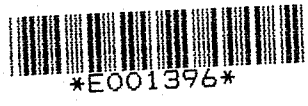
E001396

Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGIONAL MEDICAL PROGRAMS SERVICE

REVIEW COMMITTEE

VOL I

Rockville, Maryland
Wednesday, 12 January 1972

ACE - FEDERAL REPORTERS, INC.

Official Reporters

415 Second Street, N.E.
Washington, D. C. 20002

Telephone:
(Code 202) 547-6222

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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REGIONAL MEDICAL PROGRAMS SERVICE

REVIEW COMMITTEE

Conference Room E,
Parklawn Building,
Rockville, Maryland
Wednesday, January 12, 1972

The meeting was convened at 8:40 o'clock a. m., Dr. William Mayer presiding.

C O N T E N T S

P R O C E E D I N G S

DR. MAYER: I think we might begin. Did everyone get a copy of the agenda on the way in?

The first item on the agenda is the introduction of Mr. Robert Toomey as the new member on the Committee. Mr. Toomey isn't here yet, and we will introduce him when he comes in.

As some of us were discussing at breakfast this morning and last night, our hope is that the agenda by the changes in the review process will have provided us a little degree of freedom in terms of time as we move through things, and it would be my hope that we would have some time to discuss some issues that many of us have had some thoughts about. Whether we will be able to get at some of that this morning or might more appropriately hold on to it until the end, I think we will just use our own judgment as we go along.

With that I would like to turn it over to Harold Margulies for the report of the Director. Hal.

Can you all hear back there? We are working without sound.

DR. MARGULIES: I will depend upon my voice carrying far enough, and then if the amplifier comes on I will de-amplify myself.

As you can see from the agenda, there are a few

general items that I want to bring for your attention, and I do know that, as Bill has indicated, you would like to have some further discussion, and I see no reason why we shouldn't get into whatever issues are of concern to you.

I think most of you are familiar with the fact that we are going to have a meeting of the coordinators in St. Louis. This is being set up in such a way that there will not only be a coordinator present from each program unless there is some major conflict in his planning, but two other people, which means that there will be in many cases a member of the Regional Advisory Group present as well. And the conference was set up around the hope that we could develop during the process of our deliberations a kind of professional discussion rather than one which is dealing, as they so often have, with fiscal issues or with procedural issues or with general questions which have to do with federal practices.

Now the latter will not be outside of the discussion because we will have present for the meeting Dr. Duval, who will be speaking on Tuesday night, Jerry Reeso, who is the Deputy Administrator for the development part of the Health Services and Mental Health Administration, and we will be discussing some of the same things at that meeting that we are going to talk about here, including such things as the fiscal outlook for '72 and some of the major program

interests which have been evolving in RMP and in the Health Services and Mental Health Administration.

We have only in the last few days finally received the confirmation of our budget for the current fiscal year, and we still have not completed our spending plan which has been developed, is under discussion, and should be completed within the next few days, God willing.

The total appropriation which was passed by Congress has been released for RMP. That means a total of about 145 million dollars. Of that total about 135 million is available for what are not considered direct operational costs, and there have been placed on that total 135 million dollars certain specific and designated uses for funds which I would like to go through with you for a moment.

One of them is -- and these are fairly final at the present time, some room for modification, but not much -- one of them is seven and a half million dollars for area health education centers. Another is eight million dollars for emergency medical services. A third is 16.2 million dollars for health maintenance organizations. And the fourth is five million dollars for the construction of a cancer failicty which was an earmarking out of the last appropriation process. This leaves us something in the range of 97 million dollars, 97 to 98 million dollars, to which we will add in our planning for the current fiscal year an estimate, which is difficult,

extremely difficult this fiscal year, of what funds will be available because they have not been expended during the current fiscal year or during the past fiscal year. In other words, what has been considered carryover money. So we are talking about something in excess of 100 million dollars for the grant process.

Now since that represents a very significant increase over the last fiscal year it means that the general environment for spending in the RMP has changed considerably, and it means the fact that we are into mid January before we get this confirmation of news raises some serious questions which we will have to talk about during the next few minutes.

Now let me go back over some of those earmarkings to get an idea of what the issues are involved in spending the funds because they are being managed in a slightly different manne from what we had expected in the past.

As you remember, the area health education center concept has been a subject of uncertainty for some time because there was introduced the administration bill which proposed that the area health education centers be funded out of the Bureau of Education and Manpower Training in the National Institutes of Health, and so in the budgetary process there were funds identified out of the Bureau's budget which are for AHEC. There were also funds identified out of our budget for the same purpose. There is now being developed and there should be

completed within the next 48 to 72 hours a process of managing the area health education center out of both resources by a joint review process. This will allow us to have a single place to which applications for area health education centers will go, a method of deciding whether or not they are reasonable for joint funding or better designed for funding under RMPS or under the Bureau. There will be a joint kind of site visit and joint review process involved. It is not certain at this time how much of this will be done by contract and how much by grants, and that question is still under discussion.

There will also be developed joint agreement on a set of guidelines describing specifically what is anticipated in an area health education center, and those guidelines are also somewhere near the point of completion at the present time.

There have been significant differences between the position of RMPS and of the Bureau, in which the Veterans Administration has been much closer to the position of RMPS. Over time those differences have gradually disappeared, so we appear to be talking in general about the same thing.

When that process has been completed and when we get an agreement on guidelines and on joint process we can begin to look specifically at funding for the area health education center. And that process I will get back to in just a moment.

The emergency medical system is also a very recent kind

of decision which has grown out of considerations in HEW and the Office of Management and Budget. There is an agreement A under section 910 RMPS can very easily get into the emergency medical service activities. As you know, we have had elements of EMS in various programs around the country for some time. In order to manage that in an effective fashion there was created in HSMHA, again in the Development Division which Mr. Reeso manages, a committee to insure that EMS activities would appropriately involve other programs in HSMHA which are deeply concerned with emergency services.

There has been for some time an activity in HSMHA which is confined to emergency services. There is the National Institute of Mental Health which, of course, has some major suicide prevention programs and related kind of crisis intervention activities. Maternal and Child Health Services is concerned, among other things, because of poison control. And this combination and some other activities in HSMHA are being combined in the form of a general steering committee in which RMPS is active along with CHP.

The project responsibility for emergency medical services in this arrangement will be in the Division of Professional and Technical Development in RMPS, and there will be again a decision made over a period of time regarding how much of the activities initially to develop emergency medical systems will be by contract and how much by grant.

Now very closely related with this is the mass activity which we have never discussed that I can recall with this committee. That is a program which has been a joint activity of the Department of Defense, the Department of Transportation, and HEW, in which RMPS staff has been involved as the HEW part of it. And it has had a considerable amount of publicity and I believe a considerable amount of effectiveness.

It depends in part upon the use of helicopters which are available by the happy circumstance of having military installations near enough to the area being served so that the helicopters are available, in use, are required in any case for training of military personnel, and can be fit in with local requirements.

Now this has not created a system obviously, and in most cases has been available as an adjunct to an occasional emergency medical system rather than one which is well knit.

It is the purpose of the present activities which have been under way only for about ten days to foster the development of systematized emergency medical services which cover major urban areas, smaller cities, combinations of cities and rural areas, and some rural areas.

There has been set up a process through this committee structure for considering various potentialities, and there will be further action on it and expanding action very likely in the next fiscal year to help develop stronger

emergency medical service systems. These, of course, will include appropriate attention to special problems like those of heart disease, stroke, other medical emergencies, as well as the emergencies which grow out of accidents and other forms of violence.

The Health Maintenance Organization activity again takes a slightly different path because it is set up under circumstances which require the HMO development to depend upon the use of funds which are currently available rather than on funds which have been appropriated for the specific purpose of HMO.

Since we last met or discussed it, or at least in the last few months, there has been established a specific service for Health Maintenance Organizations which is parallel to RMPS and which is part of the development group. It will be their responsibility to develop the HMO's, to identify those groups which are eligible for funding for feasibility studies, for planning, and for development. And RMP funds can be utilized for those kinds of purposes.

There will be a combination in this activity of grants and contracts for their development, using some of the contract money for demonstration purposes in HMO's. There will also be contract funds available, we believe, for furthering the development of methods for monitoring the quality of medical care which will be used as a part of the monitoring strength

of RMPS and of the RMP's as the programs begin to move from a development into an operational phase. That is the Health Maintenance Organizations.

We anticipate that the RMP's will not be involved, as they have not been, in such questions as the organizational structure of an HMO, the reimbursement systems, actuarial data, marketing, etc., but will have a major contribution in the professional aspects of quality, quality monitoring, continuing education, better uses of manpower; and again as we look at such things as emergency medical services will be in a position to develop special demonstration activities as a part of HMO's to strengthen EMS.

The cancer facility which is being considered will be reviewed by the next meeting of the Council. We have an application which is in the area designated by Congress for support from the northwest part of the United States in Seattle. There is a site visit which is planned for later this month which will be joined in by a number of programs in HSMHA, by the National Cancer Institute, and by other groups which have been looking at this particular activity; and I think that that review process will probably take place without any gr difficulty.

Now this leaves us at the point where we can consider a spending plan for the Regional Medical Programs and can consider such specific items as the funds which will go into

kidney activiities. We have proposed, and I believe that we will gain acceptance of the idea, that the funding of Regional Medical Programs in this expanded budgetary year will be based upon the relative rating process which the review committee has developed and will allow us to utilize the funds in relationship with the capacity of the Regional Medical Program to operate at a higher fiscal level and to utilize the funds for effective program development. As a consequence the ranking process which you have developed and which you have been utilizing will be applied totally throughout this process of increase in funding or of restoration of funding where that has been in issue.

There are still some programs which are burdened by the fact that their funds were cut during the last fiscal year as a consequence of very limited funding. Wherever appropriate-- and I think this will apply in many cases -- we anticipate that those funds will be restored.

This should allow us for kidney activities a total of something in the range of eight, eight and a half million dollars for kidney proposal funding which would be consistent with the kinds of requests we have and which would be consistent with the needs of other programs, and for general RMP support.

Now this brings me to one final initial comment or discussion, and that has to do with the potential need to set

up an additional process or a different time related process for reviewing during this fiscal year. As we are now scheduled there would be a meeting of this review committee in April and a meeting of the Council in May. If we are to offer the opportunity to RMP's to request supplementary funds, if we are to consider new proposals for some of the new areas which I have just brought to your attention, it may be necessary for us to either consider another meeting or to set back the meeting of Review Committee and Council by one month so that we can include a larger number of proposals, so that we can give programs a longer opportunity to develop activities which they may have held in abeyance or which they may not have considered because of the discouraging influence of the reduced funding of the last fiscal year. We will have to have some further consideration of that during the course of the Review Committee meeting today or tomorrow.

We are also considering -- and this means that we have a number of things to discuss -- the advisability of using this time when we have additional funding in a relatively short period of time in which to make wise use of it a change from a four times a year to a three times a year review cycle. Now this is, I must make as plan as possible, at the point of exploratory consideration. It is based upon the thought that from the point of view of the staff of RMPS, particularly the Operational Division, if it can be worked

out in a feasible fashion -- and we haven't gone through all of the dynamics involved in that "if" -- there would be real advantages in being able to schedule application submissions, site visits, and reviews with an interval of four months between each of these activities rather than three.

At the present time with the reduction in staff in all of the federal programs, including RMPS, and with the clear evidence that our reduced staff requirements are going to continue, the workload on the Operations Division is so great that they are spending all of their time and overtime on the process of preparing for review, carrying through review, reporting back the results of review, and then beginning with the next cycle. This means that the opportunities for technical advice, for working with the regions in other ways outside of this review process, are so limited that they are quite plainly inadequate from our point of view and inadequate from the point of view of the Regional Medical programs. It is a very great problem.

On the other hand, if we move from a four times a year, a quadannual to a triannual program, it would mean that we would have to very carefully adjust the workload on those every four month schedules so that this committee, for example, is not suddenly deluged with a large number of total triannual reviews at one time, and can have some reasonable balance in the amount of time and attention which it needs to give to the

kinds of program reviews coming before it. And that takes considerable analysis and planning and a great amount of footwork. If it can be done, however, it provides this kind of advantage for the current fiscal year, and that's why I bring it up in connection with the review cycle.

If we were to decide that there is an advantage for staff, for the RMP's, and for you, in waiting one month before we get into the next review cycle it might also be the opportune time if it appears to be worth while to move from the four to the three times a year cycle because this would be the initial stage in doing it. It would provide us some kind of funding flexibility because some of the fiscal years of Regional Medical Programs would have to be changed to accomodate a three times a year cycle rather than a four, and it would allow us to be more flexible in the ways in which we fund them from one fiscal year to the next -- that is our fiscal year -- and would maintain a more even utilization of RMPS funds in this and in the next fiscal year.

That last consideration is not an essential one, but in the final management of our grant awards it might be an extremely useful tool. I would not suggest, however, that that be the basis for the decision about whether this change in cycle is worth while. So we really have two considerations in talking about changing the review cycle. One of them is only a partial change, which would be to delay the meeting this

year for the next review cycle. The other would be to move at that point to a triannual review -- not triennual, but triannual.

These are some of the major considerations that I think are worth considering at this particular point, and I would suspect that you may have some questions to raise about them.

DR. MAYER: I only comment, Harold, that as I sat here I was getting warmer and warmer, and I didn't know whether it was the heat of the room or the fact of my anxiety about the magnitude of what you were just saying or of really having a total feel for what you are saying.

Let me go back and pick up what I think must be a key issue out of what you have said to this group, and that is the issue of the talk about the expansion of the programmatic efforts of RMPS, you know, striped away from kidney, area health education centers, et cetera, et cetera. What is the magnitude of that component in your best judgment, and what are your thoughts about commitments towards those dollars on a time span?

DR. MARGULIES: We considered a number of possibilities, and what seemed to be the best -- and I have to get affirmation of this -- would be to begin with the base of restoration of funds to all RMP's where they have been cut entirely on the basis of budget reduction because this

was not last year a programmatic consideration, it was a fiscal consideration. We would then propose that there be an increase in funding for those programs which the Review Committee has rated--we will call them A, B, C, A being highest -- rated at the A level, with the decision being made on the basis of the Council approved level, the present funding level of the program, and what appears to be its capacity to utilize increased funds in an effective fashion. In most cases this would be in the range of about 20 percent, more or less, in that range, for A programs.

We would also consider those programs which were rated at the B level, but which in general had a relatively strong review and which in time have appeared to be strengthening their activities, so that they could be given supplementary funding this fiscal year -- immediately, that is -- on the basis of the strengths which have been identified and which appear to justify it.

Those programs which are rated C we would not be able to award simply because we have increased funding because there is no intention of using this money in any way excepting to maintain prudent growth of Regional Medical Programs. If we should get to the point, Bill, where we couldn't use the funds effectively without giving them to programs which don't rate it we would prefer to return the money the Treasury, which is something that no program likes to

think it is going to do. But we would be consistent.

DR. MAYER: We did in '66, you know.

DR. MARGULIES: Yes. It has only been done once.

DR. MAYER: Let me ask two additional questions. One is how much money are we talking about, and two is who is going to make the decisions and by what process.

DR. MARGULIES: We are talking about for the money which is used to maintain the Regional Medical Programs a total grant level of approximately 100 million.

The decisions on how much money goes to the program will be carried out the same as they have been and will be. These are administrative decisions. They represent essentially the decision of the Secretary, which means the decision of HSHMA in this particular case, based upon the level, the relative ranking of the programs which have been developed through the Review Committee.

DR. MAYER: Well, I think in terms of increments. I need to have the base off of which 100 million compares with.

DR. MARGULIES: It compares with last year.

DR. MAYER: Which was--

DR. MARGULIES: Approximately 70 million.

DR. MAYER: And you are speaking --let me see if I am clear then. What you are saying is you are thinking about incrementing commitments towards RMP's of approximately 30

million dollars then over a time span that presumably is before June 30, 1972, is that correct?

DR. MARGULIES: No, what we would propose to do is to first restore funding, add funding to programs. We can manage to do that and still have available approximately something in the range of nine million dollars, according to our best estimates, which then can be identified for other special purposes which we may find desirable, and this gives us a wide range of potentialities.

For example, we may find at that particular time -- and this depends upon our being able to complete the analysis -- that it would be desirable to expand area health education centers, to develop some major activities for rural health care delivery systems, to do more in the emergency medical service system, to develop some contracts to strengthen our quality monitoring activities. We can identify under these circumstances special activities such as a strengthening of our support for the Pacific Basin through the Hawaii RMP, and so on. And there is also the possibility in those circumstances of some strengthening of kidney activities if this appears to be appropriate.

We felt that it would be better not to utilize the entire sum of money in the first go-round. But part of this decision of what one would do with those nine million dollars which are still not committed would depend upon whether we

went from a quadrannual to a triannual review cycle, because if we were to do so and we were to take advantage of being in two fiscal years at one time a significant amount of the money could be expended for that purpose. This would lead to a smoother level of funding from this fiscal year to the next.

DR. MAYER: So what you are saying then is in all probability there will be an increment of about 21 million dollars into RMP's, with nine million dollars of that gap between 70 and 100 still hanging in terms of possibility of flowing into those other activities. Is that--

DR. MARGULIES: Right.

DR. MAYER: With decisions to be made administratively on the basis of, one, those that were administratively reduced, fiscally reduced; secondly, those A programs and possibly B programs on the basis of rankings of this committee, and those decisions to be made by when?

DR. MARGULIES: Well, they should have been made already. But we have proposed this spending plan, we should have a decision about whether this proposal is final, and generally speaking I think it will be affirmed proably this week.

DR. MAYER: Okay. Questions?

DR. WHITE: Is that nine million dollars sort of an RMPS developmental component?

DR. MARGULIES: Part of it--

DR. MAYER: Did you all hear the question?

DR. MARGULIES: He wanted to know whether that represents an RMPS developmental component.

DR. MAYER: That is ten percent.

DR. MARGULIES: It really represents more than anything else the potential utilization of it for changing from one type of cycle to the next because that could easily consume six to seven million dollars of it. Since we anticipate -- of course, we don't know what fiscal '73 will bring us, we will see what the President's message is within the month, but I have no reason to believe that it will not be fairly consistent with what we have at the present time, but likely at a lower level.

DR. MAYER: Leonard.

DR. SCHERLIS: I don't know how the others voted, but when I voted for some of the groups it wasn't with the idea that they were able to utilize any more funds than what we were giving them. Very often a specific RMP would be rated A, at least by my judgment, on the basis of their having all the qualities that go into a good program, but still cutting what they had asked because there was no possibility of them utilizing these funds in a manner which would justify their being granted.

In other words, while you stated that some of the reasons were purely fiscal, I question in my own mind how

you could utilize the large increment that you have stated in a manner which would justify their being utilized merely because these were rated as A's. And also you stated this would be purely an administrative decision, is that correct?

DR. MARGULIES: (Nods.)

DR. SCHERLIS: I have some questions as far as being able to really spend these funds in a way which would justify that large increment being used.

I have several other questions. Can you answer that one?

DR. MARGULIES: Yes, I think the answer to your first question is relatively simple. The level of funding which you have approved for programs and which was approved by the Council is always way above what they are actually given in a grant award. There is, generally speaking, for A programs -- and there are variations in this -- a level of grant award which is not higher than 65 percent of what Council and you have approved. So you have approved for them levels well above what they are now receiving. There is little reason to doubt that they could utilize the funds which you have agreed they could use.

DR. SCHERLIS: In other words, as far as the Review Committee recommendations are concerned your feeling is that when we ask for a full funding only 65 percent on the

average has been given after the final granting mechanism, is that right?

DR. MARGULIES: That's right. There are variations of that, and that is simply because we haven't had the funds to do it.

DR. SCHERLIS: Of the total, which was 70 million, about how much of that is going in now under direct or indirect support of development of HMO's? You have earmarked 16.2.

DR. MARGULIES: The HMO is separate from this.

DR. SCHERLIS: Is it really? I am talking about how in some of the regions a great deal of developmental work is toward HMO's. What percentage of that, not the earmarked funds.

DR. MARGULIES: I don't know the answer to that. But the amount of money which the RMP's are now currently investing in HMO's is not very great. But we don't have a figure on it at this point. It is not a large sum at this time.

DR. SCHERLIS: What sort of review mechanism are you thinking of for AHEC and EMS, and so on? Would that be part of the total review mechanism in a region or would they be separate review mechanisms?

DR. MARGULIES: We haven't settled that issue yet. My own preference on this one is for us to go through the

review process for area health education centers in a manner similar to what we would do for regular RMP review, and we have gotten close enough to the completion of guidelines so that I think we will be able to bring them to the national coordinators' conference next week in a final form, or at least give them to them within a few days after that meeting. But whether we will be free to go through the regular grant process in this limited period of time or not is a question that hasn't been settled, and it has to be settled at the level of the administrator of HSHMA.

MR. PARKS: I would like to get some information as to the actual volume of funds. As I understand it, approximately one-half of the fiscal year has expired at this point. And you are talking in terms of roughly the 30 million dollar increment that would be allocated and applied to the various programs. Isn't this in fact by virtue of the shrunken year a double impact for programmatic absorption? By that I mean 30 million with half a year expired would have the impact of roughly 60 million if you are talking about utilizing it between now and expiration of the fiscal year. Or do you anticipate in this that there would be rather substantial carryover balances that would go to extend programs? That is one question.

The next question is this: that shouldn't there be some review identification of the total problems that you

have within RMP's, and I am talking now about the programs throughout the country, and shouldn't this money be earmarked so that there is some specific onus or burden, if you will, upon these programs to achieve those things that you are trying to get done either nationally or those things which regionally you feel to be desirable?

DR. MARGULIES: Let me answer the first question, which is less complex than it would appear. I am glad you asked it. What we did after the last review cycle for those programs which -- you see, our fiscal year is not the same as their fiscal year, which is a saving factor in this. The review cycle which was completed in August was for programs which had a fiscal year, their own fiscal year beginning in the fall, in September and in October. At that time we decided to run the risk, or rather I decided to run the risk of anticipating a higher level of funding, and so those programs have already been given a significant increase in their funding to begin their fiscal year. So that they have started at a higher level, at a level which is fairly consistent with what I am now proposing. That is the A programs and to some extent the B programs.

Now the last review cycle which you completed when you were here last time is for programs for the fiscal year which began January 1, so that they have a full fiscal year coming up, and if we supplement the grant awards which were

initially made before we got the release of funds for them they will have lost no more than one month out of the fiscal year by the time they get to them.

The remaining funding which is in this review cycle and in the next one is for fiscal expenditures which have yet to be started in their fiscal year. So that in fact we will be dealing with new fiscal years for the Regional Medical Programs, and it isn't as though they were all half way through their year.

We have accomodated for it in the first group, and the other three-fourths of the programs have just started or have yet to begin their fiscal years.

DR. MAYER: Does that answer that particular question, Mr. Parks?

MR. PARKS: Well, I assume then administratively you can handle the allocation of these funds.

DR. MARGULIES: I think we can.

DR. MAYER: Without a significant build up in carryover obligation. I think that is the question.

DR. MARGULIES: I think we can, and, of course, that has always been a problem when you get this late in the fiscal year. It is distressing because in fact the appropriation process was completed in August and there is a determination in Congress right now to get this year's appropriation process finished before July. If we had this

kind of allocation early in our fiscal year it would obviously be much easier.

And the answer to your other question is yes, there is a desire to emphasize some of the major movements which HEW and the administration have been supporting in the health field, and one of the reasons for designing the coordinators conference around the issues that we have, access to medical care, emergency medical services, area health education centers, improved forms of health delivery, is to emphasize movement in that direction. That is also why I think such things as emergency medical services and area health education centers have been identified as special kinds of activities for increased emphasis.

DR. MAYER: Jerry.

DR. BESSON: I have a somewhat complex question. We have a new stated mission for RMPS articulated in the past year, and as a review committee we have been asked to emphasize in our assessment of individual regions the compliance of program regionally with new mission. As I will come to when I discuss the regions which I have been assigned, the staff opinion and the director's opinion about the appropriateness of a particular program has to be in light of new mission of RMPS. But yet as I add up these figures I find that we have some 37 million dollars allocated to area health education centers, HMO's, and emergency medical

services, and construction of cancer facility, all of which is consistent with new program. Implicit in this then is that the 100 million dollars should be allocated to the old program, if you will, and yet we fault individual regions for not being in line with new RMPS directions. Specially when I come to my region I will note that staff has allocated only maybe 20 percent of the requested amount because the program was not in line with new mission.

I am not sure that I really understand how this review committee should function, whether we should view the entire 140 million as being available only for new mission, whether we should view that money as having to be spent because if it is not spent it may not be again allocated next year no matter what the program is, whether we should be selective in viewing an area as being A, B, or C depending upon how adequately it is in line with new directions. And I think we really as a review committee have to have a little bit more clearly articulated modus operandi in light of your statements this morning, and perhaps you can do that for us generally, although most of us have done our homework before we came here.

DR. MARGULIES: Well, now that is not a complex question. You can do better. There is no question but that there is no implication in the 100 million dollars which is not earmarked for anything other than the new directions

which are part of the mission statement. One year ago today the new obligational authority which had been recommended for RMP was 52.5 million dollars. We are now operating at the level which I have just described. The reason for the change in the level of support of Regional Medical Programs is essentially because it has designed a new direction which has support in Congress and in the administration, and if we should utilize these funds for anything other than to strengthen these new directions I think we would be doing a disservice to the intentions of those who have appropriated the funds.

There is no suggestion so far as I am concerned that we should utilize these funds merely to be utilizing them. As I indicated earlier, if there is not an effective way to use them in a manner consistent with the mission statement and with the total directions in which we would like to see the RMP's go then we certainly shouldn't spend the funds.

In other words, I think that it would be inappropriate for this review committee within the limits of what people can humanly do to review these Regional Medical Programs now on any other basis than what they have done in the past. We have asked you, and you have, I think, reviewed them not on the basis of what kind of money might be available, but rather on what they are merited in terms of support. We have tried to keep separate limited funding from the quality

of the program. We should also keep separate more generous funding from the quality of the program. It should be review on the basis of the merits of the RMP and the way in which it is consistent with the review process, with the mission statement and the directions in which RMP's are now going.

DR. BESSON: Again the legislation says something a little different than that statement of a year ago, and I am not sure how this 140 million dollars jives with these two statements which seem to be somewhat inconsistent. The legislation asks for support of programs that are in line with improvement in the care of heart disease, cancer and stroke first, and also not as an afterthought necessarily, but maybe as a political statement, include something which has been expanded to be the new mission.

I am still not sure then as I review a program whether any programs that are not in line with the objectives that were articulated a year ago, whether those programs should be funded.

Now eight months ago this came to a head in this committee when as a matter of testing the waters I was reviewing the Iowa program -- excuse me, Miss Kerr, but we will get this out in the open -- I was reviewing the Iowa program and asked that the Iowa program be denied completely because it was inconsistent with the new mission of RMP even thou each of the new programs were meritorious. The Review Committee

upheld that position and passed it up to Council. Council reversed the Review Committee decision, and the message that I got from Council at that time was that this was an inappropriate action of the Review Committee. Maybe in the intervening eight months the entire emphasis of RMPS has changed. Were that action to be taken today I would be very curious as to how Council would react. And I am not sure that I clearly understand how I should review a program in light of this statement.

DR. MAYER: Let me just emphasize that one, Harold, because I just blew all of last Sunday going through that exercise myself in another frame of reference, Jerry, in terms of legislation, and what I assume you are calling our RMPS mission statement was that rather lengthy letter that tends to confuse frankly mission, goals, objectives back and forth, and it is hard to get a fix on what it is that is really being specifically stated, and then take a look at other information that has been provided by RMPS in various devices and it does get a little fuzzy in terms of what really is being said. And the thing that got to me was the very point you are making.

In an attempt to try to get some clarification of this I went back to the new law, and all that did was serve to confuse me even further in terms of where we are. And I think we really do need some clarification here on this

one and what are you intents also about a more explicit statement than the one that has already been produced.

DR. MARGULIES: Well, I suppose the best thing I can do on this is to paraphrase what the Secretary said and which I think is a valid statement, and that is that you can read the RMP legislation and make out of it anything you want.

When I went before the Appropriation Committee last year I described the kinds of directions for RMP which we have been supporting here, and these were acceptable to the extent of the kind of support which you have witnessed. I don't think that we are at the present time trying to be non-categorical, but we are trying to eschew the narrowly categorical, the kind of thing that picks out one part of one phase of one disease and concentrates on it because that appears to be a nice thing to do.

I don't believe that I can settle for you the line of distinction between an effective program which is concentrating on one aspect of the system and an effective program which is taking a broader base. I think there are ranges of distinction, and I am not convinced, although I would like to hear more from other members of the Review Committee, that this is as difficult a distinction to make as it appears to be. Unless you are talking about whether it should be a program as it was three years ago rather than as it is at the present time, because there has been a

significant change in what the RMP's are doing; there is a movement in the Regional Medical Programs toward the creation of a more effective kind of goal, and I think the review process has identified that. But there has not been produced in this process of review evidence that each RMP is like every other RMP, and I think that those kind of differences can continue.

So far as the Iowa program is concerned, Jerry, that was not overruled on the basis of your interpretation. That was a difference in your interpretation. They did not agree with your analysis of the program, which is fair game.

DR. BESSON: Say that again.

DR. MARGULIES: The change from the Review Committee to Council was a change in perception of what the program represented.

DR. BESSON: I thought our decision here represented a statement of principle, namely that, at least as I phrased that resolution, we were testing the Council's intent to fund only programs that were in line with new mission. Seems to me that that particular program, the kinds of things that they were asking for were still on the old model, and that this might have been a good test. But maybe we chose the wrong test.

DR. MARGULIES: That was just a matter of professional disagreement.

DT. MAYER: Dr. Brindley.

DR. BRINDLEY: I would like to ask a question and make a comment if I might. I have a disagreement with Jerry about the point he was just mentioning. I really question the -- I would like for us to say that we would review each region having been proposed to us, what their needs were, how they could best meet those needs and how they would utilize money to improve health care. The question would be who determines what national goals, objectives and priorities are. If the regions, like Jerry mentioned, all have to conform to national goals and priorities what input do they have to comment on what they need and how it will apply to them? We don't seem to determine it. Does the Council determine it? Who does determine that?

DR. MARGULIES: National goals and priorities are always the prerogative of the administration. That is true year in and year out. The legislation for this, like every other program, says that the National Advisory Council will review programs and it will make recommendations to the Secretary. The decision about grant awards -- the decisions are made by the Secretary. That is always an administrative decision. And consequently so also is the definition from one period of time to another of what represents the major goals and objectives of the government in the development of budgets and in expenditure of funds

of its programs, and that is a part of the general political process. Now whether that is right or wrong is something that I don't believe I am competent to judge.

DR. BRINDLEY: Let me ask you one question concerning the HMO's and area health education centers and things of that nature. That might be the very best way to use our money in some areas, it might be in some areas that is not the most effective way of delivering health care. Now according to Jerry, we would be critical of that area that doesn't wish to go about it in that way because for them another method is better.

DR. MARGULIES: No, I think that is a perfectly clear point. Let's be specific about something like the Health Maintenance Organization which is something that the administration is keenly interested in. There is no constraint upon a Regional Medical Program to get itself deeply involved with HMO's. If they say that they think we can serve the broad purposes of our region and be consistent with national goals by restricting our activities to a certain phase of the health delivery system -- a good example that we reviewed last time is the Ohio Valley RMP which you are familiar with. Their concern has always been concerned with the improvement of ambulatory medical care and with an emphasis on better uses of health manpower, and they have not covered a lot of other activities, that they say for our part of the country

that is the best thing. If you measure that against the broad statements which the administration has been emphasizing of increased access to care, of improved product of the system, greater efficiencies, cost containment, etc., there is no inconsistency.

On the other hand, if the purposes of an RMP were to provide transplant facilities in as many hospitals as possible over a short period of time, to pick an absurdity, I think this would be unacceptable.

Now it is the range in between which causes great difficulty, and it is why we have a review committee upon whom I don't think we can impose a very strict kind of set of rules, but one which is broad enough to allow you to use your judgment.

DR. BRINDLEY: If Ohio Valley says they can do the best job in this manner that is all right?

DR. MARGULIES: That is the main purpose of the program.

DR. MAYER: Mr. Hilton.

MR. HILTON: I just wanted to say prior to what has just been said the suggestion perhaps that there needs to be better communication between the Executive Branch that articulates national goals and the local regions. Part of the reason that my recent site visit was agonizing was because we ran into the situation the Jerry and others have

identified where people were in effect quite frustrated, wanting to know from us what it is that they should do so we could evaluate them so they could get money. We talked as best we could about program management and kinds of things to keep in mind, but I think we all had a flashing around there of the real issue, and that is we cannot perhaps effectively evaluate unless it is quite clear to us what it is that needs to be evaluated, and give ratings and what have you. And the issue of money always gets in the way. People always want to do whatever it is they are going to get money for.

So I think that needs to be made clear in our minds as we look at the program precisely what it is we are evaluating for, and I just echo his point.

