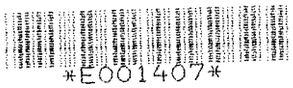
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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

PUBLIC HEALTH SERVICE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS

- - -

Review Committee

- - -

Conference Room GH
Parklawn Building
Rockville, Maryland
Thursday, May 4, 1972

The meeting convened at 8:45 o'clock a.m., Dr. William Mayer presiding.

Council Members Present:

Dr. Gladys Ancrum
Miss Dorothy Anderson
Sister Ann Josephine
Dr. Gerald Besson
Dr. G. V. Brindley
Dr. Effie O. Ellis
Dr. Joseph Hess
Mr. William Hilton
Dr. John Kralewski
Dr. William Mayer
Mr. Jeanus Parks
Dr. Leonard Scherlis
Dr. Alexander M. Schmidt
Dr. Mitchell Spellman
Dr. William Thurman
Dr. Philip White

TRANSCRIPT

REVIEW COMMITTEE MEETING
May 4-5, 1972
Volume II

Mr. Nash

CONTENTS

P R O C E E D I N G S

DR. MAYER: I think we might begin. As some of you are aware, there are four of us who will not be with you at the next meeting. And I note that all four of us are rigorously in attendance and on time. And as a consequence of that, I thought we might commence and pick up the others as we go along.

Hopefully, because of the changes that are here and that we have laboriously worked at and staff has laboriously worked at, maybe we might be able to get through without working all night tonight and without starting at 7 or so in the morning but at a reasonable time.

A great deal has happened since the last meeting of this committee. Harold kindly did send us an interim report and try to keep us up to date on it. I would have to say that my grapevine suggests that even since that interim report, a heck of a lot has happened. And I thought I understood what a rapid rate of change was, Harold, but I must admit that I am developing a new perspective on how rapid that change is and the degree of that slope.

With that, let me turn it over to Harold Margulies for comments.

Harold.

DR. MARGULIES: Thank you very much.

The title of this presentation is "Present Shock."

There are a number of things I would like to go over with you, but before I do and at the risk of saying the obvious, I would like to comment on the fact that the end of the period of activity of the four people who have been serving on the review committee is a point of real concern for all of us. I was just talking to Bill who confessed to something like six years and six months with the Regional Medical Program which should represent some kind of a badge of honor, purple heart, or something of that kind or purple heart for each year, but it is going to make a big change. And it is going to be a notable loss when we see these very, very effective people leave the committee.

And it does not mean, of course, that we won't anticipate being able to call on them regularly as we have with others who have served on both committee and Council. And we don't expect to let them leave the program that effectively.

I would like to bring you up to date on a series of events which are not necessarily related, but all of which have a heavy impact on our activities and on the Regional Medical Programs.

First, let's start with the current legislative interest which suddenly built into a point of great concern and people realized that the Regional Medical Program legislation along with just about every major legislative

program, legislative act, which supports programs in Health Services and Mental Health Administration was up for extension during the coming fiscal year. I think there are at least 14 major health legislative acts which have to be renewed by June 30 of 1973. RMP is one of them.

I don't believe that the Administration has established a clear position on the whole range of them, but it has made it clear in the first response to Senator Kennedy's bill that it hoped to address the legislation this time in a much more inter-related fashion rather than having a separate extension of Acts which have come to have a relationship with one another, but were created at a different point in time without that relationship clearly spelled out.

What did happen is that when Senator Kennedy introduced his bill on Health Maintenance Organizations, he added to it for purposes of opening the discussion the extension of several of the legislative Acts. And Title IX for Regional Medical Programs was one of them.

I believe that hearings are already underway and will continue. I don't know the format in which they will be carried out. There have been discussions inside HEW simply leading up to what the legislative form of the RMP should be. The coordinators independently have suggested certain legislati bases for Regional Medical Programs so that this will have a very clear-cut influence on what we do in the future.

The issues are all those which you have discussed here in the review committee. They raise the questions of how RMP relateds to comprehensive health planning. They raise the question of the relationship of the National Medical Programs to educational activities, to the implementation of planning, to the categorical devices which have been a part of RMP since its beginning, and to a number of other organizational issues which will probably carry the debate until well after the election. I would be surprised if there is any final action on our legislation until sometime after the next Congress meets. But, of course, it is conceivable it could be done in the present Congress. It is conceivable, but very doubtful.

I also don't know how much the House and Senate committees are going to call on other people to provide testimony. And it is perfectly possible that if they have not already, they may ask members of this committee to testify regarding their recommendation on Regional Medical Programs.

While all that is going on, of course, there are appropriation acts. We have had hearings before both the House and the Senate Appropriations Subcommittees. They have made every effort this year to complete the appropriations actions prior to June. I don't know where the Senate stands at this point, but the House has completed its actions. What now is necessary is for the two chambers separately to

reach an agreement on what they believe the appropriations should be to get those through the House and the Senate, then to reconcile any differences.

The request on the part of the Administration for RMP was, as I think we have already indicated at the last meeting, one which would allow the Regional Medical Programs to maintain their present level of grant support which is in the general range of about $98 million. They indicated during the testimony before both chambers that there would be no special funds set aside in the coming fiscal year for health maintenance organizations out of the RMP budget and made it quite plain that the funds used this year for HMOs were all that they had expected to use out of the RMP appropriations.

They also indicated that the construction funds which we will talk about in a moment for a cancer facility were one-time funds in the Regional Medical Programs. And there would be no further request for construction funds. They prefer to keep those under other kinds of administrative authorities, especially Hill-Burton. And I would assume some under the new cancer authority and possibly some under the educational institution support programs in the NIH.

There was an indication also by the Administration that they wanted to raise the level of support for emergency medical services from the current $8 million to $15 million in

the next fiscal year and that this would be all that would be requested for special demonstration purposes which I will refer to again in a moment.

There was no real discussion of the Area Health Education Center concept during the appropriations deliberations but we will talk about that in a moment also. So that I would anticipate some final action on our appropriation level in the relatively near future which means one would guess by midsummer which is far better than we had been doing during the past several years.

Now, there is a word of warning on that. Although the appropriations action was completed last year by August, there was no final disbursement of funds until well into the -- well, it wasn't until after the beginning of the next fiscal year. So completing appropriations action in Congress is not enough to assure us that we will know our actual level of funding. And as you will be hearing, this has produced some specific problems for us during the present fiscal year.

Now, I have got several other items, but if there are some questions about that, perhaps I should stop. That is really fairly mechanical up to this point.

DR. MAYER: Harold, would you translate the appropriations into dollars for RMP grants?

DR. MARGULIES: What has happened this year is that with the final resolution of carryover and so forth, we ended

up at about $98.3 million for RMP grant support. And that is what we anticipate for the next fiscal year.

DR. MAYER: Other questions?

DR. SPELLMAN: You said the emergency medical services grant funds are being increased to $10 million?

DR. MARGULIES: The emergency medical funds are going to be increased from the $8 million of this year to $15 million next year, but that gets a little bit more uncertain because during the discussions of budgetary process, since that money is being utilized not as an RMP activity, but rather as a HSMHA-wide activity in the current fiscal year and probably will be next fiscal year, it will very likely drop out of our budget and become a separate item. So it will not be carried as a part of the RMP budget, but this will not affect the basic level of grant support for RMPs which will remain at least constant. This is on the assumption that the Administration recommendations are the same as Congress'. In the past, they have not been. Congress has regularly increased the level.

DR. BESSON: To what extent does that apply to the current $8 million, that same suggestion that you just raised about the $15 million being HSMHA funds for emergency medical services.

DR. MARGULIES: I will get to that in a moment. But the question that is raised is how the current $8 million for emergency medical services is being handled. And that is

being managed as a HSMHA-wide emergency medical service activity with contracts out of the Office of the Administrator. It is not being managed by the Regional Medical Program.

DR. BESSON: Is RMPS then not allocating money separately for EMS activity?

DR. MARGULIES: I have that on my agenda to discuss. This is as good a time as any if there are no other questions about that.

All right, let's talk about the emergency medical systems activities.

When the President indicated in the state of the Union message and subsequently that he wanted to raise the level of investment in emergency medical systems, there was at the same time a decision made to do this in basically two ways in HSMHA.

One of them was to develop some major emergency medical systems demonstration activities with the emphasis on it being a total system and to do this in such a manner that the various emergency activities which are fairly widespread in HSMHA could be well coordinated at one point.

There is, for example, in NIMH suicide prevention and crises intervention emergency activities, maternal and child health services, general pediatric and poison control centers. There is a Division of Emergency Medical Services in HSMHA, etc., a whole range of emergency activities. In order to bring

the full effectiveness of these together and to produce some major demonstrations, what was established was a central coordinating group which includes Regional Medical Programs. And I sit on the general group and on the small executive body which decides the basic management and contract processes for these activities.

The determination, then, was that there should be in this fiscal year five major demonstration activities which would be funded by contract. And these contracts were invited in a request for a proposal which went out sometime ago which had an initial deadline of April 15, then extended to April 21. So that all of the proposals are now in and are under review. That is a discrete separate activity.

I would assume that next fiscal year, if there is another $15 million added to the funds available that it would be carried out in essentially this fashion, but would allow us to also at the same time establish a centralized data gathering and evaluation activity which the initial investment is probably only going to get started rather than fully develop.

At the same time, it was felt that all of the existing emergency activities in RMP and in the other programs should be continued, but in such a way that they were consistent with and whenever convenient supplementary to the major contract demonstration programs so that we did in RMP, to make sure

that these demonstrations did not simply be demonstrations with no effect, which is too often the case, initiate and encourage the development of emergency medical activities to the RMPs as a separate grant activity eligible for supplementary grant award. And we have done that. And so the Regional Medical Programs have received and are responding to a description of a well-coordinated total emergency medical service to be supported by grants which is complementary to the contract activity. And in fact, we exchange day to day data between what we are doing in grants and what we are doing in contracts with the hope that when the whole thing has been completed, we will have a total body of knowledge and of action which is effective in order to carry out that emergency medical activity. As I think you know, we have set up a separate special review body which is going to look at the responses to our invitation to submit supplementary grant requests.

DR. MAYER: This is within RMP?

DR. MARGULIES: This is within RMP.

DR. MAYER: And separate from the contract?

DR. MARGULIES: Quite distinct and separate from the contract. The contract activity is another issue entirely.

In order to give enough time to the RMPs to respond and to develop something which is meaningful, we have given them a fairly tight, but reasonably broad period of time

in which to work. The grant requests, applications, are at the present time all in. They reach a fairly formidable level, and they will have to be reviewed on May 15.

What we have done, in order to set up an effective review mechanism for a kind of special action, was to ask Dr. Besson, Dr. Toomey, Dr. Scherlis, who will act as chairman from the review committee, Dr. MdPhedran and Dr. Roth from the Council to act together for these two bodies and for the RMPS in making a review of the Emergency Medical Systems grants requests. When that occurs, we will give them full information regarding the status of the contract proposals so there is no confusion between the two. And we will try to keep them as discrete as possible.

We would anticipate that the Emergency Medical Systems activities would continue beyond this year. We have not set aside a specific sum for that purpose, and I will get into the funding aspects a little bit later. But you might want to ask further questions about the Emergency Medical Systems.

DR. SPELLMAN: When you say that the grant awards will complement --

DR. MAYER: Mitch, could you use the speaker?

DR. SPELLMAN: My question is in making one of the qualifications of grant awards for Emergency Medical Services projects funded by RMPS, does this mean then that the grant

awards are in effect supplements of contracts, or does the complementary process occur in a way in which the contract and grant awards are two different things, different institutions or entities?

DR. MARGULIES: It is complementary in a conceptual sense. What we are saying is we don't want to develop contract activity which would represent a total approach to a system and have some grant awards which have a piece of equipment here and training program there. We want both of them to represent an effective approach to organizing a total emergency system. But with the RMP activities, I think we have some laterality which may not be true of the contracts because we are dealing with a Regional Medical Program in that case.

Being very specific, if a contract is awarded, contract this time is awarded, for an Emergency Medical System to a unit of government in a community, it will be with the understanding that this is a very time-limited and emergency-related activity. It has to do with the moment at which an emergency is identified until the point of resolution of what you do with that emergency in the emergency room or whatever. And beyond that, the contract activity doesn't apply.

It doesn't, for example, go to in-hospital emergencies, to referral activities. It has to be that discrete.

We will be interested in the Regional Medical Programs in this being more than an EMS carryout effectively, but in addition to that being something which has an influence on the rest of what that RMP does and on the rest of the system which is around it such as the other ambulatory care, the referral services. And, of course, with our special interests in heart disease and in stroke, we would be particularly sensitive to how effectively they include competenc to deal with acute infections, acute strokes and so on.

DR. MAYER: Two questions, Harold. One is you are talking next year in terms of that move from $8 to $15 million of the operation being there to start to develop centralized information. Is it the intent to expand on those original five contracts, to extend it to more or to expand on those original five? What is the intent in terms of next year?

DR. MARGULIES: It is to expand it to more new contracts, I am quite sure, because I believe what we will do -- and this depends in part on the demand -- I just looked at some of the contract reports, submissions, yesterday -- is contract in such a way that we obligate funds which will carry them over the full period of the three-year contract so that they will be full funded contracts and the ones which we would be looking at in the next round, therefore, would be new contracts.

DR. MAYER: Jerry.

DR. BESSON: Maybe I can ask my question in a different way. How much money would you anticipate would be allowed for the five contracts?

DR. MARGULIES: The five contracts will for the most part consume the $8 million.

DR. BESSON: Then, the moneys pertinent for RMPS-EMS are outside of anything in --

DR. MARGULIES: Yes, they are separate.

DR. BESSON: And the only reason they are not being considered by this committee is because of the lateness of submission of the grant proposals.

DR. MARGULIES: We have the same problem with those and with the community education activities which I can get to in a moment also.

DR. BESSON: You previously have spoken of RMPS money as maybe not being allocated, but somewhat sequestered for kidney activities or other activities. Is there any thought in RMPS about how much of the --

DR. MAYER: Can you hear him in the back?

They can't hear you, Jerry.

DR. BESSON: Is there any thought in RMPS as to how much money would be allotted from RMPS funds for other activities?

DR. MARGULIES: There is some thought about it, and I will get back to that, Jerry, but it is wrapped up in several

things in our final funding level and the change in our review cycle which is not too complex, but it is interlaced. And I would rather go over it all at one time. I think it would be clearer.

DR. BESSON: Well, perhaps I can indicate why I am asking the question. In describing the five contracts which are going to be let for what you refer to as broad systems for Emergency Medical Services contracts, the way RMPS would approach it, the implication is that we are interested in finding out on a demonstration basis how to organize geographic areas for the provision of a total system. But RMPS has served a somewhat different function historically in relating to the various health institutions in a community. And I am wondering whether it might not be a more appropriate stance for RMPS's interest in EMS, rather than fund demonstration programs to fund what I might call seedlings and spread its moneys as wide as possible rather than concentrating them on single large, grandiose activities.

This is peripheral to the review committee's activities, but since I have been immersed in the 60 pounds of reading material I received the other day, I have become very much aware of RMPS's emerging role in EMS. And I wondered whether it might not be appropriate that we give consideration to being very lenient in funding some of these 35 proposals that are being received from the point of view of encouraging

the development of EMS thinking and development of EMS activities without necessarily following the straight criteria that we have laid out in the past for grant requests, hewing very closely to a certain set of criteria and either being very meritorious and therefore having priority or being somewhat lower merit and therefore being passed over.

I am just wondering as to how we can most effectively spend whatever dollars RMPS considers they are going to allot to this aspect of their new activity.

DR. MAYER: Harold, would you care to comment on that?

DR. MARGULIES: Well, I don't think you need feel bound by the size, the scale, the specific requirements of the contract activities, Jerry. We would anticipate there would be a fair range of potentialities in the grant requests. And what we are really talking about is the avoidance of funds expended for unifocal interests like training 16 ambulance drivers when there isn't anything for them to drive or heavy investments in radio equipment when there isn't anybody at the other end. That is really what I am talking about.

I think in looking at requests for grant awards in the RMP, one merely needs to make sure there is quality or potential for quality. And it doesn't have the same kind of rigidity that the demonstration does. But at the same time, we are hoping it represents a method of pulling the system together rather than dealing with only one segment of it. And

that is really the only issue.

DR. MAYER: Additional comments on EMS?

(No response.)

What would be the intent next year in terms of RMP activity in EMS?

DR. MARGULIES: I think this is going to depend pretty much on the total influence of the current round. And there are really three things involved.

One is our general appropriation level.

The second is the final decision on what will be done with the additional emergency medical activities in the $15 million zone.

And the third will be some judgment about how ready we are to do more emergency activities.

I told you I thought the $15 million would go in that direction, Bill, but it really hasn't been formalized yet. It is perfectly pssible the role of RMP in the EMS activity will be redefined either by legislation or by something else during the coming year. But assuming everything I have said is true, I would anticipate we would continue to show a high level of interest in the support of Emergency Medical System activities in the next fiscal year as well.

DR. MAYER: Under RMP?

DR.MARGULIES: Yes.

DR. MAYER: Under separate kind of review effort?

DR. MARGULIES: No, we wouldn't do it separately because this was a matter of duress. At that point, we could enfold it into the regular review system.

DR. MAYER: I think that is an important concept for this committee because it is the bits and pieces issue. Slowly but surely you dissect everything off.

DR. MARGULIES: Well, let me deal with that issue now.

DR. MAYER: Before you do, let me make a comment as someone who is absolutely and irrevocably addicted to nicotine that as all of you are aware, the Secretary of this superb organization known as HEW has indicated a mandate which has come on down through this. I think everyone is on their own in relationship to whether they feel the lightning bolt coming down from downtown or not in regard to that issue.

I say that in preface to I have already made by decision. I want to leave tomorrow, not today.

DR. MARGULIES: That statement is part of the confidentiality of the meeting.

I think it might be easier for us to deal with the budgetary issues because they keep coming up rather than with such things as the area health education center concept. What has happened in this fiscal year has been the appearance of a funding pattern which might have embarrassed us badly, having us reach the end of the fiscal year with more money than we had anticipated and no way to spend it or the appearance of that

amount of money with us very well ready to spend it as we are or no additional money whatsoever which might yet occur.

Now, in that range of possibilities here is about what happened: We did not get a clear statement about our total funds for this current fiscal year until after the end of January. Even when we had received that information, there was uncertainty about the funds which would be spent for Health Maintenance Organizations, some $16.2 million, and the funds which were set aside for Area Health Education Centers, some $7.5 million.

Furthermore, the $8 million which had been identified for Emergency Medical Services Systems had not yet been set aside as they are now as I described to you for contract activities. And so we had this range of uncertainties.

There was from the preceding fiscal year, you may recall, approximately $44.5 million which was not released in that fiscal year which we had been promised would be released in this fiscal year. It was released, but only in part. So we got to about March knowing that there were several possibilities which gave us a range of difference in the month of JUne which is turning out to be true of about $22.5 million uncertainty.

Well, with $22.5 million uncertainty and the desire to be able to use it effectively, you have to develop some footwork. And so we developed some footwork. This

included the decision to support Emergency Medical Systems, decided on rather late when it became clear how the other EMS activities would be, that we would decide educational activities which were like, but not the same as, an Area Health Education Center which had to be decided late for other reasons which I will get back to, and we would at the same time to cover our potentialities decide now to change the review cycle from 4 to 3 a year. That became the pivotal point in the whole budgetary romance because what we had to do was to make a decision to go from 4 to 3 a year, thereby change fiscal years, and thereby give us the opportunity to use funds either in fiscal '72 or '73 according to what we had available and in the process of doing that anticipate the level of commitment for fiscal '73 and '74 so we didn't over-extend ourselves.

Added to that was the uncertainty of whether the HMO funds would actually be totally used. And as time goes on, it appears to me personally more and more likely that they will not be totally used. So this adds some more potential funds to the program.

While all this was going on, the $7.5 million which had been set aside for Area Health Education Centers was kept back and remains back. So we still have the uncertainty of whether we will have available $7.5 million for educational activities, whether some of the HMO money will be returned to us

and whether we will have funds available at varying levels, depending upon the grant requests from the Regional Medical Programs in fiscal '72.

What we decided on is a rather simple maneuver to give ourselves maximum flexibility. And the way it is going to work out, we will be able to expend all our funds no matter what the decisions are. We extended the fiscal years of each of the programs in this review cycle, but we did not give them grant awards to cover the whole period of time. So if an RMP went from 12 months to 16 months, the grant award was for 12 months. And what we told them was, "Show us what your rquirements are for the full 16 months. And if you require X level, you can be assured of getting that if that is an appropriate level. But we can decide with you whether you need it this fiscal year or next fiscal year." That meant that in the majority of the program --

DR. MAYER: In terms of release, Harold.

DR. MARGULIES: In terms of release, yes.

It covers the same period of time, but this meant that up to June 30, we had a liability just in grant award for basic RMPs of something in the range of $8 million which could go in one fiscal year or the other and produce the same result. This is the only year we will ever be able to do that, but it is also the year in which the uncertainties appear to be maximal.

That last statement, don't believe that for a moment, but the flexibility is maximal.

(Laughter.)

So we are really trying to play these varying kinds of games.

If you say in the middle of that, "Exactly how much is it you are going to have for EMS and how much for educational activities," I can just add to the fringe of interest by telling you about what we are thinking about. We hope that we can talk in the educational activities in the general range of about $3 million. And in the EMS, we have had a greater level of uncertainty because it has been awfully hard to predict what might actually come in. But I would not be surprised to see us working in the same general range for the Emergency Medical Systems.

Now, this depends on an action which may be taking place today, I am not sure. Part of it does. And that is that we have gone through, and I will have to complete this, Bill -- I am sorry that this gets complex, but, damn it, all of it is complex. It has been like that. We have gone through an interesting tango -- you can't tango with four partners -- we have gone through an interesting square dance on the Area Health Education Center activity trying to decide who does what. And it has at least reached a point of some definition. And that is that in the opinion of the Office of Management and

budget and of the Office of the Secretary, something called an Area Health Education Center is related to the Carnegie Commission model which is essentially an activity conducted primarily under the auspices of a university health science center with the Area Health Education Center a satellite thereof. And this with some embellishments is the concept.

The essential ingredient is the extension of the energies and interests of the university health science center. That is not exactly what the Carnegie Commission report said. It has become the general concept in the JAMA and the article by Margaret Gordon and in the Office of the Secretary. OMB and I believe the Office of the Secretary feel that that is fit for NIH Bureau of Education and Manpower Training to do, not for HSMHA RMP.

There was in the middle of this discussion of Area Health Education circulated in among other places what is known as the blue sheet a statement which said that General Counsel opinion deleted RMP from educational activities. That was in error. There had been at that time no General Counsel opinion submitted to anybody. There had been some grants which were incomplete and which we asked them to complete at a later date.

The General Counsel opinion on educational activities for RMP is quite clear-cut. It says that under 910(c), we can indeed conduct educational activities which need not be

confined to the categories which are concerned with improving the utilization of manpower, expanding their capacity, but they added the comment that they felt clear that RMP should not be involved through 910(c) in the support of training activities which essentially changed the unskilled into skilled.

And to be definite about it, they said such as training a high school graduate to be an RN, paying for that or paying for the stipends or faculty for medical students and so on, and that we were concerned with the community activity which linked education to service. And they are quite comfortable with that differentiation.

Since that is basically the policy under which RMP has been operating for some time and causes us no concern --

DR. MAYER: Since the beginning, Harold. CC and I wrote those exact same guidelines five years ago.

DR. MARGULIES: This is buttressed, then, by the General Counsel opinion, so we have no problems over it. So what we had done without any of these decisions having been made and without any General Counsel opinion is to run the risk of circulating to the Regional Medical Programs the description of a program community based education activity to which we invited their attention and for which we are going to provide supplementary grant awards. This is parallel to the Emergency Medical System activity.

We could not put this out with any term that said

"Area Health Education Center." We were not even sure at that point anyone would allow us to do it because this fall's draft opinion was floating around. But anyway, we did it. And this meant we had to wait until the last minute, hoping to get some clarification. We got no clarification so we went ahead and circulated throughout the country a description of what we meant by some kind of a community-based educational and service consortium. This has led to a careful review by the RMPs.

We do now have in hand a number of submissions for grant awards. They will be reviewed on May 20 to 21 because some of them are still coming in from both Emergencies and Area Health Education Centers. And the ones involved in that review process which will be carried out at the same time as the Allied Health Conference from the review committee will be Hilton, Anderson, Kerr, and Hess, with Perry as chairman, and from the Council Tony Komaroff and Bob Ogden. And we have asked Al Popma formerly on the Council, former RMP coordinator, to join the group so that we will be taking a review action en bloc on these educational activities at that time.

There was justno mechanism by which we could conduct this under an orderly review process. And as one more feature to it, it is likely -- Well, let me stop at this point because the additional feature gets complicated. The rest of it has been easy.

Leonard.

DR. SCHERLIS: Have you distributed to the members of this committee the same information you sent out to the various regions as far as their coming in for EMS or these educational centers?

DR. MARGULIES: Yes.

DR. SCHERLIS: We had that?

DR. MAYER: No.

DR. MARGULIES: Didn't this go to review committee? I am sorry, it should have gone to review committee. I thought it went to review committee and Council. That was an error on our part, then.

DR. SCHERLIS: Perhaps we can have those.

