationship of the Washington/Alaska RMP to the FHCRC. And he indicated that it has complete regional endorsement with the Washington/Alaska RMP which is represented by five members on its board of trustees. So we do have five

members on the board of trustees.

I think that I might point out that we will not have a part in the internal management of the center when it is a going concern. Dr. Sparkman does not want to continue to be on the board once it is a going concern if this happens. And he feels that it would not be necessarily good politics inasmuch as there are five members already represented on the board of trustees.

The whole thing at the moment is a highly coordinated effort with full support of all the health organizations in the area. The task force has certainly done its job well, and I think in the six months of planning that they did, they certainly convinced Dr. Sparkman that the RMP effort was more than justified.

The director of the Oregon RMP, Dr. Reinschmidt, indicated in every way that Oregon would work as closely as possible with the Washington/Alaska RMP in the center activities. Dr. Reinschmidt was a little reluctant to make any specific commitments, but we did note that Oregon was and continues to be well represented in the planning.

I think that I might point out that undoubtedly there will be a cancer center established in Oregon, but this, I think, rather than a building at the moment, will come about as an internal project so to speak.

Dr. Sidney Pratt, Director of the Montana Subdivision

of the Mountain States RMP, was helpful. He discussed the relationships of the Montana RMP with the Center as well as with WAMI -- WAMI being a coalition of the Washington, Alaska, Montana and Idaho programs, designed to improve medical and allied health education in those states.

Presently, acute cancer patients of Montana are referred to Salt Lake City, Utah, and Boise, Idaho.

One of the most impressive things that has happened in the cancer field is that there is a six-state tumor registry which includes Montana, Idaho, Wyoming, Nevada, Colorado, and Utah. And it is believed that the tumor registry now funded by the Washington/Alaska RMP could be tied in with the tumor registry in Montana and Idaho.

We heard from Dr. Willis Taylor who is from the Department of Therapeutic Radiation of the Virginia Mason Hospital. Actually, this is the only individual -- No one was there, Dr. Lemon, from Virginia Mason that appeared before you?

DR. LEMON: No, that's right.

MRS. MARS: -- who appeared before our group. And he spoke on his involvement in the planning of the center. The programs of the Virginia Mason Medical Center were described at length, including the inpatient, the research, and the outpatient facilities.

If anyone is interested in seeing it, I will pass

it around the table, and if you care to look at it, it is the cancer activities of Virginia Mason Medical Center and what they do. Six percent of the patients of the Virginia Mason Medical Center come from Alaska and 50 percent of their patients are physician referred.

The research programs of the Virginia Mason Center are primarily clinical, involving mammography studies, prostate studies, and programs in radiation therapy, including two cobalt units. And one of these is being replaced by a linear accelerator.

There will be no duplication, he stated, of services in the proposed FHCRC. He felt that the proposed center will complement the programs of the Virginia Mason Medical Center and research programs will be pursued jointly with FHCRC.

While at that time there was no formal letter of endorsement presented, Dr. Taylor stated that he would poll the board of directors and send in a letter of endorsement for consideration at our meeting. We now have in hand such a letter. And among all this, I will see if I can find it.

I don't know what has happened to it. It is down here somewhere.

Here we are.

This was addressed to Dr. Hutchinson.

"Dear Dr. Hutchinson: This letter is written to

restate our position as regards the relationship --

This is the Swedish Hospital.

I don't think we have that other.

MR. MOORE: No.

MRS. MARS: We didn't get it. However, I am sure that this will be forthcoming if it is not in hand at the present.

Mr. Austin Ross, the Administrator of the Virginia Mason Medical Center and President of the Hospital Association of the State of Washington, also reported on the general endorsement of the Virginia Mason Center as well as the Hospital Association. So I don't think there is any doubt but what we will be receiving a letter from the Virginia Mason because certainly these two people were their most reliable representatives, I would say. Dr. Ross did describe a very interesting relationship between the urban and rural hospitals whereby one urban hospital system through what he called a buddy system relates to three rural hospitals, and they have one such program now under way.

We also heard from Dr. David Johnson, the Regional Health Director for Region X, who spoke in favor of the concept of the FHCRC. He stated that this could be an example to other agencies for integrated programs of activity, particularly with the Comprehensive Health Planning groups of the entire Pacific Northwest. He emphasized his pleasure

with the evidence of cooperative efforts and the participation of the W/A RMP in such efforts.

Then, we heard from a Mr. Henry Mudge-Lisk. He is a black who is Associate Director of the Puget Sound Comprehensive Health Planning B agency. He reported that the B agency is extremely pleased with the cooperative efforts evidenced in the development of the proposed center. The CHP Council has reviewed the proposed center and believes it will be a vehicle to emphasize the health planning needs of the community.

Dr. Tanaka who was President of the Oregon State Medical Society made a rather interesting presentation. He said that the Oregon physicians were at first suspicious of this program and that actually it was due to pressure that he had to look into it, there were so many inquiries. And he finally was directed by the Executive Committee of the Oregon State Medical Society to look into this and to attend the site visit to find out just what the Fred Hutchinson Cancer Research Center was all about. He stated that after listening to the sessions that he felt that there would be no conflict with physicians in the State of Oregon, and he believes such a center would prove to be of some value and help to the Northwest.

As to my part that I listened to, there was no question that there is a very favorable and intense public

interest in the establishment of the center with certainly moral and financial obligation from responsible citizens and civic leaders as well as organized labor in Seattle and the Northwest. And as you probably know, in Seattle, you can't do anything without labor supporting you.

The American Cancer Society looks to it hopefully as an educational training center and a means for effective clinical research. The Society has been generous, as I said, in research grants in Seattle, and so there is no reason to doubt that it will continue to support grants for work at the FHCRC.

The relations among the university, the Virginia Mason Hospital, the Medical Societies, and the hospital administrators appear friendly. They are cooperative, and they all will welcome and support the FHCRC.

Again, I say the need was emphasized for a focal point for coordinating basic research and clinical activities. And I believe the site visitors agreed that FHCRC can fill this need with beneficial results to the patient. The linkages will be established between hospitals dealing with cancer research and treatment where none at present exists.

As to organization and administration, the team believed that the plans are sound and will be capably handled. The task force has operated, I felt, in a specially dedicated

and efficient manner. Dr. Hutchinson, I think, is almost revered. He has the highest respect of the community at large and those involved with the development of the concept of the FHCRC.

The judgment, the integrity and the capability of this group of citizens, I felt, is very obvious. It isn't any helter-skelter scheme. It is just unfortunate that there has not been time or money to finalize the plans, but the team believes that with the RMP support, this will be satisfactorily executed.

We will leave our recommendations, I think, until after Dr. Lemon tells you about his part of the program concerning research and patient care.

So,Dr. Lemon, would you continue, please?

DR. LEMON: I would like to emphasize, and one of the things they emphasized for us, was the size of the area which stretches if you place Washington and Alaska across the United States from the northwest corner of the country down into Florida, practically. There are about 7 million people here, and this is a very complex setting from the standpoint of the flow of cancer patients.

I think one of the reasons Mrs. Mars spent so much time on the Virginia Mason is that this is the number two cancer treatment facility after the Swedish Hospital. And one of our concerns was to make sure that number two was

satisfied with their role. And Dr. Willis Taylor will be a continuing member of the board of trustees, of the scientific board.

Now, we had nearly a full day on research in patient care beginning with Dr. Edward Perrin who is chairman of the Department of Biostatistics at the School of Public Health and Community Medicine at the University of Washington. And he emphasized he is very anxious. He has quite a vigorous Ph.D. training program, and he is very anxious to expand the role of his department in research in biostatistics and in training, using the facilities of the Institute.

He provides a very excellent scientific back-up to Dr. Ann Carter who has been the Director of the Washington/Alaska RMP automated tumor registry which is just beginning really to bring forth data. And she showed me some very interesting information on how just in the last year they are getting much more complete biostatistics on cancer mortality back from the -- I think there are 35 cooperating hospitals now in the area. And this would be one of the cornerstones really of the outreach of the Cancer Research Institute which we were very concerned about. And I speak here for Dr. Brennan who can't be with us.

We felt that in this Cancer Institute arising in one of the very strong RMP areas that here was a superb opportunity for development of a facility which really could

provide a great deal of educational and outreach training activity and not just become a sort of an ivory tower for very specialized types of clinical investigation.

Now, the two scientific programs which are commanding the greatest support nationally from the American Cancer Society and the National Cancer Institute are Drs. Hellstrom's, Ingegerd and Eric Hellstrom's immunology program. Dr. Hellstrom was there and very strongly indicated his interest to move lock, stock, and barrel into the new institute when it was ready because his facilities are far from ideal at the University of Washington now, and there is no prospect for any improvement in the situation until after 1976.

Similarly, Dr. Donald Thomas who is heading the very large oncology program which is largely based, but not exclusively based, at the Public Health Service Hospital -- it also covers three other hospitals -- indicated that he might have to move his whole program if the Public Health Service Hospital is closed and there is no room for him at the University Hospital, University of Washington.

Now, at the present funding level, you have to recognize they are a little bit warm under the collar up there because they did put in a request for cancer construction back in 1968, and they were approved, but unfunded. And the award was cut back in half on the basis there wasn't all that amount

of cancer research activity that was going on up there. So they made quite a point of it that the present monies that are research budgets devoted to cancer are about somewhere on the order of $1.3 million between Dr. Thomas and Dr. Hellstrom and the other activities.

Now, one of the points that should be made, Dr. Hutchinson already for the last five years has served a very important catalytic role in bringing in additional cancer research. Starting five years ago, he brought Vernon Riley in and his group from Sloan-Kettering. And that was the next group we saw in the afternoon, the microbiology program, which is a rather large program with about 13 staff members.

Interestingly enough, it is related to the Department of Experimental Animal Medicine, the University of Washington, but not to the Department of Microbiology where Dr. Riley felt he would really prefer to be.

Dr. Riley has brought in Dr. Donald Sparkman who is one of the leaders in amino acid analysis. In one of our site visit activities, we did do something besides sitting in a smoke-filled room. We went out and saw the very fine facilities of the Northwest Research Foundation. I did not go to the kidney area, but I went to the other area, the cancer areas, and these are superbly equipped, superbly planned, on the rather limited space on the grounds of the Swedish Hospital.

So we were able to see, in other words, a great deal of progress had been made since 1968 in actually developing and implementing a program. And this is under the personal leadership of Dr. Hutchinson.

Attesting to this, not only didwe review the first recruit, Dr. Vernon Riley, but a more recent recruit, a young investigator, John Scribner, who brought the carcinogenic programs from the McArdle Laboratories last year because he felt he could see in the present cancer activities of the Northwest Cancer Institute the kind of unfettered basic research freedom that he had been accustomed to at the McArdle and he felt was promising for his work for the future.

Similarly, a Ruth Shearer had moved over from the University of Washington where she had been for 7 years with her molecular biology program just in the last year. And these people spoke very highly of Dr. Hutchinson's recruiting abilities.

And another thing that attests to this, about 50 to 60 percent of Dr. Hellstrom's work is now on human patients. Many of these are patients of Dr. Hutchinson. So that there is a very active cross-reference now between the experimental immunology the Drs. Hellstrom have been working on and the many human cancer patients.

The Swedish Hospital, I might add, has about 1800 new cancer patients a year of whom about 1200 go through their

radiation therapy program.

We also talked to Dr. Russell Ross who is the Associate Dean for Scientific Affairs at the University of Washington about a situation that has not been entirely resolved concerning the granting mechanism. It is in the process of being resolved, we believe. This would depend on the primary basis of the investigator whether he was university based or institute based, the overhead would go to the appropriate location and the grant would go through an appropriate channel. But I would like to emphasize that this has not been spelled out fully in detail. It is covered, I think, adequately in the site visit review.

Then, we talked with Dr. Orliss Wildermuth who is the Director of the Tumor Institute of the Swedish Hospital who, as most of you know, has been a leader in high voltage radiation therapy for more than 20 years. He brought along Dr. Sol Ribkin, one of two chemotherapists who may have added to their program. And they are doing more and more phase two and phase three chemotherapy on a very careful basis to get as much information out of it as possible.

And Dr. Wildermuth made the interesting statement that the Swedish Hospital had plans, and we did not have time to go into this, to develop an accompanying clinical research facility which he felt would be well along before the FHCRC was completed.

And finally, Dr. Donovan Thompson, the Dean of the School of Public Health at the University of Washington, spoke. So that looking at the main criticism that had been given to this area in the past, there had not been enough scientific research going, we felt that with the very wide-ranging activities of Dr. Donald Thomas which encompassed not only a very large program of bone marrow transplantation in advanced terminal leukemia patients, but many other facets of chemotherapy and cancer biology and Dr. Hartmann's large center program which is based at the Children's Orthopedic Hospital which is primarily Children's Hospital, not Orthopedic, these programs would funnel into the new Cancer Institute.

I think I came away with a feeling that they had underestimated their need for beds, they had underestimated their outpatient needs, but we have to remember that the setting of this institute, the space is there for this, it is on the grounds of the largest hospital serving cancer patients with the largest outpatients and referral patients in the State of Washington. In the Swedish Hospital, about 20 percent of the patients there come from outside Seattle. And again, around 5, 6 percent come from Alaska.

I think that pretty much covers what we saw, and I think that we did have some question among ourselves if something happened to Dr. Hutchinson in the next few years, obviously he hs been the person who has worked behind the scenes along

with John Sparkman and the Cancer Task Force to bring about a harmonious collaboration between hospitals who might somehow or other be somewhat jealous of this in private.

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

MRS. MARS: I did go through the kidney center, and it was quite remarkable. It is down in the basement actually of the Eklind Hall, and they have set up a whole training program which is exceptional. This center runs from Monday through Friday, 24 hours a day. And they are training people on home dialysis. This requires 8 hours a day for 3 days of the week, of course, for the rest of the patient's life. But after 6 weeks of training, the patient takes his equipment home to administer treatment to himself. And this treatment will be provided for an average of 70 to 80 new patients each year.

Of course, there is a large financial requirement, but the home treatment does lower the patient cost. And this is some of the literature on it which again I will pass around for anyone who is interested in kidneys. They can look at it. I don't particularly want it back.

MRS. WYCKOFF: How does this relate to the cancer center?

MRS. MARS: Well, there will be cancer, of course, research done on kidney diseases along with it. So they are promoting that.

What I didn't say was that the level of operational support of the center has not as yet been determined. But the present and projected levels of support look as though $300,000 to $650,000 a year of research money will be available to operate the center.

And in addition to this, there is approximately $100,000 a year of community support for the center with the projected intramural and extramural programs planned for the center. So that it seems realistic that we can anticipate that the center will be qualified for a major bloc type grant from the National Cancer Institute.

It is recognized that detailed programming of the activities within the FHCRC has not been carried out and that only sketches, but no preliminary plans, are available for the center.

The final award of construction funds, of course, must be contingent upon satisfactory demonstration to RMPS that there are approved construction plans based on a realistic research of extramural program that has been developed consistent with the needs of the institution.

I felt that the educational potential for the entire region is very noteworthy, and I see no reason to not believe that these will materialize. They are anticipated by those located at great distances, as I spoke of Alaska, as well as in the immediate area.

The team certainly felt that the outreach, the element of an outreach program certain will not be submerged and that FHCRC will fulfill the purposes of a cancer research center.

Now, our recommendations are these, and many of these have already been complied with since the site visit.

They have worked very fast and been very busy little people so the recommendations are as follows:

The site visitors recommend approval of an amount of $5 million with appropriate matching funds as provided by the law to the Fred Hutchinson Cancer Research Center, conditional on the following requirements:

(a) That the Board of Regents or other equivalent administrative body of the University of Washington give official sanction and approval of their relationships with FHCRC as evidenced by an affiliation agreement.

Now, we have a letter here from the University of Washington which says:

"Dear Dr. Hutchinson:

"The University of Washington and its Schools of Medicine and Public Health endorse the goals and objectives of the Fred Hutchinson Cancer Research Center.

"We intend to participate in the use of the facilities of the Center as well as the Center's personnel for cancer education and research. We will provide whatever

support we can to the Center, and endeavor to cooperate with it in all phases of cancer research and education.

"I have seen the draft of an affiliation agreement between the University of Washington and the Fred Hutchinson Cancer Research Center. It has been recommended for approval by the Vice President for Health Affairs, Dr. J. Thomas Grayston, to the Office of the President where it is being processed for presentation to the next meeting of the Board of Regents of the University of Washington. It has my personal endorsement and I recommend its acceptance by the University Board of Regents in February.

"Sincerely yours, Charles E. Gdegaard, President."

So that takes care of that one.

That the Board of Directors of Swedish Hospital give official sanction and approval of the FHCRC and provide and affiliation agreement. We now have a letter from the Swedish Hospital which says:

"Dear Dr. Hutchinson:

"This letter is written to restate our position as regards the relationship of The Swedish Hospital Medical Center to the Fred Hutchinson Cancer Research Center. We clearly understand our facilities will be required by the research center.

"The Swedish Hospital Medical Center is in a position and has the facilities at the present time to make

available such services as will be required to service up to 50 beds in the new research building.

"The Board of Trustees and the medical staff reaffirm their encouragement in the development of the Fred Hutchinson Cancer Research Center and will cooperate to the best of their ability. They appreciate the excellent relationship which has existed up to the present time."

So that takes care of that.

Recommendation (c) that relevant requirements are met including all necessary licenses, clearance, permits, and approvals, where required.

Further, the team recommends that $50,000 be awarded to W/A RMP for the cost of program development and preliminary schematic plans providing that 10 percent of local funds are matched for this phase of planning. At the completion of this phase, RMPS will appoint a technical consultant group to review program and schematic plans for technical sufficiency.

Naturally, they were unable to go ahead in great detail with any plans. And this grant, certainly, if we are going to endorse the center, is very urgent and necessary because they do not have funds in hand. You cannot blame them for not wanting to spend money that has been gathered for research to put it into plans unless such a building is going to materialize. So therefore, if we grant this, I think it

is very essential and very necessary that we do award this $50,000 immediately so that they can go ahead and pursue their plans.

MRS. WYCKOFF: Do you want a motion to that effect?

MRS. MARS: Just a moment, dear. I want to read the letter of Dr. Hutchinson to Dr. Margulies. He says:

"We are sending you a revision of the Administrative composition of the Fred Hutchinson Cancer Research Center. These changes consist of the planning for a Director of Extramural Activities" -- as you will note, we did stress this phase -- Although the activities were listed, the on-site visitors in our discussion on January 25th believed that having an Associate Director who was given a position of authority to develop this activity would develop the type of program the Regional Medical Program had in mind. Our belief is that the development of this Division would give us a unique institution making more readily available information, new concepts, and the latest in cancer know-how, to the local doctors and lay people of this region.

"Since this is a departure from the customary cancer center and since we both believe that this program would have far-reaching benefits and a real impact on cancer in Region #10, we shall ask, in the not too distant future, for support of the Associate Director from the Regional

Medical Program.

"Our arrangements with the University of Washington have been completed and we are in agreement as to our program. We have proceeded with our architects and our Policy Committee will meet February 5th.

"Obviously we cannot proceed with definite architectural plans as we have no funds for doing so, but hopefully we can proceed as soon as we hear from you after February 8."

One of the questions that came up in their plan was the fact that there was a tremendous amount of space allocated for parking. And this upset us because it was spending, I think, $100,000, was it?

DR. LEMON: $350,000.

MRS. MARS: Was it that much?

-- $350,000 on a nice parking area which could be utilized. However, I think at the time in all fairness when this was drawn up, they did not realize that Swedish Hospital was going to expand its parking facilities. And these are in the making at the moment.

What you must understand is that Swedish Hospital is here and this cancer center is going to be right sort of in the center of Swedish Hospital. There will be tunnels underneath the ground which they will be able to bring the linenes and food and etc., right through the tunnels. It is

all one very nice compact little unit there. And this center will be built right smack more or less in the center between Eklind Hall and Swedish Hospital, you see. So the location is superb. There is no question of blocks and blocks to go and miles and miles to go. This is part of more or less this group, this medical group.

DR. OCHSNER: Does Swedish Hospital supply the food service?

MRS. MARS: Yes, they will supply a good many of the housekeeping facilities. And also, they will supply, I believe, the cobalt radiation and that type of thing, would they not?

DR. LEMON: Yes, they would provide the full panoply of medical outpatient and all the specialty services required of cancer patients which really means the dollars that go into the beds of this institution for the care of the patients are greatly facilitated by being set in this particular setting.

MRS. MARS: This really is a terrific setup. It is sort of made to order.

Another thing that my little groupie questioned was what would be done as far as housing facilities for people who had to come with patients from Alaska. And this is being taken care of. There are already moderate housing facilities available which Dr. Thomas has arranged. So that there won't be any problem here. And they will set up, of

course, a social service system to also help with these type of problems.

"Letters from the University of Washington and the Swedish Hospital Medical Center are also included in material that is being sent to you because there seemed to be some questions arise in the site visitors' minds regarding complete cooperation of these institutions."

So those fears are obviously being alleviated.