DR. MARGULIES: Well, I think that is a very valid criticism. I think we have been inadequate in our capacity to get to the regions and to do more than simply send them pieces of paper. We need to have a better capacity to work directly with the regions; and at the present time with the staff strength we have and with the demands that I have described in the review cycle this is being done very inadequately, and I see little kind of relief from it unless we are able to lessen the demands of the review cycle, which is one of the reasons for going on a three time a year basis.

The people in the Operations Division, people in

the Professional and Technical Division, are so heavily involved with the activities which are now consuming their time that that aspect of it which is -- really the way to communicate is to be with people and talk with them and to examine what they wish or what they think needs to be done against what their understanding is of what should be done, is essential. And yet we do have a real limitation on how much we can do about that.

MR. HILTON: Once that kind of communication and dialogue is under way then will staff be communicating these local needs and concerns to the appropriate people?

DR. MARGULIES: That is our intent, and, of course, that is one of the reasons that we worked so hard, and we almost were unable to do it, to get Dr. Duval and to get Reeso to the national coordinators meeting, because this will give them the first opportunity to not only lay out for that group what it is they expect of Regional Medical Programs, but also to answer the kinds of questions which the Review Committee is raising.

But there is a long chain of events from Pennsylvania Avenue to Independence Avenue to the Parklawn Building to the regional offices to the RMP's, and in the absence of close working relationship it is extremely difficult. I am not satisfied with it. I would be most dishonest if I said that I was.

DR. MAYER: Harold, one of the questions which I asked which got lost which I would like to reiterate is is there going to be an attempt to develop a more explicit statement and perhaps a more organized statement than the one that has been developed as of now relative to RMPS mission, goals, objectives?

DR. MARGULIES: Yes. I must tell you that the production of the one that you are talking about was in itself an extremely complicated task. Interestingly enough, even that one, when we have met with coordinators and staff, has been looked at by very few people. We had a meeting of several coordinators in here not long ago and 65 percent of them had not even looked at that mission statement. So, you know, we can do it and we will do it, but it is going to require a great deal more than that.

DR. MAYER: It is very, very important for us that have read it five times and still don't have a clear picture. I think, you know, you gear your educational program to the bright ones in the class as well as those that are moving along slowly.

DR. MARGULIES: Well, I can say this about it. I like the way it was written in the original form.

DR. MAYER: All I was commenting was that there are some of us who didn't, and we would appreciate some--

DR. MARGULIES: No, I don't mean that form; I mean

the original form.

DR. MAYER: Jerry.

DR. BESSON: Well, I think that is critical for the entire program, and the whole way in which the Review Committee operates has been very elusive. The way the Council reaches its decisions -- I have used the term capricious before, and I will use it again, because we seem to be operating under directive guidelines. Now that is because the administrative staff of RMPS under the Director is somewhat chary about ordaining how RMP should be run and would like to remand to the periphery making decisions, and, of course, the anniversary review process implied that this is the way it should be done. But in so doing the periphery and the Review Committee are left in a double bind.

On the one hand we are told that the center will not ordain how the periphery will run its affairs, and the periphery will organize itself to do its own program priority determination and we will either say yea or nay depending on whether they did it right or not. But on the other hand, as I review programs now I see that staff does ordain because they say these particular projects don't seem to be in line with new mission, therefore we will cut funding from X to X minus 100 K, or whatever. That leaves the region in a double bind, and they grasp the straws that emanate from this center when they see the mission statement, and I see

it quoted very widely, because there is very little guidance they have from the center.

The Review Committee I think is left in the same position. Even after having served on this Review Committee now for close to three years I am not sure that I understand what I am doing and how I am supposed to be doing it; and in that candid statement I think I must say that others on the Review Committee and Council, let alone the coordinators, must feel in the same position of trying to grasp at clouds and not quite sure whether what they are doing is appropriate.

So I again make a plea for some frequent articulation of what it is that we should be up to, or telling them what we are goingto do and how to go about it within broad guidelines and let the area choose its own modus operandi within those broad guidelines. But these guidelines are necessary again and again.

MISS KERR: I think what we are generally saying, we are floundering somewhere, and Jerry just said let alone the coordinators -- and while my information came to me very informally, I think it is the appropriate time to bring it out, I think the coordinators are floundering. Some visits I have made and have heard others have made, there were comments "when you Feds make up your mind," actually from the group as we visit them. So they, too, are feeling anxious about this.

My understanding is that the coordinators have employed an attorney. The source of the funds I don't know. One wonders. But for what reason, I would ask the question. Is their level of anxiety so high that they feel they need legal advice, or is my information incorrect?

DR. MARGULIES: The only one that I am acquainted with is the fellow who serves as a secretary to the Southeast area coordinator group. Presumably the fact that he is an attorney is incidental to his general organizing and secretarial responsibilities. I have the impression, however, that he extends his efforts in many other directions, and I am not very keen about it. But it is being paid for, I believe, by a combination of Regional Medical Programs. What he does is help convene metings and help develop common programmatic concepts among the Regional Medical Programs in the Southeast area.

DR. MAYER: Leonard.

DR. SCHERLIS: I would suggest that they could better put these funds into getting a psychiatrist.

(Laughter.)

I didn't want Dr. Besson's comments to go further uncommented upon because I share a great many of his doubts and anxieties. I confess I always feel better after the morning session than I do after the end of the second day at these Review Committees because I am reminded of "Of Mice and

Men," there are two characters, George and Lennie, and since my first name is Leonard I have some feeling for it. Lennie is rather simple-minded. In fact, he has some cerebral impairment.

DR. MARGULIES: Bigger than you, though.

DR. SCHERLIS: Much bigger than I. But for assurance he always asked Gorege to tell him about the rabbits and then he feels better; and it is always nice to have Hal tell us about how the review mechanism might work.

I do have a great deal of concern because frankly when I go to some of the regions for site visits -- we are there very much on a very important basis obviously, their longevity and their very existence can depend on our decision, and I find it very difficult to really be in a position, except very often have a good guts reaction to what goes on. I have a feeling abdominally that is good or bad, and then I translate this, as I will today, into specific funding recommendations in terms of dollar value, and I can put a color value on it, it is pink or blue, but it is hard to really put a dollar value on it.

I am getting increasingly impressed with the similarity of goals and objectives in the regions, and I could be naive and assume that they all openly define the ultimate truth simultaneously which doesn't really seem to be realistic. Or else the realistic thing is that they know what

the goals and objectives are, because if I put out my hand frequently enough with the wrong bottle I am sure I will get it slapped,eventually I will know that other bottle is the right one. I am sure they get the message. The rewards are obvious enough. And I think that what we discern as the regions are beginning to really decide what their real needs and objectives are, the question whether it isn't really a cyclic mechanism, if they know that if they define the goals and objectives a certain way the funds will not be forthcoming. And I am impressed when we talk about some regions having turned the corner that it is merely that the smoke signals have become denser and denser from the spot from where they emanate.

I do have concern now that we again are talking about defining goals and objectives and now that we are adding what are really tremendous challenges -- AHEC's, as I view them, are tremendous challenges to regions, and the potentials of duplication, of confusion, of overutilization and few resource people, the attempts to define needs on the basis of groups as set up in that document are horrendous. It was a document which I went to bed last night and I awakened not any clearer in my own mind, though very often sleep does have benefit. I am increasingly confused about the goals and missions of RMP, particularly how they get translated into the field, how we can sit here and decide how these funds

can best be expended.

I hope that as the morning goes on we will have further discussion because I think that as you determine the dilemma many of us face it isn't quite as clear when we are out there in the field working and trying to reach an important decision how we can put into clear focus some of the priorities that are obviously required.

DR. MAYER: Let me raise two quick points, Harold, and it relates to AHEC's because I think that gives us an example of two issues. You talk about a combined effort with the Bureau. You commented that 7.5 million would be set aside, and possibly more if there is some left over of the nine for that activity. How much is the Bureau putting in?

DR. MARGULIES: At the present time approximately 11 million.

DR. MAYER: Then the second question, which gets back to Dr. Brindley's point in terms of who sets national goals and priorities, I think it would be helpful to us if we had some feeling of how your document of December 23rd on the relationship of area health education centers, how the RMPS position paper was evolved and who developed it, because I think that does in fact have an impact on policy very clearly as people think about that kind of effort.

DR. MARGULIES: The area health education center document which will emerge, and as I indicated earlier in

the morning, is just being completed as a set of guidelines is being developed commonly -- and by that I mean by staff work within review and approval by those under whom they operate, with the Veterans Administration, the Bureau of Education and Manpower Training, the Regional Medical Program Service. And the process that will be followed so far as HEW is concerned is to create a set of guidelines which are accepted both in the National Institutes of Health and the Health Services and Mental Health Administration; this when it is in a form which is acceptable to Dr. Wilson and Dr. Marston will be signed by them, sent to the Assistant Secretary, to Monty Duval, and if it is acceptable in that form will then be used as the guidelines for the development of area health education centers governing the activities of both Bureau and RMPS.

We will continue to operate together under those guidelines in the process of review and support of area health education centers as the proposals come in and as they go through a joint review process.

DR. MAYER: Let me just pursue this one step further. You indicated that in that joint review process there would be the possibility that it may be funded totally by NIH, totally by HSHMA, or combinations thereto, which sort of implied to me that there were different kind of labels to justify the reason for that. And if we are talking about joint

guidelines then I don't understand why there isn't a joint pool of money.

DR. MARGULIES: Simply because the funds have been appropriated by different processes for different organizations, and the best that we can do with them is to work out arrangements in which there is a reason for both of us to be involved in the funding of one activity.

But you are quite right in suspecting that there is still some difference in perception in the Bureau and in RMPS, and I don't think those differences have been completely resolved, and I agree that that is an unsatisfactory state of affairs. That could be resolved in the office of the Secretary, and up to the present time has not been.

MR. PARKS: I raised some questions about certain things of national emphasis and how the money was going to be used and this kind of thing. I am going to raise it a little more specifically for two reasons. One, I think it was oversimplified when it was originally put out. And secondly, it would require me, I think, to compromise a bit with intellectual honesty.

For example, I am concerned about the overall civil rights compliance, the whole process of RMP's, their existence, their operation, and the mechanisms by which they carry out whatever it is that they are doing. Do we really know about it? In terms of our evaluation sheet, which is fairly

specific, we have minority interests here which is rated 7, I guess, in terms of weight. Yet in terms of the status, the articulation of the law -- this is a law and order matter -- by both the Executive Branch, the President, and your Secretary, there are certain specific things that I have question about whether there is in fact compliance with the law.

The question I put to you is whether additional money should be put into a process that further extends this kind of aberration is a fact that needs to be addressed here honestly and openly.

I am not sure, for example, from my review of these papers and from the one site visit that I have been on, which was not terribly helpful, that there is an equal employment opportunity, that there is an opportunity for equal participation of the black professionals, that there is an equal opportunity for access to the granting process, that is to participate as applications for grants or for programs from the Regional Medical Programs themselves. I am not sure what it is in terms of so-called staff administration, what instruction do they have. Are the instructions of the Secretary of HEW in fact being carried out?

And let me give you an example. I have here a letter from the Secretary, and it is a letter addressed to me, and this will give you the kind of example that really creates a

tremendous problem. And we are talking about money. Money is it. Health, everything else revolves around money. This is a money system. We are talking now about the dispensation, if you will, of 100 million dollars cash or in favors, whatever it might be.

This is a letter dated August 9, 1971. It is addressed to me. It is from Elliot Richardson. It says:

"Dear Sir:

"It has been the policy of the federal government to encourage and promote the development of minority owned enterprises. In conjunction with this policy the government has intensified its efforts to increase the deposit of funds in minority banks. These institutions are themselves small minority enterprises with most of their commercial accounts being other minority business heads. We should like to encourage your organization to deposit a portion of the funds received from this department and other sources into minority banks located in your vicinity. Stimulation of minority banking communities will enable these banks" --

He goes into this, he has attached to it a list of the banks. Has this in fact been dispensed to the RMP's? Is it a part of the process that you go through in reviewing these RMP's?

I take this as a specific kind of example. I just happen to have this in connection with something else.

There are a number of other kinds of directives that have come down that pertain directly to the dispensation of federal funds, and I am not so sure here with the guidelines what role these things should play, whether we should continue to participate in the further extension of these kinds of law and order aberrations -- by that I mean in terms of compliance. Should we compromise, as I have seen in some of these things where we say that the fact that the minority involvement is not present in either the delivery or in the RAG and that kind of thing, that it is oversight of nice people and that we pass on?

I mention it here, and I think it ought to be out openly and honestly.

DR. MARGULIES: Let me answer the specific issue which you raised, the Secretary's letter. That information was transmitted to every grantee and every coordinator in the Regional Medical Programs with strong emphasis that it be followed. That is not enough. We have, as I indicated in the last several sessions, placed great emphasis on equal employment opportunity in Regional Medical Programs as we have in RMPS. We have not -- and you are quite right -- raised this issue in my judgment to the proper level of consideration in determining grant awards.

I would be completely sympathetic to making it a stronger issue and identifying it as one of the reasons for

funding or not funding a Regional Medical Program. We have seen improvement. Improvement isn't enough. And this is true in the range of areas in which grant funds are expended. It is true in membership of Regional Advisory Groups, and it is true of staff employment, both professional and nonprofessional.

The figures that we put together recently -- and I would like to have you see them -- indicate a level of employment which was quite striking the last time we had a review of minority employment. And I think we probably have those data available, and I would like to distribute them and get your comments on them.

But this is an issue which I think has to not only be looked at, but has to be given greater emphasis or we are mismanaging our affairs.

Now the other aspect of it, of where the funds go and what opportunities minorities and underserved groups have to gain benefit from a Regional Medical Program, get us into the question of how one is able to utilize RMP funds and what should be the mechanisms involved. I have been talking to Dr. Duval, and I will be seeing him again later this week, about this kind of a question as it relates to comprehensive health plans. Under good circumstances comprehensive health planning activities should be so developed that there is a true minority representation, so

that there is a selection of priorities for the community, an identification of what that community wants to get with what it is investing and what is being invested in its name by federal, state and local government. And the Regional Medical Programs should be totally responsive to those identified needs. CHP has not been able to produce yet that kind of a structure. I think it should.

My own feeling, which is not generally shared, however, is that not only should that be developed in such a way that the total community interests are represented with strong emphasis on minority interests, but Regional Medical Programs and other federal agencies should be bound by it. Not just review and comment; I would favor a much greater authority for CHP, because I do not believe that what we are aiming for is going to be produced by the Regional Medical Program operating as an independent agency. It is too much provider dominated, which is the nature of it, and it is not going to spontaneously seek out, and even though it may try it may not do it effectively, those kinds of investments for RMP which affect the principle that you have been stating.

I would be happy to see this Review Committee pay a much higher level of attention to those issues.

MR. PARKS: Well, in terms of what we are really addressing, and this is in terms of focus and the kinds of emphasis, what roles and fate this plays in the evaluation

of the programs and this kind of thing, it is a particularly hazy area, fuzzy, if you will, because I think in terms of utilizing the things within the Department of HEW that are identified for some of these purposes we need that kind of advice really before another cent is dispensed. We need the advice of the civil rights compliance unit within HEW as to whether in fact -- not whether they have signed the forms, but whether in fact these programs are doing what they should be doing under HEW guidelines, under guidelines of various statutes, under the guidelines of the various executive orders which date back now as long as the Eisenhower administration. We do not know. And these are things about which there certainly is neither obfuscation or question. We need not search for these, and the mechanism for providing us with that advice is present and is a part of the establishment.

What I am suggesting to you is that I think there are some things that we could do with it.

DR. MAYER: Further comments?

Yes, Jerry.

DR. BESSON: I think Mr. Parks introduces a new notion in the review process, one I think we should pursue perhaps a little more vigorously. If these morning sessions are going to be more than psychotherapeutic catharasis I think they really have to be translated into direct action.

I think it is not sufficient for us to platitudinously say that we need greater emphasis on this, and if I read Mr. Parks' comments and the Director's acquiescence to his comments correctly I would like to suggest to the Review Committee that we do take the step that is implicit in his comments and make -- and I would like to make this in the form of a motion, Mr. Chairman, for Council's consideration and decision -- that no RMPS program be funded without prior indication of compliance of that program with the civil rights unit of the Department, and that a sine qua non be established. And I would like to put that in the form of a motion for Council's consideration with decision at its next meeting.

DR. MAYER: You are making a recommendation of this Review Committee to Council?

DR. BESSON: Yes.

DR. MAYER: I need to have clarification, Jerry. Well, is there a second before discussion?

MR. PARKS: I will second it.

DR. MAYER: I need to have clarification from staff. I frankly have been assuming that that in fact was happening. If it is not, then I think the motion is in order.

DR. MARGULIES: Jerry, do you want to comment on it?

MR. ARDELL: The only thing I can say is to the best of my knowledge what we are doing here I think kind of goes

back to your comment. I don't know the extent to which the desires of the administration are carried out by this Department. And the only notice we have gotten to date is the continuation of what Mr. Parks has just mentioned from the administrator, and we in turn gave that to the programs.

I don't know if we move in this direction -- I think what you suggested, Dr. Margulies, is that we are independent, we are one show doing this. I don't know who else would go to this extent at this particular time. I think we need to pursue this before we--

DR. MAYER: Let me be explicit. I need to have the question in order to answer -- you know, because if the answer to the question is one way then the motion is in fact appropriate. If it is not needed then we need to know that.

DR. BESSON: Mr. Chairman, in the review of the program that I have had for this session I have had no indication that there has been compliance by a reviewing unit with civil rights legislation as far as HEW programs are concerned. I would like that to be an incorporated part of the materials that are presented to me for Review Committee decision.

DR. MAYER: Well, that is a different motion, Jerry. Then I wouldn't have had any trouble with it. Your recommendation to Council was that they take the necessary steps to insure that funding does not occur. Now what I have just heard you say is that you would like to move that this

Review Committee request that that compliance be provided to them before they go through the review process. Have you changed your motion?

DR. BESSON: No, I haven't at all. I just added the teeth that such compliance be a sine qua non to funding.

DR. MAYER: Well, I am still unclear. Do you or do you not want to have that information before you go through the review process?

DR. BESSON: Yes.

DR. MAYER: Or do you or do you not want the assurance that it is there before funding occurs?

DR. BESSON: Yes.

DR. MAYER: So there are two different levels and two different issues.

DR. BESSON: I would like to have the information, but if the information doesn't represent compliance I don't even want to look at the program. I would consider that it is a sine qua non of program approval, and without it that program not even be bothered to be reviewed. Does that make it clear, Mr. Chairman?

DR. MAYER: Yes, you are going to have to modify the motion that you made then, because what you in effect from an administrative standpoint have just said is that you want to have that compliance before the review process is initiated.

DR. BESSON: Right.

DR. MAYER: That is a different statement than the statement you made earlier. That's all I am saying, and I need to be clear what it is you want.

DR. BESSON: That's what I would like. I would like Council's decision on that point.

MR. PARKS: He said the compliance report, and that a certification of compliance be a sine qua non, without which condition--

DR. MAYER: Somehow I am not coming through.

DR. BESSON: Perhaps you can state my motion, Mr. Chairman.

DR. MAYER: What I heard, Jerry, without writing it down, was your request for certification of compliance and adequate review to insure the compliance occurred was a recommendation you were making to Council so that that had been accomplished prior to any funding.

DR. BESSON: And add the additional clause that no funding be considered without such compliance.

DR. MAYER: All right, but that still doesn't get at what I then heard you say, is you don't even want it to go through the review process until it is there, because that's a different frame of reference.

MR. PARKS: Well, let's write it down.

DR. MAYER: You see the point I am making. The

point I am making--

MR. PARKS: We will take care of that. Let's try to write it down. The first point is -- again I don't want to usurp your motion because I am only the seconder of it.

DR. BESSON: Well, I would add the third clause that you just stated, that the program not even be reviewed unless such compliance is part of the information.

DR. MAYER: All right, fine. I just need to have it clear because those are two different issues.

DR. SCHERLIS: Is there a specific written directive which is a checklist as far as what is or is not compliance? I ask this from a sense of naivety of instruction; You have talked about compliance. Is this a written checklist document. Dr. Margulies, do you have such a listing. What would the certification of compliance indicate?

DR. MARGULIES: No, all grants and contracts of the federal government require civil rights compliance, but I am not acquainted with any kind of checklist which would determine whether or not that compliance has occurred.

For example, every university which receives federal funds has to have civil rights compliance which would cover a wide range of legislative acts. It is separate from -- what Mr. Parks was also talking about was executive order, which is another kind of, but related, questio

And I am not familiar -- my own ignorance -- with what kinds of check-off lists might exist and what kind of measures have been carried out to confirm that compliance has in fact occurred or prove that it has not occurred.

DR. SCHERLIS: Another point of information, how would passage of this motion affect your operation?

DR. MARGULIES: Herb says we would go out of business.

DR. PAHL: So would every university in this country.

DR. SCHERLIS: Could you amplify that, because that is a very interesting response which I didn't anticipate.

DR. PAHL: Let me not comment as Deputy Director of the program, but as an individual. I think all of us are aware of civil rights acts and what has happened and what has not happened in the country. I have only been in the federal government for ten years, and I am not sure I know what does and does not go on in compliance with all the rules and regulations for awarding grants and contracts.

I think what it is we wish to do and what we do accomplish in the country are two different things. It is my personal opinion that if this resolution were adopted and implemented our program would not be able to operate at all, because I daresay that I don't know a single community in the country that fully complies with the civil acts and

regulations, civil rights legislation of the country. I am sure such communities exist, but I don't know of them.

This doesn't say we shouldn't strive to meet those goals. But if one sets an ultimatum for the next review cycle that no funds would be awarded unless full compliance were achieved it is my personal opinion, not that of a program official, that this program and no other program in the federal government probably would be able to function. The highway program I am sure couldn't. The Department of Defense couldn't. HEW can't. That is not to say that we shouldn't strive toward it. But if it is an ultimatum, I have been in several universities and at least from my personal observations those universities would not be able to receive another penny either if full compliance with all the legislative requirements had to be met by the time the next disbursement of funds occurred. So I will be very interested to see what occurs.

What I think we do have is civil rights legislation with appeal mechanisms, etc., built in. But as we all know, even in the case of Virginia and its integration of schools in the newspapers, it has taken many, many years, and we are still not at that point. I don't see how it is possible for RMPS in the next three months to achieve national compliance with civil irghts legislation.

I am not in disagreement with the goal. I am trying

to look at it from a very practical point of view. I think the subject should be explored, more should be done, but it has to be done in the practical sense if we are to achieve anything.

MR. PARKS: May I get a point of clarification? Are you saying the law should not be complied with? Is that your position?

DR. PAHL: Indeed not. I want to make that perfectly clear.

DR. BESSON: But, Dr. Pahl, perhaps some of us neither share your diffidence nor your semantic choice of words when you use the term ultimatum, implying we are in no position to use that kind of approach, implying further that it is going to take some tooling up. I think that if we hold the purse strings -- and I suppose we do as a review committee, as we really are a policymaking body in advising the Council -- then we would be negligent in our leadership role if we didn't do what we thought appropriate, if the authority is truly vested in us rather than yourself and Dr. Margulies, which I think the law asks us for, then I think it is our choice and the staff really must comply with the policymaking body.

If I am incorrect in that assumption, Dr. Pahl, perhaps I should stop right here and perhaps you can either reassure me--

DR. MARGULIES: May I respond to that, because the Review Committee is not a policymaking body. The Review Committee is created as an administrative device to support the activities of the Council. The Council is a policymaking body and is advisory to the Secretary. This is a review committee.

DR. BESSON: I accept that. We are advisory to the Council, and we would request Council determination on this as a policy matter. But I think initiation of policy change may occur here for Council concurrence.

DR. MARGULIES: Certainly, but that is not the same as being a policymaking body.

DR. BESSON: No, no.

DR. MAYER: Sister Ann.

SISTER ANN JOSEPHINE: Yes, I would like to ask Dr. Pahl what steps are taken to review compliance. I mean is there any supervision of this as appropriations are made, the degree of compliance? What steps are taken to review the degree of compliance?

DR. PAHL: In our program to the best of my knowledge none are being taken. Perhaps staff can mofidy that comment. Jerry.

DR. ARDELL: Except to the point that there is a published list of thoe organizations that are in compliance, and if they are not in compliance we are informed and we do

not make grants to them until they are in compliance.

DR. MARGULIES: I think one must recognize that the whole process of reviewing civil rights compliance involves a very large segment of the government which I think most people would recognize has not been able to do all that it would like to do and all that should be done. But I doubt that you could read the newspapers for a week without finding evidence of a challenge to civil rights compliance in schools, in hospitals, in construction work. But it is a part of HEW, it is a part of DOD, and the civil rights review and enforcement activities are of tremendous political prominence, so it could hardly escape one's attention. But we are a part of the HEW civil rights compliance activities.

SISTER ANN JOSEPHINE: I raise this question because I know that we have many, many fine -- just as in any kind of business, we have many, many very fine policies, but unless there is surveillance of the implementation of the policies their formulation may simply be a political move. And I think that as we are looking at Regional Medical Program services we need to ask whether we feel at this point in time that we are looking at one of the weaknesses of the program when we say we have a policy that applies not only to this program, but to every federal program that is being funded, and yet we are not exerting good management supervisory control to see that the policy is implemented.

This is as I interpret the question.

DR. PAHL: I would like to agree that we are not exercising the degree of management surveillance and control that we would like. This also holds true with other areas, and that is in the management of grant funds. It also holds true with copyright laws. Again it comes down to a question primarily of not what one would like to do, but what one is able to do.

There are other sections of HEW that are large and have the responsibilities for carrying out surveillance, appeals We must in all good conscience depend upon some other unit of the government than ourselves in a very practical sense because society is interrelated and we can't do everything.

Again that is not to say that one is is disagreement with the goals. But I think Mr. Ardell would agree that every grant and contract that emanates from RMPS has many conditions attached, and in all honesty I don't think any of us in this room can say that we provide surveillance over most of the conditions under which we make the grant and contract awards. There is a mechanism by which if matters come to our attention that there is noncompliance in this and other areas then there are routes, mechanisms, etc.

I do not see us in practical terms having the wherewithal to carry out what the Review Committee is suggesting, however desirable it may be.

DR. MAYER: Dr. White.

DR. WHITE: I think this kind of resolution clouds our role. I think we are mixing up what our purpose in life is and what the purpose of other people might be in reference to this particular point. And it puts me in the position of having to choose between the consequences of being a bigot or the man from Lamanchia. I don't believe this is an inappropriate concern by any means. I don't want to be classified as a bigot. On the other hand, I think it is totally inappropriate for us to be acting as a policeman, which is what we are trying to do.

DR. MAYER: John.

DR. KRAWLEWSKI: Let me just carry on with that comment a bit because it is along the lines of something I wanted to say before. I think one of our real problems is trying to determine the role of this committee here. If we see Council as a policymaking body and then we see the RMPS staff carrying out that policy and implementing it throughout the regions, it seems to me then our role is one to look at the structure of these regions to try to assess their ability to formulate and carry out programs and advise in that capacity.

Now it is disturbing to me in a way that we find the funding levels are only about 65 percent of what we recommend, because we look at the capacity of a region, we

recommend the level of funding that we believe they can handle. In many cases I guess Council may alter that a bit, but essentially establishes a level along those lines, and then sometime later when the real decision is made apparently when the money is parceled out and you determine who should get what, and the decision at that point I think is the crucial one, and the factors that are taken into consideration at that point are the factors I think that are the important ones, whether they concern compliance with certain laws, whether they concern whether or not the region has developed goals and objectives that are in line with national priorities. I would like to have you comment on the kinds of things that you take into consideration when you give that money out.

If in fact you are acting in a capacity where you believe that these regional offices should be very closely aligned with your central staff here and that you have specific things that you would like to have them do, and if they do that you are going to give them money for it, then I think probably this Review Committee is inappropriate and that what you need is a body of individuals that might site visit programs and give you a written report on it as to what their capacity might be or their estimation of their capacity, and then you use that when you make your decision, but disregard it if you wish, and parcel out the money on the basis of

specific things that you would like to have accomplished and whether that management team is accomplishing it or not.

DR. MARGULIES: Well, that statement I think is the crux of what we have been talking about.

Let me go first to the question of why we don't fund at the level that has been approved. It is pretty simple. We did this, we took a look at what would happen if we awarded grants to all programs at the levels which have been approved by Review Committee and approved by Council, it would far exceed our budget. So it is simply a matter of making adjustments on the basis of what funds are available.

The question of how we make that decision -- the answer to that is determined by what kind of relative ranking and what kind of input is made by this Review Committee, which in fact is the most critical, formalized, careful review process that we have available.

Now the next point that you raised, of having some kind of a process by which we determine conformity versus something which determines whether or not this program represents an effective institution for the region, is one that represents the range of differences which we see here present. Len was saying that he sees programs coming up with the right words, they parrot the kind of sounds which are being made at the national level. It is my belief that if you

then follow the general statements which are made at the national level with a specific guideline as to what each RMP should do, that that is exactly what each RMP should do, and we would be deciding in the Parklawn Building what should be done in every Regional Medical Program. I don't think we have that ability. I think it would be a sad mistake, and I guess the real difference lies in how general our description of goals should be and how within those generalities the review process should be carried out.

I understand your anxiety over it. For what it is worth, I think this review process, considering the fact that we are trying to describe a new institution in shifting times and with heavy demands being placed upon us, works remarkably well. I think if you were to set up a different kind of system which is analytical and careful it would come out very close to the kinds of determinations which this review committee is making. If we get very explicit about it then we might just as well switch to some kind of formula grant and see if the program is doing exactly what we told them they ought to do, in which case I can't see much point in having a Regional Medical Program.

On the other hand, if we want to go to a series of projects scattered around the country there is also no need for a Regional Medical Program. We can simply make the grant awards to the project directors and carry it out in a

scattered fashion.

Somewhere in between is a structure which manages to elicit a sense of coordination and of general direction and determination for the providers of medical care in the region. They base their actions on a series of analyses and judgments which lead to a finite program. They do this with varying degrees of skill. They are hampered at the present time by the need to move from old patterns to new ones.

But in general I think the process is representing region by region the emergency of an understanding of what they should be.

For example, just to add one more comment to it, if it is true that comprehensive health planning plays a significant role or should play a significant role in what an RMP does or what other federally supported activities do, then to have a strict kind of description of what RMP is based upon that as a theory, when the fact is that B agencies and A agencies are highly variable, would be a sad mistake. I can point out areas for you, and you know them, too, where there is a powerful B agency in an RMP. And I can show you the reverse. And the circumstances which prevail in those communities are totally different. And they need to be measured by the kind of specific site visit and review mechanism which is carried out here.

It is not a program like a university which admits

so many people, graduates so many people. It doesn't have this kind of a finite function. But I think its purposes are becoming clearer and clearer.

I think this Review Committee from my point of view is an essential part of the activity. If the Review Committee decided that it didn't need to do what it has been doing we would have to go to the trouble of forming another one, because it adds tremendously to this review process, and at this point I can't feature a way in which we could operate intelligently and honestly without that input, including all of the differences which we have this morning.

DR. MAYER: We have a motion that is on the floor. Let me see if I can recapture at least, if not the precise wording, the intent of the motion -- that the motion recommends to the Council of the Regional Medical Program that the Council consider the adoption of a policy which would insure that before funds are awarded to an individual Regional Medical Program that that individual RMP was in compliance with the Civil Rights Act, and that furthermore, that they further consider the establishment of a policy which would insure that regions not be reviewed through the existing review process until such clarification of compliance were there.

Now does that catch it or not?

DR. BESSON: Yes.

DR. MAYER: Okay. Further discussion of the motion?

DR. WHITE: I wonder if the originater of the motion would define compliance for us.

DR. MAYER: The question was what is meant by compliance.

DR. BESSON: Is there a body in HEW that is charged with the authroty of definition?

DR. MARGULIES: Yes, the whole structure which enforces the Civil Rights Act has measurement of compliance.

DR. BESSON: Is there a division that is assigned the responsibility of doing so for HEW?

DR. MARGULIES: Broadly in HEW, yes, for all of HEW. There is in education, there is in health, there is in welfare.

DR. BESSON: Then I would ask that the application be presented to the Review Committee with the definition outlined by that group.

MISS KERR: Maybe I am getting to a simplified version of this, but a ball park figure -- and as I have been reviewing regional medical programs, making site visits, etc., I tend to come to the conclusion that they are complying if there is an equal representation percentage in the people involved and in the staff as we find in that particular region. That is the only measuring stick I have had to go on.

MISS ANDERSON: Includes females, too.

MISS KERR: Well, I can't argue that. You know, I don't have much -- but, for example, there are Regional Medical Programs in which there are ethnic groups, quite sizeable ethnic groups, for which I have seen no representation. There are others I have seen them very well represented. So this is the way I have been measuring.

DR. MARGULIES: Well, you realize that this would have to include compliance on the part of the grantee agency, which means that every university, every medical school, every state society which is responsible as a grantee agency would have to show compliance with civil rights in all of its contracts, in its construction, in its employment, in its staffing, in the way it handles its faculty, and at the present time this also includes proper identification and advancement for women in employment or on faculties, which, as you know, is quite an issue in itself.

DR. BESSON: I don't care about the details. It is the principle.

DR. MAYER: Joe.