DR. MARGULIES: We can get them to you today.

DR. SCHERLIS: Fine.

DR. MARGULIES: Let me add one more feature to it which gives you an idea of some of the special procedures we have to carry out regarding these two categories of interest, the Area Education Service one and the EMS. If we get funds released yet this fiscal year, and I think it is likely, which the Office of Management and Budget does not intend to have in continuing appropriations, we will have to provide evidence that that money can be spent to support activities in RMP without raising the level of commitment to individual programs.

Now, that can be done. It can be done if we handle

for one choice the EMS activity as a discrete activity in a program. If the program comes in and says, "We have a well knit Emergency Medical System activitity, it will take three years to complete, it will cost X amount of money," we can award a grant based upon their total needs for three years and reach an agreement for them to carry that as a separate item in their budget. At the end of those three years, that activity will have been completed and will not be part of their basic commitment.

I think that the Office of Management and Budget will accept that procedure.

DR. MAYER: With the commitment, however, for the three years coming out of -- let us assume $3 million -- that original $3 million.

DR. MARGULIES: That's right. It is essentially forward funding for the line item in their own budget.

DR. MAYER: In other words, the commitment that would be made, let us say.

DR. MARGULIES: We would release all the funds now.

DR. MAYER: There would be only a million dollars of annualized commitment that would be made at this time, is that what you are saying?

DR. MARGULIES: Yes, we would release the $3 million, but at the end of that period.

DR. MAYER: It would be spread over three years.

DR. MARGULIES: It would be spread out over three years. If they were smart, they would probably handle it through some kind of a contract to keep it separate. At the end of the three years, their commitment level would be whatever it had reached at that time exclusive of that $3 million which then disappeared.

DR. SPELLMAN: You would make the three-year award at one time, one sum?

DR. MARGULIES: To get the funds obligated.

DR. SPELLMAN: OMB will commit them?

DR. MARGULIES: We don't know yet. That is our plan.

DR. SPELLMAN: It is extraordinary.

DR. MARGULIES: It is not so extraordinary.

DR. MAYER: They have been doing that in construction for years.

DR. MARGULIES: The reason they have to do that is because they are committed to releasing all funds. It is their -- their being downtown, whoever is downtown, it is always they, all those people downtown with responsibility -- so the fund was not released, and they have to devise a method of releasing it and making it effective. I think they had assumed we would not be in a position to respond as effectively as we can. And we can do it because we will have reviewed and approved and identified actions on that kind of a base because I guess it was staff wisdom 8 months ago this is exactly

what would happen now.

DR. MAYER: O.K., other questions.

(No response.)

That was the easy part. Have you got the hard part, Harold?

DR. MARGULIES: Let me just run over two or three other things quite quickly because they might take some further time. We can come back to them because this gets to be quite a long unifocal dialogue.

DR. MAYER: We are listening.

DR. MARGULIES: The Cancer Center proposal which was reviewed by Council last time represents for your recollection the investment based upon Congressional action of $5 million for a cancer construction center in the Northeast part of the United States. That was reviewed, and there has been favorable action with certain requirements attached to it by the Council for a cancer center in Seattle called the Fred Hutchinson Cancer Research Center.

There were specific requirements by the Council and some that we imposed which had to do with such regulations as are in the legislation, in State regulation, certificate of need and so on. They appear to be moving quite well to complete their requirements.

We said that we would release the funds only when all of these requirements were met. So that the award was made

by Council, but we will not make the award a formal award until all of these requirements are met. And Council will have an opportunity to look at it again at least informally to see if it satisfies their needs.

Probably the key issue for some members of the Council was the plan to have patient beds in the research center which is connected with Swedish Hospital by a tunnel, but which is not a part of the building itself. And some members of the Council felt very strongly that this might produce a good research environment, but they worried about the adequacy of regular, around-the-clock medical care in that circumstance.

DR. MAYER: It is going to be physically linked to Swedish, is that it?

DR. MARGULIES: Yes. And they have responded showing us ways in which they are going to give assurance of good medical care. And it is going to be up to the Council to judge whether that assurance is adequate.

DR. SPELLMAN: Those would be the only beds, I take it.

DR. MARGULIES: For research purposes, yes.

I don't really know how much to get into this next issue because we could spend a lot of time speculating on it. I would be glad to speculate with you, and it is an election year, and that is the popular thing to do, but this has to do

with the meaning of the emergence of the new cancer authority and of the new heart disease push in the form of two major forms of legislation. You may recall that there was new cancer authority passed to produce a special center for cancer research and control. And there is a parallel bill for management of heart disease.

This, of course, raises the question immediately of what relationship either of these activities may have to the Regional Medical Programs which are identified with the same diseases.

It also raises the question of whether there will be a continuation of this kind of special interest and special disease categories, perhaps rejuvenation of interest in neurological diseases or some of the others. I don't know about that.

What has happened, however, has been a desire certainl in the cancer bill to produce a consistent pathway from the cancer laboratory research area to the delivery of good care tothe public with prevention, diagnosis, treatment, rehabilitation.

This could be done by establishing or re-establishing the control programs which were carried under the Division of Chronic Diseases in the past. It could be done by other mechanisms. It could be done by the National Cancer Institute managing the whole thing from the research end to the delivery

end. Or it could be done by arrangements which they work out with programs like the Regional Medical Programs.

There has not been a decision made at present about what our actual working relationship will be either with the National Cancer Institute or the National Heart and Lung Institute. Tomorrow I am to go over and talk with a group of people in the National Heart and Lung Institute about heart and stroke activities which we might be able to carry out in common. But I think the negotiations are taking place currently between the Office of the Administrator and with Bob Marston at NIH to decide how best we can work this out.

What I hope for is a union of the special cancer interests and special heart and lung interests which represent NIH's major interest and constituency with those in the Regional Medical Programs. And what many of us hope for would be if there is a re-emergence of the control program that this be designed in such a way that it improves the delivery system rather than operating in isolated segments thereof.

But we will probably have a clearer answer to that at some time in the future.

In the meantime, interestingly enough, just to add to the confusion of the picture, when Senator Kennedy extended our legislation, he dropped the categorical designation out entirely and put his total emphasis on education, manpower, and the improvement of delivery of health services. So we are

in a continuing period of time of struggle between these issues which, if you had thought would disappear with anticipati events is not likely to occur in the next few years. I do not know what final arrangements will be carried out.

In the meantime, it has caused us to look again more sharply at how much of our activities are dealing with heart disease, cancer, stroke, and kidney disease. And they still remain a preponderant part of Regional Medical Programs.

What we have difficulty with, and it is distressing that we do, is the idea thatyou can by improving -- well, we talked about it earlier -- total emergency medical services make a contribution to the control of heart disease. That never emerges from the kind of data which are put together. If you are talking about a categorical disease activity in the way most of the people looking at it at the budget end like to look at it, it has to be exclusively for a specific disease within that category. If not, they can't recognize it. If you improve basic primary care services in a rural area, the assumption is, I guess, that somehow you do that and exclude heart disease, cancer, stroke, and kidney disease and related diseases when in fact that is an absurdity.

If you try to tote up what you ae doing in some kind of dollar terms to improve management of these diseases, it is very difficult to do. And we are in that kind of a dialogue. I have no answers for you.

DR. MAYER: O.K. Other comments, Harold?

DR. MARGULIES: One other, and some of these others will come up again.

We have issued the new kidney guidelines very recently, and they are available to you. And I think rather than go into detail at the present time, since we have been over quite abit of ground already this morning, that we will bring up the details of that at a point where you are actually going to deal with the subject. Or we can do it now if you prefer, Bill. It is up to you.

I have a more significant issue to deal with, though, for the time being. And that is the nonpayment of consultants. All I can do is read you the note.

What happened was that the central payroll converted to a new system. An old consultant timekeeper number was used which resulted in many consultant checks not being written. Research has been conducted to double check on the consultants not paid and to clear up other errors. Hopefully, all work will be completed and checks written for the May 23, 1972, pay day.

In other words, we operate our pay system when we change from an old system to a new system just as others do -- ineffectively. So that those who have not been paid have not been paid because they had wrong addresses, wrong numbers which the switchover managed to produce. And we will, if we

can get the machine to listen to us, make sure everybody gets paid as he should have.

Some people are in arrears clear back to last October.

DR. SCHERLIS: It has been speculated that is a source of funding for your expanding EMS programs.

DR. MARGULIES: As a matter of fact, we linked it up to another failure in another subscriber system. And if you don't get paid, you are going to get a 10-year subscription to the National Geographic.

(Laughter.)

DR. MAYER: Other comments?

(No response.)

Thank you very much, Harold.

At the risk early in the meeting of fixing dates, I would like to turn to the calendars which are contained in your notebooks under the first tab which is labeled simply "Calendar" in an attempt to get the link with Council or closer link to Council at least temporally if not philosophically, we need to pick two dates out of the following three weeks in the subsequent year.

If you will put a circle around the September 17-23 week, a circle around the January 15-19 week and a circle around the May 14-19 week, what we need to do is pick two days in that period of time, each of those weeks, that you

would like to schedule for meeting. And this is part of that going from four cycles to three cycle year.

Preference is in September? We are now on a Thursday-Friday go. Is that good, bad, indifferent?

How about the 21st and 22nd of September as possibilities?

Going once, twice, all right, gone.

In January, is the 18-19 appropriate?

All right, other time during that week?

DR. ANCRUM: Any day except that Friday. I have to be back in Seattle.

DR. MAYER: O.K., 17-18.

DR. ANCRUM: That would be fine.

DR. MAYER: How is that, O.K.?

17-18, then, of January.

And in May 17-18 of May?

DR. ANCRUM: The third Friday is out for me.

DR. MAYER: Then what about the 16-17?

DR. ANCRUM: Am I the only one that has this conflict?

DR. MAYER: I don't hear anybody moaning about the other cycle. There is no magic about Thursday-Friday.

O.K., then the 16-17 of May.

O.K., then what we have said is 21-22 September, 17-18 January, and 16-17 May, as the next three go's.

I would like to turn now to some other additional comments which I think are very pertinent to the review process itself as we go through the review process from Dr. Pahl.

Herb.

DR. PAHL: Thank you, Bill.

First of all, I would like to mention for you that there is the dinner this evening at the Flagship Restaurant close by here to the Parklawn Building.

And, Bob, perhaps you can give detail arrangements later. But this is something that we are looking forward to because we do have several of the members of the committee leaving. And we believe that the other members of the committee together with staff would like to meet together informally and have an opportunity to socialize and wish those who are departing well, although we do hope we have close and continuing relationships with each and every one.

I have just a very few comments because I think Dr. Margulies has indicated the complexities that we have been going through. And you will again obviously have a very full agenda of information items in September because the program does continue to change. However, my remarks are much more mundane and specific.

Specifically, I would like to indicate that the staff anniversary review panel is continuing to function very

well and that this time they had an unusually heavy task before them because the applications that came before them had not received initial priority ratings. Therefore, there was in this period along with all of the other specialized activities the need to review in depth these particular programs and assign priorities. These priorities are indicated to you in the applications in the book.

There are some few programs which are behind the blue tab in the book where you are not required to take action. Those applications are being brought before this committee for information purposes only. The other applications for one reason or another do require certain kinds of action.

However, I do want to make it clear that the committee does have the opportunity and privilege of raising a question about any priority on any application that the staff anniversary review panel assigned regardless of whether that application is before you for action or for information only. And we will be asking you to formally concur in those priority ratings or to modify them as you see fit.

Should you have questions about any priority rating, we will have the chief of the operational branch responsible for that region prepared to present to you the basis on which those ratings were assigned. And you should know in this connection that the branch chief for that region was not a member of the voting team for that application so that he

would be presenting a summary, if you will, of what the staff anniversary review panel concluded relative to the application to reach that assigned priority.

You will also note that we have introduced certain new formats in the paper work which has come to you both at the time of site visits and in terms of primary and secondary review of the applications. And I believe you will see very readily that the purpose of this has been to try to tie into our analysis of the application in question the review criteria which have been developed and are increasingly being used not only by RMPS, but by the RMPs themselves as they view the progress of their programs.

There will be an opportunity provided to this committee at the end of this meeting tomorrow to comment upon and make constructive suggestions for modifications in these new kinds of forms and so forth which we are using. We hope that the information is being organized perhaps somewhat better for you, particularly for comparison purposes between and among programs since by having the items organized along the lines of the review criteria it is more possible now to review one program in comparison to another and look at the similar items of information.

Internally, there certainly is not complete agreement that this is the ultimate way to present information. We do feel, however, that there is an opportunity here to improve

matters. At the same time, we feel that the information as we are now receiving it and presenting it to you does contain perhaps less narrative and more pithy substance on the particular points in question. However, we do look forward to your comments at the end of the meeting as you have had an opportunity to use these new forms.

DR. MAYER: I might just interject, Herb, each of you, I think, at your desk had a long sheet which does have the May-June review cycle, SARP recommendations on it which you need to have for referral as we go through.

DR. PAHL: And it is the five applications at the bottom of the sheet which are being brought to you for information purposes only and are included behind that blue tab in the back of your book.

In terms of the NIS printouts, in just a moment I would like to ask Mr. Ichinowski to present very briefly for you what the printouts are designed to do. And he has distributed these large binders for you.

There is no intent to have you try to look at or absorb any such information here at the table. Rather, those of you who have been assigned primary and secondary review of applications have already received the appropriate printout packages. And this merely represents a compilation for each application before you today so that you will have some appreciation of how the NIS, National Information System, is

being utilized more and more to bring information to you, site visitors, and the National Advisory Council, and to be used more effectively by our own staff as we go through the review process and analysis of regions.

I would indicate again that we look to this committee and to our non-committee site visitors for constructive suggestions as to how to bring to you those kinds of information and present them to you in some organized fashion that will be more effective in accomplishing both site visits and the anlaysis and discussions of the regions' programs.

Now, with that slight introduction, I would like to ask Mr. Ichinowski to take a few minutes and review for you not any specific numbers within these printouts, but rather what the nature of the format of each printout is designed to do for you.

And, again, I will appreciate as well, particularly at the end of tomorrow's meeting or at any time, of course, that you so desire suggestions as to how this kind of activity can be improved to serve your purposes better.

Frank.

MR. ICHINOWSKI: Thank you, Dr. Pahl.

We put together a number of printouts on each region that is going to be discussed here today and tomorrow. And these packages were previously sent to the primary and secondary reviewers for those regions that they had under their

responsibility. So maybe they are not completely new to you.

We have, then, all 14 regions here with the exception of the new Ohio RMP. We have six printouts for each RMP. And if you would be so kind as just to take your big black binder, maybe we could run through for a minute or two the kinds of things we have there and perhaps how you could use them in your determinations.

First of all, they are all alphabetical, the RMP, starting with Kansas, Missouri, and so forth. We have reduced the printouts, as you know, from the large size which we found somewhat unwieldy to this reduced version that you see in front of you.

If we could use perhaps the Kansas RMP as an example and run through the printouts, maybe that would be of assistance.

The first printout is a funding history list which identifies for you for each RMP all of the projects that were ever supported by RMPS funds and then in each column by year the moneys that were put into that activity.

For example, in the Kansas, you see there they have it awarded for five years. So the first five columns are the moneys that were awarded in each project and total at the bottom for each of those five years.

To the right of the asterisk column are those moneys that they are requesting at this time for subsequent years. In the case of Kansas for years 06, 07, and 08. Again,

at the bottom, the totals that are being requested.

O.K. For the next printout, you flip over behind the number one tab. The breakout of request which identifies for each RMP by type of support being requested, whether it is continuation within approved period of support, which is the first column, continues beyond the approved period of support which is the second column, and so forth, those moneys that are being requested for a particular year.

Each page is a program period. The first page for Kansas is their 06 year of request. The second page will be 07.

At the right of the page, you not only have the direct cost being requested, but also the indirect and total dollars.

Now, behind the number 4 tab, under Kansas, we have an identification of the RMPS funds that are being requested as a percentage of other sources of support.

Now, in the financial data record that the RMP submits to us on each project, they identify if they are going to be getting other sources of support for that activity. And we have displayed this in terms of identifying in the first column after the title the RMPS funds that are requested. The second one is those funds that they have indicated will be coming from other sources, with the total then in the third column. And in the fourth column is that percentage of money that RMPS would be contributing.

In the case of Kansas, as you can see, they have not indicated any other sources of support for any of their activities.

We can go, then, behind the number 9 tab of Kansas, And these are printouts that come from the descriptor summaries that had been submitted to us by the RMP. We have this broken down into three major groupings.

The first groupings are operational components. In the case of Kanasa, on the top left-hand corner, you can see that they are requesting 12 operational components which total $693,243. Within each of the 12 major groupings of descriptor categories, we have broken those down to identify for you the number of components that relate to that specific element, the dollars that are related and then the percentage of those dollars that that money identifies of the amount that they are requesting.

There are four pages for that particular printout. And then right behind the little yellow tab, we have a similar type of display for the planning studies that they have identified in their application which runs the same pattern, -- the number of programs that they are requesting and the amount of dollars.

And the third batch are the program feasibility studies and central services again in a similar arrangements and array.

The next printout under Tab No. 11 is a repeat of their page 7 of their application which identifies equal employment opportunity data they have submitted to us. There are four major columns, the first being core staff, again broken down into professional, technical and secretarial and clerical, the same breakdown for project staff.

The third major column is the regional advisory group.

And the fourth one other committees.

The rows, I believe, are self-explanatory. The top row is total which are members. Then you have the breakdown between male and female. Then you have the breakdown under minority groups, total minority, and those that are appropriate to blacks, Indians, Spanish, oriental and others. This is a direct take-off from page 7 of their application.

The 1st printout we have provided for each RMP behind Tab 14 has been derived from the financial data records where we have identified for those objects of expenditur that are on page 16, moneys in each component that have been reported to us. Each column is a particular component, the first being core, the second one developmental, and then the component numbers. The total in each object of expenditure for each RMP would be the furthermost right-hand row of the last page. In the case of Kansas, the last column on page 2.

Now, there is one other set of printouts that we have

provided which is helpful for those of you who want to do some analysis. And that is at the very back of the book, there is a tab that is identified as miscellaneous printouts, if we can flip back there under the No. 10 tab, there are four different printouts in this series. And what these printouts identify are those RMPs that are in this review cycle broken down according to the number of years that they are operational. So you can see that there are four RMPs that are in their first year of operational, one in the second and so forth.

If we can use the Kansas example which is the second line from the bottom that we have been following through, you can see that Kansas has been operational for five years.

Now, what we have attempted to display on this printout is a comparison of the moneys that they are requesting in column 3, $1.7 million, as a percentage of their currently budgeted dollars in column 2, $1.3 million.

In the third column request is the percent change from current. You can see they are requesting 19.9 percent more moneys in total direct cost than they are currently being funded for.

In the subsequent columns in that page, we have also given you a comparison for you to see in terms of the history of that RMP, the percentage change that occurred in that RMP between years 1 and 2 -- in this case 177.7 percent. And then the second column would be between years 2 and 3, a plus 27

percent and so forth down the line.

Now, there are four printouts to this series. The first page that we have gone over is total direct cost. The second page has to do for core components, the third one for project and the fourth for those that apply developmental components.

Yes, Sister.

SISTER ANN JOSEPHINE: I am interested in this five years.

DR. MAYER: Sister, could you use the microphone?

SISTER ANN JOSEPHINE: In this five-year operational, as you look at Kansas and Missouri, and you look at the current budget and requested, immediately the question comes up what is changing there? Because it is changing very rapidly.

MR. ICHINOWSKI: In the case of Kansas, they are requesting $1.7 million. And they are currently being supported at the $1.3 million level.

SISTER ANN JOSEPHINE: I am talking about Missouri. As I look at these two, they are being funded at $1.9, and they are requesting $4.4. There are some significant changes taking place here.

MR. ICHINOWSKI: In Missouri? I believe you will discuss that at the time the Missouri application is to be presented.

SISTER ANN JOSEPHINE: This could highlight these

of things I suppose one would look at.

MR. ICHINOWSKI: That is the intent of my covering this.

SISTER ANN JOSEPHINE: I keep hoping we ask the right questions because if we don't, we work on the wrong answers.

MR. ICHINOWSKI: Are there any other questions?

MR. HILTON: Yes.

DR. MAYER: Yes, Mr. Hilton.

MR. HILTON: Is the current plan to have these printouts replace much of the reading material we have in the other book? Is this the idea?

MR. ICHINOWSKI: Yes.

MR. HILTON: Is there some way to make this printout clearer? Some of these figures are --

MR. ICHINOWSKI: Yes. We have just in this last cycle made the decision to go from the large printout to the reduced printout. It is an internal problem with the use of a Xerox 7000 machine in the building here. And if we can get to use the Bruning or one of the other machines which we are negotiating for right now and get it perhaps printed rather than xeroxed, we can improve the quality significantly. And I believe by the next time these printouts are presented to you, you will note the difference in the quality.

DR. MAYER: That is extremely helpful data. When I tried to dissect out that "new" Ohio program, I would have

my eye teeth for this data. And I have just asked to try to get some comparable data for that one because there is literally no way you can view the thing in a total picture over time without some feeling of this kind of data displayed. There is just no way if you haven't been involved, at least that I can capture, without this kind of information. It is absolutely essential.

MR. HILTON: Perhaps this is a question for Dr. Pahl. I notice some new colors in the form. Is there a color coding formula somewhere? Does it mean anything? Or are we just more decorative, surplus paper?

DR. PAHL: Well, to answer your question, I will try to go through it with Lorraine Kyttle here. I am sure she will check my accuracy.

The Staff Anniversary Review Panel acts on only certain types of applications, you will recall. And when they do, the report of that panel is given on sort of this pink sheet.

DR. MARGULIES: It is good you asked him. I am color blind.

DR. PAHL: A yellow sheet indicates that this is a staff document for use by the committee and the Staff Anniversary Review Panel has not acted. Therefore, this kind of staff summary is coming to you as an initial consideration without prior review by an internal staff panel.

And the whites are generally the back-up information.

And Lorraine, do we have another color?

MRS. KYTTLE: No, sir, only one little thing that jarred us, and that is that the printer contracted out and, therefore, we have several shades of the same color. A pink is a pink, no matter what its shade is. It depends on what contractor printed it.

MR. HILTON: What is a salmon?

MRS. KYTTLE: Mr. Hilton, the salmon indicates material generated by staff or the initial review of the Staff Anniversary Review Panel.

DR. MAYER: Salmon-staff, that is the link.

MRS. KYTTLE: We are all swimming upstream.

DR. MAYER: Other comments?

DR. PAHL: I do have one or two points of information for you. And then I have something to state about the kidney proposals. So let me take up the first two points relative to information at this time.

There has been over many months now an increasing need by RMPs for a clear statement from RMPs relative to the responsibilities and relationships of the grantee, the RAG and the coordinator. And many months of staff work have now gone into a statement which has been looked at by the steering committee of the coordinators and has received the approval of the HSMHA grants policy office. And we will be getting out

hopefully within the next week or two weeks a statement on responsibilities and relationships of RAG, grantee and coordinator.

Now, we are aware that by making this statement, and it will be policy, there will have to be some modifications in some of the RMP regions' by-laws and relationships. But in general this is what the director and HSMHA and the steering committee of the coordinator believe is appropriate. And since it is rather lengthy, I won't read it into the record.

We do not have it for you today. We have been working intensively to make such a deadline, but have been unable to get the HSMHA clearance in order to do so.

The value of this, I think, will be that for once there will be an opportunity for both the regions and their organizational groups and ours to have a common document to look at as we discuss problems which do arise in the various regions.

In general, the key statement which has been itself so easy to read and has taken so long to get clearance on, I would like to read into the record because I think the rest of it amplifies this statement.

The grantee organization shall manage the grant of the Regional Medical Program in a manner which will implement the program established by the Regional Advisory Group in accordance with Federal regulations and policies.

And then there are a number of items describing in detail the role and responsibilities of the grantee, the Regional Advisory Group and the coordinator who in this document is also identified as the chief executive officer. And it represents, I think, a major step forward. And there will be some specific, isolated problems, but most of the problems which have arisen are because of misunderstandings and lack of agreement as to a common theme.

So we do hope that this results in better understandings and relationships. And over the course of the year, I am sure the few specific problems will be able to be worked out on a negotiable basis.

MISS ANDERSON: Are you going to include the make-up of the RAG and definitions of what consumer is?

DR. PAHL: Not in this document. As we have brought before you at earlier times, there is a requirement by the Department that more aspects of all HEW programs be put into regulations. This is a mandate by the Secretary's office, and we are proceeding as we develop these documents to then couch them in broader, more general language in terms of regulations. We are trying to keep the formal regulations as broad as possible to provide maximum flexibility to both the regions and ourselves and to use these statements to make explicit what is understood and intended and HSMHA policy.

But the points you mentioned are not in this

document and probably will be the subject of further work. These take quite a while to get everybody to come to some agreement on.

DR. MAYER: When will these be released, Herb?

DR. PAHL: It has been cleared by HSMHA. I would expect in the next two weeks we would be able to begin mechanically getting them printed and out.

The second point I would mention is that HSMHA has now established a policy effective April 11 -- and this is only for your information -- which now makes it a requirement, places it as a requirement, on all HSMHA programs to inform the appropriate regional health director of any proposed grant or contract to be made by HMSHA in that HEW region and to give to that regional health director the opportunity to comment upon prior to the final decision either grant or contract. He is not required to submit comment, but he must be provided the opportunity to make comment.