So I would like to move that we do accept this and delegate the $5 million to the foundation of the Fred Hutchinson Research Cancer Center as a reality with the addendum that $50,000 be awarded to the Washington/Alaska Regional Medical Program for the cost immediately of program development and schematic plans.

DR. PAHL: Thank you, Mrs. Mars.

Before asking for a second, I believe Dr. DeBakey was trying to get a word in.

DR. DeBAKEY: I have some very basic questions I would like to ask about this. First, I haven't seen any application. I am not really prepared to vote on this.

Secondly, I would like to ask some questions in regard to the construction money. Having been one of the prime movers in getting construction money into the Regional Medical Program appropriated for construction purposes, I know the difficulties we had both within getting approval of

the Administration which, of course, didn't approve it and objected to it, and getting it through Congress. We have made a strong effort for a long time to get construction money for the Regional Medical Program. When we did finally get this approved by the congressional committee and congressional appropriation for this purpose, it was done with rather severe stipulations.

These were certainly written into the intent of Congress that these construction monies would be used for a very definite purpose, and that was in the interest of moving the Regional Medical Programs' objectives and only when it was essential to that. And I would like to know whether we have met those intent of Congress in this kind of a proposal.

Since I haven't seen the details of this application or the objective, I have simply heard what Mrs. Mars has said, I am not at all satisfied that these requirements have been met. So I would like to know a little bit more about this before I am prepared to vote.

It is not that I don't want them to have a center, I do, but I think it is important from the standpoint of our responsibility for the intent of Congress in the use of this money to be sure that we have done this.

DR. PAHL: There is an application in hand and can be made available for perusal.

Dr. Merrill, you had your hand up.

DR. MERRILL: Yes. My comments, I think, touch on what Dr. DeBakey had to say. I think if one were to play the role of the devil's advocate in assessing this proposal, one might say that this is going to be a fine physical adjunct to the University of Washington and that the local community certainly has given its approval.

It is stated that a good portion of the proposed facility would presumably be occupied by the oncology program currently run by the University of Washington. And I detect also on the other hand something less than full enthusiasm from the rest of Region X about this.

And then, specifically to Dr. DeBakey's point, I do not see detailed how this hospital is going to serve the interests of the region. What specific plans do they have of coordinating with Oregon and with Alaska?

And I really think that those questions do have to be answered.

DR.PAHL: Yes, Dr. Ochsner.

DR. OCHSNER: There are two things that distressed me. One is that it is obvious from the report that the region has done a fine job in their homework of getting the unanimity of support by all factions, including labor. But because of this, I fear that an institution with only 20 to 50 beds, there is going to be a tremendous demand upon that which they cannot supply. And I am afraid it is going

to be terribly frustrating.

The other thing is a statement that Mrs. Mars made that I don't think she meant. You said there is a good deal of American Cancer Society money now allocated to the region in research. And you said ultimately that would all go to the center.

MRS. MARS: No, not all of it.

DR. OCHSNER: That is what you said.

MRS. MARS: I am sorry if I did.

DR. OCHSNER: I hoped that wouldn't be so.

MRS. MARS: No, there was hope some of these grants may be transferred and would be used.

DR. OCHSNER: I would hope the center wouldn't be the only place in the region in which cancer research could be done.

MRS. MARS: If I did say that, I did not mean it.

DR. OCHSNER: I am sure you did not mean it.

MRS. MARS: No, I did not.

DR. PAHL: Dr. Schreiner.

DR. SCHREINER: I had a question also along the lines of what are the pieces of pie put together. We heard about the parking lot. I was curious about the statement it was going to have a library. I personally think that stack libraries will be obsolete within the lifetime of this Council. And I think we ought to give some attention to

whether there is continuous support to those kinds of static ideas rather than put money into technological development that we know is going to replace them sooner or later.

And I was just wondering what proportion of this is for the library. What kind of a library is envisioned? How are they going to work in the community? Is it going to be just a stack library in another building?

We have the same problem we have with open heart surgery -- every university wants a stack library.

DR. PAHL: Perhaps the site visitors might reply to that.

MRS. MARS: I think it would be a very small section.

What is your impression, Mr. Moore, of the gentleman that presented it?

MR. MOORE: Well, 4,000 feet, gross square feet, of library space, and the auditorium facilities in terms of ~~100~~ 100,000 per 2nd Moore, 3/2/72 gross square feet of facilities, the gentleman presented as a tie-in with the National Library of Medicine with the regional approach. It would be a regional library concept.

DR. DeBAKEY: I think it would be very worthwile for the Council members to hear again or read again the report of Congress Appropriations Committee in regard to this construction money. I know I participated very actively in getting this money and in drawing up the requirements for it. And I feel a sense of responsibility that we use this money

with that objective in mind. And to be frank, I am not at all satisfied that this $5 million given in this way, oriented in this way, meets that objective. And that is really what I am concerned about.

I don't know whether it meets it. That's really what I am saying. I don't know whether it meets it. And I haven't heard anything so far on the basis of what Mrs. Mars has told us to convince me that it does meet it. So I won't be prepared to vote on this on the basis of what I have heard so far.

DR. PAHL: Dr. DeBakey, while staff perhaps gets the appropriate materials which I will identify in a moment for that, I would also like to read a letter into the record which perhaps you haven't received, Mrs. Mars and Dr. Lemon, which just arrived from Dr. Sparkman to Dr. Margulies.

And while I read that, I wonder if some of our staff might get for me so we may read into the record the legislative wording together with the appropriate paragraph in the hearings which builds the record for this money together with the letter which went out to all coordinators from the Administrator of HSMHA relative to the utilization of these funds.

Perhaps Jerry or Bob Chambliss might.

MRS. MARS: I think that will be very helpful.

DR. PAHL: I will wait until I get all the documents.

Meanwhile, I would like to read into the record a letter dated February 3 to Dr. Margulies from Dr. Sparkman because it bears precisely on the points which you raised, Dr. Merrill, and some of the other discussion.

"Dear Harold:

"During the RMP site visit to Seattle regarding the Fred Hutchinson Cancer Research Center, our attention was directed to the need to develop a more aggressive and explicit extramural program if the center is to embody the RMP philosophy and be more than another good research center. While we had such activities in mind as expressed in the description of the Regional Cancer Council on page 117 of the application, we welcomed the emphasis given by the site visit team and with this letter address ourselves to the problem.

"The Regional Cancer Council as described by our Cancer Center Task Force is an instrument to help translate the increased cancer research capability of the center into a greater impact on cancer care in the Northwest. The Regional Cancer Council with broad representation from all five States and with adequate staffing, would help to accomplish the interaction desired between the center and other centers and all areas of the Northwest. Health care needs would be uncovered and resources identified or marshaled to meet them. The many fragmented areas in cancer research, in care, in professional and public education, would benefit

by this coordinated effort. The gathering and display of epidemiologic and ecologic data would be fostered. If possible, the tumor registry of the five States would be merged or their data made compatible for regional utilization and surveillance.

"Progress in the formulation of plans for the Regional Cancer Council has been delayed pending final agreement as to the center as the only applicant for the $5 million RMP cancer center construction funds. This has now been settled. At a meeting of all RMPs involved in the five States on January 7, there was agreement on the Regional Cancer Council concept as an advisory and communicative function for cancer activities in the Northwest.

"We agree with the site visitors that adequate staffing would be necessary for the functioning of this group and accept the recommendation that the staff person in charge should have a responsible role in the center organization and should be housed there. People in institutions in the Northwest have demonstrated a willingness and ability to develop cooperative programs. The availability of cancer center construction funds under the RMP has already stimulated thinking and early planning for a degree of coordination in cancer programs that has not existed before. We are confident this will lead to a more effective regionalization and linkage of cancer efforts than has existed.

"With this letter, we indicate our intent to pursue this extramural part of the center vigorously. The position of the Associate Director for Extramural Program as shown in the attached organization chart is evidence of our recognition of the importance of the position. Assuming the National Advisory Council does in fact support items 4 and 6 of its guidelines of November 1971, regarding the cancer center guidelines, and agrees with the site visitors on the importance of this part of center activity, we plan to request supplemental funds from RMPS as of January 1, 1973, to support necessary staff for the Regional Cancer Council.

"We think it is important to capitalize on the increased interest in the Northwest in a coordinated cancer program which has become manifest during planning. It would be unwise to wait until the center is constructed before inaugurating this effort. Until the center is completed, the staff could be housed in the Washington/Alaska Regional Medical Program offices.

"We hope the application will receive favorable action by the National Advisory Council at its February meeting and welcome the opportunity to answer any questions about the application or the material included in this letter.

"Yours very truly, Dr. Sparkman."

Now, while we are waiting for the other materials, Dr. DeBakey, I would like to read the language in 91-515,

Section B.

"Section 902(f) as amended by striking out 'includes' and inserting 'in lieu thereof' means new construction of facilities for demonstrations, research and training when necessary to carry out Regional Medical Programs."

And I believe we will have to wait for the language which was developed in the record and also the letter from the Administrator to the coordinator which was sent out relative to the utilization of these particular funds.

DR. McPHEDRAN: Dr. Pahl, I just wanted to add a word which I think fits in with what Dr. DeBakey and Dr. Merrill brought up. And that is how it appears to the medical community when they are confronted with a center which selects its patients that it admits according to some precepts about teaching or research. Something which is funded by RMP, but which is by its nature selective in what it takes in is, I think, going to hurt how RMP appears.

I am not putting this very well perhaps, but I have been confronted with such an institution in my own State which selects patients according to their teaching value in a certain discipline. And it earns the disrespect and disfavor, not only of academic doctors like me, but people in practice of medicine. They find it a troublesome kind of institution to deal with. And I don't think that it is a particularly good kind of thing for RMP to support.

Really, I have a concern about this.

MRS. MARS: I think this is one reason Dr. Sparkman did not want to have anything to do with the inner workings of the center once it is established and likewise not to be on the Board of Trustees of it because I think that he felt that this problem could be avoided by his staying off of the board. And still we have representatives of RMP on it.

And on the other question that came up, I think that they already have agreed to add an associate director for extramural programs to assure the administrative development of the center would be in keeping with the spirit and the philosophy of the RMP.

DR. DeBAKEY: I am not concerned about that. You see, almost anything you do in cancer and heart disease and stroke can be in the spirit of the RMP because broadly speaking that is what it is, to advance the cause of it.

MRS. MARS: Well, I think it is actually to carry out the goals, let's say, of the mission of RMP.

DR. DeBAKEY: That is exactly the point. In carrying out the goals,though, I don't know whether it is absolutely essential to build a $5 million building. That is the question I am raising, really. Because in the construction money that we requested, it was stipulated that these monies because of the problems relating to construction particularly in terms of construction facilities, the fact that facility construction

has been virtually abandoned within the last few years, research facilities construction almost are nonexistent any more, here you are going to take $5 million of RMP money to build one building for cancer purposes. And the stipulation is that, or rather the requirement for this money as it was obtained was that it would be only used if that is the only way the goals of the RMP can be achieved. That is the only means by which it can be done. And that was the basis for getting the money under conditions in which it was almost impossible to get construction money. And this is the first time that any construction money was obtained for RMP.

Now, I think you have got to demonstrate within this region that this is the only means by which the goals of RMP can possibly be achieved.

MRS. MARS: I think it is the only means as far as outreach and teaching, education, on cancer that can be achieved.

DR. DeBAKEY: It may well be, but it has not been demonstrated to me.

MRS. MARS: Because of its outreach into Alaska, Montana, and Utah, this truly is the only way that continued cancer teaching, I think, can be achieved.

DR. DeBAKEY: Well, that may be, and I am not questioning that. The reason I am questioning is I don't see the evidence that it is.

MRS. MARS: We have a very extraordinary geographical setup with --

DR. DeBAKEY: Maybe money ought to be put into more communications, better means of communications.

DR. PAHL: Dr. DeBakey, I believe when we are able to array the documents, we will be able to provide you with a better feel for what this evidence is. But until that time, I think Dr. Lemon had his hand up first, and then I think Dr. Komaroff.

DR. LEMON: I would just try to bring out some things from the site visit that may help answer your questions.

In the first place, one of our concerns was this was not related closely enough to the University of Washington which is about 10, 12 minutes' drive halfway across the city of Seattle. So that this is physically remote from the University of Washington.

Secondly, the University of Washhington School of Medicine has had a long policy of working with community hospitals, has very close ties with about 4 or 5 community hospitals, but has not developed close teaching ties as yet with the Swedish Hospital. There is no reason this cannot develop, but this is one of the steps that will develop this.

Thirdly, and I think this is the most important consideration for the construction, there is no place recognized where cancer research as such can be coordinated in

this area. Dr. John Hartman's program based at the Children's Orthopedic Hospital is piloting inter-hospital, multiple doctor cooperation in protocol studies of cancer chemotherapy. Dr. Wildermuth is doing this from the Swedish Hospital. The Virginia Mason people are bringing in cancer chemotherapy into their program, but there is no single focal point. And as the committee saw, Dr. Donald Thomas' program is spread over four hospitals. He is actually running four outpatient departments and trying to coordinate a very large staff of about some 30 professional personnel and trainees out of four hospitals. And he may lose his main base of operations.

Dr. Hellstrom was very explicit he could not expand his activities any further and would like to move closer to patients instead of having to go halfway across Seattle to work with clinical material from Dr. Wildermuth's service at the Swedish Hospital.

I think these are points that must be considered in this.

DR. OCHSNER: Is it necessarily bad these are in different institutions? It seems to me that is a point in favor of it. If you concentrate it in one, then the other institutions that are getting the benefit from it now will lose it.

DR. LEMON: I don't think there is anything in this

plan that will mean that any of the programs that are now going on will be concentrated. In other words, Dr. Hartmann is going to continue his base at the Children's Orthopedic Hospital.

DR. OCHSNER: I thought you said the others were going to move lock, stock, and barrel into the new facility.

DR. LEMON: Dr. Hellstrom would like to move all of his basic research into the institute because he feels he is crowded in the Department of Pathology where he is now. And there is no chance for further expansion.

The other program is Dr. Donald Thomas which is based in scattered facilities chiefly at the Public Health Service Hospital. And no one knows when this will be phased out.

DR. OCHSNER: It would be more convenient for them to work in one institution.

DR. LEMON: Right. And the tumor registry activities that are now going on are scattered. This would allow for bringing together a number of activities into a focus close to a natural regional flow of patients that has been established over the years by the Swedish Hospital.

We were troubled by the problem of how to select the patients for these 10 beds. And we felt that they had to give a lot more thought to this. And I wish Dr. Breannan were here. I wish he had been there during the first day of

the site visit.

I think much of this would be conditioned by the relationships which they have already established and which appear quite effective in the Regional Cancer Council of the physicians in the area knowing what types of particular research activity, especially in the care of advanced leukemics, that the people who will be associated with this cancer center will be undertaking in this small number of beds.

The other thing is I believe that the Swedish Hospital, and again we needed to have this spelled out in more detail, but there is obviously a lot of coordination that will have to be developed with the Swedish Hospital in terms of increasing the care. And as I indicated, they are increasing their plans of continuing care of all types of patients, including radiation, chemotherapy and so forth.

DR. PAHL: Dr. Komaroff I believe wanted to get a word in.

DR. KOMAROFF: Am I correct this $5 million would deplete all construction monies available in this fiscal year? Are there any other regions which have demands on construction monies in this fiscal year and would a similar $5 million be available in fiscal '73?

DR. PAHL: This would deplete all construction funds for this fiscal year.

Secondly,other regions have expressed interest in

these construction funds, but from the documents which we hope to provide you shortly, it will be clear that the funds are limited to the Northwest and with appropriate discussions particularly with the Oregon and Montana State Regional Medical Programs, this has been resolved in the manner which you have heard in the site visitors' reports.

And thirdly, there are no funds for construction in fiscal '73 in the projected budget.

MRS. WYCKOFF: Are there any in that $100 million for cancer?

DR. PAHL: For cancer construction.

MRS. WYCKOFF: Are there any for construction in the $100 million allocated for cancer research?

DR. PAHL: No.

MRS. WYCKOFF: Cancer construction?

DR. PAHL: You are referring to the NIH?

MRS. WYCKOFF: Yes.

DR. PAHL: Yes, but I don't know the level.

MR. VAN WINKLE: Just alterations, I believe.

DR. PAHL: I thought it was for the construction.

DR. EDWARDS: I think there is $16 million allotted this year for construction.

DR. PAHL: Thank you.

DR. EDWARDS: And I think that is expected to just about double next year. There are no construction funds

allowed for it in our RMPS budget, though, in '73.

DR. PAHL: Yes, Dr. Roth.

DR. ROTH: This concerns me a little bit -- a great deal -- in terms of the appropriateness of RMP involvement because in a total oversimplification, it seems to me that the emphasis on research, while I certainly am not against research and wholly in favor of it, the byproduct or the product of research is to develop ever more useful and sophisticated things you can do for cancer patients. And the problem to which RMP was originally addressed, and I think continues to be addressed, is that our incapacity is to do for the many people those useful things we already know how to do on the basis of past research. And I am concerned about RMP supporting a project which greatly facilitates operations, I am sure, for the scientific community in Seattle, the researchers, and has 10 beds, I guess Dr. Lemon said.

MRS. MARS: Twenty, actually.

DR. ROTH: But at any rate, a small sort of experimental clinical unit. And I wonder if construction funds were tagged with the restriction that they could be used by RMP only if this was the last resort on how RMP accomplished its mission. If you took $5 million to really do good for present and future cancer patients in this Northwest area, is this the best thing you can do for them? And I would have to

look at it a lot harder in order to vote on this myself at the present time.

I am totally in favor that this is an excellent area, and I am totally in favor of research,but I am not sure that this is the RMP bag as much as it is the $100 million extended funds that are available through other sources. And I am still sort of jealous about RMP money and what we do with it to further the ends which I think we should have in mind.

DR. PAHL: Perhaps the documentation which has now been placed in front of me will assist.

MRS. MARS: This is a specific award that we didn't really have very much choice about. This was for this specific purpose.

DR. ROTH: If it is for this specific purpose and the Council is being asked to be a rubber stamp on it for somebody else, let's get it on the table.

MRS. MARS: This was specifically for this purpose which was tagged on.

DR. PAHL: Although we don't have the original source documents of the appropriation hearings, I have a letter here which was sent to Dr. Sparkman dated September 27 by Dr. Wilson referring to the legislation and the conference report and the administration's further interpretation of this language.

"Dear Dr. Sparkman:

"We have received a number of inquiries concerning the $5 million construction funds appropriated in 1971. This letter will provide you further information about the availability of these funds.

"Public Law 91-515 first authorized the use of funds for construction in the Regional Medical Program. This legislation, Section 902(f),permits support of 'new construction of facilities for demonstrations, research and training when necessary to carry out Regional Medical Programs.'

"Section 901(a) of the same law limits appropriations for construction as follows: 'Of the sums appropriated under this section for any fiscal year ending after June 30, 1970, not more than $5 million may be made available in any such fiscal year for grants for new construction.'

"Congress appropriated $5 million in 1971 for new construction, and the committee of conference in its report on the appropriation directed that the $5 million be used 'for construction of a regional cancer center in the northwestern part of the United States.' The $5 million appropriated were not released for use in 1971, but have been carried over into fiscal year 1972. It is our intent to locate such a center in the geographic area served by the Department of Health, Education, and Welfare Region X when these funds are apportioned.

"Sincerely yours, Vernon Wilson."

And then further communications to all coordinators from the Office of the Administrator reiterated the geographical limitation of the funds.

DR. DeBAKEY: I would like to come back to the same question now because the question I am raising is not in any way related to whether or not there should be a cancer facility built there. The question I am raising is really concerned with meeting the, I think, important requirement that this facility will promote and in a sense is essential to the cause of RMP. And that is what I want to know. And that is what I don't think has so far been documented at least to my satisfaction.

I think $5 million is a lot of money to put into anything, any activity, and especially one that is going to be in a sense so well constricted as to be concerned primarily with some patient care and research and so on limited to 20 beds. To me, this has some qualities in it that don't indicate that the overall objectives and the primary motivating force that underlies the whole philosophy of RMP are being met. And that is what I want to know.

DR. MILLIKAN: Do you have the legislation?

DR. PAHL: Yes. I was about to read into the record the Senate Committee on Appropriations report on page 24. The relevant paragraph is:

"The Committee understands that the cancer treatment

programs and resources sponsored by the Regional Medical Program and located in the northwestern part of the country are approaching a critical stage in their development. Lacking is such a facility which would serve as a focal point for organizing a system of health care that is acceptable and responsive, but linked to regional resources not available locally. The community has added funds to the bill to expedite the construction of such regional cancer centers, $5 million."

MRS. WYCKOFF: Centers, plural?

DR. PAHL: Dr. Schreiner.

DR. SCHREINER: I think there are several points to be made at once. It will be hard to imagine a better way of getting cancer pulled together in a widely disparate area to provide a place where groups can work together and have communications. I think this part of it is very, very appealing.