DR. HESS: I wanted to ask, Jerry, if you had any time deadline in mind in making this motion, and if so, the administrative mechanism for dealing with that deadline in terms of ability of the arm of the federal government that deals with this question to get in and participate in a meaningful way in this process so that proper certification

could be done in keeping the review cycle and process--

DR. BESSON: Well, Dr. Hess, I am sure that we could discuss for another week the reasons why it is impossible to accomplish or implement this motion. But if the Council decides this, then it is for staff to have the problem of implementation. I am interested in the principle involved, and I am interested in assuring ourselves as a review committee that this question is considered by Council; and maybe the details make it impractical, but this is a question that we are discussing, whether the weights that are assigned here for judgment of the ranking of an individual region could not have minority interests changed from the weight of 7 to a weight of 16 as a sine qua non. That is all. Now that may be impossible to implement. But if that is the case then staff will have to decide that with Council.

But I am not being coy when I say that is not my problem. It really isn't. I am interested in laying out the philosophical basis for this principle.

DR. MAYER: Further discussion of the motion?

MR. ARDELL: I would like to say I wonder if there isn't a little different area of concern here, and that is as it relates specifically to the RMP, because really there is no application that can be processed in this Department that does not comply with Title VI as one of the

assurances. It is in the boilerplate in every application that we review. And I think you are really concerning yourself more with do we take a hard look at what the RMP is saying it is doing in the way of providing for minority involvement, minority support, et cetera.

Now if that is not so, then I think what you are asking us to do is to really go behind the assurance that the Department has already received from every applicant to make sure in fact that this is true.

DR. BESSON: Well, I am not satisfied that that is enough. I think as regions read the tea leaves daily -- and I am sure they do try to decipher the vibrations that are emanating from this august body and its counterpart, Council and administration, I am interested in sending them a message, and even if we gain no more than 10 percent or 5 percent or 2 percent, 1 percent enhancement of this effort by means of this message, I think it is in the right direction. If we gain a hundred percent that would be fine, too.

DR. MAYER: Further discussion of the motion?

DR. SCHERLIS: Dr. Besson, you stated you are interested in principle, yet as I read your motion it is one of exactly logistics, because you are saying either they are in compliance or not, and if they aren't then that's it as far as funding or even consideration of review. And I

would wonder whether or not you could redefine your motion, perhaps after a coffee break, to bespeak more to the principle than the logistics.

DR. BESSON: No, I think the principle has no meaning unless it has the teeth of funding. I think that is the only weapon--

DR. SCHERLIS: I was just using your definition of your motion, and you recognize it has having teeth in principle.

DR. BESSON: I do indeed. Our only leverage is funding, and unless we can speak with funding we have no voice.

DR. MAYER: Further comments?

MR. PARKS: Well, I will make one other comment. The total responsibility for monitoring this does not rest with the officer in the Secretary's office that is charged with -- or the civil rights compliance unit -- but there are some very specific federal agencies that not only oversee this, but will help you implement, and that is their specific charge. The Civil Rights Commission is one. The Equal Employment Opportunity Commission is another. And there are various state and other agencies that would impact upon your universities and various other kinds of operations, and that is a matter that I would leave to some extent to their expertise; and certainly in terms of burden it should represent only a mythical burden in terms of what this staff

would have to absorb.

I would think in terms of notice that they have had notice about a law that has been passed or an executive order that has been published ever since it has been uttered either by the Congress or by the President, and certainly presumably all factions of society, both donors and donees, public and private, have had notice that the law is there and understand that the law is to be complied with.

All we are asking here is that we come out with a policy position which clarifies what is or what should not be done, and I think this is not just a thing that we are going through here in terms of something nice in principle. It is indeed an obligation. And I think most of the people here, certainly every one of your public officials, including you, Dr. Margulies, and your staff people, took an oath when they embarked upon employment as a federal employee. I think this motion that is here, it simply calls upon them to live up to that oath, calls upon the Council to take a policy which would encourage that.

DR. MAYER: Dr. White.

DR. WHITE: I think the passing of a reslution of this sort simply strengthens the concept of tokenism. I think our responsibility along these lines is to make sure the program the Regional Medical Program proposes attends to the needs of these people.

DR. MAYER: Dr. Hess.

DR. HESS: I have some real trouble with the wording of the motion as it now stands. I think if this were accepted literally the way it was stated that it would be much more destructive than it would be constructive. And I am totally in sympathy with the principle which you are trying to get across, but to say that there would be no funding would be destructive, it seems to me, of many of the good things which are going on in RMP's which are indeed reaching and helping many of the very people that your motion is saying they are going to help. So I will have to say the wording of the motion as it now stands is one I cannot support even though I am in favor of what I think is the principle.

Now if you want to modify that and say further increments, without an absolute cut off -- the implication of your statement is that there would be absolute cut off of funds and the dissolution of Regional Medical Programs, and I do not think that would be constructive action. But the message that you are trying to get across it seems to me would get there by some further emphasis on this as part of the review criteria and a modification of the rate at which new funding is granted based upon heavier emphasis on this particular criteria. I think you get the behavior that you are looking for, but without destroying what is already there.

DR. BESSON: How would you modify it? I will

accept a modification if it is in line with support of the principle.

DR. HESS: Something to the effect that consideration for further increments of future funding will not be considered until there is assurance that the region is in compliance with the Civil Rights Act, or however that might be worded, putting the emphasis on the further increments rather than all funding, which is the way I interpreted your motion.

MR. ARDELL: You see, that statement can be questioned because we wouldn't make a grant unless -- so I think what you are really asking us is to go behind that compliance and see really if it has been implemented.

DR. MAYER: We will take two more comments and then we are going to vote on the motion.

DR. SCHERLIS: Are you telling us that every region states that it is in compliance?

MR. ARDELL: Every grant program must be, before it can be funded, in compliance with Title VI of the Act.

DR. SCHERLIS: Then what we are being asked to vote on is a modification of this. Do we investigate to see if they are indeed in compliance? Because on the one hand we have written statements testified to by responsible--

DR. LEWIS: I think I share the problem with Dr. White or that Dr. White articulated very nicely, insofar

I think if you vote against any such resolution you are at risk of at least upsetting your own emotional feeling towards bigotry, and I feel personally that the obstruction that we have been discussing right here is virtually impossible for me to interpret since I really don't know what any two people around this table have meant when they talk about compliance and what kind of details that really means, and I don't know whether this intent at abolishing one form of prejudice might not actually allow for the exercise of other forms of prejudice if we become highly detailed as to whether a region get all of the money due to it or not. And what I would really rather see is a test case; that is if a region that is up for its triennium is one that Mr. Parks or anyone else at this table is questioning in terms of having such a low score in this particular category as to whether it actually is in compliance with the Civil Rights Act, then I would like to bring that up to task.

But to make this across the board a motion is to me a difficult thing to fathom because I really don't know how I can vote for it, but I don't know how I can vote against it.

DR. MAYER: Dr. Thurman.

DR. THURMAN: I think that many of us share the concern of being labeled bigots, and for that reason I would to propose a substitute motion, and this would be to go back

to what Jerry said initially, to propose that we ask the Council for permission to let us as reviewers consider this in our site visits over the next three to four months, about how compliance can be adjudged, because we have the prerogative as site viewers to come back and say that piece of paper that you signed is a piece of garbage and we want some officer to investigate. This would be a much more meaningful approach than for us to get hamstrong at the present point in time with a motion that some of us find we have to vote against, but yet we don't want to be labeled bigots.

This would give us a point of four months -- and I think Mr. Parks could live with four months, having lived with it for X number of years -- to let the reviewers as they go to a place say "what does your statement of compliance really mean, you signed it, what does it really mean," because we still have the obligation as site reviewers to request a compliance visit be made. That is our prerogative as the site reviewer.

So I would offer that as a substitute motion, not as a delaying action, but rather than keep from being labeled as a bigot, as Dr. White and others said, because I have to vote against your motion as it stands. So I offer that as a substitute motion.

DR. BESSON: Well, I would be willing to accept

that as a substitute motion if we do have some indication on the review form that compliance is indeed more than just pro forma. That is really what I am interested in. I think we have a responsibility to determine the accountability of a region for compliance. I don't know that this is being done. I don't see it on the portion of the documents that I reviewed at any time. And if such a statement could be incorporated then I would be perfectly satisfied.

MR. ARDELL: There is an assurance in every application.

DR. MAYER: Let me see if I have caught the substitute motion then. It is up to both the initiator of the motion and the seconder of the motion as to whether they will accept the substitute motion or whether they will not, and we will vote on the original motion. So I gather the intent of Dr. Thurman's motion would be that we would recommend to the Council that the Review Committee as it participates in the review process be encouraged by Council as a matter of Council policy and as an indication of Council policy to give particular attention in their review of the program, both in site visits and in this committee, to the issue of compliance with the Civil Rights Act, and -- well, I think that is essentially it.

DR. THURMAN: And if question arose we could ask for a compliance officer to visit.

DR. MAYER: And you heard that -- if question arose that we would have the right to ask for a compliance visit.

DR. BESSON: Could we after that have some documentation that this has taken place as part of the material presented to us without accepting it tacitly?

DR. MAYER: The implication being, Jerry, that each site review process -- the intent of the motion would be that each site review process would carry out the motion and document that they have in fact carried it out.

DR. BESSON: Yes.

DR. MAYER: Is that clear? Is that an acceptable substitute motion?

DR. BESSON: Yes.

DR. MAYER: Is it acceptable to you, Mr. Parks?

MR. PARKS: Well, with this exception. I take it that it does not mean that we should really dicker with whether they complied with what the law is or not. I gather that is not at all the intent of this motion, because there is a requirement that there be affirmative action, plans, various other kinds of things which are very specific. Is that--

DR. THURMAN: That is correct.

MR. PARKS: I will go along with it.

DR. MAYER: Does everyone understand the substitute motion?

DR. SCHERLIS: Could you please repeat it?

DR. MAYER: Well, let me try it again. That this Review Committee is recommending to Council that Council establish a policy in which they instruct those participating in the review process, whether that be site visits or this review activity, that a special interest be given to, and attention to, the issue of compliance of the individual regions with the Civil Rights Act, and that as a part of the review that documentation occur in each and every instance that that has in fact occurred in the review process.

MISS KERR: There was also an added stipulation, wasn't there, that if the reviewer felt--

DR. MAYER: Oh, yes. And if in fact the reviewers felt that there was some question of compliance that they would have the right and responsibility to request that appropriate review of that issue occur.

Does that catch it?

DR. THURMAN: Very good. Fine.

DR. MAYER: Leonard, does that clarify it for you?

DR. SCHERLIS: (Nods.)

DR. MAYER: All right, further comments?

MISS KERR: Question.

DR. MAYER: All those in favor of the substitute motion?

(Chorus of "ayes.")

Opposed?

(No response.)

All right, let me say that I would like to now welcome Mr. Robert Toomey on board. I hope that you weren't holding back because of newness. I can assure you that that will wear off very rapidly as we go along.

Let's take a 20 minute break or so for coffee that Leonard asked for a half hour ago.

(A recess was taken.)

DR. MAYER: I think we have gotten the audio back on across the table. We haven't been able to do anything yet about the heat situation. We have left the two doors open. Does anyone have any concern about that?

I would like to move on to the kidney disease program.

MR. HILTON: Mr. Chairman, if I may, could I just interject one thing before--

DR. MAYER: Yes.

MR. HILTON: I would just like to make a motion. I think in our capacity as being advisory to the RMPS staff it might be appropriate for me to make this motion, and by way of doing so just to briefly for a couple of moments revisit the topic of discussion earlier with regard to minority interest. Someone had raised the question of

compliance and what it meant and whether or not there was in existence a checklist. To my knowledge there isn't. There is usually a glowing statement somewhere that suggests really a spirit document, the spirit of the law being such and such; and I suspect that you can trust under the motion that was passed just before we broke that some reasonable efforts will be made to insure enforcement on that.

I would like to approach that angle from a different point of view, something that we can do locally on the staff if we are so inclined. We found in my state of Illinois that we talk about the spirit of the law and the spirit of compliance, people are best able to respond to that effectively if they have the self-interest, the personal self-interest, the determination, and creativity to look around and see what it is they need to do to comply. It is often a situation, as someone mentioned earlier, nice people who simply haven't thought of this or overlooked some things that they could do.

In response to that problem locally in our own area we pulled together what really might be considered a kind of brain trust, of people who have the interest, the determination, the creativity to put special attention on this particular problem area. They advise us as to how we might best go about complying as a free consultant kind of service to the organizations and the various publics we serve, and I

think that might help the problem, if there are people who want to comply with the civil rights legislation but quite honestly don't know how, and what for very understandable reasons wouldn't know how. It doesn't necessarily affect them; as our society runs right now most of the people who comprise the establishment are not the people this compliance was designed to benefit.

I wonder if it might not be appropriate for RMPS to consider the possibility of incorporating in its overall operations a kind of brain trust, an advisory kind of group of this sort, subgroup, that relates specifically to this issue; not an enforcement body -- I would stress that -- but really an agency that reviews or looks at the various programs and their needs and makes suggestions to those coordinators and RAG groups as to what might be done in their particular locale to make them relate more better to the Indians or chicanos or whoever happens to comprise a good bit of their constituency.

DR. MAYER: Leonard.

DR. SCHERLIS: If I could respond by asking a question. Are you impressed with the good results of the brain trust in Illinois? And I don't want you to go on record as answering it, because the RAG of Illinois has 4 of 47 who represent minority groups, and looking at just the sheer data, having shared the site visit in Illinois, I would not

suggest that this would be the route that might be the most successful to contemplate for the rest of the RMP's.

MR. HILTON: I might suggest I wasn't talking about the RAG of Illinois. No, I was talking about our own educational concerns in Illinois. I am quite impressed in a negative kind of way with our own -- no, we would like to do this with the RAG of Illinois.

DR. SCHERLIS: I was just wondering how we were defining success.

MR. HILTON: Right.

DR. MAYER: I think this is a very appropriate suggestion. What we have done from time to time over the last umpteen years now, we have made suggestions to the staff relative to those kinds of things that they could do that would be helpful in the process, and staff has consistently been responsive, I think, to those needs. I think the message has been heard very clearly as a suggestion in relationship to how you go about implenting if the Council accepts our proposal.

Now I would like to move on then to the kidney proposal. Dr. Hinman.

DR. HINMAN: Thank you. I will follow the order on the agenda, although it is not necessarily the order of development of activities in the kidney program in the Regional Medical Programs Service.

At your last meeting you posed four questions to Council, by resolution, and I will report back their answers.

The first question was whether the Council recommends that money apportioned for renal disease be considered in a proportional ratio to the total amount of money of the RMPS budget. And the Council answer was no.

The second question was whether the total amount of money--

DR. MAYER: Wait a minute. Slow. Maybe we better make sure we have got that one. Let's take them one at a time.

DR. HINMAN: Well, the first two are really almost one question. That's why I was going to it.

DR. MAYER: All right.

DR. SCHERLIS: Can we turn off that clicking sound? We have enough static as it is.

DR. MAYER: Why don't we go on, and we will try to get at that.

DR. HINMAN: The second question was whether the total amount of money spent in a given region for renal disease should be in proportion to the total amount of dollars being spent in that region. Now the answer from Council to that was also no. The philosophy -- well, principle here being that we are not a categorical program nor is money allocated by Congress or apportioned in a totally categorical

fashion, nor is it our desire to become a categorical program again in the narrow sense of the word. And this was what lay behind the answers to those two questions.

DR. MAYER: Are those two clear? You all have a copy of the questions now. Comments on those two?

SISTER ANN JOSEPHINE: Are we running into a problem -- I know if they say no the answer is no, but I would like to raise a question. On number two it would be possible if there were a group who could really push through proposals for renal projects in an area where maybe the amount of money allocated to the program would not represent an allocation commensurate with the needs in the area, and that would be the thing that concerns me.

DR. HINMAN: We are very concerned about this, and when I talk about our new proposal for the review mechanism for kidney disease, which is item number five on my list assigned, it will come to that. But we are concerned that kidney not be necessarily the dominating part of any one program.

However, the point was made that the treatment of in stage renal disease requires a coordinated, cooperative effort of various providers throughout a region, and if agreement or cooperation can be secured among these providers in the area of in stage renal disease this might be a mechanism of bringing the region into a regionalized approach

to the treatment of other patients and the handling of other health care issues. And I think that that is a valid point, that there are regions in which the nephrologists and transplant surgeons may be further along and they are being willing to cooperate between institutions than other types of providers.

So that Council discussed the very issue that you have raised, Sister, and because of the tremendous cost of the resources in in stage renal disease, but felt that we should not take an arbitrary position either way, but handle it on the merits of the individual region and their total program; not projects, but their total program.

DR. MAYER: Okay, third question.

DR. HINMAN: The third question was whether renal programs funded by the regions will come out of their total budget or out of a separate budget. The review and funding will be done on a semi-separate basis, but it will be their total budget dollars when it goes back to them in the advice letter. Confusing?

In other words, if region X has a kidney program approved for $50,000 and their total budget is two million dollars -- their total budget is two million dollars, then the fifty thousand has to come out of it. In other words, the total award includes the kidney dollars.

DR. MAYER: Do they have the same degrees of freedom

with it after they get it that they have with the other?

DR. HINMAN: You mean in the anniversary triennium sequence?

DR. MAYER: Let me give you a for instance. This group decides that it approves a million and a half for a region, and it also has a half million dollar kidney proposal which the ad hoc review group reviews and think is fine and we think is fine and Council thinks is fine, and it has an award of two million dollars. All right. What I am saying is can they, if their original proposal had four mill dollars in it and we only approved half, can they take that half million dollars of renal money and pump it into something else, or have they got to pump it into kidneys? If you excuse the pun.

DR. HINMAN: I really don't know the answer to that question.

DR. MAYER: Well, it is an important question.

DR. HINMAN: The question that was asked, Herb, was can a region take kidney money out and pump it into other programs. In other words, if there was a total award to a region of two million dollars of which $500,000 was kidney money, could that RAG then pull 100,000 out of that back into other program areas.

DR. PAHL: I think we would want to have a request for approval come in to RMPS for a major change like that.

DR. HINMAN: Is that any different from any other major program change?

DR. MAYER: Now let me -- it is different. Maybe I don't understand the ground rules. All the question I am asking, Herb, is when we send back an award we send it back with some advice and then we delete some projects, but in essence we usually approve most of the projects, et cetera, that they have in it, and if that is four million dollars worth of stuff and we gave them two million dollars, it is my assumption that what the regions are now doing is coming back in to you with a proposal that says okay, this is how we are going to spend the two million dollars and you allocate it. And you say okay, sign off.

Now what I am saying is if that goes back and a half a mil of that two mil is kidney disease and they come back in with no kidney disease in that project, or only 200 thou of kidney disease in that project, do you treat that any differently than anything else.

DR. PAHL: Jerry is shaking his head. He may have some personal experience.

MR. ARDELL: Not really personal. I was thinking that again it boils down to what is considered a significant change in the scope of the program as it was determined to be funded, and if reducing a sizeable amount of money going to kidney into something else I would think that our review

process should at least get the blessings of the director of the service for moving in this direction. I think that is probably open for discussion. But that is the intent of the whole system as I have interpreted it myself, that significant changes really, we ought to be informed in advance rather than after the fact. If they are less significant then I think that they do have the prerogative to move ahead and just inform us after the fact.

DR. PAHL: Well, I think what Jerry is saying is what I thought I was saying, that we are not treating it differently than any other major change, but we will consider that, I would believe, to be a major change.

DR. MAYER: Ed.

DR. LEWIS: I'm reassured that the word categorical is considered a vulgarity in these chambers, because it saves me using a lot of other words. The thing that tickled me about the answer from Council was that we had a real problem here the last time and we asked them a question which amounts to "is this pen black or white," and they came back with the answer "yes," which is absolutely right. But I take it from Dr. Margulies that kidney activities will account for 8 to 8 and a half million dollars of this 135 million dollar budget for this fiscal year, that there is some categorical consideration to the way in which kidney projects are funded, and I would like to have clarification of that

specific point.

I just wonder if there was someone who was at the Council meeting who is aware of whether they really took it up as that specific point or whether they indeed took it up as is this pen black or white because this we knew already.

DR. HINMAN: Well, Ed, as you know, there are certain constraints upon the allocated dollar that come to RMPS even though they are noncategorical, specifically the AHEC and the HMO types of constraints. The kidney is not a constraint in that same context, but it is a level that appears to be in the context of the total RMPS program and the total request coming in from the regions, a figure that is a fundable figure that is discussed between RMPS and the office of the administrator and the various other parts of the budget cycle.

That is a vague answer, but the process is not as clear and crisp as is the pen black or white. At the end of this fiscal year it is our anticipation that the total dollars that could be identified as going into kidney will be in the order of magnitude of eight to eight and a half million. That does not mean that we are setting out to spend eight and a half million dollars.

Maybe it would be appropriate to talk about how we intend to handle the review process of kidney at this stage instead of later.

As was stated I think at the last review committee meeting, if not, it had occurred or was occurring by the time of the Council meeting, the ad hoc renal panel is not meeting any more. It had its last meeting early in September. The idea that was behind this was Dr. Margulies' desire to include kidney as well as the other programs in the total regional development activities of a particular region. However, because of some of the peculiarities of the renal disease funding necessities, some of the gaps between the state of technology and the delivery in many areas, it will still continue for a period -- I don't know whether that is one year, six months, or two years -- to be handled in a semi-separate fashion.

We are working on the guidelines at this time, and they will go something like this. When the renal group in a particular region has an idea and begins to discuss with the local RMP that they would like to submit an application or proposal for support of their program the RMP is to refer them for consultative assistance to RMPS. Someone on my staff will assist them in explaining the guidelines that are appropriate at that time, and new guidelines are being written to update the November, 1970 ones, and advise them as to whether the idea they have would seem to be at least in the realm of activities that are appropriate for the limited dollar that RMP has at this time.

If they continue -- they can at that point decide to continue and submit a proposal or not. It is their decision. If they do submit the proposal to the local RMP, the local RMP will be instructed to have a local technical review, it will be recommended that they include experts from outside their region, but that will not be mandatory, and we will be maintaining a list if they ask for assistance here to give them names of people that could assist on this local technical review.

Following the local technical review it will go to the Regional Advisory Group the same as any other element of the RMP program. It will then be submitted to the Regional Medical Program Service, at which point my staff will be asked -- Bob Chambliss's staff will be asked for two certifications that will go with it to the Review Committee, i.e., you. The first certification is as to the adequacy of the local technical review. In other words, whether in our judgment it was an adequate review on the basis of the documentation furnished by them, that the people that reviewed it were indeed competent -- or I shouldn't say competent, but at least should have been included in a review committee and whether they did review it, and that this was considered by the RAG, the recommendations from this committee.

The second certification would be as to the adequacy

of that RMP to administer the program that is requested. And that gets to the question that I think was behind Sister Ann's question, and that is whether this would be so skewing to the local region's program that they could not effectively carry out their total program activity and administer the kidney one.

This certification or absence of certification would be before you as part of the packet that you would have for the review of that particular region, and it would then stay in the cycle.

DR. LEWIS: Can I respond to that?

DR. MAYER: Yes.

DR. LEWIS: I have to articulate my response in the knowledge that I am assuming an attitude of general belligerence and will probably upset a very longstanding happy relationship with Dr. Hinman. But I really must look upon -- Dr. Scherlis wants to turn my microphone off -- I must look upon what you have just said as a very naive approach to spending a limited amount of funds in a field that requires a lot of money, because it is very clear that the ad hoc review panel was originally formed because of the requirement of technical assistance, but also because it appeared that there needed to be a body that was able to determine more than local activities. That is, there had to be an overview as to how much kidney activity was going on

around the country or in the areas surrounding a given region.

Now it seems to me that what we have done is this. I honestly believe in view of the fact that RMPS has articulated decentralization that something like a central ad hoc review committee is an embarrassing thing, politically embarrassing particularly. But I think that what has been done is this -- that we are now asking the regions to construct their own programs which they are doing anyway. In order for them to even construct the program they have to include virtually every element of expertise in the renal field in the region, otherwise it wouldn't be a regional program. So obviously the region's program will reflect the special interests of all of the expertise within that region.

Then we supply them with a list of people from the outside who are consultants, but they are only consultants. They cannot tell the region -- they can pass some judgment on whether the technical capability is there, but they cannot pass on judgment as to whether the region is asking for a Cadillac, a Buick, or Chevrolet, because they have no authority to do that. So a region can very well come through with a proposal for $750,000 when it only needs one for $250,000, not because they are trying to cheat anyone, but because they would honestly like their patients with kidney disease to be in a Cadillac rather than a Chevrolet.

And I think that this really puts renal programs into the area of political interests rather than into the area of technical interests where it should be.

And I might add that I think that this renal area and the way in which it has been approached is a very good example of the way in which the Review Committee has been emasculated in terms of having an input into RMP activities, because all of this has gone on without any indication to myself, or as far as I know, any other member of the Review Committee in terms of how this thing would be organized, how things would go forward from here or not.

When you said, Ed, that these programswould come through and be passed on to you on the Review Committee I can guarantee you that you were looking straight at me because the renal programs are being passed down to this end of the table, the reason being that most people who do not have nephrology expertise are not willing to pass judgment on these very expensive and highly technical things. And I can tell you that all that I am is a rubber stamp, and if the other members of the committee will permit me, I will tell you that I am not aboutto be the in-house nephrologist. I think that this is a very poor way in which to approach the role of the Review Committee in such a technical and expensive field.

DR. HINMAN: Let me respond. There are several

points that you raised. First, my concern is that there be Chevrolets for all the patients throughout the country, not Cadillacs.

Secondly, there are other very technical projects that are submitted for review by this committee, and to my knowledge none of them are shunted to a particular specialist or individual because of a particular area of expertise. I am not sure that kidney should be treated any differently from anything else in that respect.

Third, this could all become a very major problem if there were no guidelines to the regions as to the types of activities that we are concerned with or feel that would be appropriate for the RMP dollars to go into. As long as there is going to be any special handling of money for a particular area that has to be some sort of guidelines so the regions and the applicants can know what it is we are talking about. This was one of the issues you all spent a little time on earlier, about communication from this office to the regions.

We are concerned -- and that's the topic on the agenda called life plan -- with whether a region has developed a plan whereby any patient who is identified as being an irreversible chronic rendal disease and in impending difficulties, i.e., unable to manage his own self and needing assistance, should have available to him access to

care. This care includes medical management as well as the adjuncts of hemodialysis and transplantation when it becomes indicated. However, the costs of this, as Dr. Lewis pointed out, are extremely high. The only way in which society -- well, that's getting awfully grandiose -- but the only way in which we can begin to meet these costs is for it to be on a planned basis in which there are adequate facilities, but not duplicative facilities, in which the most cost effective method of treating the patient is the treatment of choice whenver possible.

So that we are developing a guide that we hope will become accepted by the Council and accepted by the regions as a method of going about it which will require that the region have such a plan for care of their patients, that the RMP dollars would be used for selected portions of helping them develop the resource, the pieces of this plan; so that with the assumption that the reimbursement mechanisms as they are developing in most areas will continue to develop to support the cost of the patient. This would include an emphasis that early decision be made as to whether the patient is or is not a candidate for transplantation, and if not, whether the patient is a candidate for home hemodialysis, and if not, whether a candidate for ambulatory center which is a lower cost hemodialysis, and as a last resort institutional dialysis when they reach that point.

Dr. Scherlis.

DR. SCHERLIS: I admit to being a little further confused than I was even earlier, because if I am in the position of being a member of the site visit group or being a member of a local RAG and if I have before me several projects to choose from -- let me put myself in the position of being a member of RAG, with well defined goals and objectives, and if I see that we have X number of projects, one of which happens to be renal, and by the very nature extremely expensive, and by the very nature giving service to a relatively small group of the population, I would have to evaluate this service in terms of goals and objectives, and I would suggest to you that I would not support, looking at a priority system, any renal project on a local RAG priority basis if I am to look at the problem of the total delivery of health care services.

It is not that I don't recognize the fact of its importance, but I would suggest to you that when a site visit group goes out they will be faced with the same quandary, namely, unless there are fairly firmly designated funds that you will not see eight and a half million dollars spent, but you will see only a small proportion of this spent in terms of the total health needs, particularly as we look at the overall expanded efforts of RMP.

Now if I am alone in this point of view then that

would be an interesting finding that I would be led to believe would not really exist.

I don't think the renal programs would really get the support or the priority rating unless they are given thi by point of view of specifically designated funds. And I would like to have some reaction from other members of the Review Committee. It isn't that I am opposed to renal projects, but you do jeopardize them by putting them in with the general fund as far as seeking levels of support. I would suggest that those that receive several hundred thousands of dollars now would be cut drastically and that funds be used by core for what are higher priority items in that region at this particular time. This could very well be what would happen, I predict.

DR. HINMAN: This is the justification for the continuance of a semi-marking of funds.

DR. SCHERLIS: I wanted to ask you what you meant by semi-separate. That was the best answer I ever heard to an either/or response. Referring to question three, I expected you to say yes, given that choice; but you said semi-separate, and that confounded me further.

DR. HINMAN: This is the only program in which there would be a partial earmarking of funds. Now the word earmarking or separate funds is a very dangerous phrase. If we start earmarking that a particular category

for one reason or another should be handled by eight million dollars out of 135 or such thing, then the answers to questions one and two are automatically going to start becoming percentages and yes. And then the people that are interested in other parts of the health care delivery system will be seeking and pushing to get an earmarking of funds and we are back to purely categorical project review.

We are attempting to resist this as much as possible, recognizing that the gap here in renal disease is an unusually great one, recognizing that there has been unusual interest in the legislative arm of government to see to it that there are dollars going into this program and trying to juggle between the two. That's why I say semi-separate.

DR. SCHERLIS: Let's put this on the following basis. We go to a region and they have asked for 2.9 million dollars, and we decide looking at the region that their request of that funds includes $750,000 for renal, and we feel that the needs in that region are so great in other areas that the renal program really does not deserve support, particularly since we feel that the total request is out of line. Therefore funding level is suggested which specifically excludes renal.

Now what impact does your semi-separate funding have on that decision, because the way that I would suggest we might go would be back to a national group which is

specifically charged with the renal funding and attempts to get some distribution and some sharing of these facilities on a large regional basis, and I mean the joining of several states together.

Could you first answer the first part of the question, how would you counteract that?

DR. HINMAN: The first part, I cannot conceive of enough funds becoming available for kidney that a $750,000 project from a particular region would stand up unless it were a nine-ten interregional project, and the review mechanism for that has not been established.

DR. MAYER: Let's make it $300,000, $250,000.

DR. SCHERLIS: I'll settle for that, $300,000. Whatever it is we put a red line through.

DR. MAYER: The principle is absolutely critical.

DR. SCHERLIS: This is what happens when you go out to a region--

DR. MAYER: This is what we asked the Council, and what we are getting back is mush.

DR. HINMAN: I have the 20 pages of Council minutes here, the stenotype of them.

DR. SCHERLIS: We asked that they answer yes or no, and we can't say semi-separate.

DR. MAYER: Do you understand the question that he has asked? That is a very important question he has

asked, Dr. Hinman. The question is what happens then by semi-separate funding. Let's say we implement your review process, and it turns out that you staff feels that that's a good renal program, but that review group has gone out there and said that's a good renal program but that's not what they ought to be doing in that region at this point in time. Where are we?

DR. HINMAN: Somewhere along the line what the region needs has to be taken into consideration by either you or by the Advisory Council, doesn't it?

DR. MAYER: That's the question we are asking.

DR. WHITE: May I make a comment?

DR. MAYER: Well, let me just pursue it, because I have the feeling that if in fact the answer to his question is that no further consideration is then given to that renal project because in fact it is in fact within the total region's activities that's being considered, then what Leonard has originally suggested is that you are not going to get out of this review committee anything that even comes close to approximating eight million dollars worth of recommendations for kidney disease, you will be lucky if you get a half a mil. Now that's my guess. Now that's a fact -- I suspect it's a fact. I see a lot of nods going along, just as I saw them when Leonard made the statement, and how are we going to deal with that?

DR. WHITE: Seems to me this is inconsistent with what we are supposed to be doing these days. We are determining, I thought, the quality of the region and its ability to assess its own needs and the way in which it will meet these needs, rather than our going out and sayingto them these are your needs. And if we make that decision about kidney problems then we are usurping what they presumably should be doing.

DR. SCHERLIS: In those regions when a renal project gets to the local RAG it comes in differently. It really doesn't compete for what else you are asking for. I know that many RAGS approve renal projects because it is a different way of presenting it to RAG. It's a different priority because you are told don't worry about this funding, that's a separate vehicle, it really doesn't come out of the total support that we will be given. It's a completely different type of support that has been discussed.

Now if a region knows that it is asking for X dollars and they are asking for it with a renal project standing side by side with what it feels are higher priority items--

DR. MAYER: And if they know this Review Committee is going to look at it the same way.

DR. SCHERLIS: We are changing the whole way in which it is presented. It won't get out of the regions to get to us is what I am suggesting. I may be wrong in my guess.

DR. HINMAN: At the present time, though the Regional Advisory Groups are not attempting to relate the magnitude of the renal program to the total needs of the region either. I mean you are caught between the rock and the hard place here, because it should be taken into consideration.