It also is a requirement that once the disposition has been made, either approval or disapproval and award level, this information must be given back to the regional health director. Obviously, this is in the interest of keeping him better informed about all activities, whether they are managed in his office or not, but which come from HSMHA. And we have already implemented this relative to our grant activity in that we are soliciting for current applications to go to the June

Council, EMS application, the community-based educational applications, and also the ones before you. If there have not been comments, we are so notifying the regional health director in providing him that opportunity to submit them prior to this June Council.

And then we will be implementing this in an effective way for the contract activities which the Office of the Director of RMPS does engage in.

Now, I would like to turn to the last item. And I am sorry there are so many things, but this is relatively important. And with your permission, I would like to read to you the important aspects because this has not been given to you. And it is difficult for you to select out those important paragraphs.

As Dr. Margulies indicated, we have now issued the revised guidelines and local and national review procedures for the kidney disease activities of RMPS. Dr. Hinman will pick up where I leave off and will then lead into a general discussion of these guidelines. But I would like to go over the review process with you and as a matter of information for you and also as part of our record read to you those parts which are pertinent to the review process and leave to Dr. Hinman to then discuss the more general statement about the kidney program objectives and specifics relative to this meeting and kidney applications.

There has been a very great amount of effort in trying to develop this issuance and without going into that, let me read to you, then, what the summary of the review process at the local and the national level is which is effective now and, therefore, pertains to the activities of the meeting of this committee.

Starting off with the technical review process at the local level and forgetting about initial discussions which may occur between the region and RMPS staff as a concept for a kidney proposal develops, but starting with the technical review process at the local level, the issuance reads:

Prior to submitting application for a renal disease program, the RMP is expected to obtain a technical review of the proposal by a group which has not participated in the program's development. The technical review group must be comprised of at least three renal authorities from outside the geographic area served by the region. Payment of the costs of such consultant services will be made by the requesting RMP.

The region may obtain the names of consulting renal experts by calling the appropriate Operations Branch for assistance. The Division of Professional and Technical Development maintains a list of renal consultants, and is responsible for coordinating their assignment. Should the RMP desire to choose its own review panel, the names and curriculum vitae of prospective consultants must be cleared with the

Division of Professional and Technical Development.

Technical reviews of renal programs need not always be made by consultant site visits, but may be accomplished by mail when appropriate. The RMP will negotiate any compromise needed should conflicting technical advice be given by the technical reviewers.

Forwarding Proposals - only those proposals which are recommended favorably by the local technical review group shall be eligible for consideration by RMPS. In addition, an opportunity must be provided prior to consideration of the proposal by the RAG for review and comment by the appropriate CHP agency or agencies as required by Section 904(b) of the Act.

The RAG shall consider any CHP comments and comment on the ability of the RMP to manage the kidney project without hindering the development of the overall RMP program, and the reasonableness and adequacy of the kidney budget proposed. The RAG is responsible also for indicating how major issues raised by the local technical review group will be resolved.

Since kidney proposals are reviewed separately at the national level, the RAG need not give priority ranking to kidney proposals in relation to other non-kidney RMP operational activities. Kidney proposals shall be considered by RMPS in relation to national priorities.

The complete comments of the members of the technical

review committee, and any CHP agency comments, must be included in the forwarded proposal.

RMPS Staff Review - the initial review at RMPS shall include:

a. The contribution of the project toward kidney program objectives.

b. The completeness and nature of the comments of the RAG.

c. Comments of CHP agencies.

d. The preferred method of funding.

RMPS Review Committee - RMPS staff will summarize for the RMPS review committee available information as to how each kidney proposal proposes to support the National Kidney Program objectives, and the substantive points developed through local review processes by the Technical Review Committee, the RAG, and the CHP agency. For those applications for which the RAG; CHP agency; director, RMPS, or RMPS Review Committee has indicated a concern apart from the technical merits of the project, the RMPS Review Committee will be asked to make a recommendation to the National Advisory Council.

The RMPS Review Committee specifically will not review on a technical basis the merit of the proposal, or establish formal numerical ratings for individual proposals.

And, finally, section 6, Council Review - all kidney proposals shall be submitted to the National Advisory Council

for final recommendation. In keeping with the categorical nature of the kidney disease program within RMPS, the Council will review and recommend funding levels for kidney proposals separately from the funding level of the specific RMP. Kidney program funding will be in addition to other RMP program funding

Now, those are pages 3 and 4 of this issuance. And I would like before we entertain discussion, because I think this is not in the complete framework, to have Dr. Hinman have distributed to you these which were just issued and perhaps comment on some of the other features of this -- namely, the framework of kidney program objectives.

DR. MAYER: Before we do that, could we talk about the specific role of this review committee --

DR. PAHL: Of course.

DR. MAYER: -- to make sure we have got that understood?

DR. PAHL: Of course, Bill.

Perhaps what I should do is indicate to you that the review committee responsibilities are on page 4, item 5, and if we can have Dr. Hinman come up perhaps the two of us can try to respond together with Dr. Margulies to the questions that may be raised.

DR. MAYER: I guess my problem relates to how we deal with this. We are not dealing with the technical aspects of it. We are dealing with its presumed relationship to the

rest of the regional activities. Is that correct?

I am trying to get a feel for what is our role vis-a-vis the kidney projects.

DR. PAHL: Well, this issuance came about as a result of the extended discussion at the last committee meeting and at the Council subsequent to that meeting. And perhaps in order to abbreviate it, Dr. Margulies can reiterate, I think, what was a statement to the committee that afternoon of the second day and which has been embodied in the principles enunciated here.

So let me ask Harold --

DR. MAYER: I need to have a positive statement, perhaps with examples of concerns apart from technical merits which is what it defines as this and what kind of range is that.

DR. MARGULIES: I think the most important issue here is the one that we wrestled with over quite a period of time. And that is the relationship between a proposed kidney activity which may be technically satisfactory and a Regional Medical Program which may have some problems with it.

At one time, we had been operating with, at least, the implicit assumption that an RMP which was in real trouble was probably not a very good site for the establishment of an effective categorical kidney program. That appeared in many ways to be as a general principle unacceptable and unworkable. So what we would ask the review committee to do with that kind

of a question is essentially to operate on review of kidney activities by exception -- by exception meaning when you see a kidney proposal which has gone through technical review and is acceptable, but it is in a Regional Medical Program about which you have some doubts, review committee should on that occasion raise those doubts and make some kind of decision about whether it is appropriate for that RMP and not ask itself to carry out a technical review, to second the technical review which has already been completed. So it really is action by exception in those circumstances.

DR. MAYER: I guess my problem is I can conceive of a poor RMP, if I can use that term, having a superb, not only technical, but superbly organized kidney effort. So I have got that problem. And I am going to comment that that is a miserable RMP, and they have got a great kidney proposal in it. And the RMP ought to grow up to be as good a cooperative arrangement as that kidney proposal.

Now, what have I done? I am having a tough time dealing with what is the role of this review committee in that process and how do we get ahold of the data to deal with that role?

DR. MARGULIES: I think it is an extremely difficult problem. We have gone at it two ways. In both instances, we have felt uncomfortable with the result. There are at least in our experience to date two possibilities in those circumstanc

And that is exactly the kind of situation we are talking about.

One of them is a possibility that the kidney program will be the only thing in the activity which is any good. It will be relatively large. It will not involve the Regional Medical Program in any kind of regionalizing activity and under some circumstances, based upon your judgment of those circumstances, might serve as an excuse for the RMP to go on doing a bad job because they are doing something good with the kidney activity, in which case you might decide no matter how good the kidney activity is, the total result for the whole region will be made worse rather than better.

The alternative probability is that a kidney program which is put together which is truly regionalized and which is designed to meet the needs of the population in the best possible way may prove a good vehicle in a weak program for learning how to do things in an integrated, effective fashion, and might be an additive stimulus to it.

There aren't any specific rules on that. These are the kinds of events you have to examine on an individual basis. And it is exactly that kind of dilemma which the review committee, I am afraid, is going to have to deal with. I don't know any sharp rules for it.

DR. MAYER: Sister Ann Josephine.

SISTER ANN JOSEPHINE: I can anticipate another proble where the consultants do not have to examine the project on

site on a site visit, but can be consulted by phone or mail or however. And I am becoming more and more aware of the fact that sometimes what is written and what actually exists is quite different. And I can see that the validity of a technical review could be in question under those conditions. And I can even visualize the conditions.

DR. MARGULIES: These consultant visits will have to be on site visits. We are not going to accept the paper review.

DR. HINMAN: Harold, that is not what it says.

DR. MARGULIES: It doesn't?

SISTER ANN JOSEPHINE: No.

DR. MARGULIES: Well, in that case, we have to reach full agreement because I can't see just a paper review of it either. There has got to be some site visit involved in this.

DR. HINMAN: As the committee can tell, there has been considerable amount of discussion, both within RMPS and between various committee members, Council members, RMPS, and various people in the field. And it was not until Tuesday there was a final decision on most of these things, the thought being on the ability to have a mail vote. And we have in hand some technical reviews in which in Seattle at the ASAIO meeting which was convened, a review committee on a proposal for five members that were present there, and they discussed it thoroughly, but they had not site visited the

the region, whether this would suffice or not.

It is very similar in the anniversary applications. This body sits in review without having physically gone to the region to site visit.

DR. PAHL: Sister Ann, I believe that both of the questions that have already been raised and those that will come up, you really have the answer couched in this statement by exception which is as broad as we could conceive it to be and yet be helpful. And that is, where the RAG, where the CHP agency, where the Director and his staff, or where the review committee has a concern apart from the actual technical merit of the proposal, then this review committee is asked to review the data and to make a recommendation.

Now, the concern can be on any point. We felt there were occasions when it would not be necessary to make a full site visit because of recent actions by staff or knowledge. And we were trying not to bind every applicant into a specific. We would imagine that most activities would involve site visits, but we wanted to be free on that. But if there were a concern by any party to this review process that it weren't an adequate, valid review, this committee is given the full responsibility for raising that concern, having full information from the staff, and making whatever recommendation it so desires to the Council.

It doesn't solve it point by point, but that is the

heart of the whole issue in safeguarding at the national level abuses that inadvertently may arise through local actions and not seeing the total picture as the review committee might here.

DR. SCHERLIS: I am curious as to why the device is used permitting the region submitting the kidney project to select its own technical review members. I would think that if we carry that to the extreme, we should allow RMPs to select their own site visitors. I think this gets the national RMPS in a position if they don't like a technical review member to be in an embarrassing position to say no. Why can't you just maintain your own technical reviews?

I would think a local group could utilize this mechanism in ways which I think should not be part of the national policy. I don't see the reason for having them initiate their own technical review when it should be done, I think, through RMPS. Isn't that the responsibility of RMPS?

DR. MAYER: Harold, before you answer, let me amplify the question as I read it and as I heard it.

It is my understanding that the major component of the burden of technical review belongs to those local technical reviewers who are brought in by the region from the outside. Is thatnot correct?

DR. MARGULIES: That is right.

DR. MAYER: Then I think Leonard's question is a very

pertinent one.

DR. MARGULIES: I think it is a pertinent one. The difficulty we find ourselves in in following your suggestion is that we are still trying to maintain some reasonable balance even in the categorical activities between a centrally controlled activity and one which is locally developed.

You might raise the same question about technical review for all activities in a Regional Medical Program. The basic plan for non-kidney activities is the technical review is carried out under the purview of the local Regional Medical Programs selecting its own specialists and its own consultants, its own advisers.

The reason we have made an exception in the kidney activity is no more complicated than the fact it is almost impossible to get technical review by people within the RMP without involving those who will be in fact in the project. And all we are really aiming for is to make sure that those who are not actively personally interested are involved in the review. And so long as they select competent people, the individual selection, it would seem to us, is reasonably left in the region as it is with all other technical review.

DR. SCHERLIS: Then you are particularly exempting any technical review by this committee, are you not?

DR. MARGULIES: That's right.

DR. SCHERLIS: I guess I have to wrestle with that

as our chairman does.

DR. MAYER: Let me make a suggestion, and I am not sure what your time is and Dr. Hinman's time, but we have been at it two hours in terms of time sequence. And I have a feeling we are getting a little heavy sitting. And let me suggest we take a 15-minute break at this point in time and then come back.

(Whereupon, a recess was taken.)

DR. MAYER: Could we take our seats, please?

We would like to go back to pick up where we were on the kidney proposal issue and see if there is further discussion about that.

Yes, Phil.

DR. WHITE: It is with some degree of pleasure that I can make this comment without fear of the future, but it has been interesting to watch the gradual emasculation process that goes on in the sense that we were never allowed to drink coffee in these conference rooms, some short time ago, we were told not to look at projects, today we are prohibited from smoking. And in view of the new guidelines, it probably will be unnecessary for us to make any decisions in the near future.

I hope that the remaining members of the committee can be comfortable with this gradual process.

DR. SPELLMAN: It is emancipation, that is what it i

I wanted to ask a question. How many renal consultants are there to draw from? I asked because I got the impression the numbers are so small, so-called qualified ones, that it ends up in a sense of a kind of round robbin in which the same persons are repetitively looking at them. And I ask that because then it would bring some reality to the question if, indeed, the region can select its own consultant and there are precious few of them, what liberty is this in the final analysis?

DR. MAYER: Does someone have information? Ed, do you have information on it?

Did you all hear the question?

DR. HINMAN: The question revolved around the number of consultants we would keep available, the names we would keep available here to assist the region.

At the time that decision was made to proceed in this direction, we mailed out requests to approximately 55 different experts in the field we felt could be of use in this activity. I don't know exactly how many responded yet, but we would anticipate having a list of about 50 people regularly who could be used by the regions in the review process.

I would like to address this issue of the reviewers a little more since it was the subject upon which the coffee break was taken. It is sort of appropriate the coffee break was taken during the kidney discussion. I assume that a

bladder break is involved, too.

The issue of who does the technical review is one that has been of major concern. The point that Dr. Spellman just raised about the number of consultants was the reason that prompted us to insist upon there being people from outside the region. Because if you can imagine within any one RMP, the total number of consultants that could be available and would have the competency to do the kind of review we are looking for is such that they almost undoubtedly will be involved in the projects initially.

DR. MAYER: Or if they aren't, were concerned about it.

DR. HINMAN: That's right. Or if they are not, it is because they are from another medical school and have the scratch-each-other's-back approach.

So what we were concerned about was attempting to assure there will not be a casual or cavalier approach to the technical review. So the decision was made to insist upon three people from outside the region.

Now, it is impossible for us to keep up with who might qualify on a monthly basis or semi-annual basis. And this was the reason why there was the freedom for the region to come to us and say, "May we constitute our review committee from someone other than those on your list?"

To date, the regions that have called in and said,

"Who is on your list we can call," they have not proposed ringers from the outside.

The criteria we would be concerned about is that it be someone who has technical knowledge in the area, i.e., if it would be a pediatric nephrology type of application, one dealing with children only, I would be very distressed if the technical review were done only by physicians treating adults only because the problems of children with kidney disease are different than those of adults with renal disease. So we do have the right to say that this is not an adequate review committee.

We also have added the requirement that the written reviews be sent to the national level, be available for perusal either by this group or advisory council or by staff. This will tend to limit again people giving a very superficial review, I would think. And it is conceivable some people would, but again the number of potential consultants being, as I said, in the 50 to 70 range, the number of potential applicatio being in a similar range, possibly if each region had applications in, again I would be surprised if someone who is potential applicant from Region A would gloss over a poor application of Region B because he in turn is going to be submitting an application somewhere along the line. So I think it will be somewhat of a policing activity.

Of the reviews that have come in so far since the

word began to leak out of the change -- it was in the Council minutes last round of some of the change, how it was going to occur -- I have been surprised that even when the review had started locally and they were people from within the region, there have been some fairly grave questions raised about the adequacy of some of the proposals that have come in by people within the area since they know it is going to be a written review.

The staff role in preparing applications that come to you or to the advisory council will be to assure that there has been technical review, not to say whether the guy is right or wrong, but assure there has been technical review.

In the various rewrites of the document that went out, that particular sentence was left out under the staff responsibility. But in two of the applications that are going to be discussed this morning, the local technical review recommended major changes in the application, the RMP did not heed those recommendations and forwarded the application anyway. It is our recommendation that these be disapproved.

We see our role as being a watchdog to assure that the process has gone on as defined.

DR. MAYER: You are going to feel free to comment only on process, not on content.

DR. HINMAN: Content if it is disparate from the national priority. This is one other area, thank you, that I

had forgotten to mention. In the beginning of the document, -- I have lost my copy here -- on the first page, the sentence under current RMPS program, emphasis for kidney disease, it sort of casually refers to a panel of regional authorities. We have two plans, and we don't know which is going to have to go into effect because there are changing decisions.

Kidney is no different from the other RMP programs. At one time, we were asked to submit some recommendations for expansion of kidney activities. If this was to occur, part of this would require the constitution of a formal advisory group advisory to Dr. Margulies on kidney disease which would have regular scheduled meetings to determine priorities. If that does not occur, we will anyway constitute a group of authorities to come in and suggest priorities to look at how well the regionalization of treatment facilities is occurring and whether there is a program that is knit together. And their findings will be submitted to the region so they will have them, the RAG chairman and the consultants, this list of consultants, so when they go into a region they will have something to judge by.

In turn, when it comes here, if staff looks and sees if it seems to be missing the target, this would be one of the occasions we would bring it to your attention and the Advisory Council's attention. It does not seem to fit into the needs as determined by this outside group of experts. So

we would comment on content in that context, Dr. Mayer.

DR. MAYER: Let me ask one more, and I will stop. And that is the concern -- and this is an issue I was trying to get out but doing it poorly before the break, let's see if I can do it better after -- about the issue of regionalization process.

One of the things I commented on is a good region that is going through that process or a poor region that isn't and a kidney program that is. And my problem is who is looking at that regionalization process? In other words, you can have the greatest technical competence in the world across the street from one another who are not interrelating in a regionalized effort in kidney disease.

Now, I guess I need to have a feel for who is looking at that. And if I am not out there to sample that and if that is a part of the responsibility of this committee, somebody has got to be out there to see about that issue. Or is it a responsibility of technical review? Who has that responsibility?

DR. HINMAN: The basic responsibility for regionalization rests in the hands of the regional advisory group in each RMP. We see our staff role, my staff sees its role, here to again watch behind this. As you know, there are the regular review processes, verification review process, which goes on which attempts to look at these issues of regionalizati

as well as in things other than just kidney. But my staff feels the major responsibility in looking at the question of whether there is some concept that at some point in time every citizen in the country would have access to a kidney flow system. And we take this responsibility to watchdog the regionalization and again bring it to the attention of review committe and council if it is not followed.

DR. MAYER: So is that part of technical review or is that part of staff effort? In other words, I feel free to comment about the regional advisory group locally in terms of how are they functioning in terms of the regionalization process.

What I thought I heard this morning was that there is a possibility that there is good regionalization in kidney, bad regionalization RMP. I want to know who is looking at regionalization kidney.

DR. HINMAN: I am going to bring an example of that to you when we get into the specific applications because we have a region in which the kidney program is becoming regionalized and wishes support to finish the process. And it is not the strongest RMP as a whole. And we are bringing that to you for advice and suggestions, comments, this morning.

DR. MAYER: Well, O.K.

DR. PAUL: Bill, let me try a statement. I think this will be a continuing staff concern because it is one of

the basic themes of RMPS is to promote regionalization. The responsibility for carrying out regionalization lies within the local RMP, but this would be a point that staff would be looking at and comes under the point of if the Director, RMPS has a concern apart from the technical merits of the project, it comes to this committee or if anyone on this committee has such a concern. So that I don't think it is pinpointed to just staff. But certainly it would be a responsibility of staff to look at this and bring information to this committee.

DR. MAYER: Bill, you had a comment?

DR. THURMAN: Let's take a very specific example, one you were recently on with us. And that was the Greater Delaware Valley.

Going back to Bill Mayer's question, that regionalization was not approved by the RAG. There are good facilities across the street from each other which don't need to be there. Who does have the responsibility for looking at the Delaware Valley? Is that supposed to be the RAG? And if so, it certainly doesn't work.

That is what Bill is really asking in a way.

DR. MARCULIES: This is a very key question. It involves the whole change in structure.

One of the things that we have done in the process of changing the review cycle from four to three is free a considerable amount of staff time from the review process and

spend more time in the region.

The answer to your question is this is an explicit responsibility of staff to look at what we cannot depend upon technical renologists to do. I think it is quite clear a man can look at whether or not dialysis, transplant, can be done effectively. And he may try his best to be regional minded and may not be.

The rest of it which we will not for the moment call technical review, but call regionalization review, is something which staff will be looking at. They will be in that region before the application is in, while it is in. And this will be brought to your attention as a part of your understanding of what is being done in that program.

DR. THURMAN: What is the role the committee plays? I guess we are back to that question one more time.

DR. MARGULIES: Not technical review.

DR. THURMAN: And not regional review as you have just defined it. So I am not sure what role this committee plays if it doesn't play those two roles?

DR. MARGULIES: You know, a few minutes ago there was some mention made of emasculation. And I would like to respond on that because that is one of the reasons we are increasing the number of women on the review committee so we won't be too deficient.

That really isn't a very good word you used before.

DR. MAYER: You should have used castration. That goes either sex.

DR. MARGULIES: That's a little broader. It is a little better.

(Laughter.)

There is no evading the fact that when you are running a program as we are which is dealing 95 percent of the time with Regional Medical Programs and the way in which they function that you cannot at the same time use the same processes on what is a narrow categorical project kind of activity. And there is little doubt but that the review committee's role with kidney review does not have the same penetration and the same meaning as it does with triannual review, anniversary review, and total attention which it gives to Regional Medical Programs. And we have been saying that now for some time.

What we are asking you to do is to look at the kidney proposals in terms of the Regional Medical Program when appropriate, but not ask yourselves to be technical review people and not ask yourselves to be fiscal people in determining what the actual budgetary level should be.

DR. MAYER: Leonard.

DR. SCHERLIS: I guess having started the problem this far as the discussion of consultants, I would like to pursue that further.

After carefully listening to you, Dr. Hinman, I see no reason for --

DR. MAYER: Jerry, could you hand him the microphone?

DR. SCHERLIS: After listening to your comments as to why the regions should select their own consultants, I can't really discern the point you made. The mere fact that the lists change, they change locally as well as nationally. And I would think if a technical review is indeed to come to us with all of its finality, as we have been told, that I would much prefer that the technical review be done by consultants wh are indeed selected nationally.

I see no reason for having local option on the selection of consultants. And I would indicate that if the review committee -- What is our responsibility? Do we have any at all? In other words, if it goes from here to the Advisory Council, is it assumed that we have made some action upon it or do we just sort of ignore the fact there is a kidney proposal?

The point I am going to make is if we have any action whatsoever on this, I would find it impossible to make such action unless the consultants are indeed appointed from the national office and not selected locally. I would like that point pursued in some detail. I have rather strong feelings about it, and I would like to either have them altered by your comments or carry it further to an action by the

committee.

DR. MAYER: Mac, you are commenting on this issue?

DR. SCHMIDT: Yes.

It seems to me there is an inconsistency in what I have heard about the reasoning for the local people to select technical review locally and yet have them approve somehow at national. There are national constraints to be placed on the technical review process. There are few people to be called upon. They have to be expert, I would think, not only in the technical aspects of the renal programs, but also hopefully at least something also concerning Regional Medical Programs and its purposes in funding these. The site visitors have to be educated at least to some extent beyond simple technical aspects of the renal program.

And the policy would be far more consistent and understandable to me if regions could ask for people to be placed on a national panel and thus the national panel broadened by nominations, if you like, from regions of experts that they would like to see and then have the technical review team picked nationally and sent to a region. This would be a consistent policy, at least, and would meet the desires as I have heard them expressed.

And I believe as written up here, it is inconsistent at some point. So I won't ask for comment.

Again, I would like somebody to explain to me the

second paragraph on page 4, particularly what is meant by "Since kidney proposals are reviewed separately at the national level," and finally, "Kidney proposals shall be considered by RMPS in relation to national priorities." And I would like to know by whom that is to be done.

DR. MAYER: Two issues. Let's deal with the issue of the selection of the panel.

I guess the concern that I am hearing is a concern that is expressed on the potentiality of packing the courts, so to speak, if the selection is made by the individual group. I am not sure how much energy is involved in setting up the option of the sort of marriage mart being arranged centrally in the manner which Leonard and Mac have suggested. It would seem to me that that is not too great a process, and it takes away -- I am not saying that it will or will not improve it -- at least it takes away that potential question that is going to be raised by people, I think, consistently about this area.

DR. HINMAN: I have no problem with that if that is Dr. Margulies' decision. It would not be a major problem to do what Dr. Schmidt suggested.

DR. MARGULIES: I think this is a very interesting and reasonable idea. And if it expresses what the review committee would prefer, we will certainly bring that recommendation to the council and discuss it with them. I don't see it

as too difficult a thing to achieve. And I think your points are well taken.

DR. MAYER: Jerry.