I think one could on the other hand also realize that obviously this appropriation is near and dear to Senator Magnuson, and that is one of the reasons it was earmarked. But I think that doesn't get around our responsibilities that Dr. DeBakey has mentioned. And that is to put the RMP coloration, if you will, on the operation of the project.

And there are three aspects of it that bother me -- the parking lot, the library, and the beds.

MRS. MARS: The parking lot has been eliminated entirely.

DR. SCHREINER: I would much rather see empty space built with the idea that cancer funds, NCI funds, could be used later on perhaps to expand these crowded facilities if this thing really works. There is no question in my mind Washington and the Eskimos would be a lot better off with this project than not have this project at all, watching it go down the drain. But I don't think we should let it go.

And I am a little worried that the coordinator thinks he shouldn't be a part of it. This is a terrible indictment, I think, of the planning of the unit.

MRS. MARS: He will be a part in planning of the unit. It is just after it is operational when he would like to --

DR. SCHREINER: That is why he wants to stay away from that because it is a headache. Anybody at the NIH knows it is a headache with all of this protection to keep the clinical center subject to political pressure. What is a local 10-bed or 20-bed unit going to do?

It seems to me you are putting it in a hospital, and the hospital has its now method of admitting patients. And all these fellows really need is housing laboratory space and better communication facilities for their outreach. And I don't see that 10 to 20 beds is a very elemental part of the

RMP message.

MRS. MARS: I don't think that is true because I think to the end that basic research and clinical activities exist, they will be brought together in this and certainly in such a way that clinical investigation will be speeded up and the patient consequently will benefit.

DR. SCHREINER: Well, Mrs. Mars, I worked as a visiting teacher in some cancer wards and cancer hospitals. Some of the worst medicine in the world is practiced in these isolated little enclaves that are in the center of a big hospital, but not in contact with anything real.

MRS. MARS: This is not in the center of a hospital. It is in the center of a medical center.

DR. SCHREINER: If you have a medical center and you have a big hospital, why not put the patients in the hospital? They are there through a tunnel. Why build 10 little beds as an isolated thing? Who is going to service it? Are all these hundreds of people going to come in for all the day-to-day care to these 10 beds? What is going to happen is they will get isolated in time, place, intellectual contact and excellence.

DR. PAHL: Dr. Roth.

DR. ROTH: Well, at the risk of being abrasive about it, if I understand the situation, would I be correct in saying that in essence Congress has mandated the construction

of this cancer unit for about $5 million in the Northwest and really all the discussions of the pros and cons, variations and possibilities, are sort of academic, almost post facto, at this point?

If this Council disapproved by any chance, what would happen to the Northwest Cancer Center and the $5 million?

DR. PAHL: Let me answer part of the question. If the Council does not recommend approval of this request and if no other means are found for providing this money for the construction of such a facility, the funds would lapse and be returned to the Treaasury.

I would like to take the prerogative of the chairman and go off the record for a moment if I might.

(Discussion off the record.)

DR. PAHL: Perhaps we will go on the record again, and I believe Dr. Roth did have his hand up.

DR. ROTH: I had intended to go back on the record and provide a second to Mrs. Mars' motion and then ask for the previous question, but I guess the only thing necessary to do now is to wait until we see the release unless it is appropriate to approve it before we see.

DR. PAHL: Perhaps appropriate, but still not desirable.

Dr. Sloan of our staff has a comment.

DR. SLOAN: I have one little contribution that I

think will be of interest to this Council. There has been interest in developing a cancer center in Seattle for quite a long time. And an application was made to the National Cancer Institute which gave a planning grant to the region to try to help develop one. There was so much fighting between the different groups in the region, so much conflict, so much bitterness, that I think the Cancer Institute was about ready to give up on this effort.

And I have been told by the people in Seattle that the only way this particular application could ever have been developed was to have such a body as the Regional Medical Program coordinate the interests of all the groups in the Seattle region and that they have been able to abridge all kinds of conflicts that seemed completely unresolvable before.

DR. PAHL: Thank you, Dr. Sloan.

If I may indicate in the handout to you, the primary difference in this handout which the site visitors recommended is that under part B, we would recommend that the $50,000 be made available by RMPS to the Washington/Alaska Regional Program without any requirement for additional 10 percent matching funds. This is an insignificant dollar level, and we feel it is inappropriate under the circumstances, particularly those that have developed in subsequent communications following the site visit.

The other important aspect of this draft for action is that it does incorporate under Part A-3 the conditions in the Council's statement which were developed in November relative to this particular proposal and which we understand are still the basic guidelines that the Council wishes to pursue.

Staff feels that this draft would not do violence to what site visitors have recommended and would in a sense be more appropriate for what has to occur within coming months should the Council endorse the proposal.

DR. OCHSNER: Move approval.

DR. MILLIKAN: Second the motion.

DR. PAHL: The motion has been made and seconded to accept the draft statement proposed by staff for awarding the funds to the Fred Hutchinson Cancer Research Center with the contingencies as noted.

Is there further discussion by the Council?

DR. SCHREINER: Is there real sentiment against this, specifically making a statement about the bed portion which I think is the largest bone of contention in my mind? There is nothing wrong with it if they want to put the beds in, Mrs. Mars, let them put it in, but if it is an RMP project and you incur all the wrath of the community as you build a little of each center nobody can get into except with RMP money, it is very bad press for the RMP.

If American Cancer or any big brother wants to add onto our building 50 beds, that is a different situation. Let them go ahead and do it. But why should we abort our traditions? I think we can give the money, but give it in such a way as we indicate our desires.

DR. PAHL: I would speak from staff point of view, to my knowledge, there has not been any particular disturbance on the part of the community, either regionally or nationally, about this particular aspect. I know of none. Perhaps some of the staff have.

Dr. Sloan has a comment.

DR. SLOAN: Dr. Pahl, I believe the intention is to use these beds as demonstration beds.

DR. PAHL: They would be demonstration beds, yes.

DR. SLOAN: And physicians from all the state area would be invited to come there and see a patient with the most modern cancer treatment which they can then hopefully take back and initiate in their own institution.

MRS. MARS: It will be a teaching facility.

DR. PAHL: Yes, I think it is well accepted. The only concern that has been shown throughout has been related to the specificity of the location of the center, but I do not think in terms of the teaching demonstration beds.

DR. McPHEDRAN: The beds I referred to were well accepted before they were built and people tried to use them.

The problem comes afterward when they are there to be used and you can't get your patient in because they don't want to manage this particular kind of problem. That is bad news. And I think it will be bad news for the Regional Medical Program. I think this is a burden of unpopularity that the Regional Medical Program will find it hard to bear. That is my view about it.

DR. SCHREINER: That is the point I was getting at.

DR. McPHEDRAN: The second thing is from the professional point of view, the point Dr. Schreiner makes is a professional one. Small enclaves of 20 or 30 beds, it is very difficult to manage these in a really professional way, I think. And they are far better managed in a larger institution. Subspecialties of medicine who compartmentalize themselves off in little places in your larger institutions, for example, leave themselves, I think, sometimes in a bad way for getting good medical care because they separate themselves too much from other disciplines. They need the input of these other disciplines to do their work well.

DR. PAHL: Of course, it has to be understood once the center is constructed and operating, it will be receiving funds from many sources, and I think the identification with the RMP will not be anywhere near as great as it now is in the planning and development stage.

I think Dr. Sparkman is aware of these considerations

and again, as Mrs. Mars stated, has as one of his concerns this very matter to the extent that he does not wish and feel it appropriate to continue on the board past these initial activities.

MRS. WYCKOFF: Is their reason we didn't get the application that it isn't finalized here?

DR. PAHL: The application, as you may well imagine, has been undergoing rapid changes. And it literally would have been inappropriate to distribute this to those of you who have not been directly involved because there have been supplemental materials and changes and modifications. And it would have been most difficult really to have kept you fully informed as to what the status of negotiations among all the various parties were.

There is an application in hand. It is still from the staff point of view incomplete with what we would have liked to have seen, but it is quite adequate for the purposes of review and continues to be improved and changed as indicated by the letters which have been read into the transcript this morning.

Even with regard to the administrative structure of the center, I would say that we do not wish to have anyone on Council uncomfortable in the sense that the application has not been seen. And if it is the desire of anyone to look at this prior to voting, I think it would be most

appropriate for us to delay action until afternoon or so in order for you to look at it. But it is something that is quite complex to go through if we are in fact to give it the kind of consideration which the site visitors, of course, did give to it.

MRS. MARS: I might say that Swedish Hospital has very extensive plans which they reported to us going on through till 1990 with enlarging their facilities. And I think that probably in the gross allocations of space that a good many, if there is a question of there are not adequate beds for some research project that is being carried on in the Fred Hutchinson Center, undoubtedly some of these patients would be able to overflow into the Swedish Hospital to continue and be incorporated in the research that they are doing. So I think this might relieve some of this question of who is going to get which bed.

DR. OCHSNER: Because of that association and affiliation, why do they need any beds? Why couldn't all the beds be concentrated in the Swedish?

MRS. MARS: Well, because they are not doing too much specialized clinical research there.

DR. OCHSNER: They could if the institute was on the ground.

DR. PAHL: Dr. Lemon, I believe, has a comment on that.

DR. LEMON: I think the interest of the investigators, Dr. Donald Thomas is working with patients who have ingrafted bone marrow in a live virulent type situation so they will need special care facilities. This is the major intent of this small bed unit to provide special type beds which I am sure one would not find in any of the community hospitals at the present time. He has constructed a few make-shifts in the Public Health Hospital.

MRS. MARS: It isn't possible for the hospital to give that space.

DR. SCHREINER: If you have people in a little tower and they get cardiac arrest, what areyou going to do -- call the resident to run through the tunnel and up three flights of steps to treat the cardiac arrest? You just can't mobilize everything you are going to need for a ward that size. It is an impractical situation. The specialty situation for the life islands is great, but why not put it next to a medical ward?

DR. DeBAKEY: Isn't it possible for us to go on record as being in favor of the general objective and principle, but frankly I think there are too many questions raised about the facility itself for this Council, at least certainly for me as a member of this Council, to approve.

On the other hand, I certainly approve the objective and principles of it. And what I would like to see us do is

perhaps just approve the general principles of it and leave these questions to be answered.

DR. MILLIKAN: We have a motion, Mike. It is in front of you. Adjust your glasses.

DR. DeBAKEY: I would be willing to approve this because that does what I have in mind.

DR. MILLIKAN: That gives them the $5 million.

MRS. WYCKOFF: I call for the question and lunch.

DR. PAHL: Perhaps in that order.

Is there further discussion by the Council?

DR. CANNON: Question.

DR. PAHL: All in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

DR. KOMAROFF: Does the motion include about the beds?

MRS. MARS: It is 20 beds at the most.

DR. SCHREINER: I am opposed to that.

DR. OCHSNER: I am opposed to that part, too.

DR. McPHEDRAN: Can we just oppose the beds part?

MRS. WYCKOFF: You have $50,000 to do some designing.

DR. PAHL: If the motion will be withdrawn, I believe then we can again consider whether you would like to add an additional condition or phrase a different motion than

the one that accepts this statement as proposed.

DR. ROTH: I am pleased to withdraw it.

DR. PAHL: The motion has been withdrawn. Is a substitute motion now proposed?

MRS. MARS: Can we hear it?

DR. KOMAROFF: Could it be we add a recommendation C that the planners come back to us with a justification for why those inpatient beds would be isolated from the adjoining patient facility? That would give us flexibility, and they might have a good reason that we haven't been able to think of.

DR. SCHREINER: I think if there is that good a reason they can get support for, I would say we give them the $5 million with stipulation RMP money not be used for construction of isolated beds. And if they want to add some construction money to it, go ahead, that is their business. But we can say there is no RMP money.

DR. PAHL: Dr. Lemon.

DR. LEMON: I hate to keep sticking my neck out, but I would just like to say the two most avid scientific proponents of this, Drs. Hellstrom and Donald Thomas, are working with patients. And certainly Dr. Thomas and his group feel they need to have their patients close to their laboratories for the multiplicity of types of special studies they are doing. We felt very satisfied that they have the expertise and the know-how to plan what they needed there.

I think to put a restriction like this when they have been planning this now for five years is very hazardous.

DR. PAHL: Dr. Roth.

DR. ROTH: There is a distinction between demonstration beds and research beds, is there not?

DR. LEMON: Well, yes, there is. I think one of the strong features to me is that this institute plans to deal with human cancer problems, not just cancer in rats. And this to me makes the setting superb. There are many types of cancer problems that don't need inhouse beds. But there are certain problems, certainly in the care of leukemic patients. And I think if you look across many of the existing cancer institutes, they certainly have special facilities for care of special types of patients.

DR. PAHL: Is there further discussion by the Council with regard to the proposed additional stipulation?

Dr. Merrill.

DR. MERRILL: I would just like to ask a question. It seems to me a good many of the objections that have been raised would be covered if we could be assured there were real teeth in paragraph 8 on page 2. In other words, if there were an on-spot advisory committee to provide periodic review and consultation and if their advice carried some weight and it were followed out. In this way, if it proved these beds were not being utilized correctly, the advisory

committee would so advise, and that advice would have some weight based on actual experience with the center and the utilization of beds.

DR. DeBAKEY: That is the paragraph 9, too, because that really is the key to my concern about that. That is why I am not satisfied.

DR. MARGULIES: We would in any case, as I think you have already understood, not award this grant until these stipulations have been met. Your action is an action of approval. The award of the grant would be delayed certainly until all of these questions had been appropriately answered, and there would in fact be an opportunity to bring the responses back to you at the next meeting before the final award is made.

This doesn't include the $50,000. We are talking about the total grant award for the construction. And quite clearly, there are some questions that have to be explored and some uncertainties that have to be resolved. And I think this would work out much more comfortably. That gives a period of time of several months for us to negotiate.

MRS. MARS: Another site visit should be made as they progress in their plans.

DR. PAHL: The point you make, Mrs. Mars, I think would be indicated under item 1 of the proposed action where the kinds of requirements that are involved in expending

Federal funds involves visits and approvals and so forth.

And I believe also the reason we put in point 3, the conditions of the statement would have to be followed, was to try to get at some of these questions which we felt the more limited site visitors' recommendations implied but didn't explicitly state.

I think we could assure the Council staff would be very observant of all of the discussion and would bring back reports to the Council and exercise close scrutiny over the conditions which are stated in the action if this is taken by Council.

DR. MARGULIES: No matter how this comes out, you should know that no member of the Council or staff will as a consequence be eligible to become a member of the baseball hall of fame. We take a very objective position in this.

DR. OCHSNER: Unless we specifically take some action againstthe inclusion of the beds, they will be included, there is no question about it. And that is a point that I feel once they are included, they are there whether they will be utilized to the greatest advantage or not. It is too late then to do anything about it.

MRS. MARS: You are referring to isolation type?

DR. OCHSNER: Yes. This is the thing I don't like. I think it is wrong to isolate a small group of people from a place where they can get good medical care. As has been

brought out here succinctly before, these people don't get good medical care generally. They get specified care, specific care, but they don't get good general care. Emergencies happen to them just like they do to everyone else, and it ends up they don't get good care.

MRS. WYCKOFF: We should see the application and see what they said about it.

DR. MERRILL: I think we have asked for justification for those beds, and that is one of the contingencies which we will consider at the next meeting, is it not?

DR. MARGULIES: Yes, we could ask not only for justification, but a response to the issue you raised, Dr. Ochsner. It isn't just a matter of sending out two or three lines. We will have to transmit to them the full text of the Council's concern because it is a big issue, and there is $5 million.

DR. PAHL: Well, the chair needs clarification, I think, of the nature of the discussion. It is my understanding that there be an additional point incorporated into the draft, point C, which stipulates that the isolated beds not be included as part of the application until such time as justification is brought before this Council and reconsidered and acted upon favorably. Is that the sense of the Council?

Dr. Komaroff, I believe, raised this as a stipulation, and I would assume is making this as part of the

motion.

Is there a second to that?

DR. SCHREINER: Second.

DR. PAHL: The motion has been made and seconded as an amendment. Any further discussion?

DR. McPHEDRAN: Question.

DR. PAHL: All in favor of the motion as amended, please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

I think we should adjourn for lunch. May we try to reconvene at 1:30, please.

(Whereupon, at 12:50 o'clock p.m., the meeting recessed, to reconvene at 1:30 p.m. the same day.)

AFTERNOON SESSION

(1:45 p.m.)

DR. MARGULIES: I would like to have the meeting come to order again, please.

One of the business items this morning had to do with the outline which Dr. Hinman presented to you of the method of review of kidney proposals which, as he said, will be augmented by an updated guideline statement for kidney proposals. If you find you are ready to do so and would like to accept this at the present time as the procedure which the Council finds satisfactory for kidney review practices, I would appreciate a motion to that effect.

DR. MERRILL: So move.

DR. ROTH: Second.

DR. MARGULIES: It has been moved and seconded the review process outlined for the Council be followed in future kidney proposal reviews. All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

I would also like to bring your attention to item B which has to do with the computer assisted EKG and ask Dr. Hinman to summarize it very briefly for the moment.

What we would like on this is your willingness to endorse or not endorse this as a position paper for staff to

implement. We will let Dr. Hinman describe to you how it was reached and why we have it in your agenda book.

DR. HINMAN: At the August meeting, there was a staff paper presented for your information that had been prepared by our staff, particularly by Dr. Kenneth Gimble on computer assited electrocardiography in the Regional Medical Program service. This paper evinced a considerable amount of discussion both in and without RMPS. And as such we felt it critical to subject it to critical analysis.

There was additional analysis of the literature. There were comments submitted by the affected regions, and we convened a conference here in November of proponents of computer-assisted electrocardiographic progarms to answer the questions that are in the first appendix. It was an all-day meeting chaired by Dr.Scherlis of the review committee. And we took the substance of their comments and looked at them in the light of what we felt were the program needs and in light of the comments of RMPs and what is in the literature and put together this document which you have received in the mail in the call of this meeting.

It is a position paper. And on page 2, it actually lists what it was we were concerned about. But the critical issues are on page 31 through 34. And at this point we have made some conclusions and recommendations.

Basically, that the region should be concerned

with the improvement of cardiovascular services to patients. That should be the first and foremost concern in this area and that one of the adjuncts to improving cardiovascular services might be that the electrocardiographic services should be improved. And if they should be improved, there were a number of methods of improving them, one of which might be a computer-assisted electrocardiographic type of service. But it should be thought of in that sequence and not the other way around.

We were fairly explicit in that we felt that the RMP role should be one of consultation advice, of providing linkages and helping develop systems rather than this pouring of money into technology. And we were very specific, and we did not feel it was an appropriate RMP role to be developing new computer-assisted programs in this area.

It would be our proposal if you will give a general edorsement of this position paper and instruct RMP staff to implement it to convert part of this to a shorter grants management type statement that could be utilized in the region. And we would also distribute the position paper to the regions.

DR. MILLIKAN: I so move.

DR. MERRILL: Second.

DR. MARGULIES: Is there any discussion?

(No response.)

It has been moved and seconded. All in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

I would like to just take one moment to pick up another related issue. You will recall that at the last meeting of the Council, we were asked to start looking at the whole question of advanced technology as it relates to Regional Medical Programs and improved delivery of health services. Events have overtaken that and put it into a much larger arena so that if we were to report to you on plans for an inhouse study, it would be incomplete.

There is at the present time a very large effort in which we are deeply involved and to which Dr. Wilson referred this morning. And this is really a government-wide look at advanced technology as it relates to all of the social systems in contrast with the hardware systems for which much technology has been developed. What is being examined is the kind of effort which has been mounted in the aerospace industry.

What is also being considered are the employment problems which have occurred as investments in that kind of industry have dwindled and as interests are mounting in social problems. And so the look at health and also such things as housing and transportation.

We have been deeply involved with the Office of Science and Technology and also other agencies in the search for some basic concepts and some positions and some proposals which might prove effective.

As the President indicated, there will be a message from his office to Congress regarding the implications of advanced technology in the coming years. And it would be unwise for us to mount a separate and competitive effort under the circumstances. So what we will do is continue to work in that environment and keep you as well informed as we can. And as soon as there is something which emerges of substance, we will talk further with you about it.

I don't know at this point whether this implies new legislation, new budgetary authority and so on, but I rather suspect those are big considerations.

There were some proposals including the one that I mentioned this morning on kidney which are specific and which were transmitted. But there are a wide variety of other activities which are being examined.

As a kind of footnote, I should say among the proposals not being transmitted were a good many we had inaugurate and supported throughout RMP and which this Council decided to hold back on for a period of time. From noplace did anyone initiate the idea that we should go through a wide expansion of what we have had some painful experience with. So at least

we are starting with a higher base of knowledge than we might have had a few years earlier.

I would in this same connection like to have Dr. Hinman make a specific statement about multiphasic health testing as an aspect of this.

DR. HINMAN: First, I went through so fast on the computer system electrocardiography, I forgot to publicly thank Dr. Gimble for the superb effort and the other members of the staff that participated. I thought they did a superb job.

Last spring you all received a report from a subcommittee on automated multiphasic health testing. You took two actions as a result of that.