I think Dr. Pahl was just -- do you want to make the comment that you made to me?

DR. PAHL: I don't think it will clarify it except to say what the present procedure is, and one that we have no alternative at the moment but to follow, is that we are requesting both the region and the site visitors review committee to consider the kidney proposals as a separate consideration from point of view of merit and involvment in regional activities and in funding, and that these dual recommendations, if there is a kidney proposal and the regular regional medical program proposal, go to the Council where in fact it has been up to this point also handled in separate fashion.

We are identifying -- coming back to the budget matter, we are identifying funds to the tune of eight and a half million out of this fiscal year, but there is not a hard line item in the budget. And I think this is where some of the semantic difficulties come in about separate and not separate. We have been required to identify for HSHMA what our level of spending is anticipated to be for kidney

projects, and we hope to identify kidney activities at that level by the end of this fiscal year. There is no item within the Congressional appropriation which says that we will spend that much money for kidney.

DR. MAYER: What you have just said then, Herb, that it is separate--

DR. PAHL: Yes.

DR. MAYER: And we should consider it separate?

DR. PAHL: We are requesting that it be considered separate and transmitted to the Council in that sense, where they in fact up to this point, including the last Council meeting, are also looking at the kidney proposal in any RMP proposal as a separate issue, and at the last Council meeting in fact have made separate motions relative to the RMP level of support and the kidney.

Now I am afraid I can't clarify further, and I would suggese that if further discussion is to occur that we have Dr. Margulies here, because I don't think Dr. Hinman and I can say anything except over and over again what we have been telling you.

DR. MAYER: We went through this at the last meeting and spent a lot of time on it, sent it up to Council for a good reason, because this committee didn't know how to act -- you know, they just didn't know how to deal with the issue. Now, you know, if we are going to wait another three

months to find out how to deal with the issue, fine, tell us. But my assumption was we were going to get this resolved at this meeting so we knew how to deal with this. And if you want us to deal with it separately then let's talk about a review process that deals with it separately, and I'm with Ed -- I think the review process you have established doesn't provide me with what I need as a review member. If we are going to deal with it together, then we will deal with it together, and you will have a limited number of kidney proposals approved by this, but the review process is adequate. And I have to have an answer to that one way or other.

MISS KERR: And we have to go one step further, too. And that is if the regional program level is separate, lest we have happen what we were discussing a while ago, that they take the renal funds and use for another priority, unless it is a separate priority.

DR. MAYER: Ed.

DR. LEWIS: Just in answer to your initial comment, I really would not be so pretentious as to insult the other members of this committee by suggesting that renal projects or their scope are any more technical than any other project or philosophically are different in any way. I think that's absurd, and I have never suggested that. But what I would suggest is that both historically in terms of Congressional

hearings and in terms of the spirit of why money was initially given to kidney disease, and on the basis of there being relatively few people involved, and however you want to look at all subjects being equal, I can tell you that the budgets of these kidney programs are a hell of a lot more than I have ever seen pass through this committee, that the thing is a separate topic. And I cannot sit in judgment of every one of these things, and I would doubt very much that Doctors Merrill or Shriner sitting on the Advisory Council would want to. And I really think that what you have done is essentially emasculated what was not a bad way of reviewing things in the interest of decentralization, the politics of noncategorical approach, and so forth. And right now I am left in a situation where I don't know how to consider kidney project, and boy, they are coming in in droves, I can tell you.

DR. SCHERLIS: Would the Chair entertain a motion?

DR. MAYER: Well, Dr. Pahl was getting ready to comment.

DR. PAHL: Well, in Dr. Margulies' absence I would suggest that within RMPS conceptually we are treating kidney as a separate activity from the review process and the funding level in the manner in which we have tried to state. There is a real separation at the staff level, at the review level, and at the Council level. And if it is appropriate to have staff reconsider its proposed review process I think that's

most legitimate.

The best advice I can give you is that we are requesting that you consider the kidney proposals separately because we are into this semi-earmarking of funds and this does require us to look at it in a separate fashion. So the conceptual framework is, I think, quite clear, and we must ask you for specific advice on the kidney proposals.

I think also it is fair again to have you look at, consider, and advise us as to whether you think we now have an appropriate process to do this or not. But I don't want to leave you in doubt as to how we are reviewing kidney--

DR. SCHERLIS: I just want to ask one question. What do we do when we go into a region and they say, part of our budget is a renal project. Do we say we don't want to look at it because that has a separate mechanism, or do you want us to say we recommend zero funding, in which case what do you do in RMPS? This is the logistical bind that we are in. I don't think I had an answer to that. I don't mean to be difficult, but this is exactly what we face when we go into a region now. What do you recommend we do, look at it or not look at it, and what level do we look at it?

DR. HINMAN: We recommend you look at it as you look at the rest of the program, but we hope to be able to supply you with specific questions, concerns or comments from their review to guide you in looking at it.

There were two site visits held during the December cycle of site visits in which there were specific questions posed that needed to be answered so that recommendations could come to you today. We hope to be able to provide this type of support for the site visit teams.

DR. MAYER: Let me try to get at the same question in a different way. As I listened to your original report, Dr. Hinman, I implied that the answer to question three, which was whether renal programs funded by the regions will come out of their toal budget or out of a separate budget, my initial reaction was to write down comes out of their total budget; and when I got to question four from your comments I implied -- whether renal programs should be considered outside the total regional activity or not -- I wrote down not outside.

Now what I heard Dr. Pahl say to me suggests that what I answer to number three is it comes out of a separate budget, not the total budget, and what I have also implied is that it comes outside the activities.

Now we have just literally got to have an answer to those questions or we can't function in the renal area in the manner in which I think we have an obligation to function, and that's why we sent the questions up to Council four months ago. And I can't be more explicit -- I'm not trying to be obstinate, I'm just trying to -- tell me what to do, and

by George, I'll go ahead and do it, but don't give me something that I can't do or I object strenuously.

DR. HESS: I would like to ask for perhaps some historical clarification at least as to why we are in this dilemma with regard to renal disease. How come this is treated in such a special way as opposed to coronary care units or cancer treatment centers or any other kind of categorical type activity? Is it a matter of political wisdom that some people in Congress or somewhere else have a real thing about renal disease programs and this is the price that we pay in order to get favorable activity on other funding for the Regional Medical Programs as a whole, or is this something at the Council level, or where did this all come from?

I think if we know the reason why we are at this point in history it may be able to help us see our way out of the current dilemma.

DR. PAHL: Let me preface my going off the record by saying I will give you the best answer I am capable of. Now I would like to go off the record.

(Discussion off the record.)

DR. MAYER: If that is the case I need to know then what is the answer to question three and question four that this committee asked of the Council.

DR. PAHL: Let me try once again. The Council

provides a budget to the region which specifies whether or not the kidney activity has been approved in whole or in part and specifies the dollar level for the approved portion of the requested kidney activity. The applicant receives one grant award statement together with the information about the specifications. So trying to get away from the semantics, there is one budget figure for the region which is shown on all records, but which involves a number of dollars specifically earmarked for whatever has been approved by the Council for the kidney activity. In that sense the region has one single total budget of which a portion is earmarked by the Council.

From our point of view one grant award is given out of RMPS funds, but we identify for the office of the administrator and other units of government that a certain number of these dollars are for kidney activities, the sum total of which we anticipate will approximate eight and a half million by the end of fiscal '72.

I hope that identifies total budget and separate budget.

DR. MAYER: Now question four.

DR. PAHL: Well, let me first try to answer point four, and perhaps Dr. Hinman can read you an appropriate statement from Council.

We in RMPS believe that the kidney activities from

a program point of view should be reviewed at all levels within the total context of the Regional Medical Program for that area. So forgetting funding aside, we are interested in having our own staff, site visitors, review committee, and Council consider whether the program in kidney activity proposed by the region makes sense for what the region is proposing to do, and whether it has the capability to carry out its total program, including its kidney activity.

We are not trying to keep it separate from a conceptual or programmatic sense. Yet we must identify at all stages that it is separate up to and including the funding in the manner in which I have tried to explain to you.

DR. MAYER: But that's where we are on the horns of a dilemma, because you dan't do that. In other words, if you go into a region and you take it within the total context -- you know, what I indicated and Ed has suggested or Leonard suggested might occur, will be that there will really be that there will really be nonapproval of kidney project after kidney project after kidney project, and therefore the political decision that has been made -- and I am not saying that that was an inappropriate decision, you know -- is not going to be adhered to. So you can't unlink program and dollars, and anybody who tries to unlink them is going to end up with chaos. And that's where this committee is, and we have to know whether you want us to review that as a part

of the total program, and including their funding, or whether you do not. And if you do, you know, then are are going to take one approach to it, and if you do not then there's another approach to take to it, and it's really as simple as that. It's not that complicated a question.

DR. PAHL: Well, I would have to state that since we have spent several meetings and seemed all to be acting in good faith and toward the interest that it would seem to be that complex. We have requirements on us which we must discharge which are complicated by the history, the political context, and the funding. And yet we are attempting within the concept of a Regional Medical Program to look at the capability of their carrying out what they propose to do and the manner in which they propose to utilize their own staff and funds. And it is a dilemman, it's not the only one we have. I really can't clarify what it is further that we are attempting to do. I recognize the dilemma. I do not have the answer for you. I believe that unless Dr. Hinman has it from Council, which is a transcript which we will be happy to place before you in xerox form, let you read and discuss further, or read it to you, which is somewhat lengthy, or have Dr. Margulies give you the clearcut answer, I cannot be of further assistance in resolving the dilemma for you.

DR. MAYER: Then we have to resolve it ourselves. Is that what you are saying? We will be glad to do that because,

you know, we have got to have some resolution. If Council can't do it and staff can't do it, then we have to do it ourselves. And we are glad to do that, I suspect.

DR. PAHL: Well, let me throw it open to staff, because I really feel I have failed the Review Committee in trying to do something which which Dr. Margulies apparently to this date has not also been able to do either. Is there anyone in the room that feels that they can state better than I what we are attempting to accomplish or say it in such terms that we can get off the horn, because we all are trying to act in good faith, but I am unable to do more than what I have just attempted. So I would have to say if it comes to one or the other acting, you act and we will respond.

I would suggest before the committee takes the action that you permit Dr. Hinman to read what he thinks are appropriate sections which I think we can condense from the Council transcript, because part of our difficulty is that we are intermediaries and it wasn't that much clearer at Council meeting. So if you would like to have it perhaps it would be helpful.

DR. HINMAN: After the lengthy discussion about kidney at Council Dr. Margulies summarized what he took to be their sense of discussion, and they passed it.

"It is the sonse of the Council that you wish to continue to review on the basis of the merit of the proposal,

that you are not in the position to determine year by year budgetary allocations; that you would like to be in a position, however, to criticize the budgetary decisions which are made and have some accounting of how those budgetary decisions were made; and what you mean by regionalization of being associated with regionalization of kidney activities, that this can be either through an RMP or through a section 910, but that it should be designed in such a way that it services the broadest possible public interest."

DR. MAYER: That doesn't deal with the issue.

DR. HINMAN: I have a practical suggestion for today, which is what you were getting to, Dr. Mayer. It would seem -- and the thing that will allow something to be transmitted to Council for them to have the dilemma would be a three level thing. One, to approve or disapprove the kidney projects that are in the particular regions you are reviewing today, to establish a dollar level for the region without the kidney project in it, and to suggest a dollar level for the kidney keeping the total regional needs in mind. Is that clear? Or possible, I should say.

DR. MAYER: Well, without having the individual proposals before us -- you know, I was very fortunate in the one I had which had a kidney proposal because I wasn't presented with the dilemma because it did have ad hoc kidney group report on it, and they voted against it, all three parts

of it, and so it solved my problem. I didn't have to face the issue. But I suspect there may be one that is meritorious, and then I don't know with the ground rules we now have how I am going to make a decision relative to that, and I guess we just have to wait until we get to that or we establish a principle now in terms of how we are going to deal with it, because it really relates to your proposed review process, because depending upon the answer to that question I either accept or reject, you know, the kind of assistance you are going to try to provide us in the review process.

Yes, Ed.

DR. LEWIS: I would just like to add to the chaos that exists by saying that these proposals by virtue of the fact that the signals keep changing are not being reviewed in a uniform way; ergo, I was on the site visit team to Florida, the Florida program was reviewed by me, the budget was reviewed on Monday here in Washington with the people from Florida and with the prople from the kidney program, by myself, and it has now passed up to the review committee. On the other hand, other renal programs have come other ways. Some have come straight up in the manner in which Dr. Hinman is suggesting it should be done in the future, others have come through the ad hoc review panel. And I think that this is really highly unfair to people who are applying, and I don't know what the answer to this is, because

there is a definite need, the money is there, and we have to do something. But I think that this must change.

DR. MAYER: What is the sense of the committee in terms of how we want to approach this? Do do want to wait until they get to the test case, or do you want to arrive at some other kind of approach?

DR. SCHERLIS: I would suggest that we might best defer all renal projects until we can consider them in a uniform way, because I am sure that practically every renal project which we present to this committee will have cleared RAG on a totally different priority system. And I'm not opposed to renal projects by any means. Having two kidneys myself, I cherish them. But I think that on a priority basis looking at the overall needs of a health region, I think there are other things that a RAG might act on, and unless we have uniform instructions to RAGS and to this Review Committee and to all members of site visits we are going to be measuring renal programs on a changing yardstick, and I don't think this is fair to those that are turned down for reasons outside of consideration that we impose on other regions.

I know your confusion, and that is you were not given any clarification at Council. That's quite apparent from what has been said. But I think in all fairness to having to answer yes or no to regions which have spent literally years evolving well coordinated projects, I don't

see how we in fairness can compare one region to another, one having a program, the other not.

DR. MAYER: What is your suggestion then? Could we then move on to some other parts of the kidney activity and assume that we will get at this head on when we are faced with reality testing.

DR. HINMAN: There were two other points that I wanted to bring to your attention unrelated to review mechanisms.

One is that there are a number of federal programs that are involved in various aspects of funding in stage renal disease, and to date the level of cooperation and coordination between them has not been at its highest. We feel that in certain key areas, three specifically, that there should be a central protocol or some central agreement as to how funding and support of these areas goes on so that at some point in time information will be available to providers as to what will be the best thing to do for patients.

The three areas are antilymphocyte globulin preparation, HLA typing and its value and necessity, and registry information of both dialysis and transplantation.

To this end we have initiated discussions with the agencies involved to attempt to come out with some sort of common protocol, the most crucial one being antilymphocyte globulin, because if it does turn out that this is of value

in transplantation patients the necessity for the Food and Drug Administration to license it so that there can be commercial production becomes an overriding issue at some point in time. So we are trying to get the FDA, three Institutes from NIH, the Division of Biological Sciences, Arthritis and Metabolic Diseases, and Allergy and Infectious Diseases, the V.A., and our group together, and possibly including some of the Department of Defense activities, because we are all involved at some level in funding. So we hope that from this something can come forward that will be of assistance in the field of kidney disease.

The second point is in light of this, and because of some of the other controversy and problems in the area, it is recommended that any project that requests funds to produce antilymphocyte globulin, that review or approval of this be deferred until there is a coordinated strategy. This recommendation was accepted by Dr. Margulies.

DR. MAYER: Is that here for our information or for our--

DR. HINMAN: For your information.

DR. MAYER: All right. Do you want to comment, Ed, anyway?

DR. LEWIS: Yes, I would like to comment anyway that I think it's unfortunate that one of the few things that RMPS can do, and that is fund at least local use of

antilymphocyte globulin, which I would put out to you is effeective, because I think a panel of experts will argue from now til the cows come home about whether it is or not, but at least it is as effective as coronary ... in the care of the patient with the MI, and I think this is the one area where people could have gotten some help and now it's an area that has been cut off. And I would also put to you that I personally believe that FDA will never, never pass antilymphocyte globulin for interstate commerce. Never.

DR. MAYER: Any comments from staff about that? Okay, we have got a prediction on the record then. Dr. Hinman, any other items?

DR. HINMAN: That's enough headaches for today.

DR. MAYER: All right, I would like to turn now to report from Mrs. Kyttle. She has a couple of issues she needs to point out to you. Lorraine.

MRS. KYTTLE: Should some of the items that Dr. Margulies discussed earlier today require a movement of the Council -- and I would ask you to turn to the calendar in your books -- if we were to move Council from May back to April, and therefore move committee back from April to March, would the dates--

DR. MAYER: The other way around.

DR. PAHL: Move committee from April to May.

MRS. MYTTLE: Right. Excuse me, I'm going in the

wrong direction. I'm sorry. Would the dates -- asking you still to keep April 12 and 13 logged for the standing meeting, would the dates of 10th and 11th of May be agreeable for a meeting that could be put on the books, and when the thing finalizes we can say whether we will be meeting in April or May?

DR. MAYER: Not for me, for one.

MRS. KYTTLE: All right.

DR. MAYER: I have seen three. Any others? Four.

MRS. KYTTLE: To move it up or back in that week, would that help?

DR. MAYER: 8th or 9th, 12th or 13th. No. No. 10th and 11th.

MISS KERR: There is a regional conference that has been long scheduled.

MRS. KYTTLE: The whole week. May 8 or 9, or 9 or 10, some time in that week of the 8th through the 12th of May, two days.

DR. MAYER: How many cannot be there on 8 or 9?

(Show of hands.)

DR. MAYER: 9 or 10?

(Show of hands.)

DR. MAYER: 10 or 11?

(Show of hands.)

MRS. KYTTLE: At the risk of pushing it into

Council, is the week the 15th through the 19th better?

DR. MAYER: It is not for me since we have graduation and that's one thing a dean doesn't miss.

MRS. KYTTLE: The latter part of the wek of the 4th or 5th? And that will put staff on its ear.

DR. MAYER: That's better. All right, how many can't be here the 4th or 5th? There's one. Just one.

MRS. KYTTLE: Now thinking of your travel, it is sometimes hard to get out of here on a Friday, which is the 5th, is the 3rd and 4th--

DR. MAYER: How many can't be here the 3rd or 4th?

DR. PERRY: 3rd only.

DR. MAYER: So that's one and a half.

MRS. KYTTLE: 4th and 5th seems the best. Dr. Pahl, do you think maybe it might wind up as a one day -- Friday is darned hard--

DR. PAHL: I think we have to consider a two day meeting, and please understand this is still predicated on our receiving instructions as to whether we are going to be bringing you additional grant applications in the area health education center, and that one is trying to be decided by the office of the Administrator. It may go contract route, in which case we may not be compelled to hold the meeting later than the currently scheduled one. So we are asking really that you consider a two day meeting in May rather than

a two day meeting in April, but holding all dates open for a few days until we can try to come back and cancel one of the two proposed meetings.

DR. MAYER: Okay, then let's tentatively hold on to May 4, 5, because even though Friday travel is abominable out of here, if you have got a month's notice or two months' notice you are in pretty good shape.

All right, other items.

MRS. KYTTLE: The green document that we passed out, we have because we thought it might help you with some of the deliberations that we were wrestling with this morning.

The other document that I am passing out is showing you how through the last review cycle your ratings placed the region. The box in the middle shows the specific ratings by the committee, and the items to the right show the staff anniversary review panel's conclusions that came out of the last review cycle as well.

DR. MAYER: Try me again.

MRS. KYTTLE: The box in the middle represents the ratings and therefore the placement of the region in an A, B, or C category on those regions that were site visited and specifically reviewed by committee last time. That's the box in the middle. The box to the right are the ratings that came out of the staff anniversary review panel,

and you remember last time our procedures, we were just beginning, and those regions that were anniversaries within the triennium just went through, they are coming to you this time as timely information rather than post information. But this is how the regions that were anniversary applications on the right fell out via staff anniversary review panel's rating. That's how they fell into A, B and C. And, of course, the information to the left is as it says, the July, August cycle.

DR. MAYER: And the adjusted raw, what--

MRS. KYTTLE: Well, the July, August cycle was the experimental, and for openers some of these had to require adjustments, because when October, November cycle came out you could see the differences between the settled rating and the for opener ratings, and that's the difference between raw and adjusted.

MR. PETERSON: What we found, Bill, was as a result of your initial trial the average rating in the July cycle was around 260. When we looked at your next average it was, if I remember the figures correctly, 301, and the first staff panel was 303, which was, given a 500 scale, seemed about right. So we took an adjusted mean and multiplied your earlier scores to make them roughly equivalent to the two succeeding actions which tended to cluster the mean right at about 300.

MRS. KYTTLE: This places 27 regions, and next time

we will come to you with the chart that will add 12 to it from this.

DR. MAYER: All right. Other comments? You were going to comment on some discrepancies between Council and--

MRS. KYTTLE: Yes, from the last October, November review cycle the recommendations of committee on Arkansas were accepted by Council, the recommendations on Arizona, and Colorado, Wyoming were accepted; the recommendations on Connecticut were not accepted, and when we finish I will have something before you on that. Iowa was accepted, Indiana was accepted; and Ohio Valley had an adjustment, a modification. Virginia was accepted.

The items going to Council from the staff anniversary review panel generally were accepted with two slight modifications; Tennessee Mid-South had a slight modification and New York Metro had a slight modification.

The three standing kidney proposals that came to you last time were accepted by Council. Georgia and Rochester came out to be negotiated with budgets, and those budgets have been negotiated.

In your book under the pink tab at the very back under other business are three documents. Two of them concern Connecticut, and one concerns Ohio Valley. And at the risk of working from the back up, the difference in Ohio Valley turned on Council's disapproval of the kidney project within

that proposal, and their rationale is there.

The rationale on the modification of the Connecticut recommendation is more extensive. Yourecall that committee came out with several suggestions, and there are two responses there, one to the decision that the Council made on the recommendation itself, and the second is Council's response to several of the suggestions made by the committee. These have not gotten to you before. You see them in your book for the first time. And, Dr. Mayer, if you would rather take a minute to read it or take it up again tomorrow, whichever you wish.

DR. MAYER: No, I think it is very important that this review committee do understand where it is running counter to the wishes of Council because it is helpful to us, because in a sense that's one way in which policy is established. And I would simply suggest that we take this information and review it and think about it, and set aside a little bit of time tomorrow to discuss it rather than to try to do it now.

MRS. KYTTLE: Attached to your agenda is the statement about the confidentiality of the meeting and the conflict of interest.

DR. MAYER: And I think I would only add to the confidentiality a more even explicit feeling that the review cyclo rating sheet which you have is handled with extreme care,

because if in fact there are going to be dollars attached to those, as was suggested at the outset of this meeting, it takes on even more importance that they be handled with exquisite and extra care.

MRS. KYTTLE: Dr. Pahl, would you want to mention anything about the discussion of the rating and the criteria with the steering committee?

DR. PAHL: Well, the only point is that as we had informed you earlier, we would not fully implement the rating and review criteria until the steering committee representing the coordinators had had an opportunity to comment upon this to us, and over the time period since we last met we have again informed the steering committee of our interest in formalizing this as a part of our total review process and asked for comments again. And then we met with them in Chicago the first week in December and they uniformly endorsed that we proceed with it, and I believe, Pete, a communication has gone out now.

MR. PETERSON: It is in the process of going out now. The actual letters to the 56 coordinators are being put in the mail now.

DR. PAHL: But it is clearly understood by the steering committee, and thus all the coordinators, that the review criteria and the ratings, weights, etc., that you have before you are now part of the RMPS review process.

I should really say that this endorsement by the steering committee was not given in a grudging way. Many of them felt it was a marked improvement in communication in the sense that they now for the first time did understand some of the points on which they would be reviewed, and there was a common basis that would be applied across all regions. So there was some degree of enthusiasm voiced at least by the steering committee members that we have this, and let's stabilize on it and move ahead, subject to change after a year or more of experience. But we have stabilized on what you have before you.

DR. MAYER: Could I just ask one question while we are on it? The figures that are there on the RMPS rating sheet which you provided us, Lorraine -- and I am now asking this because it is quite clear -- I'm talking about the single sheet that had the box -- I need to know if those figures are the sum of the weighted numbers or are they represented as overall assessment numbers only?

MRS. KYTTLE: They are the range of the weighted total score given by reviewers. Your middle block, for instance, Arkansas and Iowa, ranging from 339 to 341, those then represent the scores of all of the reviewers with the weightings taken into consideration, divided by the number of reviewers, and one of those attaches to Arkansas and one attaches to Iowa.

Does that answer your question?

DR. MAYER: Yes, I guess it does. It causes me some problems. How have you handled those in which someone has failed to put a number down in one of those little blocks?

MRS. KYTTLE: Frank.

MR. ICHNIOWSKI: We treated it as a blank and took it out of the calculation.

DR. MAYER: That becomes important because what we were doing, you recall, was circling those ones in which we had some discomfiture with. How are you handling those?

MR. ICHNIOWSKI: We counted just as you scored, even with the circles.

DR. MAYER: All right, because that has some implications about whether I am going to circle or leave it blank from now on.

MR. ICHNIOWSKI: The number of circled items last time comprised only about 15 percent of all the scores, which didn't have a major effect. We tested taking them out and it didn't change it.

DR. MAYER: Is everyone clear on those questions?

All right, why don't we break for lunch, try to be back by 1:30, and we will start in on the individual projects. It would be my intent to go through them roughly as they are outlined on the sheet.

(Whereupon, at 12:50 p.m., the meeting recessed, to reconvene at 1:30 p.m.)

AFTERNOON SESSION

(1:30 p.m.)

DR. MAYER: I thought we might before we started in, in that Harold is here fortunately with us, we might just comment briefly on the kidney issue that we were discussing with him present. I think he understands the kind of dilemma which we are faced with fairly clearly. And I guess the feeling was in this morning's discussion, Harold, that the answers we got back from Council and as staff then interested it left us the same place we were four months ago when we sent the request up to Council for clarification. We are still on the horns of the same dilemma we had previously.

DR. MARGULIES: Well, I think that the best way to handle the kidney review and funding activities is to keep them separate from the Regional Medical Program application itself. I think it is quite clear that this has caused a great amount of confusion. So what we will do is allow regions to submit requests for support for kidney activity. We will continue to identify a separate amount of funding as we have indicated we would for this purpose.

We will ask the review committee, with the assistance c outside technical review on each one of the kidney projects, to review the proposal and to make its recommendations, and we will keep that separate from the review of the

Regional Medical Program. This will mean that for each renal project there will be outside consultation -- that is consultation outside of that region, to make sure that there is adequate technical review, and the committee will receive the results of that kind of technical assessment as well as, of course, the staff assessment of it.

DR. HESS: Any given renal project will be used specifically for that then.

DR. MARGULIES: That's right. It will be regarded as a separate category. We will continue in this process to try to build it around a national network of completely adequate facilities for dialysis and transplant and have that kind of a design in mind, as we have had for well over a year.

DR. SCHERLIS: And when we go to a region as a member of a site review committee we should not make any judgment or recommendations on that project, is that right?

DR. MARGULIES: Keep the kidney project separate.

DR. SCHERLIS: In other words, we make no evaluation of that project.

DR. MAYER: Well, I suspect that the evaluation ought to at least include now that Regional Advisory Group and others themselves look upon that and what are that staff's capabilities of administration. I think those kinds of issues are probably appropriate.

DR. SCHERLIS: As far as funding we look on that entirely separate, don't make any recommendations on the funding of the renal project?

DR. MARGULIES: Not as a part of the site visit or the RMP. The kidney activity would be considered separately. If there is a request for a kidney proposal at the time that the RMP is being reviewed and if the review is carried out at that time then we will have people to look at that particular activity separate from the rest, although as Bill has indicated, where there is obvious need to look at the two together that should be done.

DR. PERRY: This is probably the best part of all. If you are fortunate enough to have Ed Lewis with you on the review committee you can look at it in relation to the total, but you can really look at its merits also at that point.

MISS KERR: Then these kidney funds are earmarked and are not interchangeable with the other funding or the other program?

DR. MARGULIES: Tha'ts the way we will administer them, yes.

DR. SCHERLIS: Has that decision been made on the basis of the discussion we had earlier this morning or is that the decision reached at Council?

DR. MARGULIES: That's pretty much the way it was

understood prior to the meeting of the Council and after the meeting of the Council. As I have tried to say on many occasions, there is just no question about the fact that the kidney activity is categorical and that it in fact addresses only a part of the kidney problem, in stage kidney disease, and it's a purely categorical activity which needs to be kept separate from the broader ranges of RMP activity. And since it has been difficult to try to look at them in a common context I think it is quite clear that we should apply the separate categorical review process.

Now the only difference between this and what we have done in the past is that we are attempting, and we hope to get more effective in the course of time, to do this in such a way that we do over time cover the nation's needs with centers, so we are going to be looking at it here in terms of locations for geographical access.

DR. THURMAN: I think one thing that makes that exceedingly difficult -- to take a very specific example, the Greater Delaware Valley -- if you had two hands and two feet on which to count on the site visit at Delaware Valley, it was obvious that they had no plan that really went to regionalization of kidney disease. They are talking about opening more when they don't have enough to run one. It's very hard emotionally, mentally, fingers, toes, or any other way to sit there and say these guys really know what they are

talking about in any category if they are that blind in kidney disease. That's the real problem, and I think that's the one that precipitated most of the discussion here this morning. You cannot take any categorical disease and remove it from the rationale of what RMP really stands for, because that's where it started. That's where even though the category has changed -- I mean even though the mission has changed, it's still very difficult to look at a group of people who are going to be spending a dollar and not say can they really do it even though this process would be categorical.

To give you a numbers game, they don't have a hundred transplants a year and yet they are talking about opening five centers. Well, that's just totally unrealistic, and it certainly puts a bias in the reviewer's mind about the rest of the program if they are not working together well enough to do that.

DR. MARGULIES: I think your point is perfectly valid. But one of the things we would anticipate would be looked at in the process of carrying out technical review of a kidney proiposal is whether there is evidence of a capacity to concentrate facilities andto produce a regionalization of the program, and if it's evident either directly or indirectly that that's not the case then this would not be a fit project for support.

I think you will find if you keep them separate in the review process that it will be possible at the time that the review committee meets to raise the kind of question you just raised more comfortably than if you tired to intertwine them at the time of the review process. We are caught a little bit one way or the other.

DR. THURMAN: I would just argue the reverse. When you are sitting there talking to the guy who is doing all the rest of it, it's very difficult when he says "I can't count potatoes, but I can count oranges." You wonder how the hell he's doing it. And that's really what it amounts to. And that automatically puts a degree of bias in the rest of your evaluation if we are doing to look at it that way and yet still think of it entirely separately.

DR. MAYER: I guess, Bill, where I am, is that I am far more comfortable with a decision having been made, that if those recommendations come from that expert panel and I have been into that region and looked at other issues and look at what that region is doing about regionalization in other issues, and that review panel on kidney disease comes in, one of the key things that I am going to ask as a review member here is not, you know, the quality of the people involved because supposedly they have looked, but I can ask them about regionalization because I think I know a little bit about it. And if it's not there in it then that becomes

issue in my decision. So I think we will have at least at review committee a chance to meld them together, whether or not we meld them on site or not, on individual site visits.

Any further comments on that?

Harold, I have to say that's the most helpful, succinct two minute statement that I have heard for some time relative to this issue.

DR. MARGULIES: It's easy when it's categorical. That's what is so attractive about it.

I would like to suggest that, if the committee is agreeable, we might set up a period of time in the morning for an executive session because it is quite apparent to me, as I think it is to you, that you still have a sense of discomfort over a lot of the things which we have attempted to discuss today and the last time, and I think we might be able to deal with them more effectively in an executive session. We could do that first thing in the morning for whatever period of time is appropriate to your time schedule.

DR. MAYER: I think that would be helpful and appropriate, and probably first thing in the morning would be a good time to do it. It would be an executive session consisting of the Review Committee and Dr. Margulies and whoever else he chooses to bring.

All right, are you ready, Leonard, for the great state of Illinois?

DR. SCHERLIS: So that's why we are here, isn't it?

DR. MAYER: That's one of the reasons.

MR. HILTON: Should I, Dr. Mayer, excuse myself?

DR. MAYER: I suspect it would probably be appropriate. I think the record ought to show that Mr. Hilton has left, and also ought to show that Dr. Schmidt is not with us today.

DR. SCHERLIS: The Illinois site visit was conducted on December 15 and 16, last year. Dr. Brindley was with us at the time. The other members of the site visit included Dr. Vaun, who is Director of Medical Education in Jersey. This is of significance because some emphasis of the Illinois program is on continuing education.

By the way, about how much time have you allowed for each review?

DR. MAYER: I haven't divided it up.

DR. SCHERLIS: About an hour?

DR. MAYER: That for review and discussion would be fine.

DR. SCHERLIS: About 15 or 20 minute review.

Other members from the staff included Mr. Nash, Public Health Advisor, Mr. Piatek, Program Analyst, Miss Hulburt, Dr. Gimbel, and Mr. Ryan.

The site visit I think was a very profitable one in the sense that we met the evening before. I think we knew what our problems were as far as what some of the difficult

areas were that we had to explore further. We tried to put most of our emphasis on these areas.

You all have the report. I would like to emphasize some of the things about it. The report is organized on the basis of our rating system. When we do this I think you can see it has some advantages, but at the same time it does permit a certain amount of duplication.

We were impressed with the numbers of people who attended the site visit representing Illinois. This was not alone important as far as numbers, but as far as the groups which were represented.