DR. BESSON: If we can formalize that, then, and bring it to Council so we can have an opinion rendered by Council on that question, I would like for us to do that. Because I would like to enlarge the question from that specific point to the fact that that particular point is one manifestation of a much larger question that I think we should be dealing with. And that is somewhere along the line we have got to look at the whole concept of RAG review and local review and wonder whether there isn't some kind of a built-in bias, a kind of a Parkinson's law of making sure that anything that you submit has local RAG approval that tends to remove this committee's function of making some larger decision about prioties. that I see in the rhetoric everywhere, but the word "emasculation"is very appropriate. I think that function is being removed from this committee's activities. And I wonder whether anybody is assuming responsibility for it other than someunknown, nameless, faceless people who are called vague.

Maybe we ought to dispose of this question first, Len, and then get to the larger question that I think is a very important part of it.

DR. MAYER: Would someone care to frame a motion relative to -- I gather the key issues are that the experts that

are brought into the technical program review at the local level be selected by RMPS rather than by the individual region. Is that the essence of it?

DR. SCHERLIS: Yes.

I would move that item 2 on page 3 be altered as follows:

DR. MAYER: I think probably it is a recommendation to Council that we are making, then.

DR. SCHERLIS: Yes, to Council be altered as follows: That the technical review group must be comprised of at least three renal authorities from outside the geographic area served by the region, said authorities to be appointed by RMPS.

Is there a second to that?

DR. THURMAN: Second.

DR. MAYER: Further discussionof that motion?

(No response.)

All those in favor?

(Chorus of ayes.)

Opposed?

(No response.)

O.K.

DR. THURMAN: At the risk of being called dense, could I ask Dr. Margulies to say one more time what our responsibility is. Because I didn't catch it when it went by.

DR. MARGULIES: The responsibility for this technical review is primarily by exception. Since it is a technical review, it will be brought to your attention that a kidney review has been completed. If the recommendation is that it meets with the national priorities which are described in the way that Dr. Hinman laid them out and which go back to an earlier document which is an effort to have a national network of kidney dialysis centers, if all the technical requirements are met and the Regional Medical Program is a good, sound program and we bring to your attention the fact that the regionalization aspects are adequate, there really isn't any need for you to take action on it.

When, however, these things are not true or when there is a challenge which is brought up at any point in this range of activities, then you do come into action.

DR. SCHMIDT: Is it implied by that that this committee cannot raise an exception?

DR. MARGULIES: The committee can always raise an exception. That is in the document .

DR. SCHERLIS: It specifically states on page whatever it is -- 4 -- "Those applications for which the RAG, CHP agency Director RMPS, or RMPS Review Committee has indicated a concern apart from the technical merits of the project, the RMPS Review Committee will be asked to make a recommendation."

So since technical is not clearly defined, I would

assume these are very restrictive definitions of that term as far as raising an objection.

DR. MARGULIES: We would think that probably the whole committee would not want to debate whether one form of dialysis or another is better, but you certainly want to get into the question of whether what is being proposed is going to meet the regional needs.

DR. MAYER: Jerry.

DR. BESSON: Perhaps, then, if we disposed of that, we can get to the larger question of emasculation. And it is interesting, Phil, that at our break, I used practically the same terminology in discussing with Len about a function of this review committee. So I guess as incoming members emeriti of this committee that our thoughts are not too far apart.

I would like to pursue this question if this is an appropriate time.

DR. MAYER: Could I suggest, Jerry, that that is a major, broad issue which I think is going to lead, appropriate should lead, to half an hour or more of discussion. And what I would like to do is to red flag it, see how we are progressing in terms of time, in terms of meeting our goals, and then come back to it, if I could.

DR. BESSON: Sure.

DR.MAYER: To get a very real red flag on the agenda to deal with it. Because I think it is an important issue.

We discussed it, as you know, at some length at the last meeting and I think left feeling we had made some progress in understanding that issue. Obviously there are still concerns, and I think they ought to be discussed.

O.K., other items on the renal issue?

DR. HINMAN: Dr. Schmidt had raised another question that was never answered on page 4, the second paragraph. And what it was referring to was the fact that other parts of the RMP applications are looked at as a whole and considered. In other words, when you review any one of the ones that are here today, the RMPS discusses as a whole, but the kidney is notdiscussed with that application. And that is what those two sentences refer to -- the first sentence.

The second sentence refers to the attempted process to prevent having an application that is technically meritorious passed in by a RAG, but does not reach toward the goal of regionalized kidney resources throughout the country, i.e., several regions are further along in provision of treatment facilities than other regions.

It would seem that the regions that do not have these facilities should have a higher priority than a screening program, for instance, in a region that already has the treatment facilities. A treating program may be very meritorio but it is one of the ones that are not a topic of priority list until we have the country better covered with facilities

for the treatment of end stage renal disease patients.

DR. MAYER: Other comments on the xenal issue?

Sister?

SISTER ANN JOSEPHINE: May I ask a question? I notice on page 3 at the bottom which says, "Forwarding proposals," it indicates the technical review committee and then the RAG and then the CHP agency. Would there be any merit in having the Division of Internal Medicine of the Medical Association in its appropriate committee make some comment on this? If the majority of the xenologists were in the Medical Association and in practice and weren't with the particular group who were submitting the proposal, I would think that their input would be rather significant in a case like this. And this would be by exception, probably. I don't know.

DR. HINMAN: Sister, the proposals dealing with transplantation, dealing with children, would not fit under internal medicine. Proposals in which a large element is public education, again, there would be other groups that would feel they should have the same right to comment if it is given to a single part of the Medical Society group.

SISTER ANN JOSEPHINE: I would like to think that all the children would be the same, just by pediatricians. But this is truly not the case.

DR. THURMAN: The majority are not.

SISTER ANN JOSEPHINE: Realistically, they are not.

DR. MAYER: Other comments?

DR. HINMAN: I would like if there are no comments about kidney in general to get down to kidney specifically.

DR. MAYER: All right.

DR. HINMAN: There are nine regions that have applications containing some element of kidney involved in them, eight of which are in your folder and one which is outside. There are two types of applications before the blue tab and after the blue tab.

Before the blue tab, the first region having an application is Nassau-Suffolk. Nassau-Suffolk has submitted two requests for kidney activities.

The first is a donor program. And the purpose was to procure cadaver kidneys from at least 24 donors each year from seven named hospitals in which there is a physician committed to the program.

The application further states they are working with Metropolitan New York and New Jersey in an effort to design a tri-region 910 application for organ procurement for the entire area, but that pending the negotiation between the RAGS and the staff and the individual RMPs, they would like to get started.

The total amount requested was $27,060 for the first year. This would be used to develop and train procurement teams.

DR. MAYER: Let's see if I am clear on where we are. Are we going to go through the renal applications separately at this point in time? Is that the intent?

DR. HINMAN: Yes, sir.

DR. MAYER: All right, I guess I need to be referred to what kind of material and where is it in the mass that I may be making reference to.

DR. HINMAN: Well, there are some comments in the Nassau-Suffolk on a white sheet, I believe, not having a folder.

They are there, I see. It is right behind the yellow one in Nassau-Suffolk.

DR. MAYER: Could I just make sure the committee has where we are? Nassau-Suffolk, white tab, March 31, 1972, Post-Mini SARP .

DR. HINMAN: Of the nine regions with kidney requests, using the general guidelines Dr. Margulies had laid down, eight of them are for your information. One of them is for your advice and recommendations.

Nassau-Suffolk is in the former group. In other words, my comments are informational to the review committee.

Unfortunately, as I also indicated a little earlier, some of these decisions were arrived at during this week so that the supporting material is not at the level that would be desirable either by my staff or by the review committee. We

are still going through what has been known for the last several months as the transition period. And I would hope that by the next meeting of this group, there will be tabs and information that are easier to refer to than what you have today.

This part of the renal organ procurement program had been reviewed locally and approved by the RAG. The staff review concurred in the reviews and is recommending approval of this part of the application.

The second part of the application, a home dialysis training program, the stated purpose was to develop 50 validated modular single concept lessons for home dialysis. And in looking at this part of the program, the investigators did not seem to be aware of the fact that there were several home dialysis training programs throughout the country that had already succeeded in doing this quite well. They were requesting $31,200 for this, and it was the recommendation that this be disapproved and not funded and strong advice back to the region which, incidentally, had been given to the region nearly a year before, that in home dialysis training programs, names of individuals who knew how to do it and advice to them as to how to go about it, and they seemed to have ignored this.

DR. BESSON: Mr. Chairman, are we going to be talking about these individually or are we talking about Nassau-Suffolk now?

DR.HINMAN: No, sir. I was requested to present sequentially in an abbreviated fashion the nine kidney proposals that are in this review cycle.

DR. BESSON: Will they be reviewed as part of the regional review?

DR. HINMAN: The reason for bringing them up ahead of time is so when you did get to Nassau-Suffolk, for instance, you would already be aware of what the recommendations were on it.

DR. BESSON: They might be a little bit more in context. Excuse me, Dr. Hinman, but I find myself not really listening to what you are saying because it is totally out of context with what our job is which is to look over individual areas in the context of everything that is happening here.

Now, maybe that is my own inadequacy. But I just mention that. If this is the procedure that is going to be established, fine, we will do it.

DR. HINMAN: Whatever you all want. I have no vested interest.

DR. BESSON: I would rather look at Nassau-Suffolk in context so we would know what is happening there.

DR. MAYER: Yes, Mac.

DR. SCHMIDT: Bill, I believe strongly that castrated is as castrated does. I support Jerry and believe these should be looked at as we look at the regions.

DR. MAYER: O.K. Is that the consensus of the committee?

I would feel more comfortable. That is why I asked the question what is it that we are doing at this point in time.

DR. HINMAN: Before I relinquish the chair --

(Laughter.)

-- my staff assures me these items I distributed during the break were indeed mailed to the committee members. One of them is a package dated February 25, 1972, and is the guidelines for the EMS applications that Dr. Scherlis or Dr. Basson, I am not sure which, referred to.

And the other is a series of three documents, one dated March 13, one dated March 15, and one dated April 7, that were sent out concerning the community-based manpower development program. This was mailed just Tuesday night. That is why many of you probably did not receive it. We distributed that a little earlier.

DR. MAYER: I would be delighted to talk to whoever your staff is who has got some validation that this material was mailed.

DR. HINMAN: Believe me, as confusing as things have been, I cannot be certain. That is why I gave them back to you.

DR. PAHL: Well, we on the committee apologize if

either the materials were not mailed or weren't sufficiently identified. And all we can plead is that it has been somewhat hectic. But if you haven't received it, it is really inexcusable. So we do apologize.

DR. MAYER: Other items, Herb, that need to be brought to the committee's attention?

DR. PAHL: I think the only one point which Dr. Margulies wanted me to mention which is a very pleasant duty is an appointment which has been made between the time that you last met and this meeting. And that is that Mrs. Judy Silsbee is the Deputy Director of the Division of Operations, working closely with Mr. Chambliss. And in the press of all of the business we have been discussing with you, I think we forgot to mention this pleasant duty.

So Mrs. Silsbee has changed hats and is functioning as Deputy in the Division of Operations these past few months.

Nothing other than that, Bill.

DR. THURMAN: Is she to be congratulated or pitied?

DR. PAHL: I almost prefer not to ask her.

DR. MAYER: I need to have before we move forward an opportunity to comment on the order in which we take these because of people's presence, absence, etc. Two problems that I am aware of relate, fortunately, in what is an un-unholy alliance, and that is Northeast Ohio and Ohio, both Sister Ann and myself. I am not going to be able to be present tomorrow,

so sometime today, since I am reviewing Ohio, I would like to have the opportunity of taking that one up as primary reviewer. And that is very intimately linked -- well, that is the wrong statement. It ought to be, but isn't intimately linked to Northeast Ohio. But the discussion ought to go on back to back, I think, on those two.

Are there other specific problems?

John Kralewski will be in hopefully this afternoon, and Dr. Brindley ought to be in this afternoon to pick up.

Is there anyone else with problems?

Phil?

DR. WHITE: I must leave by noon tomorrow.

DR. MAYER: Well, if there are no other major conflict time scheduling problems, then what I would propose to do would be to start out with the triennial review of Oregon which has been site visited, which Dr. White does have responsibility for.

Phil, it is all yours.

DR. WHITE: One is supposed never to preface comments with an apology so I shall not, but I would like to explain something to you as my presentation may be less than sparkling. It relates to an experience which was somewhat distressing which has left me distraught and discombobulated. It is a comment on our health care system which perhaps RMPS may eventually influence.

Tuesday, I arrived in Detroit because my father-in-law broke his hip. This is not why I arrived in Detroit, it is why I went to Detroit.

He was taken to a local hospital at 4:30 in the afternoon. At 10 o'clock or shortly thereafter, he was finally put in bed. He in the meantime occupied a corridor along with a number of other elderly gentlemen who were also apparently emergencies of one sort or another.

And I thought this was appropriate in view of the emergency system which is being discussed.

In the course of his experiences there, he was taken up to X-ray, presumably because this is essential to the diagnosis of a broken hip or at least helpful. While there he had an urge which perhaps relates to the renal problems we have been talking about.

To my surprise, there was no urinal anywhere in that vicinity, and no one who seemed to have the authority to indicate where one could be procured. So I went down to the emergency room myself. And being familiar with hospitals, knew that they would usually be in a closet and procured one and took it up. Someone was a little aghast that someone without a white coat was carrying a urinal around.

While up in X-ray, during which time we saw very few people, one of the other elderly gentlemen there had a cardiac arrest. And suddenly, all of the doctors which were

mysteriously missing prior to this event appeared and very fortunately saved the man's life or at least got his heart going again, following which they stood around and discussed their triumph for the next hour.

The point of this whole discussion is that it was my first personal experience, I guess, as semi-patient. But I stood there for all those hours with my father-in-law. I did not identify myself as a physician. I am hopeful that it wouldn't have made any difference if I had.

Finally, an orthopedic surgeon did arrive on the scene. It is still a mystery to me, however, exactly what his decisions are. He did not deign to talk to the family. He discussed it with my father-in-law who was in no position to understand the discussion, what the process was going to be.

The point of my comments, I guess, is that I hate to see large contracts being issued for emergency care systems which emphasize the technology without equal emphasis on the human elements that must be considered in our emergency care process these days. But this has disturbed me because I am a physician, and I don't like to see physicians behaving that way. And I haven't been able to get it out of my mind. And I will probably write a nasty letter to the hospital administra and never be able to show my face in Detroit again.

And I am not picking on Detroit, Joe.

(Laughter.)

Be that as it may, in March we did visit the Oregon Regional Medical Program. And Dr. Thurman was with us as well as Mr. Russell and Mr. Moore. And I understand Dr. Blomquist isback there today looking at their kidney program.

There has been a turnover of coordinators in this region over the years. I think this is, what, the fourth different coordinator. And the present one has been on board something about a year.

In the past, the activities of the Oregon Regional Medical Program were largely educationally oriented. They had circuit-riding teams going about talking about heart, cancer, and stroke. They had coronary care training units and other similar educational activities. They have an understandi of the new mission of the Regional Medical Program Service and have adopted objectives and goals which seem consonant with those which have been suggested from Washington.

They have involved their regional advisory board, as they call it, in this planning for the next three years. And it seemed to us that they were deeply involved and did participate. Their staff is involved. And Dr. Reinschmidt who is the new coordinator is a seemingly capable man who has spurred them on to changing their goals and objectives and to participating in the development of these goals and objectives.

They are, as you can imagine, related to improving

accessibility of primary health services, improving the quality of care and containing the costs, which are those which are relevant these days.

They felt that these were in keeping with the national guidelines and goals and were relevant to the needs in Oregon.

They had different methods by which these goals were to be achieved. They had different subsets of objectives and goals which related to the primary ones.

We felt in reviewing this program that they had given considerable thought and were realistic in their plans and in the adoption of these goals and objectives.

The one perhaps weak area would relate to the fact that their health data were weak, that there was some intuitive process involved in the development of their goals and objectives, although it would seem unlikely that Oregon's problems were greatly different from those of the rest of the country. Nevertheless, it was recommended that some effort be undertaken to strengthen their data base so that they could indeed determine whether or not their new activities would have an impact on the problems in Oregon.

In the past as I mentioned, they have emphasized educational activities. Nevertheless, they were also very active staff people, and they were out stirring up interest, developing relationships, and a highly qualified and dedicated

staff had been developed.

There needs to be a continuing effort to relate to the community so that the new ORMP goals are more completely understood and accepted by the community and so that the community will have an understanding as to how they can best use the Oregon Regional Medical Program. This is in the planning stages. This is in themind of Dr. Reinschmidt, and he has plans to increase the staff with this in mind.

Some of the projects that have been undertaken in the past have been phased out. They have attempted to develop other funding for these, and indeed, in the acceptance of the project, there is clear understanding that funding by RMP will be discontinued at the end of three years.

In some instances, at least, some of the projects have been taken over by other funding mechanisms. Some of the educational processes, for example, by tuition payments or underwriting by some of the institutions benefiting from the educational activities. Not all of their projects have continued, however.

You might note in the printouts on the management assessment sheets that there is some sharing of project funding by other sources. In contrast to Kansas who said 100 percent of the projects were funded by RMPS money, you will note that there is a variable percentage in Oregon.

We looked at the minority interest. It is interestin

to note, however, there aren't many people in the minority in Oregon. Or at least those who are in minority groups don't number very large. So it has been difficult for them to get equal or proper representation on the decision-making bodies in the Oregon Regional Medical Program. Nevertheless, it was recommended that they undertake more strenuous searching for representatives from the migrants, the Indian population, the blacks, and the other minorities to see if they could not entice them into serving on their bodies.

We wereimpressed by Dr. Reinschmidt as an extremely capable coordinator. He seemed to stimulate his staff. He was obviously a man with imagination. He was developing new ideas. He was able to infect his staff with a certain degree of enthusiasm. We think also that he had convinced the Regional Advisory Board that new directions were appropriate and that they should be undertaken.

He had developed close relationships with the Oregon Medical Association, and he seemed to be accepted not only by his own staff and Regional Advisory Board, but by other members of other health organizations in the State of Oregon. He needs help, however. It was one of our recommendations that he seek a deputy coordinator or someone to assist him.

The core staff is made up of professionals. We reviewed each person's credentials. We asked them to outline their background and training for us. It seems that they were

all capable people. They work hard. They have defined areas of responsibilities. And we noticed that some of the core activities may have been limited in the past because of budget restrictions. And Oregon shows when cuts in budget came about not to penalize their projects or program activities, but rather to cut back on core support.

So we would recommend to Oregon that if the funding is approved by this body and Council that steps be undertaken to strengthen their core, not from a quality standpoint so much as from a quantity standpoint.

The regional advisory body was represented in force. There were a number of representatives there who were stalwarts and sat through the whole two days of the site visit, often making comments, but at least by their presence indicating support.

We are told that the attendance at their meetings is good. They have indeed as you will note in the site visit report dismissed certain members who attendance was not good and replaced them.

We had evidence that the members of the Regional Advisory Board are serving on committees, take an active role in the assessment of programs and projects.

We did note that there was a dearth of allied health people on this committee and recommended that they look into that.

There are no problems to speak of with the grantee organization. The University of Oregon School of Medicine is that organization. It adopted a hands-off policy from the very beginning, acting only as the fiscal agent, and I think, Dr. Pahl, completely conforming to the guidelines which you read to us earlier about the relationships between a regional advisory group and grantee organization.

We did note one problem in that the salary scale of the University of Oregon School of Medicine was low. Dr. Reinschmidt has had some difficulty in recruiting certain kinds of people to his staff because he is not competitive. They are examining the alternatives that are available to them, and they may choose to go to the route of an independent corporation. However, the services provided by the University have value, and they do not want to undertake this change lightly.

We recommend that they do give this serious thought and look at the alternatives available to them.

During the site visit, we had a number of presentations by other people from other health agencies, including a number from the CHP B agencies, volunteer health associations, Model Cities people, the president of the State Medical Association, and so on. It was apparent that there was cooperation and participation both by the RMP in those activities and by them in RMP activities.

The RMP and the Oregon Medical Association are and will continue working closely together to develop a peer review system or some other quality assessment system that is pertinent to the needs of Oregon. To some extent, through the efforts of ORMP, there had already been developed by the Oregon Medical Association a requirement that their members take certain hours of post graduate education in order to be eligible for membership in that body. And indeed I have forgotten the exact number -- I think it was 11 -- members of that society had been dropped from membership because they failed to meet those requirements.

It was apparent, then, that the agencies in the Oregon region called upon the ORMP for expertise and advice and assistance, although perhaps there was a need for them to more clearly understand what ORMP was all about. And we recommended that there should be further elaboration of ORMP's role to the other health agencies in the area.

There are comprehensive health planning agencies in Oregon. There is a CHP statewide organization. Not all of the B agencies are functioning well. However, there is a close relationship between what does exist in the CHP and the ORMP. They abide by the policies which require joint review and comment where applicable.

I referred earlier to the fact that there was a relative lack of hard data in terms of health needs. And they

understand this. They have established what is called a needs assessment unit as part of their new organizational structure. And this presumably in cooperation with the health resources unit in the CHP agencies where they exist in the area will be undertaking some studies of what is necessary in Oregon to develop a quality health care system, not just only from the standpoint of defining where there is a lack of anything, but perhaps more from the standpoint of the provider defining what needs to be done, what process should be undertaken, to meet the needs. This needs assessment committee will overlook and guide the development of, they tell me, 17 different groups around the State consisting of physicians, and I think 12 or 14 nurse groups of a similar type.

They will be directed by coordinators. It will be their responsibility to determine and define what is required in a particular area of the State. We felt that this was a healthy change of direction.

We have little or no question about the quality of management of this region. The staff was good. As I mentioned, the fiscal agent was good. We found no evidence that there was any problem with the way they managed their funds or kept a handle on what was going on in the region.

However, related to this was the evaluation process.. I guess there have been some problems here in the sense that with budget restrictions, Dr. Yagi was put on half-time rather

than full time as an evaluator. Now, he will be going back full time, presuming this committee's favorable review.

And we suggested that they need to look at some other kind of evaluation. They have been looking at process evaluation rather than evaluation as to whether they have achieved their goals or objectives. And I guess as somebody has said, they have an H & H type of evaluation process, a head count and a happiness index sort of evaluation.

Dr. Yagi, however, seemed a capable sort of person, well organized, disciplined man, and we are hopeful that something more will come from his full-time employment by the Oregon Regional Medical Program. We are confident that he will develop the techniques appropriate to assessment of their achievement of goals and objectives.

Well, the action plan, I need not go into a great deal more because I think I have covered it to some extent in my previous comments. They are developing projects which will be programmatically oriented, which will be consonant with their goals and objectives. They are, indeed, looking at some of the needs. They are, I think, action oriented.

We did have one question about action, and I guess that relates to funding. You may note that in their request, they have asked for growth funds. We had a little bit of difficulty grappling with this because I wasn't clear in my mind at the onset of the difference between growth funds and

developmental funds. And I am still a little uncomfortable about this, but it appears that they have projects and activities in mind which were not at the time of this review fully developed and, therefore, they were not aware of the specific budgetary needs which would be relevant to these projects which they will undertake. They are asking for growth funds to support these specific types of projects, whereas the developmental funds are those which can meet needs which cannot be clearly defined at this point.

They feel that the growth funds would relate to their being able to develop primary entrance clinics in rural and remote areas, family practice clinics in underserved remote areas, and a television network. Having had some experience with television networks, I was not terribly enthusiastic about in a sense giving them a blank check. But after discu-sing this with them, they did seem to know that there are drawbacks to television networks, that they are not the epitome of educational processes. And they would view the television network in Oregon as more of an informational exchange mechanism which would permit doctors in remote, inaccessible areas to communicate back and forth and to demonstrate their problems with patients to more knowledgeable or resourceful people.

It may be a method which we have approved in other areas for getting expertise into remote regions by a

technological process rather than by transporting the patient or the expert.

The family practice clinic was also a little bit nebulous, I felt, in the sense that they were presuming that with appropriate financial underwriting, they could establish family practice clinics in areas where doctors had not previously chosen to practice. We reminded them that Sears Roebuck had not had favorable experiences along these lines. They felt that perhaps this was more than just building a building for someone to practice in; that they were going to make an effort to develop teams to locate in these areas. And if this is possible, then this would seem to be appropriate.

You may recall that in the Journal of Medical Education a few months ago, and I can't remember the citation specifically, there was a study of why people left practice in rural areas. And it was clearly related to the fact that doctors feel lonely when they are by themselves and that they do need some kind of health professional team about them. And if the Oregon Regional Medical Program can indeed generate teams in remote areas, it might be a worthwhile experience.

So it is with reference to these sorts of activities that they have asked for growth funds.

We feel that the Oregon Regional Medical Program is strong. We feel that with some of these projected activities, the development of the needs assessment unit and the health

resources unit, that the strengthening of the core, there will indeed be improvement in their programs and projects.

I shall not, I think, go further at this point and simply indicate that in general the team was impressed that this was a good region and that it was making attempts at strengthening regionalization, that it was trying to reach out into the totality of the State in spite of the fact that about 70 percent of the population resides in Willamette Valley. And I would like Dr. Thurman to make some comments at this time if he wishes to do so before we talk about the funding.

DR. MAYER: Bill, comments?

DR. THURMAN: There is little to say. I agree with everything that Phil has said. I think one of our major concerns was that core staff is too small to do particularly with the new thrust job that they are trying to do.

We were all impressed with one new man that they had added recently and how much time he is spending on the road and bringing things in.