One, you said there would be no funding of new MHT proposals.

And second, you requested there be an evaluation of what was currently going on.

We are in the process of doing the latter. We are convening the second week of March the participants both of the specific projects supported by RMP money and the evaluation personnel from the regions that have supported these projects in the past in a hope of being able to find some common thread of objectives or some common thread of data by which we can make an intelligent retrospective and prospective in some cases analysis.

As we have gotten into it, we find that what is available to us in the routine reports is inadequate. This is going to be a very painful undertaking to try to after the fact pin together whether the objectives should have been supported to begin with, whether they have been met and so on. We are endeavoring to do so.

This will be a working conference in the second week of March. We are having two consultants participate with us, but it will be basically shirt sleeves of our staff, the regional staff, the project staff and these two consultants. We will keep you informed as we get further information in this area.

MRS. WYCKOFF: I am very glad you are doing this.

DR. MARGULIES: I want to move to some actions which are of importance, some of which are continuations of previous conversations, but which will affect our operations during the next two days and during the next several months. And I will ask Dr. Pahl to take over on this.

The first one has to do with the revision of review responsibility statement which you have before you.

DR. PAHL: We handed out this morning to you a stapled set of sheets, and it is labeled "Review Responsibilities Under the Triennial Review System, Proposed Revision." This is about six sheets of paper. Do you all have that in front of you? We have others here we can hand to you.

I would like to have formal Council endorsement of each of these, but I would like to tell you what these are.

The first one, the review responsibilities under the triennial review system, was a document that Council accepted at its August meeting. And we have found ways to improve this, most of which is editorial, but there are one or two important considerations which we believe will make the management of the program and your purposes in meeting here at Council somewhat an easier task. So I would just like to call your attention to the specific changes.

You will recall that this document delegates to the Director authority to make the funding of award during the second and third years of triennial applications with certain matters being brought back for Council consideration. A specific change which is important is item 1 at the bottom of page 1.

The way it read before and the material in brackets is what was approved by Council last August, and that is to be deleted. And what is underlined represents the new language.

The way the document read before was that any time a region requested funds above what Council had approved for the year in question, we automatically would have to bring it back for your consideration. And, of course, what we are finding with inflation and everything is there is hardly a

region which doesn't request more than what Council had approved. So rather than automatically bring all of these actions back for your consideration, we changed the language to read that the Director, RMPS, has determined, or the review committee has recommended to the Director, that a change in the Council approved level is indicated.

And when such a determination is made by the Director or at the request of the committee to change Council-approved level not based upon what the region requests, we then would bring this back for attention which will reduce the paper flow and I believe be what was intended really in the original document. That is the major change.

DR. MILLIKAN: Up or down or both?

DR. PAHL: I said change, and I meant up or down, both, not just an increase. But if the Director makes a determination that the Council-approved level should be changed, either increased or decreased, or if the Council committee so requests, that would be brought back for consideration.

Under point 2 on page 2, it says a new, and then we would delete "or increased" developmental component is requested. Again, sometimes there are slight changes, and it doesn't seem worth your attention, and the Director has the opportunity to bring back whatever he feels is important.

The rest of the changes which represent the underlying language are editorial and minor, and I would therefore

ask Council's formal endorsement of this revised statement as being an improvement over what we had brought to you and you had accepted.

DR. OCHSNER: I so move.

DR. MILLIKAN: Arabic 1 or the whole thing?

DR. PAHL: This proposed revision of the whole statement

DR. OCHSNER: I move approval.

MR. ROTH: Second.

DR. MARGULIES: It has been moved and seconded for approval of the statement as amended. Is there further discussion?

(No response.)

If not, all in favor please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

It is carried.

I want to just say one thing. A little later during the Council meeting, we will make definite use of this action in restoring funds to regions. As I outlined to you this morning, we have found some cases in which the restoration of funds would bring the program above the current level which has been approved by Council. We will bring these to your attention either today or tomorrow with some comments on what the recommendations are. So we will be following this

procedure as outlined, and you will get a sense of how it functions.

DR.PAHL: Now, the next sheet of paper in that packet is entitled "New Policy of and Delegation of Authority by National Advisory Council on Regional Medical Programs Service Regarding Grants with Triennial Status." This statement includes a policy statement and a delegation of authority, and I would like to first read it for you and then give a slight explanation, have whatever discussion and again request formal acceptance.

Effective this date, the following constitutes new Council policy and delegation of authority which supersedes existing relevant policies/authorities.

Policy

In considering the three-year budget submitted by a REgional Medical Program applicant in a triennial application where the Council recommends support for more than one year, it is understood that the recommended level of support for future years of the approved period shall not be less than the amount recommended for the first year unless otherwise specified.

Perhaps I should stop and explain what that means before reading the delegation of authority.

We have in the triennial applications budgets submitted for the three-year period. And many times because

the applicant cannot foresee exactly what activities will occur in the future years, he is able only to project budgets which total less than what is requested in the first year of support because new activities haven't been really identified and costed out. Council acting on these budgets frequently provides levels which decrease in the future years, but in practical terms in the real world, as we get into the second and third years, the applicant is able to identify projects he wishes to support specifically and comes in with requests, as I mentioned a few minutes ago, that invariably total more than what the approved Council level is.

We feel this is really a bookkeeping problem, doesn't change the real dollars, real actions, of review committee, site visitors and council. And what we are requesting here is an understanding that when Council acts upon the first year of a multi-year budget, two-or three-year budget, it is automatically understood by staff that the second and third years, if support is approved for those periods, will be identical with the first year budget unless Council specifically recommends otherwise. This gives us a margin of flexibility, if you will, in working with the region and a sense of stability in projecting future activities within the region which we all intend, but which in practice we haven't been able to carry out as effectively.

So this is primarily a management problem and

doesn't really change what either the region does in future years or what we are required to do as we see how their budgets develop for future years.

Now, before acting on that portion, I would like to read the second part of the statement which is a delegation of authority to the director, RMPS.

The Council delegates to the Director, RMPS, authority to approve an RMP's programmatic changes during the period of transition from four- to three-cycle review, including new initiatives in keeping with the natural progress of the region, provided that the region submits to the Director a plan covering the interim period and receives approval therefor.

As Dr. Margulies indicated earlier, we have made the decision to move into a three-cycle review pper year rather than the present four-cycle review per year. In doing this, a number of regions -- I have to ask Mr. Gardell, but as I recall it is 52 of the 56 or some such number -- have to be moved forward with additional funds and have starting dates changed and so forth. Technically, it is reasonably complicated.

The programs, of course, will continue on during any administrative change that we make on the review cycle. And in order not to penalize the region in continuing its activities and starting new initiatives as current activities

would naturally phase out, we are asking the Council to delegate to the Director the authority to approve what programmatic changes are necessary for that region to continue the natural progress that it is making. But because we don't wish to have open-ended authority, we are requesting that the region provide to the Director a plan covering this interim period and that the Director provide approval for this plan prior to having the region automatically assume some new directions.

We feel that this is a safeguard, yet will permit us to act in the interim period before being able to come back to you with formal applications.

The policy and the delegation of authority have been incorporated into the same statement. And unless Council desires otherwise, I would request formal acceptance of the statement as proposed. However, we can take it separately if it is desired to do so.

DR. MILLIKAN: I move acceptance of the statement on policy and the statement concerning delegation of the authority to the Director, RMPS.

MR. MILLIKEN: Second.

DR. PAHL: It has been moved and seconded to accept the statement as proposed. Is there any discussion by Council?

MRS. WYCKOFF: I noticed during the first year, we

do invest the money in hardware lots of times. I was just looking at one kidney proposal, and it includes this. But that doesn't alter the fact it goes the other way also?

DR. PAHL: Under this new policy, it is the option of the Council to specifically arrive at another decision for future years if it is indicated. So it doesn't limit your authority.

DR. MARGULIES: I just want to make sure the second part of that is as clearly understood as possible. A number of programs in the process of change will be on 16-month funding, and this may work to their disadvantage unless there is some flexibility in working with them. They may be at the point where they are beginning to develop new programs. If they have to go that long, it isn't going to be fair, and we need to be able to negotiate with them so they can take on increased activities without interrupting the triennial cycle.

DR. PAHL: All in favor of the motion as moved and seconded, please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

Motion is carried.

The next action that we would request you consider is that termed AHEC resolution. This is the Area Health

Education Centers statement which reads:

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

What we are attempting to do here is to have the Council delegate authority to permit us to move ahead in what we consider to be a constructive fashion in implementing the Area Health Education Center program. The applicant would receive funds from the local RMP for feasibility studies, no applicant receiving more than $50,000, and a single region not providing more than $250,000 total for such feasibility studies. And we would be empowered under this resolution to reimburse the local RMP with the funds which they have given to support this activity.

The time limits seem to us to be appropriate and the

amount of $250,000, of course, merely would indicate that five such applicants could be supported under this resolution.

This may not be appropriate. It maybe should be somewhat lesser or somewhat more. We have had interest from regions which indicate that some regions would like to consider feasibility studies for five different groups for the Area Health Education Center program.

Perhaps I might ask if Mr. Peterson has anything to add to this or the explanation which I have given if you would like to comment on it and then open it up for discussion.

MR. PETERSON: Well, I might say two or three things.

It seemed to us based upon the HMO experience which we didn't have directly that there often was a need for a small amount of money and a small period of time really to see whether something was feasible rather than jumping in with both feet into a full-fledged organizational and development phase or AHEC or anything else. That was one of the underlying reasons.

Secondly, in attempting to ascertain what the RMPs, the 56 regions, knew in the way of emergent AHEC activities. I think we got some indications from a number of regions there were many such situations in their own regions collectively. This would allow us to use the RMP mechanism -- that is, we created 56 regions out there -- and to utilize

those regions in helping to launch an AHEC program rather than requiring everything to come into a central HEW operation and the existing grant mechanism we have established with them.

It also would tend, I think, in the short run this fiscal year to alleviate what I call the nickel and dime problem. You can get a lot of applications that are really fairly small, and they help get in the way of taking a much harder look at the big applications for truly organization and development or even some of the operational AHEC proposals that would be sitting out there.

It also would facilitate more rapid implementation in this first year. I think you have covered most of the points as to how it would actually operate.

I think some of the purposes we had in mind in proposing something along this line is that one of the things, going back again to the HMO experience, that people often need is really to buy a little time to see whether they can put an application together. And when one talks about feasibility studies or planning, we are really talking about sort of the political planning. Can they get the key actors in an area? Are they at a point where they would be willing to move ahead with the initial organizational and development phase?

And I think secondly, looking at it from a bureaucratic point of view, and I am a bureaucrat, it would

in a sense possibly tie some AHEC developments more closely to RMPS than someone else perhaps.

DR. PAHL: Thank you.

DR. MARGULIES: In practical terms, also, I am sure you realize at the June meeting, there will be AHEC applications in all stages of development from sort of feasibility or really exploratory approach to a fairly well-developed activity, depending upon the state of readiness. And we would like as much as possible to move events along so that when the June review occurs, there will be as much out of the way as possible to make those applications fairly complete and get as much closer to an occupational activity.

If we aren't able to do this, then we do have a long period of delay with total action at every stage of the AHEC development occurring at the June meeting.

MRS. MARS: It seems to me this should be able to come under developmental component in those regions that do have a developmental component. Certainly in the ones that don't, then they would need some help. But otherwise, it surely is part of core activity and should be part of their developmental component money.

DR. MARGULIES: I think when they have funds available, many of them have already moved in that direction. But most of those with developmental component awards have already outlined their uses for it and have made their

investment. It is rather difficult for them to switch. I am sure some will choose that kind of a course.

DR. PAHL: And those having insufficient developmental funds would then be eligible to apply.

MRS. MARS: Right. So it seems to me some sort of an amendment could be put into that that otherwise they are just all going to automatically ask for it. And usually, there are some left over funds in their developmental component that can be applied.

DR. PAHL: I think we can modify the language.

MRS. MARS: I think it should be modified some way. Otherwise, everybody is just going to rush in for $50,000.

DR.PAHL: All right.

DR. MILLIKAN: Or $250,000.

MRS. MARS: Or $250,000, right.

DR. ROTH: Some of this could also be done under the contract route, could it not?

DR. MARGULIES: Well, it can be, but then that would mean either we would be contracting directly with an AHEC applicant around the RMP or contracting with the RMP which simply complicates the procedure because then we have to go through all of the contract mechanisms, whereas a grant is a simpler, more direct way to act.

DR. ROTH: Move approval.

DR. MILLIKAN: Second the motion.

DR. PAHL: Moved and seconded. Any discussion?

DR. MILLIKAN: What is going to be your advice to the applicants concerning the local ground rules which must be met before you proceed as the directors of such an application? Is RAG going to have to approve it? Is the Executive Committee of RAG going to have to approve it or some associate coordinator slip in a message for $50,000?

DR. MARGULIES: That, unfortunately, is too good a question because it gets back to what we were talking about this morning. The meeting this afternoon, if we get agreement, ison the Area Health Education Center concept. And I will be going up there in a short time to see if we can't reach agreement. We would then have a set of guidelines to which we can add the set of RMP guidelines on how we act.

What is proposed, however, is that the AHEC activities very clearly go through the same kind of review mechanism which we use for other kinds of RMP procedures.

DR. MILLIKAN: That is out in the --

DR. MARGULIES: In the Regional Medical Program, yes.

DR. MILLIKAN: -- in the local.

DR. MARGULIES: I think we should probably add to this motion that this would be guided by the guidelines procedure as application forms and so forth.

DR. DEBAKEY: Isn't that what you have got down here? It says within such general guidelines as RMPS may establish.

DR. MILLIKAN: Or such guidelines that completely obviate the usual ones.

DR. DeBAKEY: I was going to ask whether these principles underlined in the guidelines have been established, but I guess they haven't.

DR. MARGULIES: No.

DR. DeBAKEY: I guess we will just have to leave it that way.

DR. PAHL: Well, the motion with the modifications has been moved and seconded. Is there further discussion?

MR. MILLIKEN: Question.

DR.PAHL: If not, all in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

We will bring back to you a modified statement so you can see the modifications.

DR. DeBAKEY: Can we get the copy of the guidelines as soon as they come out if they are available?

DR. MARGULIES: If you will give us the green light, we will get them to you before you leave town.

DR. PAHL: The last action we would appreciate your considering is the proposed HMO delegation of authority. And this is in reference to what De. Wilson was stating this morning concerning the mechanism by which the funds would

actually be employed from RMPS to initiate an HMO program. And as you will recall, it was indicated that the HMO service would be responsible for the identification and review and approval of applications with funding for this, then from RMPS funds. And what this delegation of authority states then, is that the Council, recognizing the need to contribute expeditiously to the development of Health Maintenance Organizations, hereby delegates to the Director, RMPS, the authority to fund HMO projects in accordance with the recommendations of the Health Maintenance Organization Service.

DR. ROTH: So move.

DR. MILLIKAN: Second.

DR. PAHL: It has been moved and seconded, is there discussion?

(No response.)

If not, all in favor please say, "Aye."

DR. SCHREINER: I would like to ask, aren't we really giving an awful lot?

MRS. WYCKOFF: We are giving $16.2 million.

DR. DeBAKEY: One thing I would like to get clarified about this, because I really am not clear in my mind, as I understand it now, the funding for the HMO will come out of RMPS funds.

DR. MARGULIES: For the planning and development.

DR. DeBAKEY: But the responsibility for spending

that money will not be the Council's.

DR. MARGULIES: That's right. They would be managed by the HMO Service.

DR. DeBAKEY: So the Council is really delegating those monies to somebody else to spend. Is that legal? I guess it is, isn't it? I suppose it is legal. I don't know.

DR. MARGULIES: We have had a look at the legislation which in Section 9-10 allows a fair amount of latitutde. And so far as we can tell, as long as we aren't paying for services under the concept of improving --

DR. DeBAKEY: This is all planning, isn't it?

DR. MARGULIES: Yes.

-- the delivery of services, improving the use of manpower and so forth, it appears to be covered. If it is illegal, we wouldn't do it.

DR. SCHREINER: This is a little different than the other things we have been delegating because there is an opportunity for comeback or review or projections, which is important. Here, you just really pass it through the conduit.

Wouldn't it be a little more honest simply to say the Council feels that the HMO program is not Council business? What we are really saying is this is Council business, but we are passing it on, taking responsibility with no authority whatsoever.

DR. DeBAKEY: I am a little concerned about our responsibility as Council members. That is why I raised the question. I don't want my remarks to be interpreted that I am against HMOs because I am not.

In the first place, the whole concept of HMO is pretty well established and has been for many years. There is nothing new about it. The term itself, particularly, HMO may be a somewhat new term, but the concept is old and has already proven its usefulness.

The idea of expanding this kind of activity, I think, is highly desirable and indeed in some respects was a part of the original concept for the Regional Medical Programs. So it seems to me it is consonant with our general objectives and our general concepts.

But what concerns me about the way this is being done is whether we are really discharging our responsibility. And I am just wondering if it wouldn't be better for us to really indicate that we are for this and if the funds that are needed to carry out these are in this amount that either they be administratively used and in a sense executed for this purpose so that the Council is relieved of that responsibility without our objection. It would be clear that this was done without our objection -- it would be clear this was done without our objection and, indeed, with the sense of our support of the idea -- or that there be in some way

arranged some kind of liaison which this Council delegates to this liaison committee of the Council to work with this organization to do this. In that sense, I would feel a little more secure about the discharge of my responsibility as a Council member.

I am perfectly willing to have sort of an Executive Committee of the Council delegate to that committee of the Council my responsibility. But I am not sure that this doesn't in some way put the Council in the position of not really discharging the responsibility because according to law, we are supposed to make recommendations about the funds that we approve.

DR. SCHREINER: Or conversely, I think we could say we don't think most funds are appropriate for Council.

DR. PAHL: Dr. Roth.

DR. ROTH: Well, in explanation of what I would think will either be a vote in the negative or at the very least an abstention, I would think that we have to recognize here somewhat as we needed to recognize this morning that we aren't really being asked for any advice on this thing. The Administration found a great necessity to develop some kind of a handover, a gimmick, and it came in the form of a set of initials out of Minnesota. They reinvested --

DR. PAHL: Perhaps Dr. Millikan should leave the room.

DR. MILLIKAN: I abstain. Northern Minnesota.

DR. ROTH: Yes, northern Minnesota. And this thing is very difficult to put into the concepts of the Regional Medical Programs no matter how devious one gets. I don't think it makes any difference whether you approve it or disapprove it. This is the way things are going to go.

If an HMO, whatever it turns out to be in practice, has survival value, it will be because it has been soundly managed and well managed. Really, in the competitive American system, it should not be necessary to pour great amounts of Federal subsidy monies into a program of this sort. Kaiser Permanente made it and has been economically successful for years. HIP in New York operates well. There is a good one in the State of Washington. You shouldn't have to spend a lot of money planning and developing these things if they have survival value.

But we are not being asked our opinion on this, and so I think it is academic how you set it up to administratively handle in this department. It doesn't make sense for me to vote against it, and I am certainly not inclined to vote for it. So when the question is raised, I would like to be recorded as an abstention. I think it is academic.

DR. PAHL: Mr. Milliken?

MR. MILLIKEN: No.

DR. PAHL: I believe I find myself in the position

again I would like to go off the record.

(Discussion off the record.)

DR. PAHL: I believe we might go on the record again.

DR. DeBAKEY: I just cannot accept this as a delegation of my responsibility. That is the point I am trying to make. But I think there is a resolution to it, and this is what I am trying to offer.

DR. PAHL: I would like to say certainly RMPS staff would in no way be opposed to an Executive Committee of Council working with the Service. We could certainly take this as the Council's position to the Administrator, and it would be my presumption this would be most acceptable.

DR. DEBAKEY: One more thing I want to say, and I will shut up about this because I have said enough, I believe. But I personally prefer that approach to it because if it is going to be done, and apparently the Administration is desirous of doing this, then I would feel more secure having this done with an organization such as ours having something to do with the way it is done, particularly in terms of the standards that could be set by this organization. The experience and the background of both the staff and the Council of this organization could be very helpful in putting HMOs on a much better basis than they might be otherwise.

MR. MILLIKEN: I would be willing to change my

motion to that effect.

DR. KOMAROFF: Second.

DR. MILLIKAN: To what effect?

MR. MILLIKEN: This be done through the mechanism of a small advisory committee of this Council to work with Dr. Margulies on this delegation.

DR. PAHL: And by my understanding to have such a group work specifically with the review mechanism of the HMO Service.

DR. DeBAKEY: Right.

MR. MILLIKEN: Right.

MRS. WYCKOFF: Can I ask a question? How does this fit into the local RAGs? What kind of a part do they play in the local HMO story?

DR. PAHL: Well, it is difficult for me to say exactly because there has been developed a draft agreement between RMPS and HMOS service which in more than detail spells out RMPS's lack of involvement in the review process, but the utilization of funding and development of quality of care standards. And this draft agreement has been seen, and we believe approved in principle by the Office of the Administrator. But it is not completely set in that it has not actually been initialed by the Administrator.