We were most favorably impressed with the executive director, Dr. Creditor, who I think used the site visit for many reasons, not alone to present the Illinois program, but I think he was also manipulative in the sense that some of the agencies which were represented -- he helped utilize their presence to try to make some points with them, and I think he did so in a sense of trying to get them to recognize what some of the problems were which they posed for RMP and how they might better cooperate.

The list is a most impressive one in terms of not alone board members, but groups which were represented from the entire community, many of whom had traveled a long way. And I must say it was one of the better organized and most fruitful site visits in terms of having good

representation and the information which we desired made readily available.

Our site visit charge was in terms of the fact that the Illinois group has requested support for a core, for projects of developmental components of its triennium application, and so our charge was to review the region's overall progress, to examine the experience and achievements of its ongoing program, determine how this would modify the program goals, objectives and priorities, to review their prospects for the next three years, and then to arrive at a funding recommendation.. We attempted to meet all of these scores as best we could.

The funds which were requested were as follows: From the present base which for the 02 year is 1.5 million, they had requested for the 03 year 2.8 million; 04 year, 3 million, for the 05 year 3.2 million, which, as you can see, is a most ambitious increase. It should be stated, however, that their 02 year did represent a drop in level of funding from what had been a previous year of, I think, 2.0 or thereabout.

The background of this group is that they now have a board, a relatively new Executive Director, Dr. Creditor, and we will get into that as we review our general overall impression.

I think our overall impression was it was good, and

then we tried to translate that into terms of documentation.

First of all, the region has made excellent progress since its last site visit in December, 1970. They have established goals and priorities which are certainly congruent with national goals, and I think practically every region in the country has a rather similar program for that. And they have administratively a board which I will get into, they have a Regional Advisory Group, and they have an organization which I think is a most effective one.

Their RAG does represent key health interests in the region, is a responsible group, been able to make decisions on a logical and well founded basis, and was quite effective in carrying out its responsibilities. It does appear to us that RAG is the decisionmaking body of the Illinois Regional Medical Program, with a heavy input from the Executive Director, but the final decisionmaking appears to lie within RAG itself.

Their chairman is a highly capable individual. RAG membership is involved in all levels. They have orientation sessions for RAG, and their members take part in site visits, and this has, I think, been a very important strength.

You will notice in our site visit documents several references to the fact that they need more representatives from minority groups. This is why I made the aside to Mr. Hilton that I did earlier as far as Illinois was concerned.

The Executive Director is an extremely knowledgeable individual, knows what is going on with the RMP in Illinois. One shouldn't have to say that, but as a member of site visits to other regions you sometimes find coordinators who are not aware of the details of the program, and certainly their coordinator is very, very well aware of all of the details. He has been heavily involved with them, yet at the same time has involved the other groups.

Those of you who may -- and I will just spend a moment on this -- there is a unique arrangement in Illinois, the Executive Director, Morton C. Creditor, and the Grants Manager, Mrs. Una Creditor, who happens to be his wife, and this is indeed unusual;but as we spoke to other members of the Illinois group and as we met with her I think she should not be discredited by virtue of the fact that her husband happens to be Executive Director. I think they are fortunate in having both people working there, and they both operate, at least during the day, I think independently as far as some of the objectives are concerned. So I don't think this speaks of patronage. I think it speaks of the fact that they happen to be married each to the other.

Well, in addition to the Executive Director, as far as the core staff is concerned he has a capable and energetic group. In addition they have Dr. George Miller of the Illinois region, and the participates as the core project

director. I will get involved in this a little more later. Dr. Miller has been involved almost more than anyone else in the country with continuing education for physicians, and his participation as a member of the core group is very important.

We did suggest that they have somewhat better review periodically of their own core projects. This may become an issue that RMPS has to consider more and more, the fact that there are such good technical reviews of individual projects, since more and more of these are supported by core there has to be technical review in addition of core, and how this can best be done may be a question of logistics. But this became apparent to us more and more during the period of our site visit.

In Illinois the CHP agencies have been very slow to develop, and Regional Medical Programs contribute markedly particularly toward the development of B agencies. So a lot of the subregionalization of Illinois has been through the vehicle of the B agencies of Comprehensive Health Planning.

Now since their new coordinator took over he has, I think, given the whole Illinois Regional Medical Program a sense of enthusiasm and of movement which had not been there previously.

And if I can now go into individual items, they reformulated all their goals this summer, and RAG is very

strongly involved with the whole RMP program, and as a result they printed a manual flyer, and I think this is important. It has had wide distribution. And this specifically states what the objectives and goals and the funding procedures are. This has been of importance as far as everyone who submits a project knowing what the ground rules are before they submit the projects.

These objectives include the following: "Improving health care delivery by making existing systems as effective as possible and catalyzing the development and evaluation of potentially effective alternate systems."

As an aside, they have used core funds very effectively to help catalyze developments. They have used three or five thousand dollars as support projects which have been able to utilize these funds to grow and project the influence of these goals further than I think largely projects have elsewhere.

Goals B is "increasing the availability, efficient utilization, and capability of health care personnel throughout the IRMP," and goal C, "controlling those major medical problems which cause economic loss, social distress, physical and emotional disability, morbidity and mortality."

They are pretty good goals, I think they are quite inclusive, and I would find it hard to fault them as much as I would try to fault motherhood.

They give priorities to all activities as best they can on the basis of A, B and C, in that order, and they try to look at these very carefully.

One suggestion we made is that they set up some subgoals on the broad general basis of these three. So we did suggest that they have some subgoals and smaller objectives listed.

They have shown that they can terminate some projects, and they have terminated two of them on the basis, I think, of good critical review; one on the basis they had not set up adequate evaluation, had no data that would indicate any success, and the second on the basis, too, that no further funds be awarded because performance was inadequate. So they have shown that they can criticize their own programs even though they had been previously funded.

As far as specific accomplishments and implementation are concerned, they supported projects of improving cancer programs, a coordinated cancer program which has involved throughout the region several hospitals. They are having some problems with this because as other hospitals improve their facilities some of them utilize the central one less, but certainly this gives some hope as far as being able to continue them.

They have set up a coordinated home health project in northern Cook County, a comprehensive health program. They

have multiphasic screening programs in the Chicago area industrial plants to detect coronary prone individuals, have stroke rehabilitation services, and all of these read as you might expect since this is a list of what they have had in the past as their whole categorical view and emphasis. But the ones that they have had have been well surveyed. They have met with the review, which I will get into, which appeared to be extremely effective.

New activities which they are proposing include home health services, a system of planning care, computerized hypertension treatment, Winnebago County comprehensive care, continuing education for Mid-Southside. And all of these are directed at delivery systems. They have set up programs which help support ongoing community health and medical care systems and to help evaluate them.

They are very concerned with the whole process of evaluation and are looking in their area under the continuing education program at the whole concept of having a much better method of peer review, and to this they are looking at program oriented charts as their standard. And they regard this as an important decision because they hope that by setting up method score evaluation, utilizing specific problem oriented charts in the hospitals and HMO's, that this would give them a way of looking at success or failure and patient problems, and they do have the medical societies

interested in this as well as their own evaluation groups.

The core activities are extremely extensive, and this is why I mentioned they have used small funds to try to move in certain specific directions, including support of their educational support resources. This is the general area which is under Dr. George Miller. It has been very effective, and the question we had about this was the need for technical review from the outside.

They have the North Suburban Association for Health Resources, Mid-Southside Health Planning Organization. They have been involved with home planning on a very active basis. Study of Physician Referral Services, Self-Audit of Family Practitioners. They have been involved in a whole series of surveys of health needs, and so on.

I mentioned their minority interest, but in passing just to summarize it, on RAG 4 of 47, nine percent minorities on committees, four percent core professional staff, 24 percent for secretarial staff, 43 percent project professional staff -- the way it averages out it comes to -- I don't have a final figure on that, but you can see there is a wide scattering. There is less than proportional minority population in the state. Twenty percent that represent minorities, 13 percent black, 6 percent Spanish surname.

As I said, Dr. Creditor is a very effective, dynamic

force in the Regional Medical Program, has changed it since he took over, and that was only on June 1st, 1970. These changes have really been done very rapidly.

Core staff -- they have 21 full time members, and they do have some vacant positions which they are trying awfully hard to fill; heavily involved, as I have indicated, in continuing education through that center supported project, some very heavy involvement with other objectives.

Administratively they have a board of directors which has reorganized so that it now has only fiscal management, specifically manages fiscal affairs of the corporation. We looked into this because we were concerned as to whether or not it became involved with policies. The board does not. It is purely fiscal and personnel concerned. It has nine members, six of whom represent the schools of medicine or osteopathy. Two of them are teaching hospitals. So all of this is very heavily oriented toward the medical school, and is purely fiscal-personnel, and by every way we could we did establish satisfaction that it is purely on that basis.

I have already read the goals to you. I won't go ahead with that.

Its organization, to move further with this, they have six standing committees, all of which are chaired by members of RAG. So there is a heavy involvement by RAG.

These are the usual, executive, nominating, review, health care delivery, and so on. These are not categorical. In addition they have committees which are categorical.

I think they are really fortunate in their leadership and involvement in RAG.

The review process is an excellent one. As I have said, they do have published criteria and published priorities, so that when a letter of proposal comes in it is easy for the proposer to determine whether or not it fits into the priorities of IRMP. Staff works informally with them putting together the original application. It goes to a technical review committee before it goes to the overall RAG group. And the review committee is one which gives out excellent reports.

As far as ongoing project surveillance they have adopted a project review which is excellent, and they evaluate the projects anywhere from two to four times a year, with at least four times a year looking at it from a budgetary point of view. They carefully go over items of the budget to see whether or not funds are being expended in the direction in which the grant was originally made, and this has been of help to them in rescuing significant amounts of funds of core supported projects. In addition they have been able to maintain a quality of control by these frequent reviews which appears to be of a high level.

We were impressed with the degree of involvement of local agencies. As we said, the A and B agencies in Illinois leave a great deal to be desired. Dr. Creditor utilized the format of the site visit to ask questions of the A and B agency representatives, which I think will get them off the center in many respects as far as knowing what their involvement should more strongly be. The worst criticism was made in terms of their not having developed overall health plans.

There appeared to be some schism between the IRMP and the CHP in the regard that Dr. Creditor repeatedly stated that the planning had been minimal and he assumed that this was the prime role of the comprehensive health planning, but in reality privately he informed us that they obviously were involved in planning as well, but were hoping that the CHP would be more involved both with the planning and evaluation. They have been of little help in evaluating projects as well. They have often left a great deal to be desired. I think the site visit group felt these criticisms of the CHP were indeed justifiable.

They have been very, I think, effective as far as their educational programs are concerned. They have established strong relationships not only amongst the medical centers, but certainly amongst the surrounding communities in addition. They have set up what they referred to as

articulated systems of health care. These projects include home health services, the Illinois kidney disease program, radiation therapy program. They help to develop models of HMO's. And this is not reflected in the amount of money they have spent, but they have utilized their staff heavily and small amounts of funds as catalysts in this regard.

They have functioned as the liaison amongst the 35 developing HMO's of the state. So if anyone is concerned about how many there are in the country I think that the amount of funds mentioned this morning don't really indicate either the number or the level of support because so much of core staff activity around the country I think is going into this, and it does not get reflected in terms of the funds which are actually listed.

They are anxious as far as developed advanced technology in health care, computerized hypertension services There was excellent representation from several of the developing HMO's in this area, and these I think are very heavily involved with the Illinois Regional Medical Program.

Some of the specific projects include a radiation therapy treatment planning center which helps to serve several medical centers; the Illinois kidney disease program, which again is one that has many different areas involved with it, appears to be a good overall program, but they, as they have admitted, have had little influence on discouraging

sporadic renal transplant surgery in other centers, which the three in Chicago appear to be developing quite well.

They are involved with a comprehensive family oriented community health center to help a poverty area of some 10,000, and this is the so-called Valley project.

They are also involved with the Hyde Park-Kenwood planning for care which will involved some 45,000 residents.

I won't continue describing some of the details except to state that we were impressed that this was a region which, given funding, would be able to utilize it effectively. They have shown the ability as far as leadership is concerned, as far as having a RAG which reaches responsible decisions, as far as having budgetary controls so that it can cut off programs which are not effective, as far as rescuing funds from these projects and utilizing them I think with good judgment. They have good technical review not only for new projects, but for those which have been continuing, and not hesitating to cut them off.

I think there is a heavy involvement with the problem of delivery of health care services and with input from, I think, many of the projects which are going on in the Illinois area.

I think that given X funds they would be able to use these funds quite well. So our concern was not on their ability to utilize funds.

We felt that we would approve them, and recommended

this -- number one, we approved their program of triennial status; number two, that we approve the developmental component request; that we approve the request for core and projects, all of this in a somewhat reduced amount.

We felt that they had the capability and maturity and program to justify the amount which we will recommend. So we got together our ouija board, and we decided that the third year they had requested 2.85 million and we recommended 2.65; for the 04 year they requested 3 million and the fifth year 3.2 -- I will go over that again -- the third, fourth and fifth years, they requested 2.84 million for the third year, the fourth year 3.0, the fifth year 3.2. Our recommendations for each of those years in order were 2.65 million, 2.8 million, and 3.0 million.

We feel this is one of the better regions as far as being able to utilize these funds, that there is the adequate opportunity in the region to do this, and therefore the site visitors so recommended.

DR. MAYER: Dr. Brindley.

DR. BRINDLEY: I agree with everything that has been mentioned. I had the opportunity of reviewing the program a year ago, and it was of some interest to compare the changes of a year ago and the present condition of the program.

Strong points to me were the coordinator -- he is

intelligent, aggressive, eager, and a good salesman. The RAG is a very good one. It meets frequently. They are enthusiastic. There is representation from all fields.

There is a very good relationship with the Governor's office, and they do keep good rapport with all the other agencies except the Comprehensive Health Planning. The gentleman that was there representing Comprehensive Health Planning was nervous, concerned, really wasn't able to propose a very good program, and apparently they haven't done their part too well. That is not directly the responsibility of the RMP, but it does hinder their program that they haven't had very good assistance from the CHP, particularly in planning.

There was marked improvement in the program over the past year. Last year they were just beginning to sit down, change their program, change their bylaws, agree on what they might try to do, and they have made a lot of progress in the last year.

They have an excellent method of evaluation and of developing projects and programs. They have a very good method providing funding and shifting those funds to areas of need and reducing funding from programs that are not very productive.

Points of concern to me, when we were there a year ago we asked them at that time have you evaluated needs in your state, your abilities to meet those needs and proposals to

accomplish these; and they said at that time well, they were just about to do this, and Comprehensive Health Planning was going to help them with it. We come back again this year and no one still has done it. Comprehensive Health Planning hasn't done it very well. And as far as I could tell -- as a matter of fact, they make the statement that they haven't done this because it was too late when they got started and now the programs are going around it, and so we just haven't gotten around to doing this, that these objectives and programs we have are all good, they are national programs, people are bound to need it, and so we are just going to move right on into this.

Well, I'm old-fashioned enough to think it might have been better if they would have looked at real needs and abilities to accomplish those, and I don't believe they have done that as well as they might.

DR. SCHERLIS: Let me just respond to that point. We were concerned about this, and I think you left after the first day, so we met specifically with their program coordinator and said you actually put out a letter which stated -- and the letter specifically stated -- let's see, I have it right here --"as a matter of fact, it should be emphasized that the Illinois Regional Medical Program is not the result of systematic collection, collation, analysis, interpretation of data, et cetera." We said what data do

you have. He said "all the data we have are dirty." We said we would like to see it anyway, and then he brings out replete volume after volume after volume of really very good data, and I don't know why they put that ploy in.

Who else was on the site visit?

This was a very peculiar ploy, because we asked them for data and they had some of the best analyses of health data that we have seen, and when you think about Illinois and their Chicago health system, and Dr. Stan and others who collected down in that area, they hae some very good data.

I think what they are emphasizing is there are certain obvious needs that you can't get very clear data on, because we took them to task on it and they brought out document after document, beautifully evolved.

Perhaps you can comment on that later as a member of staff.

DR. BRINDLEY: The goals that they mentioned to us, of course, are national goals. They are certainly excellent ones, but they really didn't have very good subgoals or intermediary points of achievement, even though they could improve on that.

The program still is largely Chicago related. They did take the pledge and promise that they are going to develop some regional goals and are now going to get with this and improve it. But they haven't done as much as they

might in that regard.

Relationships with the CHP still were not as good as they could be.

And then I was still concerned some about the size of the budget for core. I realize that core is essential, and it is very important and does lots of things other than administration. But it is about half of the total budget for the area, and although will be increased will still be at about half. They are going to double the size, they need to increase it some. But I just wondered if that is the best way for them to use their money. They are going to add three more people for the problem oriented record, which we think is probably funded higher than it should be, and three more physicians are going to join core to look into this.

So I did have those concerns. I don't mean to be unkind. I think they have made great improvement, and it is much better. It did seem to me there are some areas where they could further improve.

DR. MAYER: The recommendation -- let me see if I am clear. With their current funding budget at roughly a million and a half, which is really on a 14 month base, which translated back would be around a million two or so, what you are essentially recommending is a doubling of their operational activity. I just wanted to make sure that

we are all clear on that.

Okay, discussion.

Yes, John.

DR. KRALEWSKI: The question on that core staff, I think that is a good one. Do you think they will be able to recruit -- they are going to recruit 22 people, is that their plan, to add to that staff?

DR. BRINDLEY: Yes, and they have listed the categories they are going to try to fill. They didn't say they had those men available or they could get them, but that was their aspiration and they are budgeting for it.

MISS ANDERSON: Do they have job specs for them?

DR. BRINDLEY: Don't push me too far. I've got the names down here. They do say they have those needs, and they related primarily as getting into the subregionalizati effort. We are now going to go out and address regions and have two more schools.

DR. SCHERLIS: Illinois has a very rapidly expanding medical school system, and they are subregionalizing through that area.

Let me make one point that I perhaps should have mentioned. Council had originally recommended for the second year two million dollars. They were funded at a level of 1.5. As they pointed out, this is probably the best thing that happened to Illinois because they just had to

constrict everything they had. It gave them the opportunity for a total re-evaluation of all the system with which they were involved at the time.

Much of the increase will be core. As I have indicated, core is very peculiarly competent I think in the Illinois program. They have some of the best people, I think, around, both as far as evaluation in the field of education, and I think the whole problem of evaluating quality of care with HMO's can be greatly helped by the sort of program they are discussing in Illinois.

I think that as you look at their core project it is a very ambitious one. There's no question about it. But at the same time they have, I think, the energy and the ability and a RAG which will permit them to utilize these funds.

I am impressed that that state will have very little waste because of their method of budgetary control and review and the priority systems they have worked out. I would not be as happy about giving these funds to many other regions. I think this region can handle it very effectively, and the health needs in Illinois -- you know, this is a huge state, and you talk about increasing it 2.6 million, you think about the size of Illinois and they are getting involved now with delivery of health systems, this is a very, very expensive area.

DR. KRALEWSKI: Do they have any vacancies on core

right now?

DR. SCHERLIS: They have a few, but as I pointed out, they have hesitated to fill them because they had no idea how much attrition there would be this year. The signals from Washington waxed from little support to a lot of support. And they have been hesitant, for a lot of reasons, to hire people knowing they might not get support after a few months.

I am not concerned about their filling them. From what I can see, the morale on the staff is so high they should have no difficulty attracting desirable people to work there.

The whole feeling you get about the IRMP is one of organization and is moving along very effectively, and not just stars in its eyes, but knows how to utilize the health dollar.

DR. MAYER: How realistic do you think their pledge that they took, Dr. Brindley, to get outside the city of Chicago was? That's a big state.

DR. BRINDLEY: Well, in speaking to us they seemed sincere and genuine that they were going to make a real effort to go to the other areas, and they showed us a lot of maps and where they planned to go and how they proposed to go about it, and particularly with the new schools and area health education centers as it related to those

schools, community clinics in those areas. They did show some health plans, home health care plans that would involve other areas out of the Chicago area. They sounded encouraging.

DR. MAYER: I just wanted to make sure we had as a matter of clear record so that next year we could look at that issue and see how far they have come.

DR. SCHERLIS: There were three negative recommendations. One, they had to have increased minority representation on the RAG. We discussed this at some length with them, and I think they are impressed with the fact that this is a very high item of priority as far as we were concerned.

Number two, more clearly defined subgoals and objectives; objectives including ones for core activities and educational support resource activity. I referred to that. That's Dr. Miller's activity.

We also emphasized they had to be able to evaluate core projects technically.

And three, increase planning activities directed toward subregionalization of program.

The CHP agency was one which I think should work more effectively, and I think part of their emphasis on not having data is they want CHP to be more directly involved with planning and helping to get some additional data.

You are concerned about the sum of money we are recommending, I gather. I am not.

DR. MAYER: No, I just wanted to point out we were doubling the budget of a region, that's all.

DR. BRINDLEY: It is encouraging, I think, from the minority viewpoint that the man in charge of that is a member of a minority group. He is one of the professional members of core. It is his job to go out and recruit and to find these people. He is a very energetic, enthusiastic person, and said he was making a real effort to find these people both for involvement in the core and also in the RAG. I think they are trying their best to get good members.

DR. MAYER: Other comments? Questions of the two reviewers?

MISS ANDERSON: I was just wondering here on the core staff aspect where they are sort of contradicting themselves, where they are talking about regionalization and extending out to the rest of the state they ask for three part time staff, a specialist for Northwestern University, Western Presbyterian, Chicago Medical, and they are all in the Chicago downtown area and not spread out.

DR. SCHERLIS: Don't forget the very heavy population which centers in Chicago. They are attempting something which if they can carry it off it will indeed be excellent experience, and that is to get each of the medical

schools to take a portion of Chicago as its area of responsibility for the delivery of health care. And in doing this they had the temerity to actually put lines on a map, and this takes an unbelievable amount of gall, I guess, to try to convince deans of medical schools that this is the way to do it. And part of their attempting to do this involves having support of the schools.

We were impressed with the involvment of the medical schools in their overall community outreach programs in Illinois, and the fact that we always had at least two deans in attendance throughout this time, though if you look at where the money is going it is not going to the medical schools.

DR. BRINDLEY: I think there was an improvement in the rapport with the physicians and hospital administrators. When we were there before, why, they weren't too happy with each other, but that seemed better this time. I talked with several of the physicians about it, and they were more enthusiastic.

DR. THURMAN: You don't see any turf problems as they refer to them?

DR. BRINDLEY: Oh, sure. But they are doing the best they can with that.

DR. THURMAN: As long as they can breathe they are okay.

DR. MAYER: Other questions? John.

DR. KRALEWSKI: I understand you think it is a good program, and I am in agreement. I am sure they have some good things going, but one question yet I have on that core. If they are going to add that many people they are probably going to have to phase them in over a period of time, and if they are going to do that they are probably not going to be able to spend that core budget, and did your cutbacks reflect that -- that's where your cutbacks were? So they will probably be able to phase this group in and extend that budget out in that way?

DR. SCHERLIS: I really think so because many of these projects in which they ask support are already beginning to move along somewhat. I think they have people in mind for many of them.

I think it should be emphasized, too, that their coordinator has been there a very short period of time, is just beginning to turn programs around, and he has already fixed in his budget for heavy amounts. If he is going to have any impact it has to be by way of funding and new directions, and we put a lot of our faith in his ability to do this on the basis of what he has done by rescuing small amounts of money by stopping projects, and taking that money they weren't going to use. With RAG and technical review they have phased out projects on the basis of not measuring up to

standards, not having adequate review, or not putting funds where they should go. They haven't hesitated to do this.

MISS KERR: I got that the first time, but did I miss anywhere along the line where you referred at all to their turning over of projects or activities for outside planning? Are they phasing out any support from the outside?

DR. SCHERLIS: This is a very heavy criterion as far as their review process is concern. This is one of the very strong points.

MR. TOOMEY: As they have divided up the city of Chicago have they kind of adopted on a satellite basis hospitals within the area to relate to one of the medical schools or the hospitals have a multiplicity of--

DR. SCHERLIS: I should emphasize even if they draw lines on the map these are real thick, heavy, fuzzy lines because some hospitals here work with community hospitals out here, and they are just beginning to move in that direction, but as I said, it looks like they are doing it, and they do have satellite facilities with hospitals as part of this program. All of this is just beginning to evolve at this point.

MR. TOOMEY: Is the relationship just medical between -- in the hospitals is it the medical school or is it relating to administrative as well?

DR. SCHERLIS: Their allied health professions are

involved very heavily. They have administratively -- I can't speak to this. We had specific items that related to that.

DR. MAYER: Further comments?

MR. NASH: Dr. Scherlis, you seem to be so concerned about the size of core. This includes, of course, Dr. Miller's project.

DR. SCHERLIS: I think that is an important point, that when they talk about core a lot of our curiosity centered around the fact that within core they had some areas of activity that might be funded as projects elsewhere. This is particularly true of their educational resource center under Dr. George Miller. And so a good part of that core funding is through Dr. Miller. We suggested that they look at this administratively as well in order to not just let this be an ongoing project through core. One reason they set it up is because they had it funded three years in a row and it is a continuing resource for the state, will now become heavily involved with their own problem oriented type history.

But I appreciate that addition. This is one reason why core is so--

DR. KRAWLEWSKI: Are they going to phase out that project or do they plan to stay in it forever?

DR. SCHERLIS: I think if you look, they will be in it a while longer. We did as one of our suggestions

emphasize they look at that whole administrative structure and set up some ongoing technical review of it periodically. So this won't be free swinging. It is a wonderful resource to have in the state and should be there. The question obviously is how long should it continue to be supported by RMP. It should be added that this is not a major part of the support by any means. He has a great deal of support ongoing. I guess from the whole manpower and other agencies.

DR. PERRY: The Kellogg Foundation has just funded a half million dollar project.

DR. SCHERLIS: This isn't something he needs only for this. These funds are specifically related to RMP activities.

DR. MAYER: Other comments?

Then your recommendation is two million 650, two million eight, three million respectively.

DR. SCHERLIS: Yes, I make that in the form of a motion.

DR. BRINDLEY: Second.

DR. MAYER: Discussion?

All those in favor?

(Chorus of "ayes.")

Opposed?

(No response.)

Well, let's take a minute to fill in the blanks

while we have a chance, remembering that 5 is the highest, 1 is the lowest, and circling those that you have some guilt about.

DR. SCHERLIS: You are not requesting members of the site visit to do that, are you, because ours is already a matter of record, andI don't want to be caught in any inconsistencies.

DR. MAYER: Can it be recaptured?

MR. NASH: I have one from Dr. Scherlis. I don't believe I got one from Dr. Brindley.

DR. MAYER: Leonard, it sounds like you are excused and Dr. Brindley is not.

DR. SCHERLIS: I am safe. He has mine.

DR. MAYER: I think we might move on then, Sister Ann, to Maryland.

SISTER ANN JOSEPHINE: All right. The Maryland site visit--

DR. MAYER: The record will show that Dr. Scherlis has left the room.

SISTER ANN JOSEPHINE: The Maryland site visit was made on December 8 and 9, and members of the site visit team were Dr. Alexander McPhedran, Emory University Clinic, and Dr. William McBeath, who is the Director of the Ohio Valley Regional Medical Program. Staff present at the site visit were Dr. John Farrell of the Health Maintenance

Organizations Division-- we were very happy to have him with us because a substantial portion of the grant request from Maryland is for health maintenance organization related projects -- Mr. Harold O'Flaherty, from the Planning and Evaluation Division, who prepared a very provocative list of questions that we used the first evening prior to the site visit to kind of get on the same wave length so that we could evaluate the type of inquiry that we were going to conduct as the site visit progressed; Mr. Clyde Couchman, the regional office representative from Region III; and Mr. George Hinkle from the Eastern Operations Branch. And we had requested Mr. Hinkle to prepare a document that indicated the questions that the previous site visitors had had, and then to also indicate what corrections had been made so that this would also serve as the basis of discussion.

Following the discussion evening prior to the meeting we decided that it might be of advantage if the chairman of the site visit team were to meet with the coordinator of the program at breakfast so that possibly a good rapport could be established between the site visit chairman and the coordinator which would facilitate the site visit. And I think that we had not done this on previous site visits I have attended, and I personally found this very helpful.

The Maryland Regional Medical Program will have completed its first three years as an operational program on

February 29, 1972. And the present application was for a triennial award, and they also requested a developmental component of $100,000.

The purpose of the site visit was to assess the region's overall progress, the quality of the current program, and its prospects for the next three years and its ability to handle the developmental component.

One of the points that was obvious the evening before the site visit began was that the Maryland Regional Medical Program has responded to the directives from the national program in such a way that the program represents almost a 180 degree shift in goals and priorities and emphais. And it should also be noted that this is a program that has experienced a high turnover rate in coordinators. In the five years of the program there have been five coordinators.

Dr. Davens, the present coordinator, has had some involvement and has been interested in HMO's, which is also reflected in the proposals that have been made.

Johns Hopkins University is the grantee organization for the Regional Medical Program. And in the state are the two medical schools, Johns Hopkins and the University of Maryland.

On the prior site visit the site visitors were disturbed by the fact that it appeared that the Regional

Medical Program was heavily dominated by the two medical schools.

The site visitors found that the Maryland Regional Advisory Group has been expanded from 27 to 35 members, and this in response to a criticism on the last site visit, and the total committee structure has been changed. Five of the twelve committees which have been established to assist the coordinator and the RAG are of categorical nature. Three have been recently established following successful core supporting feasibility and planning studies. Two are structured; they are the health care delivery Maryland health data, and patient health education steering committees. Two are structured to relate to the core staff administrative organization; and one, the Western Maryland Regional Advisory Group, has been recently established to provide greater peripheral representation.

In each instance the committees have a written charge developed in part by the discussions among the committee members, and the advisory committee which has been set up advises the coordinator on the general matters of policy and procedures.

The coordinator is supported by a staff consisting of 18 professionals and 14 secretarial-clerical personnel, of which five positions are part time.

The core staff organizationally consists of the

coordinator, business manager, an associate coordinator for project development, members of the Epidemiological and Statistical Center, and the Division of Health Manpower Development and Continuing Communication.

The core staff has been strengthened considerably since the last site visit, and the site visitors were very impressed with the chairman of the Health Manpower Development and Continuing Communication Division.

Organizational changes have been made in an attempt to provide a broader base for management and also to try to eliminate the domination of the two medical schools in the area.

The Epidemiology and Statistics Center, which is associated with Johns Hopkins Medical Center, has been more closely tied to the central core unit, and is now functioning as the principal health intelligence and evaluation arm of the Maryland Regional Medical Program. Previously there was some concern that this center was funded as a unit within the core structure, however it was functioning independent of it.

In the guidelines that were developed and published in August of 1971 for the Maryland Regional Medical Program a very fine evluation procedure is described. However, during the course of the visit as we questioned the individuals who were presenting the programs at some points it wasn't too

clear exactly how the E and S Center has been providing an ongoing evaluation service.

In response to change in direction expressed in the RMPS new mission statements, Dr. Davens reported that the medical school involvement in Regional Medical Program activities has been redirected from continuing education to planning and development of health maintenance organizations and training of health professionals and new types of health personnel.

The director of the Epiodemology and Statistical Center, Dr. Leon Gordis, is moving to direct the efforts of his staff toward the new mission of Regional Medical Program, especially in the areas of collection and analysis of data with specific reference to defined areas where there is interest in and need for the development of a health maintenance organization and area health education centers.

Dr. Davrens reported that since the last site visit one of the crigicisms that was made was that there was no evidence of cooperative efforts with Comprehensive Health Planning, and this could be documented at the present time.

There is increased minority group representation.

There has been a discontinuance of the University of Maryland tissue typing project, and Dr. Davrens repeatedly reassured the site visitors that although the medical schools

support the Regional Medical Program they do not interfere or attempt to control the program.

In view of the recent changing emphasis in the strategy of Regional Medical Programs, the site visit team elected to evaluate the Maryland Regional Medical Program goals, objectives and priorities with respect to the proposed new as well as past activity.

The goals, objectives and priorities are clearly and explicitly stated, and the site visit team was impressed with the fact that the objectives proposed for the triennial period clearly reflect the objectives, goals and priorities that are stated in their application.

DR. MAYER: Excuse me, Sister, did you say are explicitly stated or inexplicitly?

SISTER ANN JOSEPHINE: No, they are explicitly stated. However, the goals are in response to the recent direction given to Regional Medical Programs.

DR. MAYER: It looked like a perfect rewrite to me.

SISTER ANN JOSEPHINE: That's right. That's right. This is one of the disturbing things, I think, as we evaluated

The emphasis during ghe discussion and in the submission of the projects, the emphasis on health maintenance organizations, area health education centers, again was stated in such a way that it was a direct restatement of the directives from the national program.

The Maryland Regional Medical Program has made substantial change in program direction, and one of the things that disturbed the site visitors was that some of the projects that had been implemented in previous years seemed to be dropped without any planning or any phasing out and new ones added, and it appeared to us that probably this was done in an attempt to meet the newly established objectives rather than following careful evaluation and in response to the needs in the area.

The two projects for HMO's were passed by RAG, but were not subjected to the evaluation and the technical review process that are very well described in the guidelines, and the same is true of two other projects that were submitted under new projects.