I would underline one point that he made and that is that their coordinator is so strong that if he had a coronary tomorrow, they might be in trouble really because there is no depth. So that all of us brought over to him again the business of needing a deputy coordinator to pick up some of these things.

I think the only other two points I would underline

about what Phil said was that they really don't understand what consumers are or have not understood what consumers are and had not made a truly honest effort despite the fact that one of their core staff was specifically assigned this responsibility. I believe that our site visit was very useful to them from that standpoint and that they understood what we were trying to say, they thought we were saying it reasonably nicely. And I believe that they intend to move on with that relationship.

The other point was the one he made about a fair amount of their money goes to help develop programs for other agencies. And despite that, there are a great many people who do not see any visibility for the Oregon Regional Medical Program. Dr. Reinschmidt recognizes this. I am not so sure that he knows how to correct it. I am not so sure that anybody knows how to correct it. But it is interesting how well he has done with his money in helping other people get their programs off the ground. But it has not provided the visibility for RMP in Oregon that it might have otherwise.

I close all that by saying I was very impressed with this program.

DR. MAYER: Mr. Moore, do you have additional comments

MR. MOORE: No.

DR. MAYER: Phil, your recommendation?

DR. WHITE: Well, as I mentioned, the major problem

was this growth fund. You may note that they were asking in the second year for $775,000 worth of growth funds. That is a lot of growing. And it appears to me that this is an unrealistic estimate of their needs. And I think the site visitors felt that.

There were things on thehorizion -- these television systems, the family practice clinics and so on, which will be coming to fruition in the near future. And some funding will be required, but it seemed improbable to us they would be able to spend that amount of money that quickly.

We recommended, therefore, a reduction in this to about $250,000 for each of the second and third years. They did not ask for developmental funds the first year, so we have recommended they get what they asked the first year; that each of the second and third years they get reduced growth funds plus their developmental components and instead of $1,588,000 the second year, we have recommended $1,063,000, the third year in contrast to $1.6 million, we recommended $1.52 million.

DR. MAYER: That is in the form of a motion?

DR.WHITE: I would move the adoption of that.

DR. THURMAN: Second.

DR.MAYER: Questions or comments by the committee?

DR. HINMAN: Do you want me to comment on the kidney now?

DR. HINMAN: Because that is included in that.

DR. MAYER: The only reason I didn't mention it was simply because I had heard somebody say that there was somebody out there today.

DR. HINMAN: Part of this application from Oregon includes a cadaver organ procurement application. At the time that the CHP A agency established its health plan for the State, kidney was a major activity and was a well-outlined plan for entry points into dialysis and to transplantation which design was accepted by the Governor. Parts of it, particularly the dialysis aspects, have been implemented to date.

Their application requests funding to enlarge organ procurement activities throughout the State, particularly in this valley right here where most of the population resides and in which there is an interstate highway and a lot of carthage on the road. So that the availability of organs is right in this particular area.

They also are requesting funds to expand their transplant capabilities. The VA hospital in Portland has been approved to increase its transplant capabilities. It is targete to procure sufficient organs for the needs of all the residents in the State, both the veterans and non-veterans.

This was reviewed locally by the RAG and by a staff group. There was some concern about some of the budgetary

items and recommendation was made that a consultant visit the area. And today was the only day in which we could arrange to get more than one of the transplant surgeons who has had extensive experience to go up.

There were a couple of areas in terms of equipment in their planning and in some of the fee items that we felt should have comment from someone outside the region. So we do not have an exact dollar recommendation. It is our anticipation that Dr. Belcher will recommend that the program be approved as it stands, but with some negotiation of the budget items.

So that in your motion, Dr. White, since it does include the kidney dollars as requested, if it is acceptable to allow some scaling down of that, depending upon negotiations going on today.

DR. WHITE: It is acceptable to include that in the motion as far as I am concerned.

DR. MAYER: I gather the site visit team from the comments in the report had no concerns about the kidney proposal

DR. WHITE: We didn't look at it in any great detail, anticipating that someone else was going to do it for us.

DR. HINMAN: Dr. Blomquist from our staff was a member of the site visit team and talked with the investigators before the site visit.

DR. MAYER: Comments on the motion?

Jerry?

DR. BESSON: Phil, do I understand then for this fifth year, you are recommending no growth funds?

DR. WHITE: No, we are recommending growth funds, but substantially reduced from their request, Jerry.

DR MAYER: Not in the fifth year.

DR. WHITE: They have not asked for them in the fifth year.

DR. BESSON: I see.

In this summary sheet of what they plan to do with their growth funds -- Oh, I see, they have just begun with the sixth, used for the sixth year.

DR. WHITE: Yes.

DR. BESSON: In reading at least your reiteration of their goals and priorities, and you mentioned the holy trinity of cost containment,the quality improvement, and what was the third?

DR. MAYER: Accessibility.

DR. WHITE: Accessibility.

DR. BESSON: Increased access to care -- that they have some money set aside in their growth fund for the additional funding of the establishment of a peer review organization on a statewide basis. $50,000 was set aside for the second year. And since they are being funded currently by the National Center for the development of such an organizati

and if these goals are going to be more than just rhetoric as far as Oregon is concerned, I wonder if in our letter to them explaining the action of Council, whether it might not be appropriate for us to encourage them in the use of their growth funds for this kind of activity.

There is precious little that review committee can do. Perhaps this might be one thing they can do. And there is no need to make a motion, but I would just like to call attention to that use of growth funds and encourage it.

DR. MAYER: Phil, would you care to comment on that?

DR. WHITE: I am sure that they would welcome this recommendation. They are highly interested in this area, and I think if we were to encourage them, they would become more active.

DR. MAYER: Could I raise a comment about the growth funds and the principles inherent therein?

As we move toward anniversary review, triennial review, whatever you want to call it, it said that each program would hae the option of and has the responsibility of coming in annually for an update of their requests. It was my understanding when we did that that provided a mechanism for requests for new project proposals of the individ regions once they have been fully formulated, fully approved by the Regional Advisory Group, to find their way to Washington.

And I guess I am caught on the horns of a dilemma

of saying, "O.K., we are or are not going to use that mechanism in terms of contingency funds." That is what the developmental component was all about.

I guess it is that problem of should they come in next year with additional project support identifying $250,000 worth of projects that they want to accomplish with the assurance that they have gone through RAG in detail and have been approved. I would have no problem with the annual review within the triennium of dealing with that.

What is the problem with dealing with it in that way? Because I thought that is what we were proposing two years back or a year and a half back when we were moving in this direction.

DR. WHITE: Well, this is precisely the same problem that we examined on the site visit itself. Some of us, at least, were reluctant to accept this blank check in a sense that we were giving this region. I do think I understand the difference between how they are going to use these versus how they would use developmental funds in the sense that they have specific projects that are being generated which presumably would be at an active level a year from now.

DR. MAYER: But don't they have the option of coming in a year from now and asking for additional funds to accomplish that?

DR. WHITE: Surely. I think they do.

DR. SPELLMAN: It seems to me this option would be retained if they got frowth funds if you would like to consider that. It seems to me if they are awarded growth funds, they could still do this because this would not in that sense be a supplement.

DR. BESSON: I see a subtle difference that if there is something new in RMP that emanates from the regions that this may represent. I see in the use of the term "growth funds" and as I read at least the summary that they mean to use this in a slightly different way than developmental funds in anticipating that what they are going to become involved in is going to increase in scope rather than actually developing new ideas, although they do list the number of projects that they hope to fund with this.

And I think that I remember a couple of years ago I made a suggestion which was unfortunately not accepted by this committee or Council that when we see a region that is moving in the direction that we are almost impelled to say, "That's it, you are doing just what you ought to be doing," that they be commended in some way. And the only way in which we can do that formally -- I had suggested some kind of certificate -- is with bucks.

I wonder whether this use of growth funds and our acceptance of their concept wouldn't be a way of this review committee at least indicating to them that, yes, this is a

very appropriate way for Oregon to be moving in contrast to some others that we will discuss over the next couple of days that are going in the totally opposite direction, and we would discourage by turning off funds.

This is a way of supplementing their request. I like the idea. I have not encountered it before. But I think it is a good one.

DR. MAYER: O.K., further comments?

MR. HILTON: Just a question, really. I am going to take advantage of my newness to this committee.

Is there still a distinction between this term "growth funds" which is new to me and the developmental component?

DR. MAYER: I have no problem with that because I think that what they are saying is in terms of the developmental component that that is priming, catalytic kind of dollars. And they are saying that growth fund, if I understand it, Phil, are dollars for new projects --

DR. WHITE: That's about right.

DR. MAYER: -- as yet not formulated in final form, but have at least come along far enough so that they can see that they are going to be in final form within a finite period of time.

DR. WHITE: That is essentially correct. And they justified this in a sense that in the past they have gone

through this process of developing an activity, a project, but they have been unable to carry it out because of serious restrictions on the budget which you are all familiar with a year or so ago. And they feel that without some kind of a little carrot in hand, they may have trouble getting these people who they need to cooperate with their transportation system, peer review system, the family practice clinic system, to go along with the whole idea.

I can see this point. On the airplane out, I felt this was a nonsensical way of approaching the problem. I felt just like you. Once they developed something, they come back next year and ask for support for it. But after talking with them, I understand their viewpoint and feel perhaps there is some legitimacy of awarding them these growth funds, particularly since I think all of the site visitors were particularly struck with the quality of the people involve in this area.

DR. MAYER: I guess I have to ask the question of staff as to whether this is or is not within existing policy of the RAG and whether this is a policy issue that ought to be surfaced. I am not saying pro or con, Phil, in terms of the approach because I think philosophically, I am in agreement with the approach. But I am not sure that that is not a policy issue as opposed to a request issue.

MRS. KYTTLE: Dr. Mayer.

DR. MAYER: Yes. Mrs. Kyttle.

MRS. KYTTLE: In back of the tab labeled "Council Highlights" in your books is a resolution passed last Council that says unless the review procedures have stipulated to the contrary when regions enter a triennium, the approved levels of the first year will hold for the remaining two approved years of the triennium.

We had to move to that because Oregon, like several other regions, proposing a triennium, particularly in your fifth year, and it catches you betwixt and between with a program that is ongoing and yet in the next year it will drop, was attempting to establish a level for its triennial period within which it could move in its triennium. That is the concept of the approved triennium.

And yet, these regions when they map out their second and third year of the triennium are not in a position at that time to specify the exact projects and the exact budget that will preserve a level. So with last Council's action that unless there is a certain reason for a decreasing level in the triennium, the first year's level of the triennium will be the approved level, not necessarily the funding level, but the approved level for the remaining years of the triennium.

DR. MAYER: Well, where does that then relate to the annual review within the triennium? They are saying is that option now no longer possible vis-a-vis the action of the

Council?

MRS. KYTTLE: O.K., within the action of the Council establishing a level for the triennium, at the anniversary a region may come in and propose uses of the dollars up to the approved level by Council. And that is an action that staff anniversary review panel considers and reports to you about.

Should they request the use of dollars beyond that level, then that would come to committee for action.

DR. MAYER: But that option is still available.

MRS. KYTTLE: Oh, yes, indeed. They may request a second year triennium budget that is over the level of the approved level for that year of the triennium if the staff anniversary review panel recommends that that level be increased. And I think last time Tri-State was one that came to committee because staff was recommending the second year of the triennium level be increased, but there was no other way for regions other than to forecast a program three years ahead that might radically change than to either do as Oregon did, provide growth funds, you remember Western Pennsylvania did it when they went to triennium. They were trying to preserve a level, give you inklings of what they would go into. But they are not yet ready to be specific about it. And it led to the policy from the Council last time.

DR. MAYER: I am not sure that answers the question

that I have raised, though.

DR. WHITE: No, I am not sure that is correct. At least my understanding is that the second and third year budget shall be not less than the --

DR. MAYER: Let me try it again.

MRS. KYTTLE: I was waiting for your action because this one increases.

DR. BESSON: That's why you are saying not less than.

DR. SPELLMAN: Is that what you said?

DR. BESSON: You said it is at the same level.

MRS. KYTTLE: It would not be less than the level established for the first year unless committee said, "Yes, we want this decreasing because we don't like that."

DR. MAYER: But that doesn't answer the question which I raised which is what is existing policy of the Council in terms of this group taking action on providing contingency funds for growth. You know, without clear-cut evidence of what it is going to be used for.

DR. SCHMIDT: You are saying it is a new way to get money. Is that what you are saying?

DR. MAYER: No. I am saying is it consistent with existing policy of the Council and in that sense legal?

DR. PAHL: Bill, we don't have a clearly formulated Council policy on the point that you are raising. And at this point in time, the concept of developmental components and growt

funds which has been coming into it has not been fully assessed by staff. This is one of our agenda items because we are getting into various ways of providing flexibility to the region. So it is appropriate at this committee meeting to make whatever recommendation you want to the Council, and they will be asked to establish a policy in connection with these various ways of funding.

But you are not inhibited at this point in time from recommending favorable action on growth funds if you so desire and to recommend different levels of funding for the different years requested.

Nothing in the Council policy that Lorraine mentioned is restrictive. Both this committee and the Council may set whatever levels for the individual years are decided upon. It is just thatunless special action is taken by the Council, then a level is fixed.

DR. MAYER: Let me try it once more with my problem. My problem is I sit here knowing a year and a half of effort and energy of a lot ofpeople went into establishing the policy of the developmental component. And I think that was appropriate because out of that came some guidelines that were known to everyone in the world about what developmental component is.

We are now talking about growth funds. And all I am saying is to me that sounds like it is as every bit as big, if

not a larger, policy issue than the developmental component. And rather than deal with that on an ad hoc basis, I would just want to get it flagged as an issue that ought to be looked at and guidelines established rather than doing it on a hit and miss kind of ad hoc sort of basis.

DR. PAHL: There is complete concurrence. It is just a question of priorities. We haven't had an opportunity to do this.

I should say that although the concept of developmental component was clear at one time which meant that there would be additional funds as a reward, it turns out that as one moves into the triennial period and where there has been responsibility delegated to the region for funding projects within the Council-approved program without coming back and looking on a project-by-project basis and where no additional funds are being provided because the developmental component is awarded, the concept of developmental component has been changing. And right now, I don't think it is as clear as you have indicated it was when it was first enunciated.

Many times we approve the developmental component without additional funds which gives them a flexibility within their program. But by now, going on to a three-year basis, they have practically all the flexibility that they need within their program. And the whole concept of what developmental component is actually accomplishing under a level budget

is quite different than what it was under a rising budget. And this is the question that staff and Council must discuss.

And it is further complicated by this new concept of growth funding that has come in.

So we are not in a position to say there is a Council policy or that there has been a staff analysis and clear statement policy. These things have yet to be done. So you are free to flag the issue, and we will be coming to this as quickly as we can. But we don't have a policy for you, and Council doesn't have a policy that I know of at this particular point in time.

DR. MAYER: Phil.

DR. WHITE: I think it is worth bringing to Council's attention, and I think it is worth pointing out that this region and I hope all, are full of integrity and honesty, but they could have said these are projects we are going to undertake, that we have them fully developed and planned, and we know precisely what we are going to do, and put down a budget and say, "This is it." This way they were honest with us at least and said, "We are going to move in these directions, we don't yet know what it is going to cost, and this is our estimate."

Their estimate varies from ours a bit, but I think something ought to be done to deal with these sets of circumstances.

DR. MAYER: O.K., other comments?

MRS. KYTTLE: Just one, please, on triennium.

When we first defined the status of triennium, we said that it declared a region as an accredited body and that it could move in this triennium.

Now, following that, the region needs some commitment of financial stability through these three years. And that is what is leading us to the concept of the funding level established for the beginning of this triennium should not decrease during that triennium unless there are specific reasons for it.

DR. MAYER: We have no problem with that, Lorraine. I think that is a second issue.

Yes, Mrs. Silsbee.

MRS. SILSBEE: As I hear it, though, I think if you decide you are not going to have any growth funds, the level would automatically go down in this particular instance.

And while we don't have a Council policy, the discussi of Council at the time Western Pennsylvania proposed this very same thing and the Council member who had it wanted to make very clear that Council knew what they were doing here, and they did agree to that as a concept. And they approved it.

DR. MAYER: O.K., comments?

Jerry?

DR. BESSON: We have amotion on the floor to accept the recommendations of the site visit team. And I wonder if

I could amend that since this may be a focal point for pinpointi this question, the amendment to include something to this effect that where a region shows evidence of implementing policies which are concurrent with its stated goals and priorities and also consonant with national priorities, that in order to encourage its expansion in this direction, growth funds may be awarded on application at the discretion of the Council.

DR. MAYER: And upon recommendation of the review committee?

DR. BESSON: Yes.

DR. SPELLMAN: I would agree with that in principle. And I think taking what Judy has said and what Herb said, if increasingly developmental funds are being used as growth funds which is really what I understand you to have said, the flexibility is even greater than was intended. Then, you might just as well drop any distinctions between developmental and growth funds and call it by a single name and let the full amount then bear some relationship to the difference between the level of funding in the first, second, and third year rather than that very modest increment in developmental funds. Because, again, you see, if he calls this developmental funds by tradition or whatever, he is limited to a pretty small amount. But by adding growth, he has an amount there that is almost a fourth of the total level of funding.

So I think you might consider now adopting a single term and that you look at it only in terms of the increment above the first level of funding. It wouldn't make any difference there, and that would take care of what everybody is talking about.

DR. MAYER: Could the chair try to separate these two out? They are linked, but I would like to deal with the individual proposal and then deal with the policy issue if we could.

DR. BESSON: Then I will withdraw.

DR. MAYER: Because you may find yourself in a position of having to vote against the recommendation that you might agree with because you are disagreeing with the principle. And I think that would be inappropriate.

DR. BESSON: O.K.

DR. MAYER: Further comment on the recommendation of the site visitors relative to the funding and level of funding for the Oregon RMP?

MR. MOORE: I would like to add one point.

DR. MAYER: Yes, Mr. Moore.

MR. MOORE: Of the seven growth fund activities they are presently participating in five as a part of planning feasibility and core activities. So these are not new activities per se. And the use of the term "growth" that should the feasibility planning studies grow to a point of

projects in the following years, then they would be submitting such projects.

DR. MAYER: Further comments?

(No response.)

Everyone clear on the motion and recommendation?

All those in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

Now, the question is how do we deal with the issue. I think it needs to be flagged, obviously, as a policy issue. And maybe, Jerry, the approach that you are taking is the obvious one. I just have a feeling that the implications of that are moderately significant in terms of how people change in approach. And having been in on that discussion on a developmental thing as many of us were, that got to be pretty sticky. And I am not sure that it isn't just raising the flag of the policy issue in suggesting that an appropriate group be called upon to look at that issue and to insist or at least to suggest that representation on that group come off of this review committee as well as off of staff and Council.

I am just suggesting that as an approach. Maybe it is as simple as you say.

DR. BESSON: In the interests of being even-handed with the bandying about of the notion of emasculation, I think

putting some -- I will block that metaphor that just came to mind -- but getting the review committee back in the saddle -- (laughter) -- that I would like to keep this idea of a growth fund separate.

Let me reintroduce my motion. But I would like to keep it separate from the developmental component mentioned because I think it really says something different.

If there is some merit to the idea that the review committee by its action can tend to move this ponderous machine in one direction or another, then the use of growth funds can be what we used to do many years ago in awarding funds for projects -- encouraging those that we said yea to and discouraging those that we say no to. But now we can no longer do. All we can do is award a lump sum and approve general principles and process.

But this might allow us to indicate to a region that, yes, they are doing what they should be doing and to other regions that get zero growth funds, that can be a very obvious sign to them that maybe this review committee and the general direction therefore for how RMPs should develop may be somewhat more re-established.

DR. SPELLMAN: I would just answer that by saying that I think the differences between what the growth fund and the developmental component are going to be used for in the future could be increasingly artificial. If you look at

that, it is only 13 percent different between the first and second year.

What this means is this is just an assurance to Oregon that they have a level of funding higher in the second and third year with a wider latitude to determine what they are going to do with that increment. That is all it is. And I wonder, what Herb said, if people are already doing this with the developmental component anyway, what is going to be done with growth funds? It just doesn't seem to me any longer to have any merit by creating two kinds of instruments which in the final analysis are used for the same thing. That is the only point I make.

DR. MAYER: Joe.

DR. HESS: As I have listened to this discussion here, I have wondered how much of this problem would have been eliminated if they had just not put in those two words "growth funds," and left those projects listed under the headings and th money attached to it and left the developmental component just sitting there and get those two words out of there. How much of this discussion we had had in the last few minutes would have gone on?

DR. MAYER: If you are saying if they had formulated projects that were there that the site visitors felt were consistent with their goals and it was clear that they had gone through the internal review process, I would have no

problem with it. But those are two big if's.

DR. HESS: But what they are saying here, it seems to me, is these are areas in which we want to develop projects. This is not completely flexible money that can be used for anything that happens to come along, but these are ideas that we have that are partially formulated that we think are appropriate to be in the regions that we are going tofund. And they are projects in process which to me is a different thing than developmental component which is sort of flexible money that could be used for something that hasn't even been thought about yet.

DR. SPELLMAN: But the evidence I gather is that the differences between these are rapidly fading and indistinguishable from what he tells me. The question is really two years from now whether we will be able to tell them in Oregon what is the difference between the way they use the $75,000 and the $250,000. They may lose their definition. That is all.

But I am in agreement with the principle that they ought to have $75,000 plus the $250,000. I was just suggesting that it be done in a way which in the future would make it a lot less complicated than inventing nomenclature that is just meaningless. It is the way of getting more money for the second and third year.

DR. MAYER: Maybe it goes something like this -- let

me try it and see if this is acceptable: That the committee is in favor of the conceptualization of the growth fund issue; that if definitive policies are to be established relative to growth funds and how they might appropriately be done, that the committee expresses its desire to participate in those decision-making processes.

DR. BESSON: But they can't do it because once the anniversary review, once you fall into that slot, then you no longer have control.

DR. MAYER: No, no. You are missing what I have said, Jerry. I am sorry. What I am saying is if the Council in its infinite wisdom listens to the fact that we think the growth funds are good, they think it is appropriate, but it finally dawns on them that unless they start as in all things to further define what the boundaries of growth funds are, what percentages might be appropriate, da-da, da-da, da-da, when they do that, all I am saying is we ought to participate or representatives of this committee in the future ought to participate in those discussions.

Yes, Leonard.

DR. SCHERLIS: Maybe I am hypoglycemic, and I don't quite know why I feel as I do about it, but I really think we are raising issues that we are looking to raise in this regard. I would much prefer that the site visitors give us a recommendation that certain priorities have been set up which

obviously require certain funds of money. And it is apparent that the money will be spent in that area.

I don't like the term "growth" now. We are going to have to define it as distinguished from developmental.

Maybe I am the only one who has the limitation of trying to distinguish between these two terms. I would much prefer we keep the developmental as it is and just ask for a little better definition of how they are spending the money.

You have defined it. You said seven areas they are moving into. They have already moved into five, they need the funds to move into the other two. After all, I would just say they found some money, that is what they are going to do, and they defined it pretty well.

I would hate to see us telling Council when they have reached a decision they have got to come back to us, and we will discuss it further. I don't think a decision is necessary in this regard.

I would move to strike out the last ten minutes of discussion.

DR. MAYER: Joe.

DR. HESS: I think we may well be creating an issue that doesn't need to be created here. If we understand what they want to do, because they happen to use a couple of words that were unfamiliar to us, let's not get hung up on formulating a brand new policy. It seems to me this could be

handled under existing policy of a region who has reached the triennial status.

DR. MAYER: There is more than just the words, Joe. There is some substantive difference between this approach and other approaches of definitive projects. And I won't say anything more about it.

DR. SPELLMAN: If it is that simple, you can predict that everybody will do that.

DR. BESSON: I think everybody else might have the option of doing it.

At the risk of prolonging this discussion at an inappropriate blood sugar level time, and many decisions we may make are based on no more influence than that, I would say that I see a difference. And I think that a 13 percent increment you referred to, implying that therefore it is not very different from the developmental component, I think I read somewhat differently here, Mitch, because I see that that 13 percent increase is a result of a 24 percent decrease in projects and an 18 percent decrease in core, but 100 percent increase in growth funds.

Now, that gives you a figure which is not far from the developmental component. But the point is I don't think that 10 percent is adequate enough for what some regions want to do in an expansioning fashion. The growth fund concept, I think without putting a percentage figure on it, allows

a region that is moving in the right direction to really blossom.

Right now it is constrained from so doing by having a limitation of 10 percent on it.

DR. MAYER: O.K., I guess the question I have to ask is, we have taken an action on one which does have this principle that would suggest we are in favor of it, at least as it relates to Oregon, and we have no objections to the principle at least as it applies to Oregon. I guess the question I want to raise is do we want to make any comments above and beyond that of a more generic nature to Council? And if we do, what is it? And if we don't, then, fine, let's end the discussion.

Mac.

DR. SCHMIDT: I believe we should comment that it seems apparent there is some change in the concept behind the developmental component and the growth fund concept is worthy of study in relation to the other. And the staff and Council should take this under advisement and so on.

I think both of them have to be looked at in relation to each other and something new developed.

I personally favor a single type of dollar. And I am really closer, I think, with Leonard than anybody else.

DR. BESSON: I withdraw my motion in favor of that.

DR. SCHMIDT: I would move the sense of whatever it

AFTERNOON SESSION

(1:40 p.m.)