And so to answer your question, if we were to proceed along that line, it is my understanding that the

applications would proceed through the Regional Office to the HMO Service for review and that there would be opportunity for review and comment by Regional Medical Programs, but there would not actually be a review and approval mechanism at the RAG level. And there would not be in all cases the actual administration of the funds because some of them will be paid by contracts, already have been, and I understand in some cases will continue to be paid by contract. So that RAG would not be involved in the same way as they are with projects under the RMP system.

MRS. WYCKOFF: Would CHP be involved in the same way?

DR. PAHL: In a review and comment procedure, I believe, Mr. Milliken?

MR. MILLIKEN: Right.

DR. HINMAN: The idea behind this, as I understand it, was the CHP agencies would have the basic responsibility for review, comment, and approval, and that RMP, the local RMP, would serve as professional advisors to the CHP at the request of the CHP.

In many of the areas, there is interlocking RAG membership and CHP Advisory Committee membership so there would not necessarily have to be a specific request to the region, but the local regional staff, the RAG members, would be utilized in the professional technical review here.

Part of the problem, of course, is the magnitude of the purely fiscal areas, the marketing strategy, the actuarial development, that is not something with which we here at headquarters have a competence in necessarily nor do our regions have a large competence in this area.

DR. KOMAROFF: Can Regional Medical Program grant funds be spent without the approval of local advisory groups?

DR. DeBAKEY: The local advisory groups?

DR. KOMAROFF: Without the approval of Regional Advisory Groups.

DR. MILLIKAN: Planning funds, yes, feasibility funds.

DR. HINMAN: The dollar amount of any one individual application is limited, as I recall. Is the 75 the upper limit?

DR. DeBAKEY: Fifty is what it says here.

DR. HINMAN: We are not talking about Area Health Education, but HMOs. It is not an inordinate sum in any particular. It is a limited dollar we are talking about. And it is a feasibility planning or development type of dollar rather than an operational dollar.

DR. PAHL: I am sorry, we had hoped to have Mr. Riso here this morning to specifically discuss the status of the HMO program. And apparently he was unable to make it. So we are not able to provide you all the answers that you

deserve. But if he is available,we can get him here later this afternoon or tomorrow.

There was a motion made and seconded.

DR. MILLIKAN: Would you read the amendment?

DR. PAHL: Perhaps it might be easier, Dr. DeBakey, if you would like to phrase a concise statement which would embody the discussion.

DR. DeBAKEY: I suggested the concept that we discharge our responsibility relating to this question of funding the HMOs -- and as I understand it, it was primarily funding feasibility studies -- by delegating our responsibility in this regard to a committee of the Council for this specific purpose to work with the HMO organization service.

Now, there was an amendment. What was the amendment?

MR. MILLIKEN: That was it.

DR. DeBAKEY: That was my suggestion of the concept.

MRS. MARS: Actually, it is almost a new motion in itself, really.

DR. PAHL: Yes, I think the chair would accept this as a new motion.

DR. DeBAKEY: Then, if you withdraw, I will propose this as a motion.

MR. MILLIKEN: I will withdraw.

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

DR. OCHSNER: Second.

DR. PAHL: Is there further discussion?

DR. KOMAROFF: What would the subcommittee of Council do if it was clear the advisory group in fact opposed an HMO proposal that was being submitted for proposal with RMPS money?

DR. DeBAKEY: It wouldn't get the money. If they had our delegated responsibility and they opposed it, then they would have to find some other money to fund that, I think.

The Secretary, I think, has a loophole there, but I think it has to go to him.

DR. MILLIKAN: Are you talking about delegating our responsibility to grant the money?

DR. DeBAKEY: Yes, but also to work with them.

DR. MILLIKAN: No, but about the money.

DR. DeBAKEY: Definitely, sure. That is the responsibility I am talking about.

DR. PAHL: Now, the problem which is posed for staff is that we can accept this as a Council motion and present it to the Administration to see how best to implement it. But I cannot commit the HMO Service and Administrator as to what action he might feel is desirable. So perhaps what we should do is take this as a motion, vote on it and transmit it if possible during the time that you are here to the Administrator which would seem to me to be appropriate in view of the interest and time limits and so forth, this fiscal

year.

DR. DeBAKEY: There are other ways. The Administration, if they want to do this, can do it by other means. This doesn't in any way exclude them from being able to achieve the purpose they have in mind.

DR. PAHL: You are quite right, Dr. DeBakey.

DR. HINMAN: Part of the reason Dr. Margulies and Dr. Pahl developed this and suggested it be accepted is to time the expenditure of funds so that the local RMP would have the maximum possible development to try to keep it within the local region.

DR. DeBAKEY: I am all for that.

DR.HINMAN: This is why we feel the grant mechanism is better than the alternatives.

DR. DeBAKEY: That is right. I agree with that, too.

DR. PAHL: I hope we would accomplish what the Council intends.

DR. DeBAKEY: I don't see why this can't be done this way. Maybe there are some administrative things, but I don't see it.

MR. MILLIKEN: One question for clarity. Dr. DeBakey made his motion, and I understand it to say this committee would work with the HMO people, or wouldn't it be better through staff of RMP?

DR. DeBAKEY: You would almost have to work through staff of this organization and that organization. Isn't that right?

DR. MILLIKAN: That is not what the motion said.

DR. PAHL: That is where I have my problem because it is working with the HMO Service, and I can't commit another program and so forth.

DR. DeBAKEY: I didn't intend for that. I meant when I said the committee of the Council, I intended for it to mean representing the Council and working with our RMP organization and the Administrator, Dr. Margulies, the Director of the RMP. I think it is essential.

DR. MILLIKAN: The national RMP staff.

DR. DeBAKEY: Yes.

DR. MILLIKAN: That is quite different.

DR. DeBAKEY: But that is exactly what I meant.

MR. MILLIKEN: Do you need an amendment for that?

DR. PAHL: No. I think we have the sense of this, and as I say, I don't believe there is any reason from Dr. Margulies' and my point of view -- This is most acceptable. There are other alternatives, and you have given us a compromise position which seems to be a good one. And we will take this to the attention of the Administrator so he would perhaps even during Council time see whether there are any problems which he might wish to address while you are here.

With that discussion, since we have a motion which has been made and seconded, may I have an expression of all those in favor? Please raise your hands.

(Hands were raised.)

All opposed?

Three opposed.

(Drs. Schreiner, Roth, and Millikan.)

Any abstentions?

(No response.)

All right, the motion is carried.

Now, I think perhaps we might turn to something else. Coffee time, I am told. And perhaps that is the best thing to turn to. And then after that, we will have a little presentation which I think will be of interest and value to you about civil rights and what we are doing in this area and hope to do with the Regional Medical Programs.

Let's break for coffee, then, and try to reconvene just a few minutes before 3. That will give us 15 minutes.

(Whereupon, a recess was taken.)

DR. PAHL: Now that we are all refreshed, may we return to Council business?

We have an item which I think is most important on our agenda which we would like to bring to you at this time. Mr. Baum is handing out to you some mustard-colored folders which have in them a number of documents which we are

not asking you to look at at this period, but to take with you and at your leisure now or after Council back home to look at these. Because these materials in here have to do with HEW and civil rights and various materials which Mr. Clanton will describe to you.

Now, the reason we are bringing this to you at this time is that on the left-hand side of the packet there is a paragraph developed by the review committee requesting that Council establish a policy and instruct the review committee and others to certain interests in the civil rights area. And rather than take more of Mr. Clanton's time, I would like to turn this over to him and say that he is going to try to indicate to you what is in the packet, what we are as an RMPS staff attempting to do and planning to do in the coming months relative to looking at problems related to civil rights compliance and minority employment and so forth in the Regional Medical Programs. And following that, whatever discussion you would like to engage in would be appreciated.

And then we would like to have a response to the request by the review committee for some instruction from Council relative to their interest in this regard.

Mr. Clanton is our Deputy Equal Employment Opportunity Officer in RMPS and as such works with all units of the headquarters and reaching out into Regional Medical Programs. It is relative to affirmative action plans and minority

employment and interests in the civil rights area. And I have asked him to take about 10 minutes to describe to you or give you a perspective and also to call on Mr. Chambliss who is the Director of our Operations Division to add whatever additional comment he might like before we open it up for general discussion and action on the review committee's request.

Dick.

MR. CLANTON: Thank you, Dr. Pahl.

I would like to begin by having you look at the folder that we passed out to you so that we can begin to describe to you some of the material that you have received. The intent of handing this to you is to give you some background as to how the Department is involved in the area of civil rights, specifically the Office of Civil Rights, at the Department of HEW.

The first pamphlet outlines the duties of the Office of Civil Rights as it goes about its business in implementing Title VI of the Civil Rights Act of 1964. It is thepamphlet entitled HEW and Civil Rights.

We have also given you copies of P.L. 88-352. This is the Civil Rights Act of 1964.

In addition, we have given you the implementing regulations to the Act following that and the amendments to those regulations.

Now, on the left-hand side -- these were all on the right -- you will find instructions for the HEW Form 441. You will also find a copy of the form itself, the HEW 441.

The 441 is a form that is signed; it is the assurance form. It is the form that is signed by all grantee institutions, grantee agencies, indicating that they will comply with the Civil Rights Act of 1964 in whatever aspect their program might be related to it.

You also have received a copy of the transcript, a quote from the transcript, of the review committee meeting which requests that Council establish a policy.

Just briefly, the EEO office of the Regional Medical Programs has been recently reorganized and has expanded its scope and its duties to include minority interests within the RMPs, to include a review of the RMPs as regards their minority participation.

As we look at the data which is available to us at this point, we are extremely concerned that the profile of regions nationwide does not truly reflect the interests of minorities and of women throughout the nation. Along those lines, we have developed some procedures, we are beginning to develop some activities, which we think will improve communications with these regions and will improve the total stature and profile of these regions as regards minority interests.

The first of these activities is the organization of

what we call the Regional Minority and Women's Interests Committee. This is a committee which will be composed of staff which will be charged with the responsibility of looking at or identifying those regions which we consider high priority in terms of minority and women's participation on their core staffs, on their Regional Advisory Groups on their local advisory groups, etc.

Following the identification of these regions, the intent is to have this committee make recommendations to the director, RMPS, for assisting these regions in improving their profiles.

Another of the activities that the EEO office hopes to become involved with is the review of applications with specific interest towards the Form 7X which speaks to minority participation again on core staff and on the Regional Advisory Groups. We hope to be working with the Division of Operations and Development in this regard.

Finally, I would call your attention to the Regional Medical Programs Service affirmative action plan, a book which has been developed by staff and which has the endorsement of the Director of the Regional Medical Programs and which contains guidelines for a positive affirmative action plan here in the Regional Medical Program Service. You do not have this. I would be glad to provide you with copies if you like.

In addition to guidelines for positive affirmative

action plan here, Rockville headquarters, it also speaks to affirmative action plans in the 56 RMPs. I would like to read to you three objectives that may be found on page 40 of this book.

Number one, equal employment opportunities will be ensured in each of the RMPs.

Number two, minorities, women and consumer groups, will be represented on and involved in Regional Advisory Groups, other related committees, and local advisory groups where appropriate.

And number three, the needs of all the people in the areas served by the RMP will be the primary focus of programs sponsored by the RMP.

So you see we have the mandate for attempting to assist regions in affirmative action programs, and we would hope to proceed along the lines of assistance, indicating as we go those regions where we feel that they are extremely deficient in working with all in the final analysis.

Bob.

DR. PAHL: Thank you, Dick.

Bob, would you like to make any comment at all from the Division of Operations' point of view?

MR. CHAMBLISS: I would only add very briefly that the committee structure will work in the Division of Operations, and each of the desks will be asked to have

representatives to that committee so that we can assist the regions in improving their profile along this line.

I might add one other thing that back last March, there was a retreat of the staff having to do with these activities. And if you will recall, sometime ago, we attempted to bring you up to date on the proceeds of that conference.

Thank you.

DR. PAHL: Thank you.

I also would like to ask Mr. Gardell without any great prior notification as to whether he might wish to make a statement more for the record, for Council, as to what is required from his office in terms of the grantee signing the appropriate documents to be in compliance with civil rights requirements just so that we have that as a backdrop for further discussion that may proceed.

Jerry, would you make a short statement, please?

MR. GARDELL: Yes, I would be glad to.

We follow the requirements of the Department, and the Department gives us a listing of all of the programs that are in compliance and also whether there are any complaints as to their being questionably in compliance. We follow these before we make our awards. And we know whether or not funds can be made available to them.

If any organization is not to receive any funds until a complaint is resolved, we are informed, and the award

cannot go. We have no such programs to date, but we have many problems.

I think what Mr. Clanton is speaking to here is our interest is trying to provide for greater equal opportunities within our RMPs, whether or not they be separate and apart from another organization which might be the grantee which is the majority in some instances. However, we work very closely with the Department on this, and our HSMHA marching orders are to accept and come from the Department, but we can go further programmatically which is what we are talking about.

DR. PAHL: Thank you.

Dr. Schreiner.

DR. SCHREINER: Just by way of information, Bob, have you been able looking at these profiles now to establish any patterns of noncompliance?

MR. CHAMBLISS: We cannot say we can establish any pattern, but certainly we do not see as yet affirmative action programs taking hold in all of the regions. As we have begun to use the new criteria, we have set in play a new kind of dialogue, a new kind of question, and we note that some of the regions are beginning to respond with regard to the criteria. We think that this data will be coming in and this committee will be looking at the forms in the applications. And then we can tabulate from that what kinds of changes are taking place.

MR. CLANTON: I might add to that as of November 24 of 1971, the program planning and evaluation staff developed a document which provides statistical data relating to profiles across the country and which includes some very enlightening information. It is this data that I mentioned and that I was thinking of when I spoke to data that we would be using earlier. This data does exist.

DR. SCHREINER: I was trying to get some feel for information as to whether you can --

DR. DeBAKEY: Is that available?

DR. PAHL: Yes. These have been sent out, but I think it would be well if staff made sure we have copies today to distribute to you. Because they may well have gotten lost or misplaced or just not read from last November on. And I think it is pertinent.

We will be bringing you reports from time to time about our progress in this area, and I want to emphasize that this particular item on the agenda originated from the review committee's very sincere effort in first establishing that our regions were in compliance with the law relative to the civil rights legislation. And as Mr. Gardell has indicated, we in fact do not make grant awards unless we have been so notified by the Department that the grantee institution is in compliance.

So we are not discussing the question of legality

of grant funding. We are talking about what it is that we as a staff and together with our regional groups can do to move forward in the area of proper implementation of the spirit of the law and the request which comes to you. And I would like to now direct Council's attention to this specific request.

The request that comes to you from committee is based in that type of framework, not the legality, but in terms of implementation of the spirit of what we are all trying to accomplish. And the meaningful part of that request is in the last few lines where basically the review committee would like to have a statement from Council to the effect that where there is some question or some indication that full compliance by the region for whatever reasons there are has not or is not occurring that then an appropriate request could be made by the review committee or Council or site visitors for further investigation in a constructive sense by staff and departmental personnel. And I believe that this sets the stage for any discussion that you might like to have on this point.

And I am sure Mr. Clanton and Mr. Chambliss will be willing to answer what our plans are for acting in a constructive fashion in this whole area. Is this discussion on any of the topics raised?

MRS. WYCKOFF: I notice in these documents that the

language does not use the phrase women and that you used the phrase women. Is this one of these little pieces of spirit you are referring to?

(Laughter.)

DR. PAHL: Dick is now bearing the heat.

MRS. WYCKOFF: Is this part of the spirit of the law?

MR. CLANTON: I might respond and say women are now included. The form may not have been reviewed or may not have been, but women are certainly included.

MRS. WYCKOFF: My goodness, I want to announce a great breakthrough. Thursday night, I am spending the night at the University Club of Chicago. I do not have to go through the tradesman's entrance.

(Laughter.)

DR. PAHL: Dr. McPhedran, you seem to indicate you might have something to say.

DR. McPHEDRAN: I would certainly support this. It seems to me that we have all of us had the unhappy experience of expecting that these issues of minority rights will be taken care of satisfactorily if we all say, "Yes, yes, we believe in them, we agree with them." And then we think that they will take care of themselves automatically. But I think that that is not the case; that they won't be taken care of unless we aim at them directly. And I think this is a step in

the right direction, doing that.

I think we need some of these things pointed out to us. So I would support the purpose of this, heartily support it. And I hope that I haven't tried to rephrase what is said here, but I would support everything that there is in here.

DR. PAHL: It would be quite easy to just put this in a direct statement if this were the Council's interest.

Is there further discussion?

DR. DeBAKEY: I would like to so move.

DR. WATKINS: Just one thing. I would like to see reasonable and adequate representation. For example, in some of the RMPs where there are 65 people, because the country has a 10 percent black population, there are usually 6 blacks, and that particular area might be 75 percent blacks and 25 whites. So I would like to see reasonable and adequate placed in there.

Of course, in this case, the women would have 51 percent, but if you would put that in, it might help some of these areas so that on the upper level, the executive level, there won't be only one black out of 20 and in the lower level there won't be -- in other words, the clerical level -- just 6 minorities, blacks, Puerto Ricans, Chicanos, 6 out of a possible 65.

DR. PAHL: I would merely state this is what staff

understands to be not only our own interest, but that of Council and the review committee. So as we develop our procedures, I think all the proper considerations which you have just referred to and others will be introduced, and we will have a report back to you at subsequent Council meetings as to how we are progressing on this.

I think a motion was made.

DR. MILLIKAN: Second.

DR. PAHL: A motion has been made and seconded. Any further discussion by Council?

(No response.)

If not, all in favor of adopting this request as a policy statement by Council in appropriately phrased language please say, "Aye."

(Chorus of ayes.)

Motion is carried.

I believe at this point, we might turn to applications and try our hand at reviewing.

Pardon me, Dr. DeBakey.

DR. DeBAKEY: I was going to ask if we ever confirmed the future meeting dates. Some reference was made to them. I don't know anything more about it.

DR. PAHL: Is there a reason? If it is all right, we would like to defer that until tomorrow morning. Is that appropriate?

DR. DeBAKEY: It doesn't matter, you can send it to me. I won't be here tomorrow.

DR. PAHL: Why don't we just do it now. I am not certain why we should delay because there will be people who are not here.

Ken, why don't you come up to the table with an oversized calendar and let's see if we can't determine what Council would like to do.

Why don't you take over and do it, then?

MR. BAUM: All right. The reason we didn't have suggested dates at this point was because there have been so many staff discussions up to the last minute about the new three-cycle review that we weren't quite sure what week and which month we are to have them except that we may as well operate on having a March, June, October cycle, right, Jerry?

MR. GARDELL: February.

DR. PAHL: Let us confirm the June dates first which I believe we confirmed by telephone.

MR. BAUM: It is June 5 and 6.

DR. PAHL: It is June 5 and 6.

MR. BAUM: Then, we need an October date. And we usually meet on Tuesday and Wednesday. And in order to keep the Council cycles roughly 16 weeks apart in the three-cycle period, they would have to come either in the

first week of the month or at the latest in the second week of the month.

The dates for the first week of October are October 3 and 4.

DR. DeBAKEY: That is in the middle of the American College of Surgeons meeting. Some of us couldn't make that.

MR. BAUM: O.K., 10, 11.

DR. MERRILL: That is the International Society of Nephrology.

MR. BAUM: Then, we are going to have problems.

DR. PAHL: We would like to determine within the first two-week period of the month what would be the most appropriate time for Council meeting, recognizing that this has potentially absenteeism because of meetings. But if we can arrange it, because otherwise we get bunched up in terms of the work that the staff has to accomplish subsequent to Council. And if you will recall from Dr. Margulies' remarks this morning, one of the primary considerations in going into a three-cycle review was to give to the regions additional time after Council meetings for them to revise their budgets accordingly. And if we move Council up too far, we defeat part of the purpose.

So recognizing the conflicts, I think we would like to consider what is appropriate within the first two weeks period of October and see where we stand.

MRS. MARS: Does it have to be a Tuesday and Wednesday? Could we do a Friday and Saturday or something of that sort?

DR. PAHL: The dates are completely open, subject to Council's indication of interest.

MR. BAUM: 4, 5, 6 give anybody any conflicts?

DR. DeBAKEY: What about the 13th and 14th? That is Friday and Saturday.

DR. SCHREINER: That is the International Congress of Nephrology.

DR. DeBAKEY: Saturday, too?

MR. BAUM: How about 9, 10, 11? 9 is the holiday.

DR. SCHREINER: What is wrong with the 4th, 5th, and 6th?

MR. BAUM: The problem is it will compress against the next cycle. In setting these meetings up, if we are going to have a three-cycle a year and we are moving up to June right now, you can't have a Council meeting at the end of June because of the time compression that comes in at the end of the fiscal year.

DR. DeBAKEY: What about the 16th and 17th? It is a Monday and Tuesday.

MR. BAUM: If it is fine with everybody, we can do it.

DR. PAHL: Please, if people have something to say -- Mrs. Silsbee is vigorously shaking her head -- we might as well

fine out.