The RAG -- although the membership of RAG has been increased, the site visitors were disturbed that the majority of the members of RAG come from the Baltimore area, and there does not seem to be the type of representation needed to better understand and respond to the needs of areas peripheral to Baltimore.

The coordinator appears to be giving leadership to the program. He appears to be relating well to the representatives from the two medical schools, and he appears to be communicating with RAG. However, as we had an opportunity to discuss the activities of RAG with the members who were

invited to the meeting, it was our impression that RAG took their direction from the coordinator, and although they were information of day to day operations, that possibly RAG was not as strong as it needed to be in order to fulfill its role. Also RAG meets once a month, and does not have an executive committee; and in discussing the reasons why they chose to go this way in their organization it became apparent that because most of the representatives are from Baltimore that it is easy for them to meet this way, and because there doesn't seem to be a well developed program they have not really experienced a need for an executive committee.

Approximately two-thirds of the core staff are full time, and there are only three vacancies, and Dr. Davrens assured us that these three vacancies could be filled.

Many of the concerns raised about the core staff in the past were predicated upon the fact that essentially they were part time, and Dr. Davrens has gone a long way in terms of changing this situation.

The site visitors are still unclear as to whether in reality Dr. Davrens and his support staff are providing leadership to the medical schools in terms of the Regional Medical Program mission or if the medical schools are dictating the direction to the Maryland Regional Medical Program.

The grantee organization, as I mentioned before,

is Johns Hopkins University School of Medicine, and it appears to have a very positive relationship with the Maryland Regional Medical Program and would seem to be providing them with the type of support help that they need.

Dr. Ancrum is going to continue with the report.

DR. MAYER: Gladys.

DR. ANCRUM: As far as participation in the Maryland Regional Medical Program, they do seem to have quite a variety of organizations and other professions in the Baltimore area especially participating in that program. They had some of the visitors there from some of the projects that were going on, also other interested citizens around the Baltimore area. Also they were very helpful in helping to get the Maryland Health Maintenance Committee started, which is a group that is currently operating--

DR. MAYER: Gladys, is that one wired down there for sound? You were coming through fine, Gladys, until we got the additional noise.

DR. ANCRUM: They did play an active role in helping to establish the Maryland Health Maintenance Committee, which is currently operating a health center in one of the underprivileged areas in Baltimore. They do utilize some of the community practitioners and also other community aides for operating this facility.

Also Sister said earlier most of the planning for

the area has been locally and throughout the Baltimore area.

The one way they seem to be moving away from Baltimore is through the Manpower Development and Continuing Communication under Dr. Herbert's leadership.

Also they do have plans for correcting some of this and becoming more active in subregionalization by involving the comprehensive health planning B agency.

There was a question among the site visitors about how they were using the assessment of regional resources. The Epidemiological and Statistical Center did collect a large amount of data, but we weren't able to determine as to how did they utilize this data in determining needs, and also using this as a baseline for developing some of their programs.

In the management they seem to be emphasizing quite a bit of strategy for developing health maintenance organization. Both schools that are connected with the program are doing further work in getting the health maintenance organization established.

Also during the course of the site visit it was learned about community activities that are being carried out through the Division of Health Manpower and Continuing Communication, and which they referred back to community activities that went on with their second Monday series several times throughout their presentation.

Also the way that these are monitored, they do have quarterly reports which include a summary of their overall accomplishments and their fiscal situation.

As also stated earlier, the main center for conducting the evaluation of all the projects funded by the Regional Medical Program for this area is the Epidemiological and Statistical Center. In addition to looking at the project for ongoing evaluation they also have a committee that reviews the proposals and helps with being sure that they do have quantitative ... that can measure evaluation in the regional proposal.

Dr. Davens did state that this would be the main intelligence center for the Maryland Regional Medical Program, and that was also now a part of the core staff rather than being a separate entity. However, we were not clear as to how much direction for the center came from Dr. Davens or they were still operating more or less as a separate entity.

They have also worked out a conceptual strategy for evaluating all the programs, and they do have five steps that they follow. These are determine the project goals, determine the project objectives, determine the measurement of objectives attained, and also establish standards and collection of the data on performance, and comparison of actual performance with standards previously set

Also there was a request for budget for the Epidemiological and Statistical Center in which they asked for additional funding for carrying out these activities and evaluating the project. I won't go into detail on that now because Sister will go back and give you a summary of the budget outline.

The program proposals that the program have, as Sister pointed out, they do seem to be leaning quite heavily on the national goals that were sent ou in the new mission statement.

In view of the major thrust in the new areas of the health maintenance organization it is believe that the proposed efforts would strengthen the service in the underprivileged areas.

I did mention about the one point that they have going with the health maintenance organization. They also had another in Columbia, I believe it is, the Johns Hopkins school.

Under the area of continuing education, here is where they are doing quite a bit of work in trying to get into other regions other than Baltimore, and one of the reasons that was given for this was with schools there and with the ease that people get into Baltimore they felt they should put their effort in the other area.

Also they have a home care program which is

designed to give comprehensive home care to families. And also with the school of nursing at the University of Maryland they are currently starting preparation for family nurse practitions.

The site visit team felt that the activities that the program had projected for the coming year were realistic. However, one thing that they felt could have been improved was that the medical schools could have made a substantial contribution to areas other than just in the Health Maintenance Organization.

In dissemination of knowledge we were assured that wider groups and institutions would receive immediate benefits from the activities that were planned and also those ongoing. However, it was difficult to pinpoint what available benefit the information would provide groups in the outer area.

One of the other projects, too, is they are starting an information center in which the Regional Medical Program will be employing some of the core staff, and it will be more of a survey type of questionnaire in which they will be getting information from insurance companies and others about people who come in for the treatment of drugs.

Do you want to add anything?

SISTER ANN JOSEPHINE: The questions that weren't

answered to the site visitors' satisfaction really were the following: we couldn't seem to find out through what mechanisms the goals, objectives and priorities were developed and approved other than that they were a response to the new direction from the Regional Medical Program. Also there was some concern that most of the proposed activities to be carried out over the next three years will be geographically located in Baltimore, and that roughtly 25 percent of the requested budget is going for HMO activities, and it was unclear again on what basis this decision was made other than again in response to legislation and existing activity that had been going on.

We were unsure about the nature of the region's planning process and at what point in the development of a project evaluation is built in.

Also we were not clear about the nature of the strategy and methodology used for carrying out project evaluation, nor was it entirely clear who carries out project evaluation, project staff or center staff. There was indication that this is presently being worked out, but that in many instances it was not applied to the projects in the proposal that were submitted for triennial support. Also we were not clear as to how the results of evaluation activities affect the region's decisionmaking process.

And for these reasons we thought it wise to

recommend that the triennial application not be approved as the triennial application, but rather approved for two years at a direct cost support level of $1,294,960. And originally the proposal was to approve it at a level of $1,325,000, but in the recent mail a communication came from Washington stating that the recommendations of the Mini-Sarp review on the anti-lymphocyte globulin for renal allograph project number 43 be deferred pending national RMP policy on funding ALG production.

We are recommending that the developmental component not be supported, and we are recommending that the project level of $861,313 be reduced to $714,004. And the areas in which we are making reduction are in the areas of the Health Maintenance Organization proposal submitted by the University of Maryland Medical School contract for $172,309.

Dr. Farrell -- is Dr. Farrell here? Dr. Farrell was present on the site visit team, and it was his recommendation, and the group concurred, that since the other organization that is supporting HMO activities will provide $25,000 for a feasibility study, and he felt that since the description of this project made it fall essentially into the category of a feasibility study that to fund this project at a $25,000 level would be appropriate.

Also it was the decision of the site visit team that mini-contracts which had been used by this Regional

Medical Program and were funded at a level of $95,270 be reduced to two and a half percent of the total funding, which would bring this to $32,335. That two and a half percent was arrived at after some discussion in the group. As Dr. Daven explained the use of mini-contracts they really were used somewhat like developmental component money would be used. If a person came and had an idea for a project that would be short term or needed some matching funds then mini-contracts were sublet. And he pointed out that these had been attracting many people to the Regional Medical Program, but it was also pointed out that many people would be attracted to any program that had money to give out. So that possibly this might become a slush fund unless it were controlled in a different way.

On page 19 of the Maryland Regional Medical Program site visit that is included in your folder are the site visit team recommendations, and members of the staff and Dr. Ancrum and I would be glad to answer any questions on these that you have to ask.

DR. MAYER: That final figure instead of a million 325 was what, Sister?

SISTER ANN JOSEPHINE: A million 294, 960 for two years, at the end of which time they could resubmit their triennial application. And the reason that we asked for two years rather than one, we felt that it would make it possible

for them to develop an application that could show that they were able to evaluate the new direction which they had suddenly taken with their program.

DR. MAYER: If what I interpreted was correct they are currently operating at a million 672 level.

SISTER ANN JOSEPHINE: Yes.

DR. MAYER: This in effect then is a reduction of almost 300,000, $280,000 over their current operating level. The interesting thing to me was it still provides them with about -- if I am reading the yellow sheets correctly, with a little over 550,000 more than they have in carryover, which means that they must be phasing out a tremendous amount of effort, $900,000 worth of effort this year, if I am reading those yellow sheets correctly. Is that correct? Are they phasing that much out?

On one hand it says that the activity this year is at a million 672 in the 03 year, and then on the other hand it shows for the 04 program continuation with approved period of support, and continuation beyond shows only 741,000, which suggests to me that they phased out about $600,000 somewhere.

DR. ANCRUM: I think they phased it out during the time there was a reduction in the funds, they had a 25 percent cut and they phased out some of the program. They used the amount that was in the ongoing program.

DR. MAYER: I guess the point is that they have got a million six now in operation, and it only shows -- well, 741 of continuation of current activities of the 03 year into the 04 year even in their request, unless I am missing something.

VOICE: You are right, Dr. Mayer. They have about eight or nine projects that come into the end of the 03 year support period. The sheet you are looking at, the only activity they have ongoing in their request is number 19 and number 27 and project number 35 which are in this summary which all of you have a copy of. Anything else, all their work in the area of stroke, coronary care units, are all coming to an end. That's what Sister Ann referred to a minute ago when she said they had done a 180 degree turn-around in the program.

DR. MAYER: So that on the one hand although it's a reduction of current operating activity it's an increase in terms of dollars togo into new program. That's the only point I am trying to make.

All right, other comments?

Yes, Jerry.

DR. BESSON: Sister, I'm not sure that I understand the relationship between the proposed mini-contracts where they request $95,000 and how they expect to use this money other than their developmental component. As I read the

application I gather that they want to be able to respond quickly to changes in RMP mission and evolving new thrusts in national health programs, and this is really a description of what the development component is. And yet you suggest that the developmental component not be funded, but that the mini-contract be funded in part.

SISTER ANN JOSEPHINE: Well, I agree with you on that. The mini-contracts as we heard them described -- and we asked several times -- were described in such a way that they could be describing the developmental component. It was the thinking of the group that rather than eliminate that entire amount we would reduce it this time, with the recommendation that it not be supported at a future date. But there really wasn't other rationale behind it.

DR. BESSON: And the other question I have relates to the $25,000 that is recommended for project number 37, the HMO health care study. Again as I read this University of Maryland HMO proposal I wonder whether the admonition that Dr. Margulies mentioned this morning about RMPS role in HMO's being eliminated to follow the assessment of manpower utilization and emergency medical services, whether what they propose to do with this HMO health care study doesn't lie beyond the scope of that. They are really asking for funds to develop an HMO for a particular area, and that would clearly lie beyond the purview of RMPS purposes, and so I

am wondering why even this 25,000 is--

SISTER ANN JOSEPHINE: Dr. Besson, there were members of the site visit team who raised the same question you are raising, and at that point we turned to Dr. Farrell who was there representing the HMO operation and asked him if he would talk to this point. And he, as I remember -- and other members of the staff may want to comment on this -- he indicated that he felt this was within the purview of the Regional Medical Program support. And I know at the time this discussion went on there were those who raised the question whether at a future date, since we do not have any guidelines that enable us to make these kinds of distinctions at the present time except consultation we get from staff, whether at a future date we are not going to have real problems since the HMO effort is being funded from two separate pots, and say, you know, how much of the RMP money should go into this. This question was raised, and probably someone else from staff wants to comment on this.

I would also share your concern.

MR. TOOMEY: Sister, I am confused, because on page 21 of the yellow sheets you have got the HMO information system which is with Johns Hopkins, and then you have a contract with the HMO health care system at the University of Maryland, and I understood you to say that the one at the University of Maryland you disallowed.

SISTER ANN JOSEPHINE: This would be reduced from 172 thousand to 25.

MR. TOOMEY: How about the one at Johns Hopkins?

SISTER ANN JOSEPHINE: Well, the one at Johns Hopkins -- and again we relied on Dr. Farrell as we were making this decision -- the one at Johns Hopkins was allowed for the amount that they requested. Apparently the center at Johns Hopkins University is already participating or providing data for the national effort in evaluating Health Maintenance Organizations--

MR. TOOMEY: Is that the East Baltimore--

SISTER ANN JOSEPHINE: I think Dr. Farrell felt that if this were disallowed that it might interfere with this other effort, and I think this whole thing -- I'm glad this came up because I think this whole HMO discussion needs whatever clarification can possibly be given here from staff.

MR. TOOMEY: And then you have another University of Maryland, the Bon Secours Comprehensive Health Center is involved with the home care program.

SISTER ANN JOSEPHINE: Yes, and that home care program is under this health education.

MR. TOOMEY: It just would seem to me that what they were doing is trying in a way to split the derivation of information between the single efforts of the two universities to provide health services through these HMO's.

SISTER ANN JOSEPHINE: Yes, we shared your concern.

MR. TOOMEY: Actually one of them could probably have taken the whole ball of wax.

DR. THURMAN: Could we carry that just one step further because on the top of 23 there is another $84,000 for HMO's which looks like it's really the E&S center. The two on 21 that Dr. Toomey has referred to and on the top of 23 is another $84,000 for HMO's, and how much of core really goes to E&S? I guess that's the real question, because it really does look like all three of these contracts, and the fourth one, too, would go back to E&S, which is going to make it a pretty expensive operation.

MR. TOOMEY: May I ask is this Maryland Health Maintenance Committee incorporated? Is that the Columbia, Maryland--

SISTER ANN JOSEPHINE: No. No.

MR. TOOMEY: Well, did you mention that they were involved in that?

SISTER ANN JOSEPHINE: No, I didn't. This corporation is one that Dr. Daven has been working with and has been interested in.

DR. THURMAN: They also have another contract from another--

SISTER ANN JOSEPHINE: That's right. The whole HMO area here is very muddy, and this was the reason I think

Dr. Farrell was provided from staff. This never was really made clear, and then today after Dr. Margulies' remarks I felt a little more unsure about this because I was prepared to come in and say that I felt that since there was another organization that was providing support for the development of HMO concepts the question I would raise is how much money should be supplied from Regional Medical Programs. But if I heard the discussion this morning I think that this is not a part of the consideration. Is that right? Which is a little confusing to me.

MR. CHAMBLISS: I would think so, if I might just answer a bit here. It is my understanding that the limited amount, not to exceed $25,000, might be used for planning and development for the feasibility aspects of the HMO, that the larger amounts have to do directly with the actuarial side, the marketing, the packaging, the establishment of an HMO and the funding of it, the front funds required to get it going. And that is not within the province of RMPS. But certainly as it relates to planning of the initial feasibility and the monitoring of the quality of service rendered therein those are two aspects which Regional Medical Programs could be involved with its funds.

DR. MAYER: Would you like to comment?

MR. HINKLE: Yes, Dr. Thurman made reference to the EMS. They are supported by total budget of 179 or 189

thousand dollars. Now with reference to the HMO part of $84,700, that is in conjunction with a contract the HMO office has made with Maryland Health Maintenance Committee in Maryland, and the RMP of Maryland decided -- they obligated themselves to take on the responsibility of setting up an evaluation mechanism for this Maryland Health Maintenance Organization committee up there, and that is to set up an HMO other than the one they have ongoing now. They have one through Johns Hopkins and this other one. And they are going to try to set up an evaluation mechanism for this Maryland Health Maintenance Committee HMO activity which is supported about $250,000, and they are going to set up a system within Baltimore that can be later on expanded throughout the state of Maryland.

And repeatedly -- and I think it was mentioned before here -- we asked the same question, why can't the EMS center set up this mechanism, and they repeatedly advised us that they are overworked now, they don't have sufficient staff to take on this additional responsibility.

So that's the reason they have a separate project in here to go out and get outside assistance in this evaluation.

DR. THURMAN: It says will also be part of the new activity of the E&S center core staff. So that's not outside.

MR. HINKLE: I was speaking about the $84,700.

DR. THURMAN: So was I. The last statement under the 84,000 one is "will also be part of the activity of the E&S center core staff."

MR. HINKLE: But this 84,000 is to go outside and get the assistance to set it up, and the E&S center has their hand in everything going on up there, and they are also going to help in there. But they dont pinpoint how much of their $187,000 will supplement the 84,700.

DR. MAYER: Well, what that said to me, Bill, was the EMS center was going to carry out an evaluation of that contracted outside evaluation system. Now is that what they are planning on doing?

MR. HINKLE: No--

DR. MAYER: They are going to do it?

MR. HINKLE: They are going to assist in it. They are going outside to get help to do it because their staff, their overworked status up there which they kept referring to, it doesn't have enough people to do it on their own.

DR. MAYER: But they are going to keep close tabs on it. They are going to subcontract some part of it.

MR. HINKLE: In reading the project anything that has to do with the mission they say E&S center is going to have a hand in it also. There is a survey which they are going

to conduct with outside funds, which is another project, and we asked them why can't the E&S center conduct this. There again they said they are overworked with available staff and they don't want to get out and hire additional people.

SISTER ANN JOSEPHINE: I got the impression, too, that the E&S center is already -- someone has contracted with the E&S center to provide some of this data collection and evaluation, and are presently engaged in it.

MR. HINKLE: This point is another aspect that the site visit kept focusing on, the site visitors wanting to know why the E&S center is doing so much outside evaluation work for other people, why can't they get these people to pay for it. And they finally in the final analysis said they have been thinking along those lines and they plan to do it, have the E&S center contract outside.

Now on one hand they say their staff is overworked and they can't do it themselves, and on the other hand they say they are doing work for people outside. This is just one of the ambiguities we kept running into every time we would ask questions.

DR. MAYER: Dr. Farrell, one of the questions that has been raised was who's on first in the HMO situation as it related to the Maryland project, and with some lack of clarity of that, and we wondered if you could comment about it.

DR. FARRELL: Yes. This is the University of Maryland?

DR. MAYER: Right.

DR. FARRELL: My reading of that was that it was -- what was the word we used -- marathon evaluation project to the extent if an HMO were started in the community what would be its effect upon present provider structure and particularly upon the state run medical school. Most of the planning contracts of the HMO service are to the extent of $25,000 limit, and this was three years for something in the range of $187,000 a year, if I remember it.

DR. THURMAN: Why was there a difference between the University of Maryland and Johns Hopkins? That was the other question. Johns Hopkins is 146. That's a big difference.

DR. FARRELL: Well, they are dealing with an operational HMO, and they are doing a specific quality care project.

DR. KRAWLEWSKI: Were you able to determine how many other granting agencies were involved in these HMO activitie in these schools and whether this logically fits in with their funding so it makes a pattern?

DR. FARRELL: Yes, the only HMO service is from the HMO's now.

DR. KRAWLEWSKI: Do they have a grant from an insurance company also?

DR. FARRELL: The Columbia project you mean?

DR. KRAWLEWSKI: Right.

MR. TOOMEY: No, the East Baltimore project. The East Baltimore project has somewhere in the neighborhood of 15 to 20 federal programs participating in that. I don't know whether you call it an HMO at the moment, but in actual practice--

DR. KRAWLEWSKI: And the national center has some money in that in an evaluation form?

DR. FARRELL: There are all the specific aspects, and, of course, it is one of these organizations that's being looked at from about twelve different angles. It is not typical.

DR. BESSON: Mr. Chairman, I think we are really talking about something that we will hear many more times before we see the end of HMO's, and it will be well for us to make sure that we have a clear statement from the Council and suggest what RMP's bag is going to be in HMO. I heard Mr. Chambliss say that one of the reasons we are funding project 36 perhaps or why we are giving this 25,000 is to study feasibility, and as I read at least our local guru's interpretation of what HMO's relationship to RMP should be it's not for feasibility. That should be the HMO organizations in HSHMA.

I think that this being the bottomless pit that it

is, feasibility studies, developmental studies, et cetera, requested from RMP can really get us far afield. Now as I read the abstracts and then go back to the original proposal I am not sure I read the same words that have been reiterated here about why one project is going to be funded and another is not. The entire project summary appears in no greater detail than this yellow sheet does except by a slight amount. And therefore we are left with just a series of cliches, some of which are okay words, and some of which are not.

But as I look at project number 36 which we are suggesting may be funded, I see some okay words like routine monitoring of the volume and types of medical services, but I see some non-okay words like providing all necessary financial billing functions and summary revenue statements for accounting purposes, data for meeting the reporting requirements of various external administrative agencies, actuarial useful data for estimating future utilization of co-payment revenues and capitation costs. These are clearly not within RMPS purview.

So I am not sure whether there isn't a little bit of misemphasis in using some words that will again push the button that gets the green pellet. And we went through this with cardiopulmonary rescussitation a few years ago and cardiac care unit, and if they said those magic words, bang went the

dollars. And I am a little bit afraid that this is what we are beginning to see with HMO's. So maybe at this early stage of the game we should get a very explicit statement from Council as to just what RMP's bag is in relation to HMO's. And I would so move, couched in more elegant language.

DR. MAYER: All right.

DR. BESSON: We have a motion on the floor, Mr. Chairman. I wonder whether with all this discussion Sister is inclined to modify any of the recommendations or--

DR. MAYER: Well, I think, you know, the intent -- I gather the intent -- let me try to summarize what I pick up now from what has been said. That what you were saying, Sister, was a deletion of the project component by about $150,000, the basis of which was really deletion of that from project 37, the University of Maryland HMO, with the provision of about $25,000 in that project for the effort as it relates to the planning for HMO activity. Is that correct?

SISTER ANN JOSEPHINE: Yes.

DR. MAYER: And secondly, you therefore were saying full funding of project 36. And Jeery just raised the question whether items 2 and 3 under the objectives of that project were appropriate. I think we can handle within the motion that was made by saying that we would recommend that level of funding, but would request that Council review

both of those two issues vis-a-vis the reduction of that by either 25,000 more, if that's inappropriate, or by reduction of it even further by whatever is represented in dollars by components or objectives 2 and 3 of project 36. And if we red flag that and ask that then I think we have handled both the dollar component as well as those two issues.

DR. BESSON: If we also add to that Dr. Thurman's concern about project 41, and Mr. Toomey's concern about project number 40, is it?

SISTER ANN JOSEPHINE: 40.

DR. BESSON: 40 for 30,900. These four programs that impinge on the HMO's,we should have a policy decision maybe focused on these four projects.

MISS ANDERSON: Do you think we will have a chance to talk about that tomorrow morning maybe?

DR. BESSON: Yes, except that even though we are not in executive session I constantly am running against the query that I ask myself as to where policymaking decisions lie. I prefer to ask Council for decisions.

SISTER ANN JOSEPHINE: I would like to say that the questions that are being raised here are the questions that continued to disturb the site visitors all during the site viist. And as we had our discussion this morning I just thought to myself Maryland is going to be just a demonstration project for the dilemma in which we found

ourselves this morning. We really had no answers. We had no guidelines. And staff was very helpful, but there just were no guidelines to provide us. And we continue to be disturbed, that here was a program that had taken an entirely new turn and was in direct response to the most recent directives from Washington, and that if certain components, major components were deleted there would be no program.

MR. TOOMEY: Sister, can I take a crack at that? It would seem to be that Baltimore, Johns Hopkins and the University of Maryland are doing so much in so many areas it doesn't make any difference where they get their support or for what they get their support, they are going to need some support for everything. And if the magic words from Washington were heart disease, cancer, stroke, kidney, and so on, they would go in that direction. If it was health maintenance organization or new forms of delivery of health services they would go in that direction; and if they went in that direction they have got two universities and an RMP and they decide that somewhere along the line they could divide the money up. They are dividing the projects up.

DR. KRAWLEWSKI: With applications off the shelf probably.

MR. TOOMEY: Well, you know, they are doing all these things and they need money, so where do you want to give it to them, for what, and they don't really care.

DR. BESSON: Well, there is one other aspect of this that I think is pertinent to put it historically, at least focusing on Maryland's move in the direction of new mission, and that is that a statement about their involvement in health maintenance organization reflects back to the RMP coordinators meeting in March, 1971 following the president's health message, and after discussion with Secretary Richardson about the new mission for RMP in HMO's, and the words they use is that, following presentation the following month, "promotion of the development of HMO's was featured as a prime activity for RMP's because of their experience and their close relation to the provders of health care."

That was before there was an HMO office yet created. Now there is one, and now the turf is being a little more carefully delineated and RMP no longer has this large potential charge, but a more refined charge of assessment of quality of care in HMO's.

Now if that's going to be our focus I would like Council to state that explicitly so that we can be sure that our funds aren't lost in the morass of funding development of HMO's.

DR. MAYER: Is everyone clear on the questions being raised? The questions are being raised relative to, as I previously stated -- relative to number 36 and number 37

in the frame of reference that I raised them, in the dollar amounts that I raised them, also are being raised in terms of project 41 and the appropriateness of that. And I assume, Mr. Toomey, that the question relative to project 40, which if there wasn't any talk of HMO's in here I don't think this group would have had any difficulty with, but I think it is being raised in the framework -- at least let me try it -- that your thought was that that is additional information that may be useful to the formulation of an HMO. Is that the context in which you raised the question on 40?

MR. TOOMEY: Well, that's part of it. The other part is that it is a statistical study, it's part of the E&S, could be part of an E&S grant. My concern is that they have overlapped so much in separate projects. This project 40 with project -- one of the earlier projects.

DR. THURMAN: Forty relates to 35.

MR. TOOMEY: Forty relates to 35, and 36 and 37 are just two parts of the whole. And I think my hang-up is that they have just divided them up.

DR. MAYER: Okay. Further comments?

DR. WHITE: Can I ask something that doesn't relate to HMO's, except peripherally perhaps? Sister, I was on two previous site visits to Maryland, 1968 I think, and I have forgotten when the other one was, and both of them seemed to be sort of in an area of opportunism, and the

original one, heart, cancer and stroke was all the word, and we had very elaborate stroke proposals, as I recall, something that had to do with congenital heart disease, and one thing and another. The next time around, I have forgot what the guidelines were at that particular time, but they responded to them also, some kind of elaborate project mechanism which seemed to me it was a system of directors of continuing education or something of that sort. And now perhaps we are seeing the same kind of response at this time.

But then there is the theme between here, and that is the epidemiology and statistics function, and on each of those previous visits there was a question of what they were doing, and we were told well, any moment now we are going to have a real basis upon which we can design our own programs, and yet now I hear again that we don't really have anything from that, and that was a very sizeable budget item, as I recall, in earlier years, and even now.

And on page 14 of your report at the top under assessment of needs and resources this confuses me again further. There is one statement about the site visitors were concerned that the overall needs assessment had not been carried out. And yet on the last paragraph of page 8 it seems as though the statement there is a little bit contradictory, and I wonder if you can clarify that. I

wonder if you can help me get a grasp of the Regional Medical Program general -- separate from whether or not this parceling out of HMO money is appropriate or not.

SISTER ANN JOSEPHINE: Well, I have never been to Maryland before, but I was impressed that the guidelines and the program as it was developed was an aspect of an opportunistic response.

In discussing and thinking about the Epidemiological and Statistical Center it was my impression that although this center had in the past been funded under core staff it had in truth not really been an integral unit in core staff. And I think that the attempt that is made at the present time with the appointment of a new director, Dr. Leon Gordis, is to achieve the objective of having some of the effort -- what percentage I wouldn't be able to determine -- but to have some of the effort of this center provide the evaluation and the planning types of services that they had spoken of as being provided in the past. We could not identify that this was being done at the present time. Everything that was described was described in futuristic terms.

And I don't know whether that answers your question. And I don't know, maybe Harold -- would you want to comment on that?

MR. O'FLAHERTY: I think basically we went there with the concern that we could not really see the pay-off

of the Epidemiology and Statistics Center. At least some of us left there having that suspicion confirmed; that really we were unable to tell, A, was the center an integral part of the program, and B, how had the results of its activities affected the development and implementation and decision-making process of the Maryland Regional Medical Program.

In querying the chairman of the Regional Advisory Group with respect to how decisions were made he informed us that priorities, goals and objectives were set vis-a-vis grou discussion, and did not really utilize the process as delineated for this center.

So we were concerned as a site visit team not only with the effectiveness of the center and its output, but also the Regional Advisory Group did not really appear to have a logical reason d'etre for decisionmaking. So these were some of the reasons we went into questioning really from both ends the role of the center.

So to comment just one little bit further, the RAG is so very Baltimore based, and we felt that it was not really reflective of the total geography of the region, and we could not really see how it went about the business of making decisions other than through the process of group dynamics.

SISTER ANN JOSEPHINE: I think it's fair to say also that many of the site visit team when they left felt

somewhat uncomfortable about these recommendations, but having no guidelines to make decisions about appropriation of funds for health maintenance organizations it's very difficult to deal with these kinds of problems.

DR. WHITE: My concern is even if these proposals were precisely relevant to whatever the guidelines might be that I can see them as simply being something they weren't really concerned about, but this was a way of getting some money, and whether this represents the quality of the program rather than the quality of the projects that we should be looking into.

SISTER ANN JOSEPHINE: Well, I think wherever there was any discussion it was very difficult to get a review of anything that was being done or had been done. Everything was described in terms of the future and how all these things would fit in, and then Dr. Daven kept coming back to the point that they had the responsibility to form this network of HMO's in the state of Maryland, and it was quite a diversified group.

MR. O'FLAHERTY: One of the problems, I think, that we see the HMO bag being fed to the medical schools as much as it is, I think from a historical perspective that there has been kind of a rift over there between the RMP and the two medical schools, particularly with respect to who would receive the tissue typing project since there was only one

tissue typing project given out, and it almost caused the Battle of Armagetta. Nevertheless, what they did was HMO's became a very popular mehcanism to have everybody involved in, so instead of putting these people on contracts or extension of core -- I'm sorry, on projects or extension of core, they have developed contracts with these two medical schools to be involved in the HMO area.

One of the things that we talked about in the report was that we could not see an emerging conceptual strategy for HMO's or the Maryland RMP's role. It was kind of a hit and miss approach to HMO's. So the 172,000 that went to Maryland was really just literally -- and some of you on the team may disagree, but we talked about this -- appeared to be a mechanism for appeasing this medical school since it didn't get one of the tissue typing projects.

DR. MAYER: Well, what's your pleasure? There is a recommendation on the floor with modification already incorporated in it. I think one of the messages that is coming through to me loud and clear, which I assume is coming through to staff, which I assume would be translated to the Maryland RMP, is that E&S Center has got to become incorporated as a useful device in the decisionmaking process of the Maryland Regional Medical Program or it's going to be out of business at least as far as funding is concerned.

Now what beyond that do you want to put as

stipulations on the motion other than the ones we already have?

DR. WHITE: The motion is for one million two nine something?

DR. MAYER: The motion is for one million 294 with the potentiality of further reduction as a result of projects 35, 36, and 41, I think it was, and their relationship to are they appropriate as funding under RMP due to RMP's role in HMO's.

MR. PARKS: Sister, may I ask you a question?

SISTER ANN JOSEPHINE: Yes.

MR. PARKS: This concerns a couple of things. Was there any feeling or concern among the site visit group that this program being administered by two rather large, and certainly universities with rather wide reputations, that they were missing or not reaching the rural population of Maryland, and did you see any -- this doesn't come through clear. There is some compromising language in several places in this report. Do you see any manifestation of what is categorized here as regionalization?

As I go down this and go down the itemization here I am almost at a point of wondering whether this program really shouldn't be put on notice that some more substantial critical changes be made within a time limitation, that only a conditional funding be given this program, and a short

review of the progress. Was that at all considered?

DR. MAYER: Well, I think that was what I heard by the intent of the motion to disapprove their triennial request, their developmental component, and to say all right, there are two years in which to meet some of these conditions to come back for a valid triennial request.

SISTER ANN JOSEPHINE: We felt that by the time the word got to them really they would have six months to pull something together. Is that right? If we did it just one year. And this could destroy a program. And this was the reason why, and this poll was taken by phone, as we realized the time limit set. Originally when we left Maryland the decision was we would make the recommendation that the triennial application not be accepted, the developmental component not be accepted, and then with the deletions indicated, and also that they be funded for one year and would have to re-apply and would have to justify their program; that by the time they get word and begin writing it up actually they have about six months in which to do this. And so in thinking it over the decision was that possibly by saying two years, which is actually a year and a half to work, that it might be a little more reasonable.

Now the concerns that you expressed were expressed by the group, and there were a number in the group who went away very uncomfortable with this. I think there was question

about the regionalization effort.