DR. MAYER: What I would like to do sequentially as a tentative agenda is go down the list and pick up Ohio and then pick up Northeast Ohio which is in a way linked, then go back up to Nassau-Suffolk and to Nebraska sequentially. And that gives John a chance to settle in before he has to go to bat.

DR. KRALEWSKI: Thank you.

DR. MAYER: And I assume that you all followed the explicit instructions given just before breaking for lunch to use part of your lunch break to complete the rating sheets on Oregon. If you did not do so, let's take a couple seconds and do that now because I am afraid if we wait after we start in another one that things may get a little fuzzy.

What we are turning to, then, is the new Ohio Regional Medical Program. I am the primary reviewer, Mr. Hilton is back-up reviewer on it.

Let me comment in way of introduction about this one, Phil said or someone said earlier you ought not to make apologies, but I really feel that I have got to make some disclaimers at the outset on this one because after six years and six months of involvement in one way or another with RMP, staff somehow seemed to have saved the toughest task that I have had to the last day of my service. For what they have

done is given me the opportunity, if you can call it that, without benefit of site visit or personal involvement six years after the funding of the first RMPs what is essentially a new RMP to review by guidelines which are long since moved on to other kinds of things.

At this stage in the development, we are supposed to be looking at total programs and not individual projects. Yet, there is as yet no really total program existent here.

At the same time, there was a mandate from us and Council that they try in the Ohio Region to put two or more of those individual RMPs together because of their poor quality to date, at least the three of them, and they have done that, at least with two of the programs. Our advice and counsel are to go up to the National Advisory Council, two of whom whose most sophisticated and long-standing members, Bruce Everist and Clark Millikan, have trod this sod which I have not trod in January, and they obviously, I suspect, have some preconceived ideas about what ought to be done in the area.

If there has ever been a setup to wipe out itself on this one, and I can see the headlines now, "Mayer goes down in flames on final mission."

To cap it all off, I am not sure how much advanced notice Mr. Hilton had. At least in the previous communications that I had, it didn't appear there was a secondary reviewer on

this. And so I really think it is going to be, "Mayer goes down alone in flames on final mission."

So I commence this review knowing I picked up an assignment befitting a chapter in "Mission Impossible," and wishing that not only my instructions might have self-destructed but the whole region from Athens to Zanesville.

As a background, you will know, as you recall in previous meetings, we felt that although the State of Ohio might be the mother of Presidents, we hardly felt it was the father of RMPs. There were four RMPs involved in the State -- the Ohio State RMP which was focused out of Columbus, the Northwest Ohio RMP focused out of Toledo, Northeast Ohio RMP focused out of Cleveland, and then the Ohio Valley-Kentucky RMP focused in Kentucky and including Cincinnati and the several-county area in southwest Ohio.

The first three, to put it mildly, had a great deal to be desired. And it was suggested by staff and by ourselves and Council that we might be able to put some bad apples together and with appropriate aging come up with a vintage wine rather than some sour cider. I am not sure how appropriate that decision was, but that was the decision we made.

Accordingly, in the April-May review cycle of last year when we had all of the bad apples together from Ohio in the review process, we extended their funding for an abbreviated

period from July of last year to January to provide them the opportunity to get together. This they did with the following results:

It looked like the Ohio State -- I think if you will take your yellow sheets, page 7, there is a map which outlines the region. It gives you some feel for the geography. What appeared was that the Ohio State RMP which is central and southeast Ohio and the Northwest Ohio RMP were making music together, but the Northeast RMP really was keeping out and saying they wanted no part of those other two. And really, the Ohio Valley RMP which incorporated the southwest component of it was never really a major part of the issue, feeling they probably were a functional RMP and it may not be appropriate to try to get them involved.

So we extended them for six more months from January to July after having extended them six months from July to January to try to work that out, then extended them another six months and then sent the shock troops of Millikan, Everist, and staff in on January 10 and 11 as a fact-finding activity relative to the three regions.

The results of that visit are outlined in the very poignant comments of Millikan and Everist on pages 27 to 35 of the yellow sheets. I recommend those to you as reading programs tonight because I think they are classic examples of what two pros can surface in just two days in a region.

In brief, they, however, discovered the following: That Ohio State and Northwest Ohio RMPs were making progress towards union and Northeast Ohio in its pristine purity was having none of it. And although they had invited the Ohio Valley-Kentucky groups to participate, they felt that it was probably not appropriate to incorporate them in it.

The end result was a series of recommendations that came out of the February '72 issues of Council which are on page 2 of your yellow sheets. And I will not go through those in any detail, but essentially I think did recommend the formation of a new RMP which combined the Ohio State with Northwestern regions and that the effective date of merger be September 1 and that this application of that merged, two merged RMPs, are to be brought back to this particular review cycle.

Well, that is the background of this particular application. And what do we have in it? We have a proposal then to merge previously existing Ohio State and Northwest Ohio RMPs into the Ohio Regional Medical Program.

We have a request for $2,082,000 in direct costs for one year activity when as near as I can figure out from data which are not totally complete, they are roughly at a $1.4 mill level of activity in that.

The request includes a request for $1.2 million of program staff, a core, compared to a current combined total

of about $800,000 now in core.

We have a request of approximately $800,000 of project funding which include the following:

One, two projects, the first and second ones there which have previous Council support for approval for support for an additional year.

Two, a kidney project in the amount of $201,000 -- that is project three -- which will be reviewed on May 8. And since this is May 4, I don't know what that review has in common.

And thirdly, there are 12 other new projects, nine of which are from the previously existing Northwest Ohio RMP and three from the previously existing activity in the Ohio State RMP. And when I am saying nine in that Northwest Ohio RMP, I have to comment parenthetically there has been a considerable amount of concern that previous activities in the Northwest Ohio RMP were moving towards the funding of the newly developed medical school at Toledo with emphasis on that rather than to a greater degree on the RMP component.

And, finally, one out of the 12 that is a health careers program of Ohio in the amount of $171,000 outside of RMP guidelines. And that is contained on page 17 of the yellow sheets as to why.

In my opinion, then, they have made progress in merger. They did attempt as requested by Council to move the

Northeast Ohio and Ohio Valley RMP. However, this whole application has the flavor of a new and developing region. And it kind of has the deja vu of four to five years ago.

William Pace, the Dr. William Pace at Ohio State who is the acting coordinator, obviously has had a great impact in trying to bring this merger about and has obviously been helpful in effecting it. However, he is pulling out or resigning on June 30 of this year, and they are looqing for a new coordinator. The reasons why Dr. Pace is leaving that responsibility aren't clear, and perhaps staff may have some comment on that that may be helpful to us.

Secondly, in terms of the review process at the regional level, this appliation is acknowledged by them to essentially having been nonreviewed in the kind of review process that they would hope to ultimately accomplish in a combined region due to the newness of the effort.

Thirdly, the goals and priorities of the group are general, not specific, but they do have a mechanism and are actively, I gather, working on them.

Fourthly, the advisory council is temporary and is in the process of -- this is the combined advisory council -- expansion in organization.

Fifthly, the staff is not yet fully formulated or organized, although there is a fairly good proposal for organization that is contained in the application activity

materials. They now have, as I gather, 19 professionals in the two pre-existing programs, 13 in Ohio State and 6 in Northwest Ohio, and are requesting 32 professionals in the core staff and the new development, an increase of 13.

Sixthly, they have agreed on a grantee and a fiscal agent, the Ohio State University Research Foundation, which is evidently a private corporation which is handling the research funds of Ohio State in the amount this year of around $20 million and obviously have competency at the fiscal level to handle the activity.

And, finally, they evidently have settled in a positive light on a relatively strong RAG chairman in the form of Dr. Brain Bradford of Toledo.

So that's where we are. And I suspect you can understand part of my problem that I tried to outline at the beginning of the presentation. When I got to this stage of the report, debating about what to conclude about all of this in light of the newness of the activity when most programs have moved on in a far more sophisticated fashion, I recall John Gardner's beautiful essay on the anti-leadership vaccine which some of you may have read. And it is in the part when he was describing one of the great dilemmas of the day and problems of today is the lack of any real confidence in the leaders of today -- that is, confidence in their capacity to perform and assume responsibility.

When he was talking about it, he described the story of the little girl in the third grade art class who was asked by the teacher, "What are you drawing, Mary?" To which Mary replied, "I am drawing a picture of God." And the teacher then said, "But, Mary, no one knows what God looks like." Mary simply said, "They will when I get through."

So what I am about to tell you is I have no idea in my own mind really what is the appropriate way of going about evaluating this activity. We have an example of two regions which have a poor track record in terms of what they have accomplished in the past. We have told them to merge. They have done that and have done that with, as I gather reading between the lines, a fair amount of pain, but nevertheless have accomplished it and do look like they are beginning to move in appropriate directions.

So that is where it is. And I guess it is out of that kind of anxiety and concern that I will blithely go ahead and give some conclusions about recommendations about the activity.

As I indicated before, the funding, as near as we can get an estimate of the program support of core staff of the two programs together, is about $811,000 on an annual basis. I would recommend funding them at about $900,000 for the first year which is roughly a 10 percent increase with recommendation for second year funding about 10 percent above

that or at the roughly $990,000 level. This does, then, at least give them an opportunity to try to take the steps of putting the two programs together and building a strong and effective core staff.

They are currently funded at about $583,000 in terms of individual projects and are asking approximately $800,000 for individual projects in this. And I would recommend a level not to exceed $500,000 in project activity with a minimum of 5 percent increase in the second year.

Included in that funding of individual projects obviously is the continuing commitment of the funding of projects 1 and 2 which have already been approved if they so desire. And included in 2, is the funding of the renal project if approved by the ad hoc panel. And if it is not approved by the ad hoc panel, then I would suggest a reduction of that amount from the $500,000 that I recommended above.

And then, fifthly, obviously excluded from approval for them to spend any of their money on what would be project 8 which is outside the guidelines of the RMP.

And, finally, I would suggest that we indicate to Clark Millikan and Bruce Everist at Council level that I reviewe this project for the review committee and suggest at least that my tour of duty with RMP, at least at this point in time, at least equals or exceeds theirs, so when they get to alter these recommendations at the Council level they at least know

whose recommendations they altered.

Mr. Hilton, comment?

MR. HILTON: In view of the weak history of the Northwest Ohio Regional Medical Program and the Ohio Regional Medical Program prior to its consolidation, it might be appropriate to ask whether encouraging consolidation would really amount to lumping together weak programs in order to create a larger weak program. I think that is the dilemma we are facing right now, and we don't really know what with the vacancy in the coordinator position and some of the other things that are on the horizon.

However, I was positively affected by the documentatic on this program. The statements of by-laws and very detailed descriptions of administrative procedures which will be implemented in this new, first operational year of the new ORMP.

The RMP recognized that consolidation really has been against the background of its history its major accomplishment for the last year. It also concedes that it has taken a good deal of time, staff time, and energy.

They face a problem, looking to this first year, I think, a dilemma which was described in one of the documents I read whether they should devote themselves aggressively to plaqning and development activities in light of this new consolidation effort or whether they should launch apparently

a real active involvement in new projects. I don't think it was really an either/or position. They opted for the active involvement in projects which I had the feeling would not be appropriate. And so I totally agree with Dr. Mayers' suggestion they not be funded to launch all those projects.

I think there still remains to be enough uncertainty about what would happen with the new coordinator. And I think we are really inviting a situation where the body controls the head to have this much predetermined before a new coordinator could be hired.

I was impressed by the participatory RAG or what they call their Regional Advisory Council, Regional Advisory Group. Apparently that body participates fully and actively. And there are some innovative ways in which RAG members will be able to through task forces continually monitor the progress of staff toward consummation of projects that have been proposed for the area.

Some of the things that worried me -- I have alluded to one already, and that is not knowing the coordinator and not knowing whether we are really talking now about a larger, more efficient program, more efficient leadership, or just a larger program. I was impressed by the efforts to keep the door open for Northeastern Ohio and even for Cincinnagi, which seems not to be inclined to join the group.

On the matter of minority interests, the Statewide

statistics suggest some 9 percent nonwhite population in Ohio. And for this region, this new consolidated region in particular it would probably somewhere in the neighborhood of at least 6 percent minority overall. But on the staff, some 19 professionals, there are 2 black professional staff. There are no other nonwhite minorities indicated in any of the reports. And there are 2 blacks on the clerical staff. I am uncertain as to the minority input into the RAG. And planning committee, I get numbers that range from 8 to 11 in terms of participation and no clarity on the degree of participation.

Nor are there any statements indicating any move at this point to act on that problem.

The new projects, 9 new projects that were submitted aside from the legal point on project No. 8 seem to have been heavily designed by Northwestern Ohio which originally covered only 12 counties. I was concerned whether the smaller number of counties to the extent that these projects might be based in those counties should dominate the entire Ohio Regional Medical Program which the other part of it is 49 counties and really the larger part of the area in question. So I had some concerns about that.

Aside from that, I think we are put in the position that we have to accept a good deal on faith at this point in time due to incomplete information and the expectation of new leadership in this region. And on that matter, I would

have to join Dr. Mayer in the uncertainty, but I would agree perfectly with the recommendations on funding.

DR. MAYER: O.K., additional comments or questions.

DR. ELLIS: I would like to ask a question. Are they working very closely with Comprehensive Planning A agency? And how are they working with the section in northwestern Ohio?

DR. MAYER: Well, I gather from the information that there is a very direct linkage with the B agencies. I missed where that link was with the A agencies. In other words, they are actually planning to subregionalize the area in accord with the B agency geographic boundaries and linked to the B agencies. That is part of their whole organizational chart.

You all got it.

DR. ELLIS: I just wondered what you thought about it.

DR. MARGULIES: Could I comment on that? Because Ohio is a rather unusual situation for CHP. The director of Comprehensive Health Planning is Sewell Millikan who is on the National Advisory Council. And he has played one of the key roles in trying to carry this merger through and in fact in trying to get what we initially were trying to achieve which was a merger of all three of the programs which was so far ineffective. So that the relationship with the A agency is unusually strong.

And then added to that is the fact that the director of the State Department of Health is John Cashman who was formerly the head of Community Health Services in HSMHA and has had unusually strong interest in uniting these activities in Ohio.

So that we are favored regardless of where they are at the present time with some unusually strong elements to pull them together better than they would under ordinary circumstances.

DR. MAYER: What they have programmed, they have programmed a major build-up in the core staff of the total region. They have developed two subregional groups with the pre-existing ones, but with small staffs there, two people, I think, in each one.

And they are proposing then they branch out from that. For example, the Northwest Ohio Region covers two CHP B agencies. And they are actually going to put their staffing in those two B agencies. And the proposal is that there are five B agencies relative to the Central Ohio one with a link to those five agencies. Actually it is right on the organizational chart.

Now, how far they have gone, I don't have a feel for. But they are at least thinking about those issues.

MISS ANDERSON: Do they have a competent deputy coordinator there?

DR. MAYER: Well, all I can comment is what I read. And the opinion evidently of Millikan and Everist was that the Northwest Ohio existing coordinator was not very effective and that Pace had proven to be moderately effective. And the problem is that they are now looking for a leader.

And this is one of the reasons why I personally suggested that two-year funding for them as a mechanism of at least providing an option for a guy to have two years of assurance of a chance to build a program.

John.

DR. KRALEWSKI: Are they actively looking for a --

DR. MAYER: Yes.

DR. KRALEWSKI: Everyone that is there knows that?

DR. MAYER: Yes.

Does staff have any further information?

MR. VAN WINKLE: They have a search committee, and they actively now have 42 possible candidates for that position, a sum of 42. Some of them are existing coordinators in other RMPs who have shown an interest, one being an ex-Ohio State or graduate of Ohio State, I might say. And I believe he is an Ohio boy.

They have hired, it is not really a deputy coordinator. They have a three-pronged organizational chart there. And they call them associate coordinators. And they have just hired Mr. Al Deitz who was the Deputy Commissioner of Health

under the Rhodes administration. And I believe Dr. Ellis is quite familiar with him.

DR. ELLIS: Yes, he is good.

MR. VAN WINKLE: He is quite an effective administrator. And he is due to come aboard the first of June.

And Dr. Pace's reason for his stepping out is that he said that he had 21 years commitment to Ohio State University, and when it came to making a decision as to whether we were insistent upon 100 percent coordinator, he had to go and stay with Ohio State rather than stay with the RMP. It was his election that he do that.

DR. MAYER: John, I think their problem is no one in their right mind until the Council takes some sort of action in this sequence, I think would dive into that. Because the message that is there is that there have been two weak programs, and we have told them to do something about it in terms of merging them. But they don't have any answer back about whether we think there is a chance.

So I think what is done as action in this next step is important. And this is why I put the emphasis on core staff support as part of the planning and build-up of the region as opposed to individual project support.

DR. KRALEWSKI: That funding that you are suggesting, what does that allow them to do? I am sorry, but I didn't follow that very well.

DR. MAYER: What it allows them to do, they currently have about $800,000 in existing core staff at the expenditure level. My guess is that they are going to lose some of those people because of the changes that have occurred. So that there will be some shrinkage and freedom that will be as a result of that.

I am suggesting another $100,000 in terms of core staff support for them. And I am also suggesting $500,000 in project support if the renal disease program is approved. If the renal disease program is not approved, I am recommending only $300,000 in project support.

Now, if the renal disease program is not approved, that produces an operating budget for next year of about $1.2 million as opposed to an existing operating budget of about $1.4 million.

Now, of that $1.4 million, a significant hunk of that are projects which are due to be phased out. Only two of those that are there are previously existing projects.

You are caught on the horns of a dilemma. You provide a significant increase for two regions who have not achieved on the hopes for the future. And I guess what I am taking is a middle road which says provide them approximately what they were getting as two separate regions to move forward into the future to see if they can do something with it.

Sister Ann.

SISTER ANN JOSEPHINE: I think it is significant they are looking for a coordinator of the Regional Medical Program. And I think there are several other programs that are probably in that same position. And I think it is not unrealistic to expect it is going to be difficult from here on out to get good coordinators of programs. There is going to be a lot of interprogram pirating.

And so I think that the national trend that we are seeing in mergers and consolidations certainly should hold on a State level. You know, in California, we could be looking for eight coordinators.

DR. MAYER: Other comments?

(No response.)

Any additional comments of staff who were on the site visit in January?

DR. SPELLMAN: Is it appropriate to include in the level of funding a sum which includes the renal project given the guidelines we have just had set? Can we do that?

DR. MAYER: Well, it was included in their total tab.

DR. SPELLMAN: O.K.

DR. MAYER: Since that $200,000 was a part of the $800,000 requested for projects, I dealt with it in that context.

DR. HINMAN: Do you want any comment on the kidney?

DR. MAYER: Fine. I would love to have some comment.

I had assumed because it was being dealt with on the 8th.

DR. HINMAN: Just to set the background, all the kidney documents did not arrive here until Tuesday which is why it is being dealt with on the 8th.

But Ohio in January of 1971 established a planning group on renal disease that is statewide. It includes representatives from Cleveland as well as the major cities in the new merged area.

They have had adult type kidney doctors, and they are appointing, either have or will be appointing, pediatric type doctors as well. And they are starting an organ sharing program within the various centers that will be in the State of Ohio.

There are three applications in for reveiw at the present time. One is to support a pediatric nephrology program. That lost its pediatric nephrologist, and it is basically geared around acquisition of said pediatric nephrologist and funding him.

The other two are organ procurement and transplant expansion programs, one for Toledo and one for Columbus. Those two organ procurement programs have had very critical technical review. Interestingly enough, one of them, the investigators took into account -- at least the RMP did --

and the applicantion as submitted has incorporated the critical review, the things that needed to be straightened out.

The other does not. But it does begin to address the issues of dialysis and organ procurement throughout the State as a whole.

DR. MAYER: It does, you say?

DR. HINMAN: It does begin to, yes, sir.

DR. MAYER: Including the troops in Cleveland?

DR. HINMAN: A little bit. They are still pretty independent in Cleveland.

This overall planning group has the sanction of the Governor's office. He in turn delegated to the Commissioner of Health, Dr. Cashman, to pull the committee together. And it appears as if there would be some State legislation sought by this group. And they are beginning to talk together.

DR. MAYER: Other comments?

(No response.)

Is everybody clear on the recommendations? Staff clear?

All those in favor say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

I would recommend to you that it might be worth taking 10 minutes tonight to read through those pages of 27 through 34

in the yellow sheets of the Millikan-Everist comments about the situation that exists there.

DR. SCHERLIS: Pertinent to that, who is now head of their RAG? Is it the physician Dr. Hudson who was mentioned or who is his latest successor?

DR. MAYER: No. Brain Bradford who is evidently a physician in Toledo who I gather from their comments and other comments of staff is showing some fairly dynamic leadership to it. In fact, the comment was made he knew more about what was happening than the coordinator which was an interesting comment.

DR. SCHERLIS: One other comment. Suppose elsewhere in Ohio a regional program comes in for funding. Is there any potential for a technical review group or that group charged with "regionalization" saying that there has to be an entire Ohio renal program and not a particulated one?

DR. HINMAN: You mean as far as the statewide committee that is --

DR. MAYER: No, as far as RMP is concerned.

DR.HINMAN: The local RMP or RMPS?

As far as the local RMP is concerned, they have been an active supporter of this Ohio Renal Disease Planning Committee as I believe is its formal name.

Technically speaking, they could address themselves only to the areas that are in the map shown as being the Ohio

RMP. I would assume in looking at the guidelines, the blue sheets that were discussed for a while this morning and in what I am hopeful will be further issuances coming from here, they will understand that the whole area needs to be looked at and not just their part of the State.

DR. SCHERLIS: I hope this is the message that this committee can help implement. And that is that even if technical review is satisfactory, if all of these areas come up with nice technical reviews, I would assume looking at the total national program, we would want to have evidence that this is an integrated program. And I think this should be noted.

DR. HINMAN: The Ohio Valley RMP out of Cincinnati also has some kidney areas of concern. And we are attempting to get into this total planning process as well.

DR. SCHERLIS: Of course, you are in a very fortunate position in that you either do or do not recommend funding. And you wouldn't have to be anything more than clear in your direction as far as regionalization is concerned, particularly if you are talking about a national network. Is that clear?

DR. HINMAN: I would hope to be able to be specific, yes, sir.

DR. MAYER: Sister Ann.

SISTER ANN JOSEPHINE: Has Western Reserve been brought into these plans?

DR. HINMAN: The Cleveland Clinic is involved, but I just don't recall about Case Western Reserve, Sister.

DR. MARGULIES: The Northeast Ohio Program is very closely tied in with Western Reserve. That is the most intimate part of their educational base.

When we were attempting to get a total Ohio program, they were one of the principal actors in the discussion. But their area of concern involved in regionalization is not East Ohio centered around Cleveland.

DR. HINMAN: The kidney area specifically, though, there is already some organ sharing going on between Cleveland and some of the other cities. Whether it is only from the clinic or Western Reserve, too, I just don't know the specifics. But I think both are involved.

DR. MARGULIES: I should tell you that the system they are using for coordinating things in Cleveland is not the same system they used for handling the poling booths.

(Laughter.)

DR. MAYER: Yes, Lee.

MR. VAN WINKLE: The kidney committee, I would say the head of the RMPs in the State in terms of taking a look at the total picture and true regionalization, they have representatives from the Cincinnati area, the Toledo area, the Cleveland area, the Columbus are. They are fully represented throughout the State on this committee. And that

also becomes their technical review body for any proposal that comes in to any RMP within the State -- representatives, you know, from that State committee.

DR. MAYER: On renal disease.

MR. VAN WINKLE: Renal disease only.

DR. MAYER: O.K., I would like to move on now to Northeast Ohio.

We will need to give some thoughts to the degree to which we feel comfortable about rating or nonrating of this proposal. I am in the comparison of apples and oranges kind of issue myself which was part of my dilemma on it. And as I go through it, I am at the one, two, three end of the spectrum relative to this.

But I would have to say given the circumstances, I don't know how they could be at other than the one, two, three edge of the spectrum in terms of trying to develop a new RMP. So the question is do we want to rate it and what are the potential implications of that.

Lorraine, any comments on it?

MRS. KYTTLE: No, sir.

DR. SPELLMAN: I don't think I could rate it if it is going to be commensurate with the decision to fund it. I don't see how to translate into this. So I just couldn't rate it.

MR. CHAMBLISS: May I comment there?

DR. MAYER: Yes.

MR. CHAMBLISS: You asked what are the implications of rating, and you had suggested some numbers. Whereas I would not suggest numbers, I would say whatever rating this committee may place on that region would certainly give it some indication as to where it stands. It would give it some water line as to where it stands as a region based on the action of this committee.

MR. HILTON: Are we talking about rating the internal structures now, the internal coordinator and internal advisory committee, as opposed to region?

DR. MAYER: Well, I guess the question of the committee is do you want to rate it or not.

DR. SPELLMAN: Let's have a motion.

DR. SCHERLIS: Again, I am in a dilemma in that I don't see why we should rate it. We are rating all regions on the basis of a lot of extenuating circumstances, some more extenuating than others.

I would think that the numbers that we come up with, and I assume you do as chairman misuse your prerogative in telling us how you rated it.

DR. MAYER: I am sorry about that. Like Mr. Nixon, I occasionally forget.

DR. SCHERLIS: I would think we should rate it just to make matters clear.

DR. MAYER: All right, fine.