MRS. SILSBEE: I understand the June Council was to cover the next fiscal year. So the fact that it is any time in June wouldn't make any difference. So I would think you have to --

MRS. MARS: We are talking about October.

MRS. SILSBEE: I know, but you have to come back from June.

DR. DeBAKEY: Haven't you already committed June?

DR. PAHL: It was determined on the basis of availability of people by questionnaire. And it turns out as to when the Council can meet, it wasn't determined on --

DR. DeBAKEY: Would the 16th and 17th -- that is a Monday and Tuesday -- push it off beyond that?

DR. PAHL: Can you manage the 16th and 17th appropriately?

DR. SCHREINER: Not for me.

DR. DeBAKEY: You won't be back from nephrology?

DR. MERRILL: He is going to Hong Kong.

DR. DeBAKEY: Well, he will be gone six weeks.

DR. PAHL: Are there other conflicts in the 16th and 17th?

DR. SCHREINER: I can take the 20th.

DR. PAHL: I am afraid that pushes us too far, Dr. Schreiner.

Does staff have any problems with the 16th and 17th in any serious fashion?

MRS. MARS: That is a Monday and Tuesday.

DR. PAHL: Since there is no serious disturbance, let's set the October meeting for the 16th and 17th, Monday and Tuesday.

And now Ken will smoothly organize the February meeting.

MR. BAUM: All right, let's go on to February. February 1973 starts on a Thursday. How about the 6th and 7th of February? That is a Tuesday and a Wednesday.

MRS. KYTTLE: Could you correlate your dates, please, Ken? The first of the month is awfully tough. At least toward the end of the second week.

MR. BAUM: Shall we hold off on the February meeting until we get Dr. DeBakey's availability and consider the February one tomorrow after we are able to get some calendars distributed around?

DR. DeBAKEY: I am off in '73, so you don't have to worry about my availability.

DR. SCHREINER: How about the 6th and 7th?

MR. BAUM: That is a Tuesday, 7 and 8.

MRS. MARS: 7 is no good for me.

MR. BAUM: 8 and 9, that is a Thursday and Friday.

MRS. MARS: I would rather do the next week

preferably.

DR. PAHL: Let me suggest the following: We have the immediate one, and let us get calendars for '73. I think it is very hard for people to think of this and not blocking out their time. And tomorrow morning in a few minutes after you have had a chance to think about your meeting responsibilities and so forth, we can set the February and hopefully the June Council meeting so you will have the year set on your calendars. Is that satisfactory with Council?

Let's just accept the June 5 and 6 and October 16 and 17. And then tomorrow after you have had a chance to look at the calendar and think a little bit about it, we will set February and June.

MRS. MARS: Preferably not the week of the 7th.

DR. PAHL: All right, thank you, Ken, we are in good shape on that.

Is there any other business that needs to be attended to prior to looking at applications? Does anyone have anything?

(No response.)

If not, let me see. Perhaps we should turn to the Greater Delaware Valley Application. Dr. DeBakey will be gone tomorrow and Dr. Watkins is principal reviewer and Dr. DeBakey backup reviewer.

Bob, would you come up to the table, please, and

help guide the discussion as we go along?

Dr. Watkins, would you like to lead off, please?

DR. WATKINS: December 15 through 17, we site visited the GDV RMP. Dr. Joseph Hess, Dr. William Thurman, Dr. John Mitchell, Miss Marjory Keenan, registered nurse, and myself were present. Dr. Hess was the chairman.

The RMPS staff included Dr. Hinman, Mr. Peterson, Mr. Spencer Colburn and Mr. Clyde Couchman.

This site visit was in response to a triennial application from GDV RMP requesting continued support of 7 projects and renewal of core and 8 projects, activation of one previously approved but unfunded, and initiation of 5 new projects, and a developmental component.

We discovered that they had a problem, especially in terms of their board, but I will get into that immediately.

There was a small core feasibility study meeting some short-term objectives. However, as long as priorities are not well established, it was difficult to determine the success of the program in moving toward achievement of long-term goals.

The accomplishments of this program -- the site visitors were impressed by the activities relative to peer review, continuing education, and manpower problem. In this area, the program is considered to be innovative and unique and should be complimented. However, coordination,

monitoring, and evaluation of these activities needed to be substantially improved.

In terms of continued support of 16 projects presently ongoing, only one was being discontinued and a phase-out over a two-year period of five training projects is proposed. At a minimum, some of the coronary care training activities should now be self-supporting.

In terms of their minority interest, we discovered, and this was one of their problems, too, here in Philadelphia were large pockets of underserved minority populations where the priority representation in terms of minority was questionable There was lack of active participation of minority representatives in the decision-making process within the professional ranks of the GDV RMP. Presence and active participation, we feel, is necessary to influence policy.

The coordinator, Dr. Wollmann, has been functioning in this capacity only four months. He does not have a strong RAG to back him, and several key staff vacancies exist, which predate his appointment.

However, we felt that the lack of time or input -- in other words, the four months -- was not a good enough excuse for the lack of dynamism.

As mentioned earlier, the program direction and thrust of GDVRMP is shifting from the categorical to broader health care delivery emphasis. The members of core staff,

board of directors, and others concerned all accepted the shift.

However, in the core staff, there were several vacancies. The central core staff reflects a rather narrow range of competencies and disciplines. The principal reason for this is that there are three of the five senior level positions vacant and a fourth will become vacant shortly.

These key vacancies are -- and these are important: the Associate Director for Planning and Evaluation.

The Assistant Director for Communications and Information.

The Assistant Director for Program Development and Operation.

All vacancies have existed for over a year, and then Dr. Close is retiring as of January 1 which will create another.

Some feel that because of the lack of longevity on the part of Dr. Wollmann, there was not enough time for them to fill these vacancies. The site visitors were under the impression Dr. Wollmann may not be pursuing recruitment for these key vacancies as vigorously as the situation warrants.

The area component of the central core was fully staffed. The institutional components, unlike central core staff, show only two senior vacancies, one at Hahneman and the other at Temple.

The reason I am giving you this background is to tell you why we had to make our decisions later.

The Regional Advisory Group, we thought, was overloaded with the medical people from the medical schools. A distinctive and important feature of GDVRMP and its RAG is the board of directors. The board of directors is not simply an executive or steering committee of the RAG by another name, but is more truly a subsidiary of the board of directors of the grantee, meaning UCSC, the University City Science Center, and was explicitly described as such. It reflected a shared authority by the RAG and grantee. In fact, 6 of the 17 board members were actually appointed by the UCSC.

The board of directors has been delegated policy-making authority for the UCSC. The RAG is adviser to this board, although the latter has apparently never been overruled -- again important.

The site visitors have no evidence that the grantee organization is not providing adequate administrative or other support to the GDVRMP. The visitors, however, did not go into this in great depths.

Participation. In an effort to give broader representation in decision-making, 6 area representatives have been added to the GDVRMP board of directors. Certainly there is no evidence as reflected by either the RAG or board of directors membership that the region's key political,

economic and community power structure is active in the GDVRMP. A notable exception to this, of course, is Representative Flood.

In terms of evaluation, there has been no evaluation director or staff during the past year, and there is inadequate evaluation within the projects studied by the site visit team. In fact, we had a demonstration which we will come to later by a medical doctor and a nurse. And after two years, they were not sure whether they were going forward or backward. They had had no statistical information, no evidence of input, whether it was negative or positive.

Regionalization. In evaluating the effectiveness of the GDVRMP in achieving regionalization of health care resources or health care delivery, two specific program areas were examined.

The first is regionalization of kidney disease treatment facilities. After careful probing by the site visitors, they found no evidence of a plan to (1) assure availability of dialysis from home dialysis training to institutional dialysis and transplantation facilities on a regional basis or, (2) to assure non-duplication of the same type of facility.

The GDVRMP did state they were concerned that all patients in the region receive this kind of care, but as yet no plan had been developed to assure its success. And we

found this also in some of their other projects. In fact, when asked about one of their outstanding projects in northern Philadelphia, we discovered it was only 10 days old.

The second specific program area examined was project 4 -- regional chronic pediatric pulmonary disease program. This is the one we referred to earlier. The physician and nurse who presented this program to the site visitors were unable to give any indication of changes in morbidity or mortality rates. The site visitors questioned the wisdom of expanding this project in the absence of better evaluation.

What they were planning to do was to try to expand this to as many institutions as possible. And in the meantime, the period over which they had promulgated it and done this work, they had no evidence whether it was a minus or plus, one or the other.

The coronary care training projects have exhibited a dedication to provide for coronary training opportunities throughout the region, even though this is not coupled with an assessment of the actual needs for coronary care units. In other words, we found that evaluation in most segments was poor or inadequate.

The region has not demonstrated a great capacity for use in its funds in a multiplier effect except in small isolated areas. One exception is the carcinoma of the cervix

project where an initial investment by RMP of $15,000 over a two-year period has resulted in activities in the target neighborhood now amounting to an estimated $100,000 from other funding sources. Even though this was possible, this also was not a well-evaluated project.

There is evidence of coordination of activity between the 314 B agencies and RMP areawide committees in several areas. Whether this will lead to a conjoint funding is not determinable because of the newness of the endeavor. Specifically the 314 B agency for Philadelphia just became operational September 1st.

The renal project, if Dr. Hinman is here, he might be able to assist us in this, but I will just review it quickly.

The site visit team was asked to determine whether a true regional renal plan existed so that the RMPS staff ad hoc panel on renal disease could make a recommendation to the National Advisory Council with regard to funding of renal projects 13 -- Renal Disease Patient Support, a presently approved and funded project, but requesting an expansion -- and 33 -- Demonstration and Evaluation of a Program of Chronic Hemodialysis Training.

With regard to transplantation, there are three units currently in this region, and there is active planning to establish three more. Since the beginning of renal

transplantation in the region, approximately 60 transplants have occurred.

With regard to dialysis, there are approximately 450 patients on home dialysis. There are 22 dyalsis centers in the region, the majority being located in the metropolitan Philadelphia area.

The site visitors cannot find evidence of a "Life Plan" which would coordinate the flow of patients through institutional dialysis to home dialysis and/or transplantation. Likewise a true regional renal disease plan does not appear to exist. The GDVRMP speak of a regional plan, but the site visitors believe that this is limited to organ harvesting and sharing on a regional basis.

In summary, the conclusions and recommendations of the site visitors were the following:

1. The resources of the medical and other institutions of higher learning are actively involved in RMP activity.

2. Some activities are beginning to have a favorable impact on manpower utilization, ambulatory care, and health care delivery problems.

3. The planning of the inner city by the medical schools appears to have real potential for the future.

4. Subregionalization is under way and has potential for the future.

The recommendations for funding follow:

1. This region does not appear to be ready for triennium status and therefore the site visit team recommends one year funding at essentially the current level of $1,900,000.

2. The award of developmental component is not recommended.

3. The site visit team is not in favor of expansion of Pr-ject #13 - Renal Disease Patient Support, or initiation of Project #33 - Demonstration and Evaluation of Chronic Hemodialysis or renewal of Project #10 - School of Radiotherapeutic Technology. The renal projects Nos. 13 and 33 are recommended for disapproval because of lack of technical merit. The School of Radiotherapeutic Technology is not recommended for renewal because it is against RMPS policy to support basic training programs.

4. Ongoing contact between RMPS staff and GDVRMP to provide whatever assistance may be necessary in interpreting and implementing Committee-Council recommendations.

The GDVRMP is asking for 01 year $2,734,990; 02 year $3,279,375; 03 year $3,442,511.

The site visit team recommended for the 01 year alone $1.9 million. However, the review committee recommended that not only the first year of $1.9 million be recommended, but also $1.7 million for the second year. And the thinking

there was that a triennium should not be regarded as -- in other words, to reduce a triennium to one year should not be regarded as punitive. And I think that at present the site visit team would go along with the two years.

DR. PAHL: Thank you, Dr. Watkins.

Dr. DeBakey, do you have any comments?

DR. DeBAKEY: Well, the only concern I have is whether or not this should be approved for two years or whether if approved for two years there ought to be some kind of review again at the end of a year.

DR. PAHL: There is a site visit recommended, isn't there, at the end of one year?

MRS. KYTTLE: Yes.

DR. DeBAKEY: Then I think that is all right. I would be willing to go along with the recommendation, then, of the blue sheet of the review committee.

DR. PAHL: All right, I understand Dr. Watkins to have made then a motion for acceptance of the review committee's recommendations and seconded by Dr. DeBakey.

Before proceeding further, I would like to indicate that the review committee gave this a rating of 213. We have now established, as you know, the rating procedure. And we have not included at this particular Council the ratings on the blue sheets. I think this was a mechanical difficulty at the time, but we will be indicating to you for each

application that has been rated what the ating is so that you will know this.

And also, I want to indicate to you that as a result of having adopted the policy statement earlier today relative to Council approved levels in future years being equal to that of the first year, this is the only application I believe, that is coming to us today where unless you specifically indicate otherwise, the staff would understand that the recommendation of $1.9 million for the first year would also be the recommendation for the Council approved level for the second, 05, year rather than the reduced sum shown by the committee unless you choose to do otherwise. I want to make that statement before we have discussion on the motion.

DR. DeBAKEY: Let me just comment about one other aspect of this which illustrates certain points.

As we certainly regionally conceived the idea of Regional Medical Programs and later as experiences proved desirable to develop it, the occurrence in this small area perhaps representing half a million, 600,000, people, several separate, almost independent units, kidney units and transplantation units, I think exemplifies a lack of proper regionalization as far as I am concerned.

DR. SCHREINER: I think there is a philosophical point to be gained from this experience. It may be prophetic

in big multi-university cities.

In the very early days when there were just a few units out there in Philadelphia, they had at one time an excellent group put together with cooperative agreements and so forth. And they shopped around to six different government agencies, trying to get some support. Everybody ducked them because it was a multi-university situation; nobody wanted to make a decision because it was hard, and the end result was failure to support strong programs.

I am sure every Council and every advisory committee that looked at those proposals thought that in the long run they would be defeating the multiplying effect by not giving grants to that kind of a situation. And the end result in fact is exactly the opposite. If you don't strengthen a program, you end up with more splinters, not less splinters. We ought to learn this philosophy. It is a positive thing.

DR. DeBAKEY: No question about it. But I think one of the policies that councils such as this can establish in terms of giving its money to support these kinds of programs is to assure that it is regionalized and that you strengthen the unit that is active in some areas such as this.

I think anyone with any experience in this field knows that you are not going to get the best quality and the best experience and the best training by having these kinds of activities fragmented among a half a dozen different places.

You have got to concentrate the experience, and that is strengthen it.

And while you can't control in a sense what is going on in the region outside of the use of the funds for this purpose, certainly you can control it so far as these funds are used to support these activities.

MRS. MARS: I think one question that should be considered in the funding is this movement in the State of Delaware to establish its own RMP. How serious is this movement? And would it occur in the next year? If it would occur within a year's time, certainly we should only grant one year's funding because there is going to be a great deal of controversy if the funds are granted for the second year as to who is going to get what -- say that Delaware, the State of Delaware, breaks away from the Greater Delaware area. It seems to me this is a very important factor to be considered.

DR. PAHL: Mrs. Mars, we will be taking up the Delaware application, and we can do that next, or we presume to do it tomorrow. But Mrs. Silsbee is prepared, I think, to provide a statement at this time as to the extent of involvement, fiscally and otherwise, of Delaware in the Greater Delaware Valley proposal.

Maybe she could do this at this time.

MRS. MARS: I think she should do that now because I

think it will influence this.

MRS. SILSBEE: It is not a major problem because the State of Delaware has not gotten much money out of the Greater Delaware Valley Regional Medical Program. And in case it comes to the regions, there will have to be staff negotiation.

They do have one staff person in Delaware, and that would have to be changed. But as far as project activities, there is very little.

MRS. MARS: But if the State of Delaware does withdraw, how will this weaken theprogram of the Greater Delaware area?

MRS. SILSBEE: I don't think it will make any difference because there is very little activity in Delaware. And that is one of the reasons they decided to withdraw.

DR. PAHL: Am I correct, Judy, was the figure of $100,000 roughly as Delaware's involvement currently in the Greater Delaware Valley activities?

MRS. SILSBEE: Yes.

DR. DeBAKEY: It is like the tail wagging the dog. If you cut off the tail, it won't make any difference.

DR. PAHL: Is there further Council discussion?

DR. MILLIKAN: What is that $200,000 difference applied to? Do you know? That is the $1.9 and $1.7 million. It is not that radiotherapeutic technology. That is a small

point.

DR.PAHL: Mr. Colburn.

MR. COLBURN: The reason behind that, Dr. Millikan, is regionally, the cycle was one year's funding. And then they felt that the areas in which progress was needed over the next year was primarily filling of the core staff vacancies. And some of the projects presently ongoing are due to be phased out. And they felt they should phase those out, start staffing up the central core staff.

DR. MILLIKAN: I want to know which ones.

MR. COLBURN: There aren't really any schedules. There are some schedules if you look on the second page of the yellow, turn that around. That gives you a total funding history, and you will see where projects under coronary care programs, projects 1, 2, 3 and 4 have decreasing decremental funding levels over the fourth and fifth year and none in the sixth. It was felt this might force the hand of the regions to speed this process up and also to bring in some of the other activities. This is the reason for decremental funding. That was the philosophy.

DR. PAHL: Is there further discussion?

DR. SCHREINER: Do you think you are going to get anywhere or would it be better to start all over again with the $1.7 million?

DR. PAHL: We hope to get someplace.

DR. MILLIKAN: As the motion is, it stands for $1.7 million for the 05 year?

DR. PAHL: Not unless it is specifically specified by Council. That's what I want to make clear now.

MRS. WYCKOFF: If we endorse the review committee report.

DR. DeBAKEY: As I understand it, his motion was to endorse the review committee report.

DR. PAHL: I was pointing out to you whether you were aware of the fact this is an exception to the specific policy adopted. The motion does accept the review committee's recommendation, and it is $1.7 million.

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

(Chorus of ayes.)

Opposed?

(No response.)

Motion is carried.

May we now turn to the Maryland application with Dr. McPhedran as principal reviewer, Dr. Millikan as backuA. reviewer, Mr. Hinkle from our staff.

DR. McPHEDRAN: This is a three-year grant application from the Maryland Regional Medical Program which is currently in its third operational year. And the site visit team, the review committee, are in accord as noted

on page 1 of the blue sheet except with a few exceptions, but in general they were in accord.

The exceptions are that the review committee wanted a statement of Council policy on funding in project 43 which is a project coming to you with production of antilymphocyte globulin. And I will go back to this and ask Drs. Merrill and Schreiner to comment on it if I may.

And also, the review committee differed somewhat with the site visit team on how far they were willing to go along with the region's recommendation about some support of epidemiology and statistics projects.

Let me first of all, though, remark on some general comments about that program. We prefer in the first place not to give the accolade of the three-year grant status to this region. Initially, the consensus of the site visitors in their discussions in Baltimore was to allow only one-year funding, but our second thoughts later were that this was perhaps unreasonably harsh, that it would require an almost immediate reapplication from a program which was showing promise in some areas, and that it was, therefore, an unsuitable restriction in their activity.

I think that, first of all, to cite the main strengths, the Maryland Regional Medical Program has changed the stated goals, objectives and priorities from categorical to rather startling calls for improvement of health care

delivery. And in this respect, it sounds very much like the other triennial applications that we have reviewed.

It seemed to the site visitors and the review committee if anything this was too facile a change and that there seemed to be not much evidence that Regional Advisory Groups had hatched any of this, that it was borrowed from the white papers and the President's Health Message. But this is a difficult conclusion to come to in some ways.

I think that I am not really sure that we have got a real sense of how the Regional Advisory Group did work on this matter. And it may be that the site visit team and the review committee as a consequence was unfair to the region. Certainly, the chairman of the Regional Advisory Group that met with us was a strong and independent character. And if he reflects the rest of the Regional Advisory Group, it may be a real asset for the region. But our tentative conclusion was that the shift in emphasis in the program was seen perhaps too easy and too quick.

Nevertheless, there are some real strengths. And the site visitors agreed that the continuing education part of the program was one of those. An interest phenomenon is that the two medical schools there, Johns Hopkins and Maryland University School of Medicine, who were formerly largely engged in continuing education now have had all that activity taken away from them. And in contrast, they

now are in the business by contract of trying to devise health maintenance organization planning and development. So the educators are working on the service and people who were formerly engaged in service -- namely, the physician on the core staff -- is taking over the educational functions.

On the whole, it seems at least part of this was a very salutary change. Dr. Herbert who is the director of their Division of Health Manpower Development and Continuing Communication -- they insist on the whole title which makes it kind of cumbersome -- was a very able fellow who seems to have made substantial contributions, for example, to regionalization, successful use of a western Maryland comprehensive health planning B group in trying to find out what kinds of continuing educational programs were suitable to that part of the State, and in beginning to devise this, sounded really like a productive activity, especially in a program which is so largely city based. In fact, Baltimore based. This seemed like a really positive asset. It is new, but it seemed that there was considerable enthusiasm for it, and we thought it showed a very promising trend in the program activity.