In the discussion with the people who were there with whom we could discuss this there was an indication that they were beginning to move in this direction, the movement was slow. And the majority of the members of RAG are still from Baltimore and are still heavily oriented toward the two medical schools. That was a point of concern.

There was a young doctor from a minority group who was functioning with one of the programs who was very articulate and very impressive and very involved, but whether this represents a move toward minority group needs was difficult to evaluate.

MR. PARKS: The reason I asked about the outreaching to the rural areas is that there is a considerable portion of Maryland that is in fact rural, and that is where I would imagine the vast number of people, aside from those few pockets close in here, Tobbytown and some places like that, where the underserved populations, especially minority populations which are not served -- they are not underserved, they are not served -- St. Mary's County and various other places, where they are not reached. And this is why I asked whether you got a feeling that there would be a kind of movement toward reaching out further.

SISTER ANN JOSEPHINE: I personally got the feeling that there was an effort being made to move out in that direction

and probably some small successes were being achieved.

MR. PARKS: Was this one of the programs, in light of the information we got this morning, that was reduced or affected at all by prior funding reductions? Do we know that?

DR. ANCRUM: I think this has been a problem for the last two years, that most of their efforts have been concentrated in the Baltimore area with very little involvement of the rural or the outer areas.

MR. PARKS: Right. This morning I heard that a number of areas were affected a year or so ago by reductions in appropriations, and now that there is a surplus that has developed or an increase in appropriation, the application of them administratively would be first to those programs that fell into A, B and C categories automatically in terms of awarding certain kinds of funds. If we are here putting some limitations on the program in this particular review I think also we ought to put an embargo on any added to it administratively.

DR. MAYER: Yes, Judy.

MRS. SILSBEE: Under the circumstances, Mr. Parks, this region is just being reviewed, so the level that comes out of Council will be what we are bound by.

MR. PARKS: This morning Dr. Margulies explained that there was--

MRS. SILSBEE: Only up to the approved level of

Council--

MR. PARKS: I'm sorry?

DR. MAYER: Only up to the approved level of Council action was the qualifying statement of the add-on even in the case of those that were reduced.

MR. PARKS: Do we know that level?

DR. MAYER: Well, this is what we are arriving at, and what we have said as part of the motion was a million 294 plus possible further reduction dependent upon interpretation of HMO. And that's a level that is about 300 to 400 thousand below the level that they are currently functioning.

DR. KRAWLEWSKI: Add-on not withstanding.

DR. MAYER: Well, further comments on the motion? We will have -- just to remind you, we would have the opportunity, of course, of the anniversary review even if this is passed to get some feel for what kind of progress has been made in this, and another opportunity to put that last six months of shot into them in case they don't hear the message very clearly this time. But I think the message that has come here is pretty clear to me, and I assume it is pretty clear to staff, of some of the real problem areas that are there.

MISS ANDERSON: I would like to hear it spelled out more clearly more community involvement should be in regard to these projects rather than a package deal by one person or one organization.

DR. MAYER: Okay. Further comments?

SISTER ANN JOSEPHINE: I would like to make just one other comment. I think that it applies to maybe a number of Regional Medical Programs, and that is that I think the group needs to be very conscious of programs where there is such a rapid turnover in coordinators, because this precludes any kind of continuity of planning and continuity of effort, and it is really difficult to evaluate the progress made by a program.

DR. MAYER: They need to provide a course like I have tried to institute in my faculty on the care and nurture of the dean and how inportant that is. They need one for coordinators.

MISS KERR: You are recommending not funding the developmental component?

SISTER ANN JOSEPHINE: That's right.

MRS. SILSBEE: Does not the committee have the prerogative to ask to see this application after one year?

DR. MAYER: Yes, I would assume that we do, and I had hoped that that was picked up as the intent of my comment.

MRS. SILSBEE: It wasn't.

DR. MAYER: All right. Do you hear us now?

SISTER ANN JOSEPHINE: It seems to me if we could work through some of the problems presented by this particular Regional Medical Program we would have the basis for other

decisions that would help us out.

MR. PARKS: Sister, may I ask you something else? In terms of continuation of support did you find that there was any involvement, technical assistance or other things from other federal programs that might be supportive in some of the areas in which these programs are weak?

SISTER ANN JOSEPHINE: Would you ask that again?

MR. PARKS: Yes. Did you find any -- someone mentioned here that the universities programwide are working a number of developmental areas, and that this apparently was one of the areas in which they figured, you know, we would just treat this as a particular thing and let those funds deal with HMO's. I believe that was the suggestion. But in light of this I would assume that there is a plethora of federal involvement in different kinds of funding of medical programs and medical activity, extension services, experimentation, the development of physical and human resources to provide medical services. And I would assume that these two universities are really the heart of it in the state of Maryland.

I was wondering whether you found that there was any coordination either at the federal level or in conjunction with the operational level at these universities, that you would tend to find a meshing so that some of the weaknesses that you may have identified here, you might have other

resources , either federal or private, tied in to those universities that could be identified to help strengthen.

I mention that because I am pretty sure that the federal establishment, and a large part of it in the medical area comes from HEW, should really be involved in this in a way that one program is not saying this is weak, and there's some other technicians that really have a responsibility, primary in some cases, exclusive in others, to do some of jobs that we are canning a program here for being either unable to do or are not doing.

SISTER ANN JOSEPHINE: I think that during our visit we were not able to -- we didn't identify things. Now probably we didn't probe deeply enough into it, and in the length of time that we were there it just wasn't possible to clarify these areas. So I would say that I really don't know whether this is true. But I do know this from my experience in other areas where there are a number of federal programs in operation, one of the disturbing features that I continue to encounter is that sometimes federal programs functioning within one institution or a neighborhoring institution tend by their guidelines and the way they develop to pit one program against another one rather than to compliment programs, and I would be surprised if the situation were any different here. And this is probably one whole area that we talked about needs to be explored.

MR. PARKS: Well, if it is possible I think we ought to pass this on for advice because I think this would be a tremendous help, not just from our standpoint, but from the standpoint of many of these programs operationally in terms of strengthening, supporting, reinforcing what they are doing, to make sure that these things do in fact compliment one another rather than being antithetical.

DR. MAYER: All right. Jerry.

DR. BESSON: I think that's an important enough point that Mr. Parks raises that particularly since the new Deputy Administrator for Development -- is that what Mr. Reeso's title is -- represents a change in the organizational format of HSHMA, so that HMO's, National Center for Health Services Research and Development, RMPS, Hill-Burton, and Community Health Services are all put into one package for this kind of coordinative effort.

However, it may be that the political exigencies of program development and the historical aspects of each program being relatively autonomous, it may be that each program should be encouraged to do the kind of coordinative thing on the federal level that is implicit in Mr. Parks' remarks. I think it would auger well for the periphery if the center can show some leadership in this regard rather than protecting their very parochial interests as they have tended to do inthe past, and probably we see evidence of

doing now.

So I think it might be in order for us as the Review Committee to recommend to Council again that a clear statement of a coornative effort at least as far as HMO's are concerned, area health education centers, manpower utilization -- a clear statement be made by Council as to how RMPS efforts might best be coordinated with other agencies that bear on these questions.

DR. MAYER: Got it.

Other comments?

Yes, Joe.

DR. HESS: One further question. If I understand the proposal, it is 1.294, possibly less, which may bring it down to the neighborhood of 1.2. They are currently funded at 1.6, 1.7. Is this cut in funding, which is really substantial over current levels, is this going to do any real damage to the program?

DR. MAYER: They have already programmed in the phasing out of about $800,000 worth of that anyway. As least as I read the--

DR. HESS: I would just like to hear from the site visit team that indeed this is not going to do too much violence.

SISTER ANN JOSEPHINE: I got the impression -- and I would like some of the others who were there to comment--

but I got the impression so far as the project number 36 that this is a project -- the things that are outlined here would probably take place anyway, but at a much slower pace. And I don't know how this relates to other projects. I am not sure that this cut in funding would necessarily change what they are planning to do. Maybe they couldn't move as fast. But they are phasing out the projects that I would be really concerned about to provide continuity in the total program, and they are phasing those out themselves.

DR. MAYER: Further comments?

Everyone understand the motion?

All those in favor say "aye."

(Chorus of "ayes.")

Opposed?

(No response.)

All right, let me suggest that we take about a five minute break at the outside just to get up and stretch and clear our heads.

(A recess was taken.)

DR. MAYER: Could we get started, please?

Let me suggest that what I would like to try to do, if we possibly can, is to get through Louisiana and Greater Delaware Valley before we quit. That may take us to 5:30, a quarter to 6:00, but I think if we don't do that the pressure tomorrow is going to be too great.

DR. THURMAN: Could we do Greater Delaware first?

DR. MAYER: I have no objection to that if Dr. White and Mr. Parks do not.

DR. WHITE: Doesn't make any difference to me.

DR. MAYER: Okay. Joe, you want to give this then on Greater Delaware Valley.

DR. HESS: All right. This site visit was made in mid December, and the members of the site visit team you can read. I will not take time to do that.

This region is in its third operational year and submitted a triennial application for developmental components requesting renewal of core--

DR. MAYER: Would you speak up or use the microphone?

DR. HESS: The greater Delaware Valley region includes the area around Philadelphia and portions of Pennsylvania, reaching up in the area of Scranton and Wilkes-Barre, and parts of New Jersey, and all of the state of Delaware.

The major educational institution that has been involved in this region are the medical schools in the city of Philadelphia. The grantee organization is the University City Science Center, which is an organization formed by institutions of higher learning in the Philadelphia area, formed to accomplish cooperative scientific project

investigations, and because this was a common meeting ground for other purposes it would mean an appropriate grantee agency in order to get the Regional Medical Programs going and provide the grantee type of support. This history has also led to a rather unusual type of arrangement in terms of the overall region's directions, and I would call your attention to the organizational diagram on page 13 of the yellow summary in which on the lefthand side we see the University Science Center as the grantee organization, and the board of directors of this center shown in this diagram in a sort of parallel fashion to the Regional Advisory Group, certain areawide committees which report to both, and then the executive director reports directly to the board of directors of the corporation.

All of the board of directors of the corporation are on the Regional Advisory Group, and the chairman of the RAG is on the board of directors. But it was clear to us as we investigated the policy making, decisionmaking mechanism within this region that the real power seems to be in the board of directors, not in the RAG. And the board of directors is rather heavily weighted with medical school, university type representatives, as well as Philadelphia representatives, and this I think highlights at least one of the important problems that we encountered.

As far as the goals, objectives and priorities are

concerned, the region has identified some broad goals which are in keeping with current national RMP goals, but have not taken the additional steps of factoring these down into ... and having any system on priorities. As we inquired about priorities, decisions are made at the moment primarily on the basis of their narrative of the particular project, and we don't have a yardstick against which to measure projects as they come in.

As far as accomplishments and implementation are concerned, the core staff has enjoyed some success with its supported feasibility studies. They have acquired some community profiles which have contributed to the development of a data base, and this data is being used by other agencies concerned with problems of health and health care. This is not occuring on a truly regionwide basis. We found this has been done to some extent in the city of Philadelphia, and a rather good study had been done in the northeast regionwide which had resulted in some good projects which seemed to be addressing themselves to the diminishing supply of health manpower. But it seemed to be very spotty and even nonexistent in some of these other areas.

We were favorably impressed with the activities relat to peer review, continuing education and manpower problems, at least in some of the areas.

The region does not have a formal policy on

continued support for projects beyond the approved period, and their application reflects this because there are some projects for which support is requested the fourth and fifth year and there still are no definite plans for phasing out those that have been funded for that long.

On the issue of minority interests, they are aware of this to some extent, and are directing their efforts, at least from the medical school basis operation, to try to assist with improving the health care of some of the underserved people in the city of Philadelphia. But as far as representation on the RAG and policymaking, decisionmaking level, we felt that this region has much room for improvement.

I will not go into great detail as far as the individual activities of each of the medical schools are concerned. But I should point out that they have divided up the city of Philadelphia amongst the medical schools and one osteopathic school, and they now have responsibility for defined geographical areas in terms of working to improve the health care in these specified areas, and this we felt was a very constructive step in terms of being able to organize and coordinate their efforts in this area, working an helping to set up neighborhood health centers and other type of health care activities. And they have also had some categorical projects in the areas of medical school

responsibility.

I might also mention that some of the other areas outside Philadelphia do seem to be giving some attention to this, although again we felt there was room for improvement.

The coordinator has been functioning in his position for about four months, and we felt that we had to make some allowance for his relative newness in this position, although he was a deputy coordinator prior to being appointed in this capacity. We do not feel that he has a strong RAG to back him. His major backing direction seems to come from the board of directors.

There are several key staff vacancies which exist which go back prior to his appointment and which have not as yet been filled, and these vacancies limit to a considerable degree what he is able to do because of lack of staff support.

Regarding the core staff, three of the five senior level positions are presently vacant, and the fourth will become vacant -- or I guess is vacant now, as of January 1. These key vacancies are: the Associate Director for Planning and Evaluation; the Assistant Director for Communications and information; and the Associate Director for Program Development and Operation. The one which is now vacant in addition to those is the Associate Director for

Continuing Education and Manpower. There is an acting Associate Director for Program Development and Operation on a part time basis, but we do not feel that this is sufficient for what is needed.

We had the feeling that the coordinator is not pursuing recruitment of people to fill the key vacancies as vigorously as he should. We were told that he was being very cautious to make sure he got the right people, and while we concurred with that, we also felt a sense of urgency to get these vacancies filled because of the obvious need for this kind of assistance.

We felt that most of the key health interests and institutions were represented on the RAG. However, there were notable deficiencies with respect to nursing and allied health professions; and as I recall, there was no real direct linkage of organized medicine to the RAG, although there are a number of physicians on it. Most of the public representatives were bankers, college presidents, et cetera, rather than the consumer type, particularly from the lower level of the socio-economic scale. There are specifically as far as minority representation is concerned only two blacks on the 61 member RAG, and we found little evidence that there was this level of consumer input into the shaping of policy and program direction.

We have already mentioned the relationship between

the board of directors of ECS and the RAG. The RAG chairman at least, and the chairman of the board of directors, are fairly comfortable with their relationship, but we question the broader context, whether or not they are as comfortable as they say in this situation.

As far as the grantee organization is concerned we found no evidence that the UCSC is not providing adequate administrative and other support. We had members of the team specifically look at some of the budgetary reporting procedures, and so forth, which had been questioned on earlier site visits, and they seemed to be satisfied that that end of it was being taken care of satisfactorily.

The region's five medical schools have been deeply involved in developing the RMP from the beginning and still have a dominant influence, and our feeling was that perhaps it is time for the medical schools to become less dominant and other forces become more dominant in giving direction to the RMP in this region.

The GDVRMP and CHP seem to be working quite closely together in developing local planning groups. The CHP is less well developed in this region than is RMP, and as a consequence the RMP area coordinator seems to be providing much of the leadership and direction in this area. But we anticipate that CHP will pick up the slack. But as far as RMP's responsibility is concerned they seem to be doing

what they can to cooperate. They have established a mechanism for obtaining CHP review and comments on various applications.

We found that there has been considerable data gathering in the region by the medical schools. They do have an epidemiologist consultant who has worked with the RMP and has performed some studies, but again this is still a bit spotty, it is not a general thing, and we believe that this is an area that could stand considerable strengthening.

As far as management is concerned, we have mentioned the organization as far as the medical school responsibility in Philadelphia. They do have a coordinating committee which is comprised of the RMP coordinators in each of the medical schools, Dr. Wollman, and others on the central core staff who meet weekly and attempt to by this mechanism coordinate activities to this extent.

The Associate Director for Community Affairs is the member of core staff who is responsible for working with the area coordinators and providing liaison, and we felt that perhaps there might be some improved strengthening and coordination between what is going on in core and some of the region.

The absence of an evaluation person on the staff is perhaps one of the reasons for the rather poor evaluation, and in some instances almost totally lacking, of some of the

projects which we reviewed.

The region recently formed an evaluation committee which met, and we reviewed the minutes of meetings of this committee, and this committee very quickly identified this deficiency and made some recommendations to the RAG concerning this. But it is doubtful that their recommendations can be implemented until they get the evaluation person on core staff.

As far as the program proposal is concerned, while it may have a number of merits we do not feel it has the qualities based on a systematic assessment of their needs and a system of defined priorities, and as a consequence suffers from the deficiencies which are a natural trend of even resulting therefrom.

An example, one project in which we felt this was illustrated was a project of pediatric respiratory care in which the project had been replicated in a number of hospitals and they were planning to replicate it several more times, and the people from the project were there and we spoke with them, and we asked them -- they had been in operation for three years, and we asked them what impact they had had, if they had any indices of the effectiveness of their programs and whether or not they really knew whether the hospitals where they wanted to disseminate it really needed the program, etc., and they had really no information, there

had been no evaluation. So it really was by dissemination by popularity and salesmanship rather than by any very solid basis of analysis.

As far as dissemination of knowledge is concerned, one of the strong points in this RMP is their team education program, part of which is related to peer review and to the model of quality of care assessment developed by Dr. Brown, and which is one of the strong areas in this total program, and medical schools are quite involved in this endeavor. And on this particular score I think they are doing reasonably well.

Up until the present time most of the region's efforts have been related to or directed to the medical school complex, and as a consequence some of the outlying areas have not been receiving as much attention and consequent funding as might be appropriate if one looked at this on a regionwide basis.

Some of these other areas I think we have already touched on. I will not belabor them.

There is some effort at regionalization. They do have area coordinators, and are attempting to strengthen these areas; in this particular category they seem to be moving in the appropriate direction.

As far as other funding is concerned, I have already mentioned that they do not have a good record of phasing

out and planning new funds to support RMP initiated projects, and they do not have a firm, strong policy in this area.

Is Dr. Hinman here?

MR. PETERSON: No, he is not. He had to go to another meeting.

DR. HESS: There were some renal disease projects which were a matter of particular concern, and Dr. Hinman was a member of our site visit team and paid particular attention to these.

There is not a well developed regional kidney disease plan, although there are active transplantation and dialysis efforts going on in the region. But the feeling was th this region as far as developing a well thought out, carefully planned regional approach to management of kidney disease, just had not achieved it yet, and this has consequences for the recommendation that we will get to in a moment.

Another particular area that we looked into was action which is being pursued by various people in the state of Delaware to form its own RMP and secede from the Greater Delaware Valley, and this I suppose has had its impetus from a variety of sources, including the Governor, and we understand that he has had some conversations with people here in Washington, and so on, and for various and sundry reasons are thinking about trying to like all health related activities in the state of Delaware into a health services

authority. So that there are many broader implications for this.

We spoke specifically with Mr. Edgar Hare, the area coordinator, and we asked Dr. Cannon to come down from Wilmington to talk with us to see what the view of the RMP people was in this business and see what light they could shed on this problem from the standpoint of RMP, and we were told that there was a fair amount of dissatisfaction on the part of the RMP group in Delaware, feeling that they perhaps had not gotten a fair shake as far as both funding as well as participation in policy setting, decisionmaking, et cetera; and as a result they were really rather ambivalent about this secession movement, and they could see some things for it and some things against it. Some there contradicted their statement that they hadn't received a fair share of the funding, and felt that they really had. So this was a point which was sort of up for grabs, it was not really clear, but it was evident that this was a bone of contention and was contributing in some way to the secession movement.

At the end of our site visit we had a feedback session with Dr. Kellow, who is the chairman of the board of directors, Dr. Wolf, the chairman of RAG, and Dr. Wollman, the RMP coordinator, and expressed there frankly some of the current concerns which the site visit team shared about the

program. We raised questions about the relationship between the board of directors and the RAG and the representativeness of the board of directors of the regionwide concerns, and suggested that they re-examine that relationship and this whole question, and see if perhaps they might have some other thoughts about it.

The second recommendation which we made to them was that they give high priority to filling the vacancies on core staff, because we just don't see how this region can function very effectively with the shortage of key personnel which they currently have.

We called attention to the recommendation of their own evaluation committee made in the summer of '71, and there also was an ad hoc committee appointed to study a special report prepared by the Arthur D. Little Company who came in as consultants to pursue a management study or organizational study of the region and really read back to them the recommendations of this committee that they give attention to setting goals, objectives and priorities of the regional plan, precisely the same ideas that we came up with, and it was interesting that this came as rather news to the people that we had discovered this and were feeding back to them information which was already currently available. And I would judge from the reaction on the faces they were probably going to go back and read those reports a little

more carefully to see what was in them.

We felt that when attention had been given to the issues of the management from the RAG level, the setting of goals, objectives and priorities, and when they look again at their total regional situation they perhaps can address themselves to this secession movement going on in Delaware. In the view of the site visit team this is not a necessary thing, and from many standpoints would be an undesirable thing to try to carve out a separate RMP for 600,000 people when really Philadelphia has many of the resources and they already have established relationships between Wilmington and some medical schools in Philadelphia, and so on. So that it seemed to us that this was still a repairable breach, assuming that other more overriding considerations at the Governor's level and elsewhere do not come in to intervene.

But just looking at it strictly from the RMP standpoint, in our minds this was, of the two options, trying to beef up and more adequately attend to the Delaware problems, it was preferable to secession and the creation of a new region.

In conclusion, we felt that there were many positive features of this Regional Medical Program. It was clear that the resources of medical schools and other institutions are actively involved in RMP activity and have contributed much to what is going on there at the present

time. Some of the activities are beginning to have a favorable impact on manpower utilization, ambulatory care, and health care delivery problems. Planning in the inner city by the medical schools appears to have real potential for the future, and they are very much involved in this. Subregionalization is under way and has potential for the future as well as important benefits already apparent, especially in the Northeast area. Now that's the plus side of the ledger.

On the minus side, in summary, we found the absence of a well thought out regional plan. We have already mentioned the board of directors and the RAG, the lack of minority representation, the high number of central core vacancies, the inadequate evaluation, the under utilization of avilable data in assessing needs, and the program's poor record for phase out.

Now as a consequence the team felt that this region was not ready for triennial status and felt that there is a good deal of work that needed to be done yet, and our recommendation was for one year funding at essentially the current level of 1.9 million.

We did not feel that they were ready for a developmental component. They are currently operating somethi close to $200,000 under their approved budget, so we felt that there was some flexibility within this figure of 1.9 for a

certain number of feasibility studies, so it wouldn't seriously impair them.

We felt that whatever report goes back to them should attempt to enforce the points that were made in the feedback session.

We were not in favor of the expansion of the renal disease patient support project or the initiation of the demonstration and evaluation of chronic hemodialysis, and the proposal for the school of radiotherapeutic technology was contrary to RMP policy.

So in essence it was for one year funding at a level of 1.9.

DR. MAYER: Okay. Bill, comments?

DR. THURMAN: I'm just less tactful and everything else than Joe, so I will just add a few things.

I think there is very little relationship that we could define between the RAG and the grantee agency. That's a very nebulous thing. Without the board of directors I don't think the RAG would know where the grantee agency was.

I would emphasize again how ineffectual the RAG is as far as geographic representation in particular, but also in other areas that Joe has already brought out.

Any time you asked somebody on RAG what thier functions were it was like talking to a machine, you got evaluation, project approval and advisory capacity back, but

nobody could define what those were. So that that made it a little difficult to see how they were really moving along.

Pete Peterson pointed out that 60 percent of their money went to three things, and has over the years -- coronary care units, continuing education, and the pediatric pulmonary disease that Joe mentioned. And none of these really have been well thought out regionally, are well planned or anything else.

The planning studies in reference to the core staff and the medical school units theoretically are being done by the coordinating committee established between the core staff and the medical units, but those are not broad based, they don't work well together, they don't know what eaqh other are doing, and rather than initiate they respond, and that's very much of a problem.

The physician who is vice chairman of the RAG, who happens to be from one of the outlying areas, didn't know half of what was being said. He said that they were really not truly involved. He happened to be from New Jersey, and not Delaware. And he was a little bit upset. He straightened out and supported everything before the day was over, but he initially was kind of upset.

The area coordinators have been stretched very thin. But as Joe indicates, that's one of the more positive features of what they have, because if that were to

work then their regionalization would really go well. They happen to have one good politician who is a regional coordinator, and he is doing a superb job of getting Mr. Flood into the act and everybody else. But the rest of them are just really getting off the ground.

There really doesn't appear, except for the business of splitting up the city, which is idea, as Joe indicates -- there doesn't appear to be any understanding between the schools about the fact that they are all working toward an RMP that means something to everybody. They really just don't have priorities. And I can't emphasize any more than Joe has how weak this core staff is, and they really just are -- something has to be done to shape that group up or else it will continue to be five or six little RMP's running all over the place under the framework of one RMP.

Despite all those things, I think there are some strengths there, as Joe has indicated. But it would appear to me that it was time to really draw a few lines for them and make those lines reasonably definite. But I have a lot less tact than Joe.

One other positive point, they have used a lot of developmental component money by small subgrants to the medical school units primarily to coordinate or to give X amount of dollars, and $75,000 they are asking to get a project going which has been developmental component money,

and they will pick up money here, there, every place else. But that has served a useful purpose as they have begun to put some guts into the core staff which they haven't had in the past.

That's all I would add.

DR. MAYER: Leonard.

DR. SCHERLIS: I guess in view of what they have asked for you aren't being very generous, but at the same time I tried to make some sense out of page 3 of the yellow sheets. Perhaps you can help guide me on that. Column 2, as I read this, a project which they will continue to support would be those which are really outside the initial period, coronary care, and as I turn over the sheet some of the pulmonary, etc. In other words, what will they really be doing with that 1.9 million dollars? Are you making your message to them clear at this point, will they be putting that money into the same old projects, since you have really told them they can't do som of the others they would like to do. What will they be doing with that sum of money that is any different than what they are doing now?

I view them as having a couple hundred thousand dollars thrown into the developmental components. If I read it correctly -- well, that's why I need your help in defining how you are suggesting they spend that money.

DR. HESS: These projects that you see here are

indeed ongoing projects, some of them go longer than we would ordinarily like to see them go. But at the same time I don't think it is fair or reasonable to the people on the other end of the pipeline to suddenly have a cut-off, and they have got to have some time to do some phasing out, preparing, and so forth, in order to not do too much violence to what they have already done. So our rationale was to give them a year to do some re-thinking on the basis of this recommendation.

And I might also say that another point that isn't written down here, but Dr. Watkins from the Council raised this point, and I certainly concur with it, that this region should have ongoing RMPS staff contact to help make sure that the message is interpreted to them so that if they choose to come in in another year with a triennial application that they indeed do the homework they need to do in order to be ready for that.

But in fairness to the people in the communities who are counting on this funding we just didn't feel it was fair to them to try to cut that back too severely, and they are attempting to move in the "new direction" of RMP. Their ability to do that largely comes out of the core staff and some of the small feasibility studies that they can obtain, and their general approach is consistent with the way they manage things in terms of the RAG, and the way they determine the overall program needs, etc., is not as systematic and

clearcut as we would like to see it.

DR. SCHERLIS: I guess my problem is instead of seeing just one or two projects going beyond the three year period you see a whole array of them, and I would hope that they might receive very strict and harsh suggestions as far as how to direct some of these funds. In fact, I would be in favor of literally telling them, you know, we can't support X projects for three years, and go on and do something else.

The other question I have is for a while written communications were going back to the coordinators indicating the exact specific areas of concern. I understand that has been modified, is that strue?

DR. MAYER: Can staff help us on that?

DR. SCHERLIS: I was caught in one of those programs of ultra detail communications which went back, and I was curious what the present policy is.

VOICE: Are you talking about technical aspects of individual projects?

DR. SCHERLIS: A very frank discussion of what the site visitors have stated in detail. How much of that is now going back to the coordinator?

MR. CHAMBLISS: Principally that goes back now in the form of the post Council advice letter. There have been before, though, some rather frank discussions with Greater

Delaware Valley. Dr. Margulies has been there along with other members of the staff, which included Pete Peterson, I was there, and others of us, and there have been some rather frank discussions with them.

DR. SCHERLIS: In writing or--

MR. CHAMBLISS: I believe they were followed by -- the visit was followed by a letter.

DR. SCHERLIS: I think this is a vital concern here.

DR. PERRY: I am greatly concerned and I am happy you mentioned the lack of allied health representation. If you look at the amount of the projects they have, they do relate to systems, they relate to these areas. That region is not utilizing resources they have. They have really very strong allied health programs in the University of Pennsylvania, one at Hahneman. Here are resources that need some kind of a voice and some kind of relationship to a program that is spending that much money, but they are not involving them. I know in one case Dr. Frank Houston has gone in to RMP asking to be involved, and they said "thank you."

MISS ANDERSON: In the recommendation, too, where it says "lack of appropriate representation of allied health, minorities, and true consumers on the board of directors and the Regional Advisory Group," they should also say "and staff."

DR. MAYER: Right, and staff. I am trying to -- you know, if I were Martin Wollman, who has four or five

vacancies already that are there, with a couple more that are going to appear evidently, and I am told that the dollars I have for next year are essentially the same as the dollars I have for this year, and I have got six months to turn the program around and then I am out of any approved funding anywhere, and I had a little bit of difficulty because I am new trying to recruit those people, and now I have got a new message which is there, and the only thing that I have got working for me is the fact that RMP nationally got a 30 million dollar increase and at least there is a general feeling that maybe it isn't going to die after all, it is out th in the hustings, but that's all I have got going for me. My program sure looks like it is going to die, and those bright people I am trying to recruit said what, the Greater Delaware Valley RMP -- now I don't know what kind of chances he has got in six months, which is what he really has, to initiate another grant application to come in here that is different than this and to create a program in six months that is different from this.

I guess I am caught up on the one year, two year approach issue in terms of the chances to do this job.

DR. HESS: I must say I have great personal regret in not being able to recommend more funding because I think this region is underfunded in relationship to what should be done there. And so I am most reluctant to make this

essentially a level of funding recommendation, and I really believe they probably should have twice that much, and the needs are there if the system were there to appropriately utilize it.

But if the question you are raising is should we make this a two year recommendation instead of one in order to give the region, particularly the coordinator, a little more to bank on in terms of recruitment, I am certainly in favor of that. I think we need to do anything we can in order to strengthen them and give them the assist they need in order to build an effective program which will qualify them for the kind of funding that I really believe they should have.

DR. MAYER: To what degree do you think those medical schools understood that whether that RMP is going to survive or not is dependent upon having a strong central core staff, and to what degree are they breaking their necks to try to see that that happens, or are they just glad to keep it nice and weak?

DR. HESS: Well, I would be most reluctant to attribute -- Bill can speak from his own point of view -- any Machiavellian motivation to Dr. Kellow in particular, who is the one we spoke to. The time we spent with him I just didn't get any feelings of this type about him whatever; and whether that's valid or not, I have no way of knowing.

It's just gut reaction. But he seemed to understand when we talked with him about the need to shift the emphais away from such heavy medical school domination. In the feedback we went into this in some detail. We told him re recognized why they were where they were now, that they needed to pull the medical schools together, and those were some of the major resources they had to get started with, but now that it was on its feet and going that it was important for the medical schools to move more in the background and let other interests play a more dominant role. And he seemed to accept this without any real difficulty, but again I can't say how much the message got across. But I, at least, do not have any reason to believe that this has been overtly intentional on the part of the medical schools.

One of the problems that they pointed out is that of the difficulty of attracting qualified professionals to essentially what many people see as a SOP operation with regard to RMP. The medical school positions are for all intents and purposes filled, and I think it's more a function of the way people see RMP there versus a university base than it is any conscious effort on the part of the medical schools to keep core staff weak. I just don't think that's there.

MISS ANDERSON: Are you suggesting a time schedule or anything for these changes?

DR. HESS: No, we just said as quickly as they could do it. We didn't give them any specific time schedule, but we told them we felt it was important and urgent that they address these problems promptly.

MISS ANDERSON: These things have been brought up before over and over again.

DR. THURMAN: I think Mr. Chambliss has a very important point. They have been talked to by a lot of people.

To go back, Bill, to what you said, I would agree one hundred percent with Joe. I don't believe this is Machiavellian at all. It is more a realization that we have five RMP's, and not one, because they are filling all the medical school components, whereas if they devoted that degree of effort to really making the core staff one who had a lot of clout they could do it, because we are in a surplus of people right now, particularly where you have five medical schools generating people who could do this and two very good schools of allied health. If you get two of the faculty of one of those schools they could fill three of the positions that are open if they would just get together and talk about it. But they are operating five little RMP's, is what they are doing, and they are not looking at the core staff. But I don't believe it's by design. It's just by the fact that Temple is not really going to shake the hand of the University of Pennsylvania too hard. They will meet

them once a month for dinner, but they are not going to shake their hand too hard. And that's where the weakness really comes up. And that's why I think again, to go back to what Joe said, I would be opposed to going to more than one year because I think they have got everything they need to make this a going operation. They have got the demand, they have the support of the people around them, and everything else. They need to know that they can do it, and I think they can.

DR. MAYER: Leonard.

DR. SCHERLIS: From a practical point of view I would certainly agree with what the Chairman stated, that you can't go and hire anyone really of any stature if he only thinks he can work for one year. This has been one of the difficulties with not just getting staff, but of keeping staff. And I question whether or not this is the way to strengthen a region by telling them they will get no money whatsoever unless they shape up and at the same time give them no way to do it.