Before we do that, I had promised Mr. Ichinowski we would comment briefly about the rating sheets before we did Oregon, and then I flunked again.

Would you care to comment?

Lee, you have another comment?

MR. VAN WINKLE: I think we are rating something that doesn't exist, sir. This new organization that you are taking a look at is not even legal until September 1. So are you now rating the two old regions?

DR. SCHLERIS: Then we are funding a non-existent organization.

MR. VAN WINKLE: That is an application for September 1.

DR. MAYER: Subject to.

DR. SCHLERIS: I think we hve to view the combination of the two and come up with some evaluating system. We reach the evaluation by the level of funding that we gave it. I assume there is something objective behind that.

DR. MAYER: Comments on the rating system.

MR. ICHINOWSKI: I have a couple of notes I would like to pass on to you which could help us as you do the scoring and some problems that we had with the rating sheets that we received from the review committee last time.

The key to remember, of course, is the one to five

rating. That second column with the numbers running down it is the weights. And regardless of whether a criterion has 15 points, the scoring still goes from one to five. We did get them running up to 10 and 15.

We would request that each criterion do receive a score because if you leave one of the criterion blank, that negates the weight. And this causes difficulty in calculation.

We also ask that you do not score, even if the region is in your opinion not worthy of but one, that criterion as a zero. Because that also causes us some problems.

With some of the raters last time wishing for some more expansion in terms of identifying a region other than 1, 2, 3, 4, or 5, we notice that some were scoring 2 plus or 3 minus. The scoring system has now been expanded to include 1 decimal such that if you want to score a region 3.2 or 2.5, you can do this in each of the criterion. But try to stay away from something like 2-1/4 because then that causes another problem with two decimal places.

MR. PARKS: Would you go over again the problem a zero gives you? I really didn't get that.

MR. ICHINOWSKI: A zero, when we multiply by the weight that criteria has just multiplies out to zero. I would suggest if you feel a region should be given a very low figure for that particular criterion, maybe give it a .1 rather than a zero because then, let's say the criterion you select

happens to be number 2, accomplishments and implementation, which is worth 15 points, by you scoring a 0 on that element, your actual output of that is 0 times 15 or 0.

MR. PARKS: That is accurate.

DR. SCHMIDT: But we don't want it that way.

MR. ICHINOWSKI: That's accurate in terms of maybe what you want to give, but in terms of then compiling it by some automated calculation technique we are using, it throws it out as a reject.

DR. MARGULIES: It is really conformity to the machinery we are asking.

DR. MAYER: No.

DR. MARGULIES: Not quite, but actually it throws off the total calculation if there is a non-entity in there.

DR. MAYER: Dr. Hess.

DR. HESS: I have a question. If I understood you correctly, you want some number of some sort other than zero in every one of those boxes, right?

MR. ICHINOWSKI: That's correct.

DR. HESS: One of the principles of rating is that you try not to halo, and you try to be as specific as you can on every point. If you don't have data upon which to base a judgment, you are better off not making any judgment.

DR. MAYER: I thought we arrived at we would circle those.

MR. ICHINOWSKI: What we have done in the past is we have circled those to indicate that the reviewer had some concern or no data regarding his rating.

DR. HESS: For example, regarding Ohio, there are many of these categories we essentially have no information on.

MR. ICHINOWSKI: That is a tough region.

DR. HESS: It seems to me it is very unfair and illegal to make judgments on the basis of no data. We have data on certain of those categories, but others we have nothing.

DR. MAYER: Joe, I suggest you circle them and say that the primary reviewer didn't provide you the information.

DR. WHITE: What if we should happen to say we cannot rate this? Does this make the machine angry at one of us?

(Laughter.)

DR. ICHINOWSKI: If you do not rate the region, we have provision for excluding all your dta elements in that particular region.

DR. SCHERLIS: If I follow you correctly, then, if we exclude some, you are going to exclude it all?

MR. ICHINOWSKI: Or else try to come up with some provision for filling in the blanks that seems reasonable.

DR. MAYER: The issue is, Leonard, your opinion is probably better than his about it even though you feel uncomfortable with it.

DR. SCHERLIS: But in reality, if you get down to what we really do is we put down these numbers after we have such a forceful, lucid presentation as we just had by our chairman. We attempt to really extrapolate what he is thinking in terms of numerical value. And in case we don't follow the directions, he lets us know what his numbers are.

(Laughter.)

DR. MAYER: In advance.

DR. SCHERLIS: It proves very helpful.

DR. MAYER: Other comments?

(No response.)

Has everyone who intends to rate the Ohio Region rated the Ohio Region?

(Laughter.)

DR. SPELLMAN: Yes.

DR. MAYER: Let's move on to the Northeast Ohio. Sister Ann.

SISTER ANN JOSEPHINE: I have some of the same difficulties in providing information on this particular region as Dr. Mayer did. The one contact I had with the data from the region was as a member of this committee at which time it was the decision of the group that rather than have three very weak programs, there would be advantage in making a recommendation that there be consolidation in the development of one strong program.

However, as Dr. Mayer indicated and the material that is in your book gives the details of this, the Northeastern groups strongly based in Cleveland decided not to go along with this recommendation and at the present time are submitting a request for funding of an individual Regional Medical Program.

In assessing this particular program, one has to keep in mind that for 17 months, no coordinator was present during which time there was not an entire lack of leadership, however the leadership was shared by many people. And as a result, the total effort was not coordinated.

More recently, Dr. Gibbons has been brought in as the coordinator of the program. And in reading some of the descriptive material concerning the new coordinator, apparently he has been in the Cleveland area for many years. He is very well acquainted with the medical community and is able to work very well with the diversified components there.

However, one of the concerns I personally would have would be with the fact that here we a coordinator who is 76 years old. And this is not saying he can't be innovative and all these things, but certainly the possibility of his availabi over a period of time doesn't exist at the same degree as it might if he were younger. And besides that, he has no assistan coordinator to work with him in this program.

And one of the weaknesses of the program as it was

described by the site visit team chaired by Dr. White in 1970 was the fact that core staff at that time needed additional development. I think the situation still exists. And I think that in this particular area of responsibility of a coordinator in the absence of adequate core staff, we are probably going to encounter a great many problems.

The operational projects, four in number, are in no way related to the objectives that are stated for the region. This was true in 1970 and apparently it hasn't been changed in the intervening time.

In 1970, concern was expressed concerning the composition of RAG. I believe some changes were made. Addition "consumer representatives" were added to the group. However there is strong domination by the executive committee which originates from the board of trustees. And in reading over the material provided, I would get the impression that RAG simply passes judgments on the kinds of recommendations that the executive committee and the board choose to submit to RAG.

I believe, Mr. Parks, would you want to give some of your other impressions?

DR. MAYER: Mr. Parks is secondary reviewer on the project.

MR. PARKS: Sister, I concur largely in what you have said. As a matter of fact, totally. And, again, I think the predicament here highlights a situation which is incapable

of evaluation.

The predicament does not lend itself certainly to any of the factors which we have on our evaluation sheets. We are faced with a situation where we have a new coordinator who did not participate, I understand, in development of this particular application that we have here and a rather sparkling record of failure in this case.

I know of no other way to present it accurately.

My basic inclination is that assuming it would be an appropriate remedy for this committee, I would recommend that this program be shut down.

The situation is tempered somewhat by some information that was delivered to us today and by some previous action of the National Advisory Council which would appear to pre-empt the action by this particular committee. And that is contained, I believe, in the papers which you have. It is a letter dated February 10, 1972, from Dr. Margulies which transmits to Dr. Glover the action of the National Advisory Committee which is to the effect that the program be retained at its present level of funding.

And so it would seem, then, that anything that we might have to recommend to this committee with respect to either continued funding or level of funding would be superfluous at this time.

It does, I think, relate to the larger question of the

role of this committee and especially in a situation where the National Advisory Council has spoken on the matter previous

There was, I think, in this case as in the other Ohio situation a site visit conducted by some members of the Council.

There are some items about which we might particulariz with respect to the Regional Advisory Group, its make-up and composition, the distribution and participation that is effective participation of minority persons, the participation of minorities on the staff, the non-application of priorities which are established to program activities.

For example, they indicate that their top priority is meeting some of the needs of the people in the urban areas. And certainly running down those four priorities, I find none of the operational effort directed to this. I find certainly again with the exception of the Urban League director, I don't find among the members of the Regional Advisory Group or the trustees the kind of participation from among the consumer element that you would expect to find in a situation like this based in an urban setting such as Cleveland.

I think there is something to be said for having engaged a coordinator who has the historical qualifications that Dr. Glover presents. Among the papers which were presented to us was a statement indicating that he has trained the majority of the practitioners within this region's scope

of activity. And it is largely through his standing within the medical profession and his personal acquaintance with the principal actors that he is able to bring together and perhaps to effectuate some change.

The papers that were handed over just momentarily -- I think Sister has those -- may throw some light on it as to prospective activity. But if what we are rating covers the period in the past, I would say that this program is questionable and based on its past performance, I would say that it was of doubtful prognosis for the future.

Nonetheless, we are advised, I am advised, that the new director, despite his years, and possibly because of it, has, I guess accentuated change and is currently developing and restructuring this particular program.

But for those qualifications, I would say, first of all, there is a very real question as to whether this business is appropriately before this committee.

The second thing is if it is an appropriate remedy for this committee to recommend, I would be for recommending the money for this program be withdrawn.

DR. MAYER: Could we deal with the question that is being raised? Because I have a little trouble with substantial inconsistency of the letter of February 10, Harold, in which it implies that the National Advisory Council recommended at this time, presumably in the February Council,

a continuation of supprt for one year at a basis not to exceed the existing level funding. And then in the concluding paragraph, it says, change in review cycle will start date for Northeast Ohio program from June to September 1, 1972. Therefore, the present grant period for Northeast Ohio will extend through August 31, 1972.

And presumably, this application deals with that period after August 31, 1972. And yet presumably there is some kind of commitment for funding in the region through to what -- February of 1973?

I understand the issue you are raising because I can't see it.

DR. MARGULIES: What happened earlier when we reached the same conclusion you did about the program which is that both Northwest Ohio and Northeast Ohio were of such doubtful quality that there was serious consideration about whether they should be continued at all, we did put considerable pressure on them to make some basic alterations. We, in fact, limited their funding during that period of time to six months and then gave them an extension of six months to see how effectively they could work out their plans.

And when they reached a tentative agreement which required the Council to act on whether or not they should continue the decision was made they should have funding for one year.

What you are addressing would affect their activities

thereafter. And so if you were to make a recommendation here that this program should no longer be continued, it would be a matter of phasing out their activities with existing funds and then closing it down.

MR. PARKS: When would be the date that their current funding would terminate?

DR. MARGULIES: Their current funding under this one-year extension -- I will have to ask for some help on that.

MRS. KYTTLE: August 31.

DR. MARGULIES: August 31 of this year as far as I know, '72.

DR. MAYER: Except there is an implied commitment by Council until February, at least one year from February 10, in your letter.

DR. MARGULIES: Well, I am sorry because the letter was confusing. That referred to the six months and then six-month extension so that so far as I know they are funded only through August 31 of '72.

DR. SPELLMAN: Was one of the clear alternatives merger or abandonment, so to speak?

DR. MARGULIES: No. We did not require them to merge. What we did was lay out to all three programs their deficiencies and recommend they give merger serious consideration. And that's why we had members of the Council go out to see what

progress they had made.

The efforts to consolidate were partially effective. So you see two programs instead of three. But we still have the problem of Cleveland and the rest of Ohio. And the viability of the program is one to be judged at the present time.

SISTER ANN JOSEPHINE: This morning when I said we have to be sure we ask the right questions, I was thinking in terms of this report. And I personally don't feel that the question is at what level shall we fund them,but I think the question is should we fund this program. Should we continue to fund this program?

DR. MAYER: Comment, Phil?

DR. WHITE: I don't understand this concern in reading this. Some of the comments by Drs. Millikan and Everist suggest that in spite of his age, Dr. Glover seems to have some leadership qualities. What has happened since that time? Has he made any move?

Is Dr. Hudson still a thorn in their side? Has there been no progress at all since that visit by Dr. Millikan and Dr. Everist, or has there been?

DR. MARGULIES: Do you want to comment on this?

DR. MAYER: Mr. Ashby, comment?

MR. ASHBY: Actually, Dr. Glover is able to contain even Dr. Hudson. He does a good job of that.

And, yes, he has been very busy. The program staff, at this time, morale is much higher. They seem to be working harder, although it is just observation. Everyone that has met him seems to be impressed. Even though he is 76, he is a young 76. He realizes his age is a limiting factor as far as being able to be around in that program for a long period of time.

He impresses me as a mover, and I don't believe he would have taken the position at all if he hadn't thought he could do something with the program. He was one of the biggest critics the program had prior to his acceptance as coordinator.

DR. WHITE: I gather Dr. Robbins --

DR. MAYER: Phil, we couldn't hear you.

DR. WHITE: I was asking if Dr. Robbins, the dean of the school, was in favor of RMP.

DR. MAYER: That to me is one of the great unknowns. Fred Robbins, in spite of his research background and his Nobel-laureacy is really committed to community health action efforts. And yet here sat that RMP all this time without movement. And I can't put those two facts together in my mind. If anybody can help me with that out of staff or elsewhere --

DR. ELLIS: I can.

DR. MAYER: All right, Effie.

DR. ELLIS: His philosophy was a little bit out of line with that of the rest of the people at the time. And I think the Midwest is pretty conservative. And this accounts probably for the fact that it would take a little while to get the show on the road.

DR. MARGULIES: Fred has been very deeply involved in the efforts to rebuild this program. When we first tried to have a merger of all three, he was one of the leading voices for a true merger.

The problem, on the other hand, getting back to Northeast and the question of why didn't it go, Bill, so far as I could tell, it was the inability of the people in Cleveland to resolve their own internal differences. It is the old issue of Western Reserve and the Academy of Medicine and the local politics. And about the time he would make a move in one direction, he would run into Charlie Hudson coming from the other direction. And he has not really been able to overcome some of the resistance.

I think if he had had a free hand and if there had been a coordinator -- You may remember when this program was first developed, the coordinator was a fellow named Barry Decker who was a very vigorous, imaginative, hard-working guy who got the program through the planning stage and promptly was recruited away. And they then were unable to get a coordinator. And I think the main reason they couldn't get one,

and this is the real stalling point is because they couldn't reach a resolution between the vying medical-political forces within the Cleveland area. They would get somebody, and if it was all right with Western Reserve, it wasn't all right with the Academy. And sometimes they would say, "Maybe we better go out of state to get somebody who is neutral." And they were really hung up on their own internal differences while Fred was trying to get something reasonable accomplished.

He is still actively interested. He still gives strong support to the new coordinator. I don't know that they have resolved those problems.

SISTER ANN JOSEPHINE: The question that arises in my mind is would it be and it would seem to me that it might well be to the interest of the total State to take a stand that might give a little more encouragement to this merger.

DR. MARGULIES: I quite agree. What we have said is that we accepted the present arrangement as a tentative one, but we insisted they continue to work toward a final resolution of a total State system. But that is sort of good advice. I don't know how strongly it is accepted or how much meaning it has. They are meeting together. They will talk with one another more and more, but it is not quite what you are talking about.

DR. MAYER: Yes, Leonard.

DR. SCHERLIS: Do I read correctly the printout their

budget essentially is divided between the four, the hospital librarian, coronary care unit training, strep culture, and strong rehab? Is this the total program?

SISTER ANN JOSEPHINE: It is really not. It is a very difficult program. They call it program.

DR. SCHERLIS: That comes to something like $800-some thousand.

SISTER ANN JOSEPHINE: Actually, I think we are describing a planning component and calling it an operational program.

DR. MARGULIES: We have had repeatedly from that program whenever we have leaned on them hard, particularly about the coordinator, the complaint that there is so much national instability in the Regional Medical Program that it is impossible to get a coordinator. And we keep telling them it is like arguing that you lost the ball game because it rained. The other team is in the same rain. Other programs have developed, have had strong coordinators, have replaced them and got good people, and they haven't been able to. But they have used this as a kind of a defense for not doing anything.

When you look at how long that program has been without a coordinator, it has been ever since they became operational up to the present time when they have gotten Dr. Glover in. And that has only been within a matter of a few

months. I think he came on board in January.

DR.MAYER: Yes, Joe.

DR. HESS: It seems to me we have to look, if we accept Mr. Parks' and Sister's --

DR. MAYER: Could you use the mike? We really can't hear you.

DR. HESS: If we accept Mr. Parks' and Sister's feeling perhaps the thing to do might be to recommend the phaseout of this program, then we have to look at what happens if that actually is taken.

I think we would be in a better position or at least I would feel more comfortable about being in favor of that if the Ohio program were in a more stable state itself. But I am just wondering if that wouldn't add an additional burden to two regions that are already trying to merge and a coordinator that is only there for another month or two. And how much can it take? What are we going to do to RMP in that whole State if we do this all at once?

Maybe one way out of this dilemma is perhaps delay this for a year and give the Ohio RMP a chance to see what it is going to be able to do and then take another look at it. And maybe merger would be appropriate at that time.

But I must say I am worried about wiping this one out and saying merge with Ohio right now in their current state of flux.

DR. MAYER: Sister Ann.

SISTER ANN JOSEPHINE: I wonder if in line with this February 10 letter which could well give us a position that we could continue the funding until February of '73 which would be nine months and say by this time, you know, we would hope you would be able to work out these differences, that would provide that leeway in keeping with something that we made some kind of a commitment to.

DR. MAYER: Well, what would we expect? I guess I need to have some feel in terms of the new cycle, what that would mean. Presumably, that would mean that would have to be reviewed in January which says that whatever new application would have to be inhouse when?

I am trying to get a feel for what kind of time is that.

DR. MARGULIES: November.

MRS. KYTTLE: I think we ought to look at Ohio's schedule more than this region's schedule. If we want them to think about effecting a merger within a certain period of time, should we not be looking at the place with whom they will merge rather than this place?

DR. MAYER: I am not sure I was hearing a clear-cut call for merger. I think what I was hearing was a clear-cut call for turning it around or else. That is what I was hearing.

SISTER ANN JOSEPHINE: No. I think we are moving

toward merger in this.

Really, it is very difficult to motivate any other way in some cases. I mean, it is a matter of really the funds are the strong point you have. And as I read all this, it is not just an arbitrary decision. It is really in the best interests of the total program for the people.

MR. PARKS: With respect to merger, if you allow this program to survive, I think the question of merger is an appropriate local decision. I think it is an especially important one. I think we should be careful not to get into a posture where we begin to dictate what ultimately ought to be a local decision because we also would be the ones who will come along and evaluate them. And we may have forced them into an unnatural situation.

And I would certainly hope that even though that may be something of a tactical guess as the appropriate direction, I certainly would dissent from any decision that would indicate to them that we expected or would expect as a factor of evaluation to have these programs merged into a single unit.

I think more important that we have an effective unit that meets with your broad national priorities. And as long as it is operational and if you can ascertain that it is moving effectively in that direction, if you can find a mechanis to close the book on a bad chapter and rate that chapter for precisely what it is and then the next time you take a look at

it, measure it from this time forward, I am not so sure I would want to be in a position of this place and with the information that we have indicating to them that they must merge or else.

I really don't have the information to make that decision.

SISTER ANN JOSEPHINE: I agree.

DR. MAYER: Let me see. To me, it seems like we have roughly three options given the kind of tenor of the discussion.

One option is that we say effective August 31, they are out of business. And they can come back in and reapply for a new RMP if they want to do that in some form at some future date. That's one step we can take.

The second step we can take is extend them to the February period and say that by November you must have a program in here developed for review or you will be out of business effective February 28.

Or, thirdly, we could say, all right, we are extending them at some level from now, from August of this year, to August or September 1 of next year with the same kinds of constraints on it.

Now, those to me seem to be the three options.

SISTER ANN JOSEPHINE: And if we did No. 2, what would be our expectations at the end of that time?

DR. MAYER: That is up to us, the committee. And we

need to have those laid out more precisely.

Yes, Joe.

DR. HESS: In connection with your third option, might we consider recommending what in essence would be reversion to a kind of a planning phase? Phase out many of these activities and ask them to take a good, hard look and come in a year from now, fund them for sort of a planning year, come back in with a better plan which reflects some very serious rethinking of where they are going to go and how they are going to get there. And this would keep them in phase with the Ohio, and that would provide an opportunity for them to look at this question of merger as well as to look at the strengths they have to pull the program together.

Is that possible?

DR. MAYER: Sister Ann, comment?

SISTER ANN JOSEPHINE: Is Ohio in a planning stage now, planning phase?

DR.MARGULIES: No.

SISTER ANN JOSEPHINE: It is operational?

DR. MAYER: Except that the recommendation we made vis-a-vis the new Ohio RMP was most of the dollars in the core staff to support that planning group and evaluation group that they are proposing for the two combined regions with very little money in terms of operation. The money that we suggested was roughly two to one, three to one, in terms of

staff as opposed to projects which is the reverse of the usual situation.

So in that sense, we have moved them in that direction.

SISTER ANN JOSEPHINE: Then, what Dr. Hess is suggesting would enable us at the end of the year to evaluate the region's capability of planning and ability to become operational or not. Is that what you are saying?

DR. HESS: Right. Cut them back, phase out the project funding or reduce it substantially.

SISTER ANN JOSEPHINE: And it might even be that during this period of time, they could begin to look toward maybe working more closely with the other Regional Medical Program in the State. Maybe that is the way they can take their first step. Maybe it isn't the most desirable way to go.

And then if their planning stage, if at the end of the planning period, the group felt that they were ready for operational funds, then we could move in this direction.

Is it just one year for planning?

DR. MARGULIES: Technically, we would not put them into the planning stage because that has too many legal complications. Functionally, in a planning stage, which works out the same way.

The only comment I would like to make regardless of your decision is I think this extraordinary attention to the

program is well deserved. If they get through the present period of pressure and emerge as Northeast Ohio feeling that they can now feel as though they are on sound ground, they will be making a very bad mistake, and so will we. Because what has come out of it is anything but satisfactory up to the present time.

But we do feel the potentials are there. But potentia aren't enough.

DR. SPELLMAN: Which means at the end of that year they would if they had not merged or had not made progress, you would have to phase them out. That would have to be clear. Otherwise, you would just be repeating the same.

DR. MARGULIES: That's right.

SISTER ANN JOSEPHINE: And the success that has been subscribed for this program rather recently is all bound up with one particular person, not a program.

DR. MAYER: Am I clear that their current level of direct cost funding is in fact $690,000? I am looking on, I guess it is pink. I am not sure whether it is pink or salmon, but it has an asterisk and says "Does not include 24-month extension for 01 year of $2,376,000." I don't understand it.

What level of funding are they currently at?

Let me make a suggestion in terms of staff. At least what I need or what I needed when I reviewed programs is to have a fix on what the current annualized, most up-to-date

operating costs are of the program as it is then functioning.

Now, maybe we have got in here that data, but if somebody said to me what are they currently functioning on an annual rate basis in terms of core staff and in terms of project -- that is the information we need to have in terms of where they are. I don't know where they are. They are somewhere between $2.3 million and $690,000 on an annual basis. I don't know where they are.

Can staff help?

MRS. KYTTLE: We don't have their current expenditure rate in here because we don't have it. We get expenditure rates 120 days after a program year is ended. And then they are negotiated and audited. And it is quite a while before the review system gets that information. By the time we get it, the review system has traditionally felt it was so old that it was not applicable to the year that we are considering.

DR. MAYER: Let me ask the question a different way. We must have some idea of what their anticipated expenditure is from September 1, 1971, to August 31, 1972, which is when the thing runs out. Or don't we even have that?

MRS. KYTTLE: Their anticipated expenditure?

DR. MAYER: How many dollars have they got to deal with?

MRS. KYTTLE: You mean their award?

DR. MAYER: Yes.

MRS. KYTTLE: This region had so many extensions that it had a 24-month 01 year. And their 690 is a 12-month proration of that 24-month money.

DR. SPELLMAN: That 831?

MRS. KYTTLE: Where is Vernon? Did I say that right, Vernon?

MR. ASHBY: No, it is not. The $786,187, they are funded now for an 8-month period. I was trying to figure it out here. It is 5 something. And it was divided by 8 and multiplied by 12 to give you the figure out here on the right-hand column.

DR. MAYER: So the ball park is $786,000, then. That is the level they are functioning at.

MR. ASHBY: Yes.

DR. MAYER: O.K.

DR. SCHERLIS: May I have some other clarification on funding? We have used the terms growth and development and found that somewhat confusing.

Doctor, looking at the record, would you give me a guess as to what you would think a reasonable amount of funds that a region of this size with a core of $540,000 to allocate feasibility studies -- that is somewhat development and growth -

DR. MAYER: I don't understand the question, Leonard.

DR. SCHERLIS: I guess what I am driving at is looking at their summaries of core, the $539,000 for core

activities, they spent $246,000 for feasibility studies which core activity in an area that has had so much difficulty with looking for programs seems to me an excessive amount of money, particularly since their entire project support is less than that.

What I am making is obviously the one I don't know how they manage it. Is there any review of RMPS of those expenditures as they go on?

SISTER ANN JOSEPHINE: I don't have any data.

MRS. SILSBEE: As a member of SARP, we looked at the money they were spending for those kinds of things under core as being the only hope for this program. It was small studies that were going on under the core staff.