Also, their Health Manpower Development and Continuing Communication Division had conducted a series of seminars on important medical care problems. This is called, I think, the second Monday series. And out of this, they had

developed some proposals for activities which had become part of the core activity.

For example, there is a Committee on Patient Education which seems to be a viable and a working committee within the core staff. And I think that these activities showed considerable promise.

Now, one of the obvious strengths of the Maryland Regional Medical Program within the universities obviously would be really what is a celebrated epidemiology and statistics group. Dr. Lilienfeld is perhaps the best known, I suppose, of this group. But the Epidemiology and Statistics Center of the Maryland Regional Medical Program has been a strength cited before in consideration of this region. But the site visitors and review committee were both critical of what seemed to be not much result from Epidemiology and Statistics Committee.

This committee, for example, is proposed as being able to help in the design of a project and also the evaluation, but very little evaluation seems to have been done or at any rate there are a few results of evaluations that have been summarized and, therefore, made available for use as perhaps more correct. A great deal of information has been collected on several of the projects, but it doesn't seem to have been provided to the region or to us in such a form that we could see what was going to be done with it.

The Epidemiology and Statistics Center has recently engaged the services of a man whose work would be exclusively in that center and devoted perhaps more to Maryland Regional Medical Program problems, Dr. Gordis, who seemed a very able man, and so perhaps new directions can be expected of the Epidemiology and Statistics Center.

Now, last, I want to comment some about relations with the medical schools. The relationships with Hopkins are two.

One is that Hopkins is the grantee organization and as such seems to offer no problems for the Regional Medical people to carry out satisfactory work with the grant. And there is no problem there.

Formerly, the program staff, the core staff, that is, had sort of four divisions. There was a Maryland REgional Medical Program core staff, there was one at Hopkins, one at Maryland, and one in the State Health Department. Now, there is just the one Maryland Regional Medical Program staff and one in the Health Department. That portion of it has been abolished, and the relationships with the universities have been made contractual and, as I say, no more continuing education now. But they now have been contracted. They are contracting to develop health maintenance organizations for some HMO-related activity.

In the case of Hopkins, it was proposed in the first

year that some $150,000 approximately would be spent by Hopkins in devising a management system for some health maintenance organizations which are already being worked on by Hopkins which are already in operation. And we had some doubts at times as to whether or not this was a suitable RMP activity.

Or I should put it this way: I think the review committee raised doubts. We didn't have the information or weren't as satisfied as the review committee was about this.

Hopkins summarizes this as their people are running a projected activity, providing a monitoring for the volume and types of medical services, not for the quality of services, but for the volume and type of medical services, to provide the necessary financial billing and review estimates. We thought that probably was a secondary matter, was not an RMP activity perhaps, to provide actuarily useful data, to establish further utilization and provide for meeting the reporting requirements of various external administrative agencies.

Some of these are administrative costs that are perhaps not directly related to Regional Medical Program activity. And I thought in reviewing these with Dr. Farrell and other members of the staff here, we could all agree perhaps providing monitoring and volume of types of medical service or providing actuarily useful data that would be helpful

in planning future activities, these might be appropriate for RMP funding, but not the rest. So in my recommendation, I am going to accept those things, those other parts of the Johns Hopkins proposal.

Maryland University School of Medicine has proposed a study concurrent with HMO development within the Maryland School of Medicine in Baltimore. And it was an interesting proposal. It was an intensively introspective study of what the HMO would do to the school, the faculty members, the students and the patients. And it sounded quite interesting but it didn't sound really very much like HMO development. So we thought that the amount that they proposed could be usefully reduced to round figure, from about 170,000 to something like $25,000 that might be spent in HMO development on a contractual basis.

Now, the last exception that we would have to make relates to a couple of the projects. Two projects are really extensions of the Epidemiology and Statistics Center activity, at least according to our view.

Project 40, the analysis of home care system in Maryland Regional Projects, 41, design and implement evaluation system for Maryland Health Maintenance Committee, Inc., this is the only RMP activity in relation to this Maryland Health Maintenance Committee, Inc. This is something of a digression, but I think this committee should be noted it is a group of

physicians and nonphysicians, about 50-50, who are trying to devise a series of prepaid plans in Maryland which they hope will run parallel to existing medical services. They have received a grant of $250,000 for this HMO planning effort,and it was proposed that the Maryland Regional Medical Program might assist them in designing this evaluation system for the several HMO efforts. The grant, I think, is a HSMHA grant.

DR. HINMAN: 314(e), I think.

DR. McPHEDRAN: The point is the Epidemiology and Statics seems not to provide the Maryland Regional Medical Program with as much evaluation of ongoing activity as we could hope for. And it seemed to the site visitors and also to the review committee a little bit uncertain whether it would be suitable now to spend an additional amount -- this would be $31,000 plus about $85,000 onto the initial $200,000 out of core funds which is already allocated to E&S. So we have serious question about that.

The last matter is the one I took up first which has to do with the antilymphocyte globulin project, No. 43. The review committee suggested that this be approved only if Council thought we would adopt a policy saying this was suitable RMP activity. I understand from conversation with Dr. Schreiner, and I haven't asked Dr. Merrill about this, that the effectiveness of antilymphocytic globulin in transplant

activities is variable. Some of the material is effective and some not and that pooling of several States activity would be desirable were it not for the fact there is an FDA regulation which prevents transportation of this material from one State to the other. So maybe we are on the horns of an insoluble dilemma. I would like to have some advice.

DR. PAHL: Pardon me just a moment. I believe before replying from Council, we might have Dr. Hinman's statement about the present status of the policy. Because he informed me that this would bear on the issue at hand.

Dr. Hinman.

DR. HINMAN: As I discussed with you in August, we are concerned about several issues where there should be joint Federal planning. And lymphocytic globulin or antilymphocytic globulin was one of those endeavors. And in this end, we met with the representatives of the National Institutes of Health, the two agencies there most concerned with it, to discuss how we might approach getting useful information that would assist clinicians and investigators in trying to understand more about the potential usefulness of antilymphocytic serum.

We found out one of the Institutes has developed first an advisory council of immunologists who have together developed a protocol in which they have a standardized method of production and testing that gives uniform testing

results in an animal model. They are working with a commercial firm who has secured an IND and are working together on a joint protocol. So that we would hope in a fairly reasonable period of time that would give us the answers as to:

1. Whether you can produce repetitive batches that ha-e the same potency.

2. Whether it is safe.

3. Whether it is efficacious.

To this end, there has been an administrative decision that RMPS would not engage in any similar efforts, competitive efforts, until these questions were answered.

DR. PAHL: Thank you, Ed.

I am sorry, but I just wanted that statement in.

Dr. Merrill.

DR. MERRILL: I think that is a very wise decision. I think the State of Maryland, to attempt to produce ALG only for the State of Maryland in the present state of the art wherein all the things Dr. Hinman spoke to are quite correct would be foolish and totally unproductive. I think what has got to be done is just the kind of thing Dr. Hinman mentioned.

I might add that in all probability on the basis of thesite visit some of us made to Minnesota some time ago that there will be another trial on a large scale by Dr. Jarring who will perhaps produce, if any ALG is effective, one that

certainly is, but it doesn't need testing and standardization.

I think the only other thing to be stated might be the possibility they have stated ALG is effective. And if we were withholding, indeed, a potent weapon or immunosuppressive weapon from them, we might want to reconsider this. The evidence is very clear, I think, from both this country and abroad that ALG as it is presently utilized, manufactured, is of questionable variation. And therefore, we are certainly not withholding a therapeutic weapon.

DR. DeBAKEY: I think I would certainly endorse that very strongly on the basis of our own experience with ALG and experience of others. It is too valuable. There is too little evidence that it can be produced and has consistent effectiveness.

DR. SCHREINER: The problem is we sit around pompously and say how much should go to Pennsylvania, and this is where the Federal agencies have been completely lacking in getting togehter well with each. The FDA is taking a stance and NIH is taking a stance, and we are getting caught in the crossfire of people who think they have good material.

I am personally impressed with Jarring's data. I haven't been impressed with any other I have seen. But that particular batch looked impressive. But on the other hand, he has stopped making the material primarily because I understand

his next batch didn't turn out quite as good as the last batch.

And Canada had a central batch method, and they adopted it and approved of the distribution. And it turned out to be inactive.

So it is something that is going to require really probably human trials on a large scale. And I think it would be the height of folly to have RMP money, even 10 cents of it, going into establishing 52 different sera all of which are not only not established, but unestablishable under those kind of programs. There is no way to get the data back. I think we should, but I think we ought to go on record as trying to push Ed's cooperative program and have more meetings.

DR. HINMAN: We will continue to pursue this. We were very pleased to find in addition to our interest in working with this group there was some coordination with a couple of the other Federal agencies. On this particular issue, it looks like there may be some interagency cooperation.

DR. SCHREINER: It is a long time coming and very welcome.

DR. HINMAN: We will keep you informed as we find out more about this centralized batch making and testing and efficacy.

DR. MERRILL: Which Institute is it that is doing it?

DR. HINMAN: Allergy and Infectious Diseases.

DR. PAHL: Dr. Millikan.

DR. MILLIKAN: What is the motion?

DR. McPHEDRAN: I am going to make a motion almost as long as the presentation.

The motion is to accept the review committee's recommendation for two-year funding with the following deletions:

One they have already made. That is the project 43 not be funded. That is the antilymphocytic globulin.

The others are that the contract with Johns Hopkins for HMO development be limited only to those aspects of HMO development that we regard or that I have taken a stand as RMP related. That is possibly the monitoring of the volume and types of medical services rendered and the actuarily useful data for establishing future utilization, copayment revenues.

And that the funds which would be devoted to projects 40 and 41, analysis of home care system in the Maryland region and design, implement, evaluation system for Maryland Health Maintenance Committee, Inc., that a look be made by RMPS staff to see whether or not it really is suitable for the E&S Center to be giving these monies, whether they can really use them to help the Maryland Regional Medical Program.

It seemed to me that such an implementation of an

evaluation system ought to be designed certainly for the Maryland Health Maintenance Committee, Inc., but I wonder whether the E&S Center is really going to be a suitable vehicle for doing that unless they can get other information out. And really, do they need the additional money to do it?

These are, I think, questions that we don't have the information to resolve here. And I would like it if staff can resolve them satisfactorily. Then, I think the money could be given, but otherwise not.

DR. PAHL: Before asking for a second to the motion, I would like to indicate that the review committee gave this a rating of 244 and would you incorporate acceptance of that rating in your motion?

DR. McPHEDRAN: Yes, I guess so. They went through the motions and I haven't done that. I have tried to do what seems more useful to me which is to cite what are the strong parts of this program. And I tried to do that. Particularly, the Health Manpower Development and Continuing Communication Committee is strong, and I think that nothing ought to be done that will cripple their continued activity.

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

MRS. MARS: I will second it.

DR. PAHL: The motion is made and seconded.

DR. MILLIKAN: A question. In your recommendation, Alex, does that take $170 off of the $1.294?

DR. McPHEDRAN: Yes.

DR. MILLIKAN: You mentioned the HMO. I would take $145 off.

DR. McPHEDRAN: The Johns Hopkins is $146,887.

DR. MILLIKAN: Take that off.

DR. McPHEDRAN: The question is whether or not the monitoring of the volume and types of services -- what portion of that $146,000 that is. It may be the whole thing. Maybe they would just consider the whole thing not worth doing.

We limited this strongly to what we thought was suitable RMP activity. I don't know about that.

DR. MILLIKAN: Taking off $145 brings it to $1.149,000.

DR. McPHEDRAN: And then you see the possibility of taking off -- a question whether this $31,000 for No. 40 and $85,000 for No. 41, whether they also would be off.

DR. MILLIKAN: How does the motion affect this?

DR. McPHEDRAN: I don't know how to decide these things, Clark. I don't know whether we came out feeling uncertain as to whether or not the Epidemiology and Statistics Center could really use this additional money. We tried to ask questions directly bearing on that, but didn't get the information. I think that I would like to find out what staff discovered about this, but I think that I would like to --

DR. MILLIKAN: Did you review the other sources of

funding to that epidemiology center, the two epidemiology centers?

DR. McPHEDRAN: One at Hopkins and one at Maryland. They have extensive other sources, but I don't know exactly what they are or what sums.

DR. MILLIKAN: They are both clinical vascular research centers in addition to other things.

DR. PAHL: Is there further Council discussion?

(No response.)

Does staff have any comments?

MR. HINKLE: I might clear up one point since I am called upon and given the opportunity. On the Project 41, the one for the design, implement, evaluation system for Maryland Health Maintenance Committee, they give a Form 15 budget with that. And about 50 percent of it is for personnel. And that is not the E&S Center personnel, I understand. I don't know for a fact, but I understand they are going to support personnel from the Maryland Health Maintenance, and in the E&S Center, they are going to give him additional assistance. So it won't go through E&S Center.

But now, the point which we tried to make when we went on the site visit was why couldn't the E&S Center provide this service to the Maryland Health Maintenance Committee? We are funding them at about $186,000. We thought that they should possibly be able to take up this slack and do this

evaluation.

When we brought up those type questions, they quickly responded that the regional center was so overworked now the only way they could do it was hire more people. It was more expedient to go ahead and do it this way.

We didn't come away, as Dr. McPhedran said, satisfied that they needed additional funds.

DR. McPHEDRAN: So the motion is that I think the RMPS staff needs to satisfy themselves. And I would if they can be satisfied these additional funds are required to satisfactorily design that evaluation system, then I would support it because I think that the activity of the Maryland Health Maintenance Committee seemed promising and worthwhile. And I think that this is a suitable RMP activity.

In fact, we could be in on the considering what we have been talking about of monitoring and improving health care and HMOs and other things. This is someplace where we ought to be.

So I would support that activity with the money if necessary.

DR.PAHL: Now, just before we ask for the question, I would like to raise the question with our staff, particularly Mrs. Silsbee and Dr. Farrell and others who will be involved, is everyone perfectly clear as to what the motion is in the sense of how to proceed in terms of budgeting and negotiations?

Because I have been occupied otherwise with materials with Dr. DeBakey and haven't listened as carefully as I should have. So is it clear to staff as to how to proceed on this application with the motion that has been made by Dr. McPhedran and seconded?

MRS. SILSBEE: It is my understanding we should look at the opposite HMO to see what part of it we support in the guidelines.

DR. McPHEDRAN: I support the recommendations as given with the exception that the contract with Hopkins ought to be limited to what seemed to what seemed suitable RMP activity.

MRS. SILSBEE: With regard to the other --

DR. McPHEDRAN: With regard to these evaluation activities which are inherent in 40 and 41, it seems that in particular 41, if the additional staff Mr. Hinkle talks about is really necessary, then I think it is a worthwhile project and activity and we should support it with that money.

MRS. SILSBEE: And implicit in that is looking at the basic support of the E&S Center if they are not providing this with RMP.

DR. McPHEDRAN: Yes.

DR. PAHL: Thank you.

The motion has been made and seconded. If there is no further Council discussion, I will ask the question.

All of those in favor of the motion please signify by saying, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

Now, before turning to the next application, I would like with your permission to come back to two of the policy statements which we took up earlier this afternoon. And perhaps I can just read them to you and if you wish to have them circulated, we can.

You recall the one had to deal with the resolution concerning the Area Health Education Centers. And the point was made that we should stipulate that developmental funds be used where possible. And so we proposed to add to the statement which was accepted the following:

It is further understood regions will first utilize "free" developmental component funds where available and that the general policies and procedures of the individual RMPs with respect to review approval and funding, including RAG concurrence, will apply.

I believe that satisfies the intent of the Council, and the chair will take this as acceptance and will incorporate it into the statement.

The second statement is the one dealing with the

Health Maintenance Organization and the delegation of authority to a subcommittee of the Council. And we have through some of our staff attempted to put this in shortened form as follows, which Dr. Margulies has accepted and Dr. DeBakey accepted before he left:

The Council shall discharge its responsibilities in regard to recommending RMP grant support for HMO feasibility studies and organization and development efforts by delegating to a subcommittee of the Council authority to work with RMPS for the purpose of making recommendations with respect to approval of HMO proposals.

And Dr. Margulies indicated to me a moment ago he thinks Dr. Wilson will find this most satisfactory and represents a compromise.

DR. MILLIKAN: Would you read that again, please?

DR. PAHL: All right, and we can type it up and send it out. My handwriting is not that good.

The Council shall discharge its responsibilities in regard to recommending RMP grant support for HOM feasibility studies and organization and development efforts by delegating to a subcommittee of the Council authority to work with RMPS for the purpose of making recommendations with respect to approval of HMO proposals.

What we mean by this, and the language can be cleaned up and presented to you tomorrow, is that a subcommittee

of the Council will be formed and will have to come and meet with RMPS staff where recommendations will be made with Council delegated authority for approval of HMO proposals. And if such a proposal is not given in a specific instance, then presumably funds will not be made certainly by the grant process for that particular applicant.

And this would mean working with RMPS. We cannot commit HMO service and the Office of the Administrator to be utilizing other mechanisms. This refers to the grant approval process.

DR. ROTH: I wanted to say this subcommittee makes recommendations for approval. Who has the approval power? Where is the approval finally given?

DR. PAHL: The Subcommittee has the approval.

DR. ROTH: Would you read that part of the sentence again, making recommendations for approval?

DR. PAHL: Delegates to a subcommittee of the Council authority to work with RMPS for the purpose of making recommendations with respect to approval of HMO proposals.

DR. ROTH: Who gives the approval finally? Who acts on that recommendation?

DR. PAHL: I understand this to be for grant proposals the same as we do here. We are not able to make a grant proposal without a recommendation for approval of the full Council. And what this is saying is you have delegated

the full Council authority in this to a subcommittee. So the subcommittee is acting for the full Council. And the Director of RMPS cannot override a recommendation by this subcommittee for disapproval.

I also understand this to indicate if a recommendation for disapproval is made on a particular grant request, also the Administrator would have the opportunity to utilize our funds through contract mechanisms which don't come before the Council.

DR. MARGULIES: I heard that rather cold because I have been in this other meeting, but it doesn't say that that clearly to me. What you are doing is delegating to a subcommittee of the Council the authority for approving a grant award to an HMO or to HMOs. That is the essence of it, though.

DR. PAHL: It is our understanding this is what the Council desires. If so, we will try our hand in a little less frantic circumstance to reword it and bring it to you tomorrow so it is perfectly clear. But that is what we were trying to say.

DR. ROTH: There is just a confusion in my mind about the wording that says recommending for approval. And I thought what it meant was approval.

DR. PAHL: We will reword it. The wording is semantics. This Council makes recommendations for approval,

But the way the law reads, we may not make a grant award without a recommendation for approval.

DR. MARGULIES: So this committee acts for the Council.

MRS. WYCKOFF: Otherwise, they would have to bring it back to us, and that wouldn't save any time.

DR. PAHL: Under the law, the Secretary approves, the Council makes recommendations. But the Secretary may not make an award without a recommendation for approval. So it would be in that analogy.

I think we will reconstruct this so it is perfectly clear and bring it back to you tomorrow. But that is at least we have caught the essence of what we are trying to accomplish. Apologies.

Perhaps we can go on to the next application which would be Western New York with Mrs. Mars as principal reviewer and Dr. Millikan back-up reviewer, Mr. Kline from our staff.

(Dr. Roth withdrew from the room.)

MRS. MARS: On December 7 and 8, I was a member of a site team which was chaired by Dr. Spellman which visited the Western New York Regional Medical Program in consideration of triennial funding. You have the report, of course, of that visit in your agenda book.

You also have the recommendations from the review committee which is adverse to the site visitors' recommendations as to triennial funding.

The chairman, Dr. Spellman, and members of the team stand very firm and are united on the recommendations resultant from our findings presented in our report, especially now in the light of the events of the last three months which I will come to later.

But I think first that I had better give you a little report of the program as we saw it and assessed it at that time. So much has changed, all the critique that was made by the review committee as well as ourselves, really no longer applies.

Structurally, the WNYRMP as it was known is quite unique. It is organized into county committees. There are nine counties, seven in New York and two in northern Pennsylvania, which cover some 8200 square miles.

The approximate population is practically 2 million, predominantly urban and white. The nonwhite is estimated to be about 150,000.

These county committees are composed of some 300 members over which has been an organization called HOWNY. This was a separately incorporated group of 33 people. HOWNY means Health Organization of Western New York. This technically was their RAG and the board of directors and the Executive Committee for RMP. It was predominated by physicians. Eighty-five percent were permanent members selected by their organizations.

I hope you notice that I am using the past tense.

Only five members of this were subject to the election process. And it was very doubtful whether or not many members of the county committees had any idea as to their relationship to HOWNY and its relationship to the Western New York RMP. There simply was not enough liaison between the county committees themselves nor to HOWNY. We strongly felt that another member had to be added to the core staff for this purpose.

This poor communication was very evident in many instances. Dr. Wormer spoke for one of the county committees and said that he simply did not understand RMP for WNY, that all grant proposals originated in Buffalo and that his county wanted to have a voice in the conduct of the program's affairs.