And what I was wondering would be the following. I think that if you look at how they are spending their money, one and a half million is core, and they only have of total projects about 400,000 for projects. And if you look at those projects practically every one of them is outdated in terms of it has been over three years, and they are just supporting them for much too long a period of time, and this

is how they get the request -- their operating level of 1.9 direct. I don't have a specific number, but I guess I could come up with one. I would be more in favor of giving them, say, two years of support, but knocking that 1.9 down and then in the second year giving them a sum that would at least enable their core and some projects to function, because if you gave them, for example, 1.9 for that two years away period they are going to have nothing to support unless they keep going on their projects, and that's an easy way to go for it.

My feeling would be something on the order of say they have to shape up and let's cut it down to 1.7 this year and 1.25 the following year, if you can really come up with a program we will accept an application year after year. At least they can hire someone for a two year period of time.

I think 1.9 is high, and I think that they won't be able to really shape up if we don't promise them some support after that one year period. I don't see how you can go out to a professional person of some stature if you want him in core and say "well, if we really do well we will hire you the second year, but it looks like it will be a one year period."

DR. MAYER: And two years doesn't, you know, bother me. Bob Marston always used to say that, you know, two years is forever. God knows what's going to happen in two years, whereas one year is not quite that, and neither is 18 months.

But two years, you know, is a pretty solid time term.

DR. SCHERLIS: I'm concerned about that 1.9 because I do have this concern about continuity of ongoing projects, and we are really telling them to continue what they are doing but do it better, whereas if we put some stringency on and say the only reason you are getting that other year is because we feel you have to get some core staff to carry this on. I am not making this as a motion because I want to see what your reaction would be to that, Dr. Hess.

DR. HESS: Our thought was they they indeed could begin to tackle the issue of phase out by trying to fund some of the new projects that they would like to by phasing out some of the old ones. This would give us a means of finding out when we review another year whether or not they really had established some goals and priorities that they were making operational, and we felt we needed to give them a little maneuvering room in order to do this.

Now your real question is how much, and if we cut them back too much will they be able to fill those core vacancies they want to fill in light of their ongoing obligation to people out in the field that they have to maintain some kind of credibility in terms of funding.

DR. SCHERLIS: I really feel more strongly about that second year of support. Do you feel it should be zeroed in view of the discussion?

DR. HESS: No, I would be perfectly willing to show support for the second year in order to give them something to bank on. I think that's sound.

DR. MAYER: The request for core in the second year, that includes all components of core, central core plus the individual schools, is 1.67.

DR. HESS: Incidentally, the major increment in core in their proposal as opposed to where they are now is in the medical school components. We suggested to them that they consider keeping the medical school components at level funding and try and get more out into the field and not put as much in medical schools.

MISS KERR: Joe, how long as Dr. Wollman been there?

DR. HESS: He has been director since last July.

MISS KERR: Which is a very short time. And in view of the fact that so many people have been talking to the director, and so forth, perhaps it was hard to evaluate on the site visit a man who had been there four months, do you think the potential for a more positive leadership was there?

DR. HESS: He was deputy director before, so he is not brand new to the program. I just don't know.

MR. CHAMBLISS: If the committee would just permit me to act as a volunteer here, may I say that in these complex metropolitan areas where there are multiple medical

schools there are very definite problems in getting the RMP going. Whether they need additional time I personally cannot say. Whether it will be additional money I cannot say. I do have this feeling, though, that it centers around the element of leadership -- of leadership of a person having a certain amount of boldness, who is willing to get things moving, and I think we have seen this very candidly expressed already today in the Illinois situation.

So what is the element that these complex metropolitan areas need that we can provide, and I think this element of leadership is one of the sine qua nons of which it will not move unless it has.

Now you make the point that this coordinator has been there since July, and the point is reinforced by the fact that he was the deputy under the previous coordinator for some time. We need your help here in trying to find what are the elements needed to get this kind of RMP under way, to help us examine what you think ought to be done and make some recommendations in accordance thereto.

DR. SCHERLIS: I have a certain allergy at least to working after 5:00, but the problem of seeing a core budget which has inner cores and outer cores and peripheral cores -- and this core budget is one which has $750,000 for the inner core and another $750,000, $110,000 plus or minus 20 I guess was the number they agreed upon, which would be centered around

the other six medical schools. And I think one way to preserve a weak RMP is to have a good portion of that budget not under his and the RAG's domain. And as I read this my concern would be that one message that should go back would be that the core should really run the RMP in that state, and not be subservient to all the other cores which operate, and I would assume fairly independent. And if they want to set up projects in the other medical schools, in one school where Dr. Pastore is, and if his thing is peer review and continuing education and ambulatory care which he does in exemplary manner, I am sure he can come in with an excellent project which would then be subject to technical review.

I don't think you can have a strong RMP where you have a series of cores which operate independently and not subject to the usual type of technical review, and I think that's what we are seeing replicated in a great many urban areas where we have a great many medical schools operating.

And I would think that one message to get back here -- this is why the system has worked so well in Chicago. Their executive director makes it very clear that he runs that program, and if a medical school wants something they work with him. This hasn't caused any schism, but it has caused an unbelievable amount of support, and I would think this is one message that should get back.

As I read core, it is a fractionated, multicentric, multilayered core. I would like a comment of the site visitors on this. Do I misread that?

DR. HESS: I think you are essentially correct, and this is the point that I tried to make earlier, that medical school domination at a number of points in the system is having an adverse effect on the region, and it is indeed going to take stronger leadership in terms of the RAG. We can't in a very detailed way evaluate the coordinator and the effectiveness of his function. We do have some serious questions about it, but again we recognize the short period of time which he has been in the full authority position, and therefore we sort of hedged on that particular issue, but fully aware that this may be part of the crux of the whole problem. It is not the whole crux because this whold board of directors, RAG is another part of it, which until that is resolved I don't think you are going to get the kind of coordinator appointed that we would like to see. Now maybe if the center of power shifted that current coordinator would be able to function much more effecgively because he would have a different kind of power base behind him backing him up at a policymaking level.

So, you see, there are all these dimensions that are very hard to get a handle on, and they all directly interact.

DR. MAYER: Would somebody care to make a motion?

DR. HESS: I will make the motion. We have made it for 1.9 for the first year, and I would like to suggest that -- pull a figure out of the air --1.7 for a second year so that that gives them some firm funding to count on, and then I guess -- well, they would have to come in for an annual application, wouldn't they, another year, another site review, and so on. Is that correct?

DR. MAYER: No, wouldn't have to be site visited.

DR. HESS: All right. I would attach a recommendation of a site visit in one year to that. 1.9 the first year, 1.7 the second, with a site visit after one year.

DR. MAYER: Is there a second to that motion?

MISS ANDERSON: Do you want to reverse those figures? Wasn't that what you suggested earlier, reverse those figures?

DR. HESS: No.

MISS ANDERSON: I'm sorry.

DR. MAYER: Further discussion? With, I assume, a clearcut understanding that not only verbal, but written message needs to get back that incorporates much of what has been said.

DR. SCHERLIS: I did not see in the site visit report specific reference to these multiple cores. I would hope that that discussion would be incorporated in the

evaluation of the unit, because I expect the Greater Delaware Valley area will not move from where it is now unless these counter cores become subject to their coordinator. I don't see how it can move.

Dr. Mayer, do you want to comment on that? Do you think that should be part of the recommendation that goes out?

DR. MAYER: (Nods.)

Further comment, discussion?

All those in favor, "aye"?

(Chorus of "ayes.")

Opposed?

DR. THURMAN: Aye.

DR. SCHERLIS: I think I should ask the Chairman to speak up and not move his head because that doesn't go on the tape. You expressed concurrence.

DR. MAYER: What's that?

DR. SCHERLIS: I don't know if the tape heard you. You agreed, didn't you?

DR. MAYER: Yes, I did.

Let us move on to Louisiana and then we will call it a day.

DR. WHITE: Normally I come to this point in time feeling fairly comfortable about how I feel about the region I visited, and I have adopted a position and I try to persuade

you to adopt the same position. At this moment I feel that I probably will be a twig which bends with the winds that blow across this table during the discussion, and I say that because I never really got a very definite kind of feeling about anything specific about the Louisiana Regional Medical Program.

This is in part my own fault because I was helped by a superlative team of site visitors, including Mr. Parks and our staff from here, and I guess it's because I tried to mix business and pleasure. As my wife and I viewed the stark, bleak, white winter of Wisconsin ahead of us we decided that perhaps she should go to Louisiana with me. But I find that it's difficult to have a second honeymoon and be an effective site visitor at the same time. Neither one was accomplished to my satisfaction.

(Laughter.)

I think that to view the Louisiana program one has to recognize some of the encrusted attitudes that exist in that state. They take great pride in their crawfish and oysters, and I think that there are other shells in that area which are difficult to penetrate or to crack open.

You may recall that there was some early trouble with the development of the Regional Medical Program of Louisiana, that Dr. Sabatier, even though a past president, I believe, of the Medical Society, was at one time to be

expelled because he expressed some interest in the Regional Medical Programs. So he has had a tightrope to walk, and he has had some difficult problems, and only now is he beginning to get some consensus on the part of organized medicine and organized health facilities that maybe the Regional Medical program has a place to play in the state of Louisiana.

Another problem relates to the two systems of health care that exist in that state. There is a system of state hospital around Louisiana, charity hospitals. These have been in existence for some time, they are pretty well established, they are supported by the medical colleges. The medical schools find them essential in their educational programs. But it has created not an iron curtain; nor a bamboo curtain, but sort of a gauze curtain between the private and the nonprivate health care systems in the state of Louisiana.

Further I think that the Louisiana medical program has suffered, in my view, from the sufferings of the other Regional Medical Programs. Sometimes the signals they have had from those of us who have made site visits or from staff or from the Council have not always been those that served them well over periods of time. By the time they began responding to that signal new ones were coming down the pathway. But I think that this is not the fault of Washington alone or the Feds alone. I think that the

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Regional Medical Programs in the context of our earlier discussion today have been hanging around too long waiting for someone to put a hoop through their nose or ring through their nose to lead them down the path. Seems to me the guidelines and messages are broad enough, nonspecific enough that the region should be able to define its own programs within those and not wait for specific types of statements that they can voice back. Louisiana has been guilty of this, and still is guilty of this.

But in honesty and in fairness to them I would say that they have gotten into the planning of things to a great extent because this is what they were told to do by previous site visitors. And this is one of the difficulties we see at the moment.

They and CHP have blurred images. It is difficult to sort them out. They indeed have become the planning body for the state of Louisiana. They are not an action oriented group.

But I don't want to leave you with the impression that there is no quality in this program, because there is quality. I think if they were now approaching the state of asking for an operational grant this would be just dandy. But they are asking for a triennial grant, and this has to be viewed somewhat more critically.

They have indeed established goals and objectives.

They both say the same thing in different words. They are going to deliver better care to the medically disadvantaged, they are going to increase productivity, they are going to contain costs, they are going to develop the additional kinds of health manpower that are necessary, and so on. These are the same kinds of words that we have heard over and over again. They are laudable, to be sure; but I don't see really any clear view as to how these are going to be implemented in the state of Louisiana. Nor do I see a clear understanding of the priorities for the actions to be taken to implement them.

They have indeed a well established data base now for the assessment of the needs. But I don't know that they have undertaken this assessment. They have the data, but I don't see that they have clearly used these data to predict a goal and objective for them.

Again, however, I don't want to be negative. These people have accomplished things. They do have, as I said, these data. They have used them in conjunction with other health agencies in the state well. They have even been requested by the State Medical Society to provide some data, and I think this is a mark of distinction for this Regional Medical Program because they were never even regarded with anything prior to that. They have planned with area health planning councils, New Orleans and State Health Departments;

they provide a data base which are helpful to them as well as to RMP.

They have developed methods for studying immunization problems which has been helpful in upgrading care in certain areas.

They have been able to determine needs for certain types of allied health manpower which may be helpful to Dr. Peterson and some of the others in the future for determining the programs to be undertaken by the respective schools.

They have one mark which I think is helpful. They undertook a study of irradiation therapy capacities in the state, and on the basis of their studies the hospitals recognized that there wasn't a need for each of them to develop a facility, there was an adequate base for care at the present time. And I think this was a significant accomplishment.

They have broad support from the pathologists in the state because they were helpful to the pathologists in developing a laboratory standards committee and quality controls which were applied to most of the state laboratories and I think this is a mark of distinction, too.

So I am presenting a picture that is mixed obviously. There are some accomplishments, there are many weaknesses. But I don't think we should focus just on the

weaknesses.

Another point in their favor is that they have been able to phase out--even though their evaluation and review mechanisms are rather weak, somehow or other they did manage to identify one particular project at least that was not meeting its objectives and goals and was just wasting money, and they terminated it.

They have been able to find certain kinds of support for some of their other activities. The Heart Association is going to continue supporting the cardiopulmonary rescussitation program. The State Department of Health will continue to provide funding for the health information clearinghouse project. The Louisiana Medical Society has indeed subscribed to and supports the dial access program that was created by RMP in that area.

Minority interests are not really represented even in a token manner, and certainly not represented, I believe, in the deliberations that are necessary for the plan of action that is required for the state of Louisiana. They expressed an interest in recruiting additional minority and disadvantaged participation with a view that they were going to do this through the CHP B agencies. They were indeed going to use these agencies as their subregionalization or local area councils. And to me at least this seems a dubious way of going about it. I am doubtful that the people involved in

CHP creation are likely to be any more concerned about minority interests than has been the RAG of the Regional Medical Program.

We saw little to indicate that black physicians were involved, black citizens involved. We saw little in the way of Indians or the Spanish speaking people. And this is certainly an area which needs strengthening.

Dr. Sabatier is a good man. He has provided good leadership. He has been able to be persuasive, has been able to meld things together. To me he is not a particularly dynamic individual, and he may not be the kind of guy that can rock the boat that someone talked about here earlier in another program, and perhaps this is a time that this needs to be done in Louisiana, I don't know. But I think he is a talented man, and he is skillful, and he has brought together a good core staff. Surprisingly, their background would lead you to think they are not very capable, but they are. Few of them have had any education in health fields or management fields. One was an airline stewardess who somehow or other got into the Regional Medical Programs, and I think is doing a heck of a good job, as well as being very attractive.

They have worked well with other health agencies in the community. I think they have created visibility for the Regional Medical Program. The Regional Medical Program through the efforts of core staff and Dr. Sabatier I think now

is regarded as a resource to be called on for help in the Louisiana region, and perhaps this is a right time for having been identified as a resource to begin acting.

I won't go into further details about how the core functions. There are strengths, there are weaknesses. They manage things very well. They have fiscal management which is very good. They have been subject to audit without fault.

I think their evaluation procedures within core are somewhat weak, but this is not peculiar to Louisiana.

The review process for the review of new projects is rather sketchy, and this obviously needs strengthening. But this relates to a problem that we will get to a little later, and not too much later because I see that's on the next page, and that's the Regional Advisory Group.

Although fairly representative of key health interests in the state on paper, I think we came away with the feeling they didn't really participate very much. There were allied health people listed, there were hospital administrators listed, there were medical school deans listed, there were medical society representatives listed, and so on. But it was difficult for us to get a grasp of any facts that would lead us to think that they actually participated, particularly in reference to defining the programs for the state, what they should be and what the action plan would be that would be likely to achieve these objectives and goals. They met

infrequently, they did not serve on any of the committees. They did not function in reviewing the projects other than to look at what was handed them when it finally came to the time of a Regional Advisory Committee meeting.

Surprisingly enough, some of them, I guess, had recognized this same weakness in themselves, and they had undertaken a task force analysis of the Regional Advisory Group roles, and they have indeed identified certain weaknesses and certain faults, but when we asked them what was to be done about this we got no really clear conception. It was sort of an apathetic "gee, I guess we really aren't doing what we should do, fellows. We know that," but hadn't really thought that maybe they should do something about the fact that they weren't doing what they really should be doing.

Well, this I think, in my opinion at least -- others may have a different view of Regional Medical Programs in Louisiana -- this is a major weakness. This is not a program in which people participate.

The Regional Advisory Group is sort of a window-dressing affair which may or may not be rubberstamp. I don't know whether that's even the appropriate term. They just don't participate. They must be made to participate. And we have some recommendations to make in our overview of the program with Dr. Sabatier when we finish.

Related to this is another program, and that is the relationship to the grantee organization. The grantee organization is a nonprofit corporation with a nine member board of trustees defined as needing to incorporate an economist, an engineer, and certain other people, so the flexibility that the Regional Advisory Group has in appointing members to this is very slight. It must include the past chairman of the Regional Advisory Group, the medical center officials, and a member of the State Medical Society.

In reality this group has full veto over anything the Regional Advisory Group does. Now they tell us that this has not occurred in the past, that they have not indeed ever vetoed any decision made by the Regional Advisory Group. But I fear in my own mind that the time has come that if the Regional Advisory Group does become active, does find a spark that gets it going, that there may be some conflict which comes about. There is the one trustee structure which likes status quo and don't rock the boat, and another one wants to start doing it, there may be areas of conflict that come about; and this relationship should be straightened out prior to that.

Many of the health interests in Louisiana are involved in programs. We don't see that any one of them has co-opted the Regional Advisory Group. No problems really in relating within the health structure at the present time.

This has improved, as I said, from the past.

The relationships between RMP and CHP, difficult to straighten out, largely because RMP has been doing what CHP would be expected to do, I think, and this is reflected in the attitude of people in the state. They have a blurred image of what RMP should be and what CHP should be. And a Dr. Acory, who was appointed -- and I have forgotten exactly how this came about -- but in any event he was appointed by somebody in authority to try and define what the respective roles of these two organizations is to be, and he confussed to us in open forum that he didn't really know. And I kind of got an idea that he wasn't terribly concerned that it be cleared up. I am not sure that he is the kind of person that should be conducting that study.

I mentioned local planning and that we felt that perhaps this was somewhat weak because it was going to be dependent upon CHP B agencies. We saw little involvement by actual citizens of the state. What we saw was not terribly heartening.

They did have one project which was called consumer health education programs, and we had others that had to do with helping people to get into the health care system, both apparently grass roots sort of project. But we weren't terribly stimulated by the individual who presented that to us, weren't sure that the concepts were entirely correct,

wondered whether this, too, was sort of a window dressing to prove that minority interests or disadvantaged people were actually getting represented.

As I mentioned, they have an excellent data base. I won't repeat that further.

Their management is adequate. Their evaluation is weak.

The action plan there really is not much of an action plan. They have said that they are going to improve certain things. They are going to improve health care for the disadvantaged, but look at what they are going to do. They are going to create a half a million dollar coronary care center in the New Orleans Charity Hospital. They are going to create a half a million dollar pulmonary pediatric center in the New Orleans Charity Hospital, and they are going to create -- I have forgotten -- a renal program within the Charity Hospital system. Now they say this will help health care because all of these guys are trained by the medical schools and the Charity Hospital, therefore they are going to go out to the charity hospitals in the rest of the state and automatically this will bring better care to the people of the state. Well, we know that this may or may not be true. These doctors trained in Louisiana don't necessary stay in Louisiana. If they do stay in Louisiana they will go in private practice in large part, and once they go into

private practice the relationship to the charity hospital system becomes quite weak. So it is highly tenuous sort of reasoning that they have used.

They have created priorities which I will read to you. The cardiac care unit is the number one priority. This incorporated the spending of several hundred thousand dollars for equipment. Something having to do with shared services, and this is a program which rural hospitals would define what they can do in concert better than they can do separately. A tumor registry is number three. And I have always had a bias, I never did quite clearly understand how tumor registries related to bringing better care to the rural and disadvantaged people.

A regional kidney program is four. Health date information center is five. Cardiopulmonary rescussitation unit is six. Stroke discharge planning, seven; pediatric pulmonary planning, eight; organ, number nine, and that has been phased out; and a health consumer education and citizens' advice bureau, the last two in their order.

They have been instrumental in developing some kinds of continuing education programs around the state for the nurses, the dial access program for physicians, and so on.

I think I shall not go into further detail about this. I think I have covered the points that I think are of concern to me, and I would rather turn to Dr. Parks at this

time before we get into telling you what our specific thoughts might be as to funding and other recommendations.

MR. PARKS: Well, due to the lateness of the hour and the completeness of that report, I can agree with most of it. There are a couple of things that I think I should probably highlight.

There was a lot that I didn't see in that room. I did walk the streets, I took the lunch hour and walked the streets to see something of the population, to see if I found any kind of representatiion in that population within the confines of the room in which we were conferring. I did not find it there, and I think that has been covered somewhat adequately.

I happened quite accidentally to ask the black receptionist that they had about opportunities for advancement, and she mentioned to me that she had just come on board the week before. So I assume from that that the word went out that there probably would be a black on the review thing and they ran out and got a lady.

This troubled me a little bit, but I leave that just as an example of the kind of thing that occurs here.

There was another black fellow, his name was Bonner. He was a parish agent for the Department of Agriculture. He was very glib, but largely impertinent in terms of the information that he gave us; impertinent not

in the insulting sense, but impertinent in terms of what he was addressing.

We talked with Mr. Roberts, who is the Assistant Director for Administration. He is a very able man. He mentioned some problems which were fiscal which were occasioned by late funding, and this was being unable to start programs and then getting money in the middle of their fiscal year. But I think there was some suggestions that would deal with that.

I did ask him about the question of whether the various programs and activities that they funded at the various medical schools and activities throughout the state; with respect to regionalization I think they probably had somewhere between five and seven outreach projects that were spread in different points in the state. But he did indicate to me beyond receiving a certificate of compliance they did no monitoring to make sure whether the programs were in fact reaching the people that they were designed to, whether there were fair hiring practices that were in fact operational, and various other things like this, which I thought was a weakness, perhaps not by intent, but by virtue of lack of direction in that area.

The RAG chairman I thought was a disaster. He was the director of the state health system, something like that. He was a state official. He was introduced as a--

DR. WHITE: He was a private practitioner.

VOICE: He sits on several boards that have jurisdiction over the state system. I think he sits on the state administration of hospitals.

MR. PARKS: This is somehow very closely tied into that operation; and to the ex officio appointees to both the RMP and the RAG, in the composition of those bylaws, there is an interlocking kind of directorate really which makes up the executive committee of both.

There were apparently problems of turf and rivalry between the medical schools, and, of course, the peculiar problems, the duality of the medical systems that they have there.

Now these were presented to me really as a reconcilable concomitance of the Louisiana situation, and that Dr. Sabatier, whom I think is a very skillful coordinator, and certainly I would assume a skillful politician seems to have made some passable accomodation with these competing forces to obtain some measure of recognition and some latitude for movement and development in this particular program.

I did detect, though, in the statement of these problems that they were almost incapable of resolution, and that they would be boulders behind which they would hide for not making certain kinds of changes that we were looking for in

terms of action oriented or delivery oriented kinds of activity.

The thing came through very directly to me that Louisiana has some very, very peculiar problems, and I did not detect that they had been not only recognized, but met, and now that they were in a position hopefully to move around them to achieve some other things.

I detected two others things. One, that the design, the planning design was sort of an operational device to get around some of the hostility, in addition to having been perhaps an invited error by prior site visitors. The other thing was as a result of that, the heavy emphasis of planning, it did present some imbalance in terms of staffing, and this was with respect to core.

There was a coordinator -- not a coordinator -- what's the name of--

VOICE: Project development officer.

MR. PARKS: Project development officer, who worked apparently by himself. And this was really the key man to their outreach and their developmental activity.

I would say that there are a number of positives, and think the fact perhaps that they have survived and done as well as they have is somewhat remarkable, if what I have been told is true.

But I would think, though, that they should be put on a basis where some of the recommendations will address

themselves to this. They can be watched and encouraged to make certain kinds of programmatic and organizational changes that would bring them more into line with the program statements and mission statements that have come from here.

DR. MAYER: Care for a recommendation?

DR. WHITE: Well, before I do that I would like to voice my feelings about the renal program in the state of Louisiana, in spite of separate or semi-separate or not separate funding, or whatever it might be.

In spite of the fact that the technology is apparently available for saving lives, in spite of the fact that some actions have been undertaken to correct what are viewed as shortcomings in this program, namely that it is going to be phased in gradually rather than all of a sudden, and that it relates appropriately to a center for transplantation, and so on, and that people now on another kidney project won't get paid twice by being on this project, too, and those sort of things, as I view the project it really does not serve the purpose of the Regional Medical Programs. It is going to be a system in the charity hospital system. There is nothing that I see in it which makes it a total system for the state.

The fact that we have some documents which indicate there is some disagreement as to whether or not there should

there should be one renal program for the charity and one renal program for the other people.

I think, therefore, that regardless of the funding mechanisms or the categorical nature or what have you, that if this renal program is to survive in the state of Louisiana that it should not be funded at this time, that it should go back through a review process and be looked at by the Regional Advisory Group, and this is a chance that they can either hang themselves or prove themselves as responsible citizens of the state.

With that as a preamble, I think the site visitors at the late hour that we met on the second day came up with a round figure of a million dollars. They had asked for a million eight, and they are currently functioning at about seven fifty. We felt that this was enough to help them strengthen their core. It might also be enough to entice them to do something other than to strengthen their core. And this might be a measure again of their maturity and ability to handle their own funds and establish their own priorities, and give us further evidence to base our judgments on in the future as to whether there should not necessarily be a triennial RMP, but one at all in the state of Louisiana.

There is a problem in reference to the coronary care units. This was previously approved by this body prior

to the time that there was any interdiction on the use of funds for equipment. They feel that it is perfectly legitimate under those circumstances for them to proceed with this. I don't know that we should give them direction along these lines. This again would be a measure of whether or not they are capable of managing their funds and programs appropriately.

So I think our recommendation is for a million dollars with a message, and that their fate is in the balance and will be determined by how they manage this million dollars.

DR. MAYER: Do you want to comment about the discussion we have now had times two about the two year funding?

DR. WHITE: I have no objections to that. That will be all right -- for myself. I don't know how Mr. Parks feels about that.

DR. MAYER: The question being do we make a commitment for a second year at some level so at least they are assured of that kind of two year continuity while they spend the year to try to get ready to put something back into the system.

MR. PARKS: Well, I have not really consulted with anyone about a second year type of funding. But I would say this, that from one of the discussions here I think it is very true that faced with the coordination or direction of

the program, especially charged, say, with a direct immediate responsibility of making certain kinds of programmatic changes, having the people aboard who will be necessary to make creditable changes is a very important part of it. And I would assume that the life expectancy of a program is a very great factor involved in determining whether a person will or will not remain in the program. And I think with some of the recommendations that we have here it might be appropriate for us to consider some figure.

I am not prepared at this time to make an estimate of what a figure should be for a second year. I would think, though, that some consideration ought to be given to it so that it would not appear that we are asking them to improve for one year and beyond that there is no light at the end of the tunnel.

DR. MAYER: Could you and Dr. White come up with a figure by tomorrow for us?

DR. WHITE: Well, I think at the time of the deliberation on the figures at the time of the site visit we were fairly much in agreement that a million dollars was an appropriate figure, and I would see no reason why this wouldn't also be appropriate for the second year.

DR. MAYER: Leonard.

DR. SCHERLIS: You knew I would have to comment. This is the only time I have had to say heart all day, and

itt's nice to mention that word in a categorical area. I do have a lot of concern about half a million dollars going into the coronary care training unit. I have concern about the way it is described as including remodeling of present heart station, expanding the cardiac catherization laboratory, remodeling the outpatient cardiac clinic, consultation, computer techniques, continuing coronary care, and also it mentions physicians and nurses.

One or two things strike me. One, either the mail is very slow between here and New Orleans, or else the visibility of the smoke signals isn't very good. But I would think that had this been submitted even three or four years ago that I would have had a great deal of reaction to it which was negative. I think that any place in the country could come up with this project regardless of how good their program is. If they have a real need for a coronary care unit that something in the neighorhood of 20 or 30 thousand dollars would be appropriate just to get the bare bedrock monitoring equipment in place, and that woule be generous. I am sure they have something going.

I think at this time to ask for a catherized adult cardiac clinic and to have particular EKG interpretation computer assistance is something that I would look at with a great deal of question. I would hope that there would be an indication that this will not be supported, but if they

come in with something for a continuing education program on heart disease I think this is more satisfactory, because this to me is out of line with not only the new directions, but the old priorities as far as the Regional Medical Program goes. If you can deduct that, which is a half million dollars, you still leave them with a good boost for what they have.

I don't think we should say to them we are going to look at how mature you are by whether or not you build that. I would first build it, and then after I build it say I have suddenly become mature and I am not going to do it again. I would not want them to be supported for that. And it appalls me in an area with the need of this particular state, Louisiana, that a million dollars of their request goes to support basically to support pediatric respiratory care unit and the rest to refurbish a heart station in a hospital which should be done through other sources, however tight they are in that state for support for health.

To end up with, if you are really raising that $250,000 over what they requested this year in spite of the failure to recognize priorities and goals, and so on, I think I share the confusion one might have with the dual mission that made you go down there, Dr. White. But I do have some concern -- perhaps you could react to it -- how do you feel about that half a million dollars? Don't you think

we should put a strict no on it, and say well, maybe a few dollars for training, and the increment of $250,000 over the present level of funding might be something they can work with if we are very strict about what the guidelines are.

DR. WHITE: Well, their present level is seven fifty, and we recommended a million. And I think the message we were trying to get to them, hopefully will get to them, the bulk of that should be used to strengthen their action planning functions, and the core staff and personnel required for that. If there is something left over it is obviously going to be insufficient for spending to the extent that they are planning for either the pulmonary or the coronary care unit. They could then perhaps use 25 or 30 thousand dollars to implement an educational program, but they would not have the resources required to begin to do what they are planning to do for the coronary care.

DR. SCHERLIS: I would hope we would go on record as saying these funds should not be used for that particular project. Now if they had come in with a system of coronary care for the state I would have urged strongly that it be supported because I think Dr. Burke and his group have men that could do this. What we are talking about essentially is going into a university hospital resource and totally remodeling all the cardiovascular facilities on a single shot

basis, and I don't think this is a proper way of using these funds. If they had asked a half million or million dollars [illegible] state and set up a total coronary care program [illegible] stratified system I would be all for it and I would urge this group go in that direction. That I think is a proper expenditure of RMP funds, but not to refurbish this sort of a unit.

DR. MAYER: Between the coronary care unit and the renal program and the pediatric pulmonary care center there is just a little bit over a million dollars that is involved in that, and I heard Dr. White, I thought, a couple of times comment about his concerns about those two programs as well as the coronary care program.

Are we implying that we feel that those three issues are inappropriate directions to be taken?

DR. WHITE: I think they are inappropriate, and particularly inappropriate until such time as the Regional Advisory Group can come back and justify their appropriateness, which they haven't done at this time.

DR. MAYER: Would we like to put a limit then that no expenditures in those three areas would exceed, let's say, $25,000 each?

DR. WHITE: It's acceptable to me. I indicated in advance that I would bend with the wind, and I so bend.

VOICE: I would like clarification. The three

areas were pediatric pulmonary, coronary care, and what was the third?

DR. MAYER: The renal program.

Yes, Dr. Hinman.

DR. HINMAN: I would like clarification on the renal, what you were saying, Dr. White. Is that the RMPS, if they could meld the two systems that have developed independently into one that you feel it would be appropriate to consider the request before their next anniversary, or would they have to put it off a year? The reason I bring this up is part of the charity system has been supported by some contracts from the kidney disease control program which expire in the next several months, and this would be a year before we could even entertain further applications from them, it would put them somewhere between nine and twelve months without any income to support their kidney activities.

DR. WHITE: Can they get a new contract?

DR. HINMAN: Well, that's another option that they could go. We would prefer -- the RMPS position would be to try to work it into the grant mechanism rather than the contract mechanism. That's why I brought the question up.

If the answer is that you think it should wait for another year for anniversary then we would have to go the contract route to try to salvage some pieces of it if it

seems worth salvaging.

DR. WHITE: Well, Dr. Hinman, the evidence I have is that the Regional Advisory Group was advised by Dr. Sabatier that there were problems in this project and they chose not to regard the comments that he made, which I think is a reflection of their activity and interest. I think it's critical that this be re-awakened.

Secondly, we have letters indicating that there is disagreement between scientists as to the appropriate way of conducting this program. Therefore I think that it requires a strong local review before it can be implemented.

DR. HINMAN: Fine.

DR. MAYER: All right, do we have a clear understanding of the motion?

What we are saying is recommending support of a million dollars for two years consecutively, one million each, with the clear indication that those dollars should not be programmed into such unit development as represented by those three units, and that the maximum amount of that million dollars that might go into each of them might be $25,000 each.

MR. TOOMEY: I will second it.

DR. MAYER: All right, any further discussion?

All those in favor say "aye."

(Chorus of "ayes.")

Opposed?

(No response.)

Let us plan then on 8:30 in the morning. We will be in executive session at 8:30 in the morning I would assume probably for about an hour for staff -- this is an approximation.

We will in the morning then start in with Western New York. We may have to slip to Metropolitan D. C. before Florida because with Dr. Lewis's absence Dr. Carpenter will be in tomorrow, but he won't be in until about 10:30 or so on the Florida activity. Otherwise our intent would be to go through them sequentially with that one exception.

(Whereupon, at 6:00 p.m., the meeting recessed, to reconvene at 8:30 a.m. the following day.)