The program has made a great deal of progress towards regionalization, but this lack of communication between these invaluable counties who really do know the needs of their communities and the RMP is due to the shortage of the RMP staff so that a golden opportunity for regionalization was being compromised.

Also, we were not happy about the void of representation of the minority providers and consumers on the committees and HOWNY. So we made a very strong recommendation that HOWNY immediately be expanded to include more representation

from minorities, consumers, and such groups as labor, clergy, legislature, allied health, and the county committees.

We also said that consideration should be given to a means by which new members could be added more frequently such as having a three-year service term limitation in order to infuse new ideas.

Personally, I felt very strongly and stated to WNYRMP that the name HOWNY was psychologically wrong, it was misleading, it did not promote unity, and it certainly does not identify with RMP. I felt that RAG should be identified as RAG, clarifying its connection in the public's mind with RMP. I had very decided feelings about this which I believe also reflected the attitude of my teammates.

The Research Foundation of the State University of New York has been the grantee organization for the WNYRMP. The thing that really shocked us was that the foundation charged 58 percent indirect costs for on-campus activities and 48.6 percent for off-campus activities. We absolutely were shocked by this.

The only advantage is that the grant receiving organization is exempted from the stringent and very involved New York State regulations which govern the expenditure of funds. The RMP staff was not very convincing as to the justification of the expenditure so we remained extremely unhappy on this question. RMP pays over double what most pay

because there is no restriction in our grant. And Dr. Brown freely admitted that we were indirectly supporting the university.

Dr. Ingall, the director of WNYRMP, is a very capable person and an extremely intelligent man. He is most sincerely and genuinely interested in RMP and has been and is working very hard to move this program in new directions. He has provided the program with very strong leadership. And in terms of staff, I would say he is a very good administrator.

However, the fly in the ointment was that he was very unhappy with his salary which was limited by the university scale. And he inferred on direct questioning that he would very much like to improve his financial status. In fact, he had submitted a resignation. And this, we all felt, was really a protest against his low remuneration. However, this, of course, created great concern to the site visit team.

My own personal mild criticism of Dr. Ingall was an impression at one point that I got when he first came to the program that at that time he perhaps had conveyed to the region the magnanimous attitude that the role of RMP has a Santa Claus aspect. Dr. Ingell is well liked and has excellent relations with the health agencies, the community leaders and the medical profession. And in the past he maintained these -- and this is purely a personal feeling -- perhaps he held out a nebulous carrot of RMP funding to a great diversity of

interests which evolved into too many irons in the fire and only a few able to get really hot.

However, in all fairness, I do sincerely believe that his attitude has changed in the past year with his deeper understanding of the new direction, the goals and mission of RMP. This was certainly demonstrated by the consistency of the changes that have been made in the WNYRMP goals.

In discussing Dr. Ingall's salary, actually all the staff members' salaries should be increased to levels which are consistent with people doing comparable jobs in the other 55 RMPs. So our recommendation also states that if a change in fiscal agent is required to accomplish this, it should be done, especially in light of the service overhead being charged by the Research Foundation of SUNY. And likewise, the core staff should be increased by at least six members and most important of all a deputy director. So this is another reason for keeping the money in the home till, so to speak.

Dr. Ingall has surrounded himself with a young, exceptionally intelligent, enthusiastic core staff. They have established some worthwhile and meaningful activities within the region. Among them are the following:

Assisting potential project directors in developing their applications.

Trying to fill the need for a liaison between the

county committees.

Gathering data for the community health profiles.

And doing studies for the evaluation model.

They gave vital help to establishing the Lake Area Health Education Center in Erie, Pennsylvania. I believe this is one of the first, is it not, of the Health Education Centers that have been established?

DR. MARGULIES: Right.

MRS. MARS: So the region should certainly be congratulated on these efforts and also for the assistance to the local CHP B agency. The latter was very, very slow in getting started. RMP staff reshaped it and helped to get a director. They also got the director for the Lake Area Health Education Center and gave the support for the university and the hospitals.

We do have some concern that the goals, objectives and priorities did not have specific inclusions to deal with improving health care to the underserved minorities. We emphatically expressed this. However, I hope you will note projects No. 24 and 27 are largely directed to the inter-city residents and WNYRMP has a definite contribution in the quality and the quantity of primary care available to the underserved minorities through the creation of the Lake Area Health Education Center.

I thought a very interesting thing was that the

staff did a study on voluntary contributions of time, talent and facilities to WNYRMP. In these, they showed that the voluntary contributions of time, talent, facilities, constituted an estimated 24 percent of the total RMP activities in 1968, 40 percent in 1970, and based on current trends is projected to be up to 67 percent by 1974. And I think this is quite remarkable. This involvement demonstrates their success in regional acceptance and contributions.

One of their most outstanding projects for which they are requesting additional funding is their telephone lecture network. They have used it in multiple and imaginative ways. One is to provide an ideomatic language course for the many foreign trained doctors servicing Buffalo hospitals. It is an inexpensive method of enhancing the quality of care.

The network is also used for project proposal review. It enables RAG members to meet when the snow is heavy. And this, of course, is a considerable factor.

It is used for specialized teaching courses for nurses and doctors, medical conferences and many, many other imaginative purposes. So we certainly endorse its continued funding for another three years.

However, it is becoming increasingly self-sufficient. This earned last year $57,747 with the result that the RMP funding has been decreased from $181,053 this year to $82,927 for next year and will continue to drop to $61,145 and

then to $41,536. And they feel that by the end of another three years, the fourth year, that it certainly will stand on its own feet.

It has a very broad acceptance among the health disciplines of the region and disseminates a simply fantastic amount of health information to the most varied of audiences. I think it is quite an extraordinary thing.

Their new projects -- the model program for comprehensive family health will identify community health needs and meet these needs through the team approach.

The master plan for planning and articulation of allied health in education is another new one. And this project seems simultaneously to assess the allied health manpower training available and the health manpower needs of the region.

The Allegheny County mobile health clinic -- its object is first to provide readily available health education and counseling services to rural Allegheny County and secondly to develop a demonstration project which will give health professionals experience in working with the rural population. It will utilize the resources of the Alfred University School of Nursing. They ask $100,951 for this.

The project was very ably and convincingly presented. However, our site team felt that some of the funds requested could certainly be found in the county itself from community

donations and also from the Appalachian money available in that area. So we do recommend the project for funding, but at half the amount requested.

Number four, their comprehensive continuing care for chronic illness, this is to develop a model comprehensive program which seeks to achieve a more systematic approach to health care delivery and an effective continuity of care for patients with chronic illnesses. This, indeed, will largely benefit the inner city population which naturally has the highest incidence of chronic illness. We felt it is a very good plan.

All these new projects -- namely, four -- are designed for health maintenance and disease prevention. They certainly will strengthen relationships between primary care providers and those concerned with the provision of highly specialized care. There is an explicit attempt to define the patient's problem, assure follow-up to provide him with the best appropriate medical care he requires.

These programs also should increase the availability of an access to health services. All have stated plans for continuing funding after the withdrawal of RMPs three-year support.

The one program that concerns us considerably and for which we are asking funding for another three years is the chronic respiratory disease program for western New York.

This program really caused us considerable worry and discussion as to its worth in value. While we were all aware that Buffalo and the area are in a high pollution region, we could not in any way from the report given justify the sum asked to continue it. $1,601,866 has already been put into this, and not over 20,000 people have benefited from it.

In asking for $346,059 for continuing funding for three more years, they state they expect to provide home care and rehabilitation for patients throughout the western New York region, provide educational programs for nurses, physicians, allied health personnel and patients in chronic respiratory disease.

All that was accomplished in three years was to develop a staff, a team approach, and lines of communication. Personally, I felt a little bit that this originally was one of Dr. Ingall's Santa Claus gestures which he now regrets, but I certainly don't question his original sincerity in believing in its worth.

So we of the site team felt unanimously and very strongly that it must be terminated. However, in order to give them adequate time to find other resources, we do recommend that funding be definitely terminated by the end of 18 months, allowing $60,809 from March 1, 1972, to February 28, 1973, and another $32,796 from March 1, 1973, to September 1973.

And then, we felt that a final report and evaluation should be required at the conclusion of this.

We advise that the region not be awarded the developmental component until such a time as when they can better define what they will use it for and the mechanism that they will employ to manage it. The staff does need more educational background experience in their jobs. They have been groping and therefore the money was not earmarked really on a rational basis, but we did suggest to them that they consider reapplying next year.

However, we do strongly recommend that the region be approved for triennial status at a reduced funding level of $1,219,000 for the first year and $1,340,900 for the second and $1,462,800 for the third.

Our team's decision was based on our favorable impression in the following areas:

In evaluation, this is in charge of an obviously highly capable woman who has set up a review process by two committees who have an excellent evaluation model by which to judge programs' worth in relation to RMP objectives and mission. After acceptance and execution, the project directors submit every six months a progress report.

Their information dissemination was excellent. Besides the telephone lecture network which I have already mentioned, their project information dissemination service

and the assistance rendered to the creation of the Lake Area Health Education Center and other activities are heavily oriented to the dissemination of knowledge.

In regionalization, the involvement of people throughout the region in RMP activities is high, as I told you.

The dedication and active participation of the RAG members.

Core staff assistance in the project.

Staff and RAG's understanding of the Regional Medical Program Services involving national priorities which necessitates modification in the policies, decisions, and activities to be conducted by WNYRMP.

All projects proposed for support are designed to provide for health maintenance and disease prevention and also to raise the quality of care and make it available to them.

Now, this is the summary of our report as it stood then. However, so much has happened in the last 100 days that most of it is really very much out of date. It is the new events that are exciting.

The next day after the review committee met, Dr. Ingall, the director, Mr. Gary Reynolds, the finance and personnel man, and Mrs. Marion Sumner, the administrative associate for business and personnel, came to Parklawn and met with Mr. Teets, Deputy Director, Grants Management Branch,

and supporting staff to discuss the current efforts of the WNYRMP to do the following:

First, to incorporate the WNYRMP as a private, free-standing, nonprofit corporation under the name Lake Area Regional Medical Program, thus terminating their association with the Research Foundation of the State University of New York known as SUNY as their fiscal agent. In so doing, they hoped to achieve the following objectives:

(a) To reduce the high overhead cost resultant from their research foundation affiliation.

(b) To stabilize their core staff, including their director, by achieving a fiscal structure which permits salary increases to a level consistent with other Regional Medical Programs as well as with other health professionals doing comparable work in the Western New York areas.

(c) Extend the RMP's latitude in the management/programmatic decision-making area.

(d) Attract new and needed core staff by being in a position to offer a competitive salary.

Two, to dissolve the RMP affiliation with the Health Organization of Western New York which was known as HOWNY so that the efforts of the RMP are no longer obscured by the association with HOWNY. Apparently I made my point to them.

Three, expand the current regional advisory group

from the board of directors as it stands now from 31 to 44 people to include representation from the following sectors or organizations: National Medical Association; Blue Cross; AFL-CIO; one representative from each of the two Model Cities programs in the region; two allied health representatives, one of which is a black, Dr. Warren Perry; a political representative; one woman from each of the three active women's organizations in the region; a VA representative; and the CHP Director from Erie, Pennsylvania.

During this meeting, Dr. Ingall was able to report that the current board of directors unanimously favors this plan and would like to accomplish all necessary actions for implementation by March 1, 1972, which is the beginning date for their funding.

Subsequent to the discussion, it was agreed that although many details needed to be worked out, April 1 was a realistic target date for this changeover. However, even all of this is out of date.

Summarized by staff, I quote: "The interpretation of the discussion at this meeting is that, barring unforeseen developments, WNYRMP will become the Lake Area RMP, Inc., by April 1, 1972. This, in turn, will result in dissolution of their current ties with the Research Foundation of SUNY and the HOWNY. It will, more importantly, mean that Dr. Ingall's indefinite status in the role of program director will be

firmed up -- meaning that he will no longer consider leaving the program in the foreseeable future. The RMP's visibility will increase due to the demise of the HOWNY and there is increased promise for a more dynamic program in light of the potential for an increased core staff and expanded fiscal freedom due to the anticipated separation from the Research Foundation and HOWNY."

Certainly, when their visit was planned, WNYRMP could not possibly have been aware of what either the site visit team or the Review Committee would recommend to NAC. That they have gone ahead to take immediate action in accord with the site team's recommendations to them and taken to heart our criticisms certainly displays an alert understanding of their shortcomings. They are obviously moving at a high pitch, wanting to go forward rapidly in the new direction, progress more quickly toward regionalization and execute their new goals which are consistent with the stated RMPS objectives.

If the Council denies triennial funding, it would take the heart out of a program which is pursuing so constructive a course, and has accomplished some excellent, imaginative, high-quality health programs. It would be devastating and destructive to the high momentum of effort they have presently achieved. This will be lost, morale and faith destroyed.

They are reassessing their health needs and evaluating

its priorities and goals accordingly. And now yesterday, which was one of the great concerns, on direct questioning, Dr. Ingall stated clearly and loudly that he now has every intention to remain with the RMP. In fact, he will stay on with great gusto.

This has been occasioned by the events that have taken place in the last 100 days. When he submitted his resignation last year, he felt restricted in his efforts as a result of the relationship between RMP and the Research Foundation of SUNY. His salary was repressed by them. Also, he found it impossible to get a competent deputy director at the salary they permitted him to offer.

Consequently, he was grossly overworked, thwarted and frustrated by not being able to find time to develop the program to anywhere near its potential or obtain its goals and objectives. So his resignation, he felt, was really partially aimed with the hope he would get an assist from RMPS.

Dr. Ingall realized that he did not address himself very clearly to us in this aspect. And now in these really dynamic 100 days in the life of WNYRMP, besides the meeting I have just informed you of, there has been a second meeting. And as a result, I can announce that as of March 1, the WNYRMP will be completely disassociated from the Research Foundation. They will have a free-standing, nonprofit corporation known

as Lake Area Regional Medical Program with a fine representative group of citizens representing the minority and the majority.

The people that will make up this group will be Mr. Herbert L. Bellamy who is an inner city successful black who is quite interested in the problems of the inner-city minorities; Mr. Richard DeVeta, a certified public accountant who owns a successful firm in the western New York area; Dr. Felson who was chairman of the RAG; Mr. Allan Korn, a professor of purchasing and business management of the State Teachers College of the State University of New York and who is probably the individual who was most likely to be named as chairman of the corporation; and a Mr. Showinski who is of Polish descent and manager of the Marine Midland Bank of Buffalo, New York. So you see these are very sensible people who will make up the new Lake Area Regional Medical Program.

There will be no further affiliation with HOWNY. In fact, I feel sure that there probably will be no longer a HOWNY as they have taken the viable portion from it. In any case, it will have nothing to do with RMP. Possibly there will be a few residual directors left from RMP.

There will be a highly diversified and representative RAG, and it will be known as RAG. It will no longer be overbalanced by the university.

The county committees will remain and will have more direct representation on and greater liaison with RAG. A new staff member is in the process of being engaged by Dr. Ingall for this purpose.

And another positive factor is that Dr. Ingall has identified a deputy director. This will permit Dr. Ingall to carry out new activity in the program and to spend more time with AHEC.

Another event that took place was during the St. Louis coordinators meeting which gives added weight, I think, to this plea for triennial funding. Dr. Ingall was appointed chairman for the next year of the steering committee of the 56 RMP coordinators. He now will have time for these duties by having a deputy director. This certainly alleviates all the fears that he will not remain in the RMP fold, and this has been one of the greatest criticisms.

I really feel that if the National Council denies support of this program, he probably might leave as he would lose so much face and be so disillusioned that he simply could not justifiably continue. Currently, he is optimistic, excited and enthusiastic as to his future with RMP.

I really feel that our purpose here is not to destroy, but rather to build and construct. And I would like to ask as a matter of principle that the object of a personal site visit and the merit of insight gained is

really made futile if the team's recommendations are not of some importance. Certainly, our visit stimulated WNYRMP to make sudden and dramatic moves toward strengthening their program. And we are very happy, all of us, that we achieved this. The whole team has been polled, and this is completely 100 percent in accord.

DR. PAHL: Thanks, Mrs. Mars. Very complete report.

Mr. Milliken, would you have anything to add?

MR. MILLIKEN: I think everything has been said.

DR. PAHL: Is there discussion by council or staff?

DR. McPHEDRAN: I just had the question how serious is it going to be if they don't get the developmental component?

MRS. MARS: I think it won't be too serious. As a matter of fact, I feel very much that this is something that might be an incentive to them rather than a decrement because it would be an incentive to work and show what they can do this year. It is kind of holding out a carrot, so to speak, that they can reapply because we have recommended in our report that they do reply next year for a developmental component. And I think that we can recommend that this be so and that in the meantime another site visit can be made to see what they are doing before the end of that period and that if they are good children, so to speak, we may grant the developmental component next year.

MR. MILLIKEN: Second.

DR. PAHL: Does staff have any further question or comment to make on this application?

DR. MARGULIES: I just want to mention there is a letter here which came in quite late simply amplifying what you have already heard about the reorganization of the program up there. This is from Dr. Felson who is the president of the Regional Advisory Group with obviously the same high level of concern over the reorganization, the broadening of the Regional Advisory Group and kinds of directions which they had laid out.

DR. PAHL: A motion has been made and seconded. I would like to indicate that the review committee gave this application a rating of 276 and unless otherwise indicated, this would be incorporated in the motion as acceptance of that particular rating.

Is there further discussion by Council on the motion?

DR. MARGULIES: What does that figure of 276 mean? I think the Council ought to be aware of it.

DR. PAHL: This places the region in the lower or C category of our regions on the rating scale that we have approved from 100 to 500.

I think this point should have been made earlier. The rating scale goes from 100 to 500, as you will recall. The

actual range of scores which review committee has given to appliations, the extremes are 176 to 412. And that gives you perspective for a rating of 276 for this application.

Mrs. Silsbee.

MRS. SILSBEE: I think it is only fair to point out when the review committee considered this application there was none of this later information about Dr. Ingall leaving and --

MRS. MARS: As I said, it was all made the next day after the review committee met.

DR. MARGULIES: This is why I raise the issue because there is an obvious inconsistency between a C in this rating and a triennial award.

MRS. WYCKOFF: It is a B rating, the middle rating.

DR. PAHL: I am sorry.

MRS. MARS: I said even our site visit, everything, all objections, have been met.

DR. PAHL: I apologize. It is in the B range which extends from 250 to 325. So it is in the B range, not in the C category.

DR. MILLIKAN: What is the A range?

DR. PAHL: 325 up. 500 is AAA gold star. So we go down from there to 100.

If there is no further discussion, I would like to ask for the question. All in favor of the motion, please

say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

Motion is carried.

And the record will show that Dr. Roth was absent during the course of the discussion.

DR. MARGULIES: Does that motion include the rating?

DR. PAHL: I think we should have a separate motion on the rating if Council doesn't wish to accept the one that I indicated.

MR. MILLIKEN: Let me ask will this be sent back to the review committee?

MRS. MARS: Could a rating be made tonight or done tonight?

DR. MARGULIES: No. The only reason I raise it is not because it is less inconsistent than I thought, but because subsequent events have all occurred since the time of the review committee. And it makes it rather difficult to know whether the rating has any great meaning. I don't know.

DR. PAHL: I think what we would like to do is have the Council assign what it considers to be an appropriate rating. We would so inform the review committee.

DR. MILLIKAN: Ask them to rerate it on the provided

new information.

DR. MARGULIES: It would be difficult to do because we would have to go through the same process. Their rating is their assessment at that time, and we are going to bring this question up at a later time on Connecticut which you raised last time. The Council is perfectly free to form a separate judgment on that rating in light of the additional knowledge it has and whatever kind of evaluation it wants to place.

We don't want to make these necessarily binding. We also want to use them as effectively as possible because they are a good device. So we don't want to play loosely with them.

MRS. WYCKOFF: Is there any harm in letting this rating business wait over?

DR. MARGULIES: You could certainly put the rating in some state of abeyance if you wish so that there could be a better evaluation over time considering the remarkable changes in the program itself.

MR. MILLIKEN: So move.

DR. MILLIKAN: With an asterisk.

DR. PAHL: It has been moved and seconded to hold the rating for the Western New York application in abeyance until the review committee has a chance at its next meeting to assess the new developments and assign a rating based on

that information.

MR. MILLIKEN: Question.

DR. PAHL: All in favor of the motion please say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

The motion is carried.

I think we should adjourn and meet at 8:30 and take up the other applications. And there are two or three points of business which should not occupy us for too lengthy a period. So let us meet again at 8:30.

One more point. Both Mr. Ogden and Dr. Scherlis will not be able to be with us tomorrow, and they were the individuals who were responsible for the Illinois application. Staff will make a presentation on this, but if any of you have special interest and time to look at it since it is a triennial application, we point this out to you so that perhaps there can be fuller discussion tomorrow on this.

(Whereupon, at 5:25 o'clock p.m., the meeting recessed, to reconvene at 8:30 a.m. on Wednesday, February 9, 1972.)