DR. SCHERLIS: It must have been a lot of small studies.

DR. MAYER: Dr. Hinman.

DR. HINMAN: One of these feasibility grants was to the Youngstown Warren area which is one of their regionalized areas and has developed into a community-based manpower development proposal which will be reviewed on the 21st. But the planning group and the concerns of the group seem most appropriate in Youngstown and Warren. So there has been some payoff for these dollars.

SISTER ANN JOSEPHINE: Were they specific about what the payoff was?

DR. HINMAN: Well, I visited with them in one of their planning sessions, and they had brought together the people from the three counties in Ohio and the two in Pennsylvania that were contiguous that are in this medical trade area -- consumer representatives, medical society representatives, education representatives -- to sit down and talk about whether or not they wish to try to do something together along the model of either the Carnegie Commission mental health education center or the RMP defined community-based manpower development.

The total dollar investment, I think, was in the neighborhood of $12,000 or $14,000. And it was basically in the salary of Mrs. Baird, the area coordinator, who was spending the time and effort in developing this program.

DR. SCHERLIS: It was $26,000.

SISTER ANN JOSEPHINE: One of the strengths of this program, if I were to try to identify a strength, has been the ability to get different groups together. You know, without going into this as a feasibility study. At least this would be my feeling.

DR. MAYER: Well, let me go back. I think we have got the three possibilities. And then under those three, we have to arrive at a level of funding with some principles hooked to it that people can understand and rationalize.

Yes.

MR. GARDELL: I just say the funding, then, is $781,000 we are working with. We had no Council level, approved level, of record because that was the end of its program period. And so we were just working on an extension basis. That was the level prior to the cut in '71. And it is the figure we have been working with all along.

DR. MAYER: The $781,000 which has roughly $500,000 or $600,000 of core and a couple hundred thousand of projects.

MR. GARDELL: I don't know what the breakout is. All I know is the total figure.

I also should say to you we don't have any expenditure reports from that year. We are still extending that'71 grant. And it is running 26 months. And you don't get an expenditure report until 120 days afterward.

DR. MAYER: Leonard.

DR. SCHERLIS: I would suggest that they spend some of their feasibility funds to learn how to write grants. I could make absolutely no sense out of that document.

What you are telling me about the length of year one, I have always looked at year one rather conservatively as being roughly 12 months, as I understand it. I don't accept 220 percent year one unless it is clearly stated in the record.

And to pick up that blue book, I want to congratulate the two of you who reviewed it for making any sense out of it.

I find it completely lacking as far as any history or what went on. Was I short-sighted when I looked at it or were there pages that were missing? Because there was absolutely no history. And I tried to figure out how they did everything they did in one year.

How they can get this bad a record in one year is something I could not figure out. It was a rather long year.

DR. MAYER: Dr. Schmidt.

DR. SCHMIDT: I don't think it would be appropriate to close them down. And I think what we ought to do is approve them for a period of time that would be approximately a year or whatever it would be to get the end of their time matching the end of the time of the Ohio program, whatever that is.

DR. MAYER: That is, I gather, August 30.

DR. SCHMIDT: And they should be instructed that the options at that point would either be that they make the case for an independent Northeast Regional Medical Program or they are merged or they will be shut down and that the level of funding be someplace around $500,000 or $600,000, something that will get them down so that they have to start shutting down their projects and enter a planning phase and come back up again. And the funds should be limited to the extent that this will force this, maybe $500,000 or $600,000 to do that with the instructions stating in effect what we are asking for is a plan for this Regional Medical Program that we would look

at and evaluate.

They have either got it or have to throw in with the other one or they have got to quit. Having the end point being the date --

DR. MAYER: Which is August 31, 1973, which is what it would be.

DR. SCHMIDT: If there is a sense to that, I would so move.

DR. SCHERLIS: Second.

DR. SPELLMAN: This August or next August?

DR. MAYER: This August there is no way they can comply with what he is asking.

DR. MARGULIES: He is talking about '73.

DR. MAYER: So what Mac is talking about is recommending funding at a level which is kind of fuzzy, and we will have to sharpen that up, from September 1, 1972,to August 31, 1973, which is one year and does include 12 months, Leonard, with explicit instructions that at the end of that period of time, they ought to have inhouse a grant application which either justifies their continuation as an RMP, as Northeast Ohio or merged or some other effective thing or their funding is going to be discontinued.

DR. ELLIS: May I ask a question?

DR. MAYER: Yes, Effie.

DR. ELLIS: I want to ask one question. I want to

ask Dr. Margulies do you think if staff works with them more closely as they are set up, they will improve and their horizons can broaden? If you could get a younger person with newer ideas to work under Dr. Glover if he is going to be there for a few years or more or something like that, this would be helpful.

It doesn't sound to me as if merger would be possible that is, a real sound merger -- within the period of a year or even two or three. Perhaps it would be better to say move toward that if this seems likely.

But I don't know if they are going to be able to do too much unless they do have someone kind of really helping them and monitoring very closely what they are doing and suggesting a way.

DR. MARGULIES: Well, so far as staff capacity to improve the program is concerned, I guess my best response is God willing. They are there. In fact, I think probably staff in that part of the RMP, DOD, has spent more time on the Ohio programs than any other. And the major benefit has been in the other part of it where a merger has occurred. And in the process of merger, some real new thinking has gone on.

Staff at the present time, as I indicated, has some hope for the Cleveland end of it doing well. But I think it will not do well unless the kind of very specific action which you are talking about does come out. So they don't think that

this is just a mild gesture, but it carries with it not a veiled, but an open threat, fish or cut bait. I don't see any other way in which staff will have the backing to have an impression on what goes on.

MISS ANDERSON: Somebody mentioned their relationship with Pennsylvania. Is that a reality? Could they possibly merge with that group?

DR. MARGULIES: No, this was just on the local basis.

MR. HILTON: I was just going to ask simply on the discussion stage on this motion, I wondered if there is a possibility or the danger that this action might be interpreted by those on the receiving end as indeed somewhat vindictive on the part of RMPS --

DR. MAYER: Somewhat what?

MR. HILTON: Vindictive, punishment for them for not -- Because it seemed there is no concept of merger. The seed has been planted already even in that February 10 letter. It has been suggested, and they have heard that. And they recognize that as a product. And would this action coming when it does not come off as being a little bit of we are punishing you already kind of thing? And possibly the suggestion that Dr. Ellis raises of having somebody work internally to bring about change might represent a more meaningful alternative than bringing down the guns quite that firmly.

I just raise it as a suggestion in terms of the

image of RMPS with regard to the local autonomy of these programs.

DR. SCHERLIS: I would like that to be made very clear

DR. MAYER: Mac, would you care to sharpen your thoughts either in consultation with Sister or how do you want to arrive at a level of funding or do we suggest that you might all do that tonight and plug in that blank tomorrow morning?

DR. SCHMIDT: Either $500,000 or $600,000.33.

DR. HESS: To resolve that dilemma, I would like to make a suggestion.

On page 4 of the pink sheets here, the summary sheet -

DR. MAYER: Page 4 of what sheet is that, Joe?

DR. HESS: The summary sheet, table of contents, Northeastern Ohio anniversary application, page 4 that has the figures on it, financial summary, if you add up out of the column "Current Year's Award", one operation year, and I am assuming that these are 12-month figures, if you add the $481,000 for core, $55,000 for subcontracts and then add approximately $70,000 for the phaseout of operational activities, you end up with $600,000. And I think that falls in the guidelines, shouldn't hurt them unduly in terms of staff and planning activities, give them some money for phaseout, and still the message should be there.

So I propose $600,000 as the figure.

DR. MAYER: O.K.

DR. SCHMIDT: The mover will accept that.

MISS ANDERSON: I second it.

MR. PARKS: I would think if we are planning to extend this operation, that some consideration be given to the recommendations from the staff which are on this, what did you call the other color -- on these pink sheets -- which do contain some very valuable suggestions, both on the first page under recommendations and on page 2 of the critique which calls, really, for certain kinds of overall guidances and certain kinds of technical assistance and support.

I think, for example, if we are going to allow this program to continue and expect Dr. Glover to produce, it is then encumbent upon RMP to provide him with all of the kinds of support that would give him at least a chance to succeed. I think that ought to be considered in light of the money, for example, with $600,000 that has been recommended and also with regard to the time period within which he is expected to perform.

That is, to disengage him entirely, whatever has transpired in the past, and try to give him some freedom of movement.

SISTER ANN JOSEPHINE: I think, too, it would be very, very important if staff can to find this assistant for him, an adequate assistant, because to fill this role effectively

is going to require a lot of hard work. And it is going to be a very tiring thing. And I think without an assistant and without the ability to delegate, you can almost predict it is notgoing to work.

DR. MAYER: Yes, Mr. Ashby.

MR. ASHBY: Dr. Glover, I don't think he intends to stay more than two years. And he is actively looking for an assistant to train. And as I said before, he has one of the biggest critics of this program. And at the same time, if you consider the new coordinator, they have been without a coordinator for 17 months. And then you limit their funding to an amount where you can't operate.

SISTER ANN JOSEPHINE: But he can plan.

MR. ASHBY: Right. But it is like saying we are going to extend you for one year, Dr. Glover, although we are going to place these restrictions, and here is what you are going to come up with. We know you are not going to do it because you don't have the facilities and --

SISTER ANN JOSEPHINE: I think it is just very, very important you reflect the thinking of this group. And I don't hear you reflecting it now.

DR. MAYER: I am reminded of the comment that Bob Marston once made when there was a leveling off at $1.2 billion in the NIH budget. And everybody was having at him. And he said, "Well, you can still do a lot of research with $1.2 billic

And I would have to say that you ought to be able to do a fair amount of planning with $600,000.

Mac.

DR. SCHERLIS: I was going to say that is particularly true when you have $250,000 floating around that can be used for feasibility studies. Most feasibility studies I have seen usually have been $3,000, $4,000, $5,000 in the developmental component stage. And these are in the range of $26,000 and $30,000 which to me is a major project and not just core function.

I think there is enough fat there to move.

DR. SCHMIDT: Concerning what Bill said, I think it is important to state the action of this committee as intended by me is not to be vindictive, punitive, or anything else. But it is meant to be a directive and be just a little bit crisper than some of the actions and some of the things that have been going on, particularly in that area.

It is clear there has to be certain things happening. And I think that there would be enough money with $600,000 to reach the end point that is, I feel, necessary to set for this region.

And the action of the committee is trying to be helpful by setting an end point and giving some clear choices.

One of them is to make the case for the region.

DR. MAYER: Yes, Phil.

DR. WHITE: It seems to me you are going to have difficulty doing what Sister thinks should be done if we are going to send this clear message you have a year to go or else. How in the world are you going to recruit that kind of guy to come in and help Dr. Glover under those circumstances?

Aren't you going to kind of have to suggest that Dr. Robbins or whoever is the head of the Cleveland Clinic or somebody lend some expertise, give them somebody on leave of absence from one of their institutions to get this thing moving? At least, he is going to have a job to go back to in case it flops.

DR. MARGULIES: We have some thoughts about how we might be able to do that on a 3- to 6-months basis with someone who can really be of direct assistance. But that is the dilemma.

We have been carrying them on all this period of time saying, "Well, you know, if we just give them the chance, they will get the people and they will get things going." And it hasn't worked. So it is a situation in which whatever decision you make, you are going to feel a little uncomfortable with.

DR. WHITE: I think the point earlier was if Dr. Robbins -- I am not picking on him particularly -- but if the people in that region want to see this thing go, there is probably enough talent already in that area that they ought to

commit some of those hours of those people to make the thing go.

DR. MARGULIES: And if they can't find something that needs to be done in Cleveland, they are having great difficulties in their perceptions.

DR. MAYER: John, you had a comment?

DR. KRALEWSKI: Back to this budget, I don't want to beat it to death, but I am sorry I still don't understand it. If we are recommending $600,000, what do we recommend as a start -- this year?

DR. MAYER: September 1, 1972, to August 31, midnight, 1973.

DR. KRALEWSKI: And that will be consistent with the letter from Council? Are we asking them to revise?

DR. MAYER: Yes. It can be made to be consistent with the letter from Council.

DR. KRALEWSKI: And the group here feels, I gather, there is enough information in this document right here that we can make that $600,000 decision at the moment rather than having maybe a small group with staff iron out a figure here later in the day?

I don't feel I can, but if the rest of the group feels they are comfortable with it, I will go with it.

DR. SCHERLIS: I would submit if you go through the entire application, you will come away with the same feeling

of restlessness.

DR. MAYER: Yes, Mac.

DR. SCHMIDT: Two comments.

One, if staff or anybody has a better figure to come up with and want to justify it, I think it would be fine to reintroduce that later this afternoon or tomorrow. And I think it would be considered.

The second one is in my conversations with people at Case, Cleveland Clinic, Medical Society, and so on, they haven't got the foggiest idea of whether they want a Regional Medical Program or what one is. And I think at some point everybody from delightful what's his name in the Cleveland Clinic on down have to get off this business of the Feds are going to keep putting money in here and we get plenty coming in anyway, and we don't need it. They have got to quit ignoring.

And the big problem of getting a Regional Medical Program going in that area from what I have been able to see is that people by and large have just ignored it. And if this is a way to get them to pay some attention, whether it is borrowing people from the university or whatever, then, fine. But people have to look at it and say, "All right, here is a decision." They have never really done that.

DR. MAYER: Does everyone understand the motion?

MR. PARKS: One question.

DR. MAYER: Yes, Mr. Parks.

MR. PARKS: On the recommendations from the staff anniversary review panel, there is a rating of 245. May I ask what that means and on what scale?

DR. MAYER: That is on the one to five scale, I assume. That puts it in group C which is the lowest grouping which at least says something, but it is at least barely in there.

MR. CHAMBLISS: If I may make a comment there --

DR. MAYER: No, I am sorry, it must be .1111.

DR. BESSON: It runs from zero to five hundred.

DR. MAYER: Yes, right.

Yes, Mr. Chambliss.

MR. CHAMBLISS: I was simply going to let the committe know that the desk chief, Mr. Van Winkle, would be available to answer any questions on that if you have further questions.

DR. MAYER: O.K.

Comments? Everyone understand the motion?

DR. SCHERLIS: Is there any feeling of staff that we are misreading the signals? I am curious.

DR. MAYER: All I have heard is a feeling that the therapy may not be appropriate. But I think the diagnosis sounds pretty good with everyone. At least, that is what I am hearing.

MR. CHAMBLISS; The comment from staff would be that I feel the diagnosis is quite proper. We have some concerns,

great concerns, about this region.

DR. MAYER: Sister Ann.

SISTER ANN JOSEPHINE: May I just make a comment to you sitting at the end of the table after you were so nice to brief us in. These are the kinds of pressures I get from my board. And several years ago, I was saying this is too harsh a way of doing it. You know what? I am learning it is a good management tool. You will be surprised how many good things can come out of it. But I do know that it is terribly important that you share our feeling about it.

This is really a measure to make it possible for them to get moving. And so you will have to be very supportive of it because they will read it very quickly.

MR. ASHBY: I want to apologize. I was talking out of school.

DR. MAYER: Further comments?

Yes, Lee.

MR. VAN WINKLE: I think one of the major reasons for their problem out there is the fact their executive committee and board of directors are one and the same. And that largely reflects Dr. Charles Hudson's thinking. And I am hoping that when we get this new piece of paper that tells us what the RAG relationships and coordinator relationships and these sorts of things are, we can put sufficient pressure on them to change their by-laws.

But that is what is a real grievance out there. And they are dictating, there is no question, the executive committee and board of directors are the same, and they are dictating to the coordinator or non-coordinator.

DR. MAYER: Other comments?

(No response.)

All those in favor of the motion say, "Aye."

(Chorus of ayes.)

Opposed?

(No response.)

We effectively have gone past coffee, but let's take about a 10-minute break to mark the sheets and stretch.

DR. SCHERLIS: Just one sentence that I think underlines what you said. The organizational structure is apparently not well understood, and it is amplified as it goes on in the next few pages.

(Whereupon, a recess was taken.)

DR. MAYER: Could we start, please? Are we ready, John?

DR. KRALEWSKI: Right on.

DR. MAYER: This is new. It isn't anniversary, but was site visited.

I might comment before John begins that what we have just done in terms of Northeast Ohio, there was a SARP rating in which the question was appropriately raised about what that

meant. And then we proceeded to go on to rate it.

I think what we might do in those that have already been rated by SARP, we need to make a first decision which is do we agree with the rating. And if we say, yea, then we stop there and go no further in terms of subratings. If we say that we do not agree, then I think we are saying that we want to also rate it, and we all rate it.

John, we knew you were coming up because I assume that is your material on the blackboard.

DR. KRALEWSKI: Right on, yes, indeed.

DR. SCHMIDT: Were you asking a question or making a comment?

DR. MAYER: I am making a statement unless you want to approach it otherwise.

DR. SCHMIDT: I think we should rate the region. Is that what you were stating?

DR. MAYER: Yes.

Well, maybe we need to take a minute.

DR. SCHMIDT: I think staff rated. I think that is beautiful. I think we ought to rate it, too, as a committee.

My gut feeling is that staff's numerical score is a little bit high, although I agree with the comments and suggestions.

Am I out of order? Am I talking about something else?

DR. MAYER: No, it is a question of -- Well, let me go back. When we originally talked, and I don't know whether I am two meetings back, one meeting back, or three meetings back, when we were talking rating scales, we said that those which are anniversary reviews within the triennium would be handled by the staff anniversary review panel, SARP, that we would also comment on those and discuss those. And then the question came in terms of how much time would we spend on them and would we rank them, etc.

And I think where we were was to say, "All right, we will look and see what the staff anniversary review panel which was set up to do that job does, and if we agree with the figure that they are at, fine. And if we don't, then we owe it to ourselves to go ahead and rate them."

DR. SCHMIDT: Are you talking about the 245 score that was brought up before?

DR. MAYER: Yes, for Northeast Ohio.

DR. SCHMIDT: I would be uncomfortable with matching my motion against that point score.

DR. MAYER: And we therefore rated it. So I have no problems with that. All I am saying is we need to address ourselves with each of the applications which on this sheet have numbers. We have to address ourselves do we want to accept that level or do we want to rate them ourselves? That is all I am suggesting.

Maybe what you are saying is you want to rate them all.

Yes, Leonard.

DR. SCHERLIS: I think having this sheet in front of us makes us focus on individual items as they are presented. And as such, it is a very good way of focusing the attention of the group. In so doing, a rating is arrived at. And I would think we should do this with each presentation that is made here.

I find it difficult to accept another rating without going through the mechanics myself to see if I agree. But once I have done the rating, then it is there and it is written and something might as well be done with it even if the committee that goes over this chooses to disregard it. But at least I would like to go through the mechanics of doing it.

DR. MAYER: O.K., does staff have any troubles with that?

DR. SCHMIDT: If there are great discrepancies in this rating and staff's rating, I think that is a nice danger signal that would signify we have got a problem that ought to be looked at.

DR. BESSON: I have viewed this as just your calling the presence of this rating to our attention, no more.

DR. MAYER: All right.

DR. SCHMIDT: You got that?

And those eight recommendations are outlined on the secondpage of the site visit report that you have.

The region at the time of our earlier visit had just come through the process of separating from the South Dakota component, just reformed as a separate Nebraska region. And there are some problems relating to that.

We found that there were some very fundamental problems in terms of program management and direction. And these eight points which you see outlined on the site visit report addressed those issues.

I could say that in summary all of these issues, that this advice letter had been taken very seriously, that shortly after the receipt of the letter, the program coordinator resigned, and very shortly thereafter a new coordinator was appointed. He had been with the RMP previously. And by September of last year, the RAG had sort of reformed itself, and they were down to brass tacks and working.

And most of this past year has been devoted to reorganization, reforming the region and trying to address those questions and suggestions which were raised in this advice letter.

The newly appointed coordinator is proving to be a good coordinator. He has shown the ability to provide directions to RAG. Many of the actions of the RAG have been upon his advice, and they have acted on it and not hesitated to

react to his leadership.

He has made a number of rather difficult decisions, one of them being that some negotiation with the medical school and the core funds now were under his direction instead of under the medical school's control. And I think that kind of action is indicative of the strength of leadership that he is providing.

The RAG is playing a much more active role now than they used to.

DR. MAYER: Joe, can you use the microphone?

DR. HESS: The RAG is playing a much more active role than they formerly had in setting program policies. They have reorganized themselves into five working committees, an executive committee, nominating, the budget and finance and the resource and development and operations review committee. And each of these appear to be performing their functions.

The program has developed documents which spell out the procedures whereby projects are to be reviewed. And the relationship between the gtantee and the RAG and all of these kinds of things, all of those issues were appropriately addressed.

They have had a management consultant from the University working with them, and they developed a new organizational structure and developed job descriptions of each

of the positions. And in terms of program management, there has also been much strengthening.

I would also indicate that the morale of the staff which is one indicator is much different than it was a year ago. A year ago, we had indications in talking with members of the staff informally there just was no communication, that they were not working together, that the coordinator wasn't listening to them and so on. But you get an entirely different feel this time. They were working together. They felt they were part of the team and that everyone seemed to be unanimous in the feeling they had made a rather major change in direction and function.

As far as identification of regional needs is concerned, there was one survey which we learned about a year ago which still is the major systematic survey that they are using. This is supplemented, however, by the information which was picked up by the RMP staff in the visit throughout the Nebraska region. And you can perhaps see from the little map they have in the yellow pages, they have project activities that pretty well blanket Nebraska. So they do get out and do spend a lot of time out in the community. And that supplements and is one of their sources of gathering information.

But another important thing which at least has the potential of having made their impacts in terms of needed identification is the study which has been carried out under

the CHP agency which will be in its completed form in June. And in talking with the AAUC director who is a very intelligent, dynamic woman, already there are things coming to the surface in that study that are going to have an impact on what RMP does. And they seem to be open, their communication is good, their relationships appear to be quite good between those two. So I feel quite confident that that study will result in some change in their objectives and priorities in the months ahead.

The question of phasing out of the programs, this has begun. And they are aware of it, and they intend to do more. There has been some joint funding now through other RMPs around them. The university is beginning to pick up certain projects which can be justified and so on. So that they are making movement in this direction.

The final issue in that letter has to do with the mobile cancer project. The core staff has been actively involved, and the RAG also, indirecting the course of the cancer project. And it seemed to us that they seem to have these fairly well in hand.

Going on with the report, they have redefined their goals and priorities. They look quite different than they did a year ago. And they are consistent with national goals.

Most of the projects which have come through the review process now tend to be ones which conform more with the older mission of RMP than the newer. And as near as we can

determine, one of the reasons for this is that much of the core staff activities and so on, the RAGs, have been in this reorientation process. They haven't had time to get out and stimulate development of new projects. But they seem to be aware of the need to do that. I think the chances are reasonably good they will do so.

We mentioned continuing support.

Minority interests, these are not very well reflected, but they have told us they have tried to get more minority representation and will continue to try. As we talked with the lady who is the CHP director, it seemed she had some ideas and techniques for doing this that perhaps they could learn from. And we suggested they might talk with her and get some assistance from her in doing so. But at least there was a willingness, and we indicated that we hope there would be improved performance as well.

I mentioned already the coordinator in relation to the RAG. The core staff seems to be quite strong, In working with the management consultant, they have identified the need for some additional staff positions -- one in the area of bolstering their program evaluation segment and others in area consultants. And after hearing the rationale and so on, we concurred with that assessment and agreed they should further strengthen the core staff.

The Regional Advisory Group still tends to be

provider dominated, but there has been some change in the balance since we were there a year ago. They seem to be aware and were receptive to our suggestion that they need to give further attention to a broader representation on the RAG.

The grantee organization is the State Medical Society. I think there has been significant movement in the relationship between grantee and RAG, the RMPs, since we were there a year ago. I think there is still some further delineation refinement that needs to be carried on there, but certainly they are moving in the right direction.

We pointed out some of the areas which we thought they needed to give further attention to. And I would hope that these further additional details will be attended to.

Their participation, we mentioned, in terms of RAG participation and so on. The State Medical Society, physicians, seem to be the majority, but there is good participation in the State Health Department, appears to be good working relationships there.

The CHP seemed to be reaching out in the communities to a considerable extent, and their record is reasonably good in that area.

Hopeful planning, they are working with CHP B agencies that exist, but that program was just beginning to get geared up. They have some of their own local mechanisms for doing it, but I think again their performance is satisfactory.

We have talked, I think, enough about management.

The evaluation has improved substantially since we were there a year ago. We agreed there is a need for more staff in this area. And this function in this area has been hampered somewhat by the ill health of their evaluation person. But I was filled in this morning they have already taken steps to bolster this area, and they recognize the need for further improvement.

The action plan, again, is more in the formative stages because of this reorganization they have gone through. They have their goals and their priorities developed now, and I would anticipate in the next few months, we would see an action plan based on those goals and priorities begin to appear in terms of projects more related to that.

They have been successful in the area of dissemination of knowledge. They have had coronary care training programs and other educational type projects which have apparently been well received and have served a real need and have been the means of bringing inactive nurses and other people back into the health care system. And there have been a lot of spinoff benefits from the projects that were built as dissemination of knowledge.

Manpower and facilities, there have been some, as I mentioned, spinoff benefits from the coronary care and other type education activities which have had an impact on this.

But we really were unable to get a very good handle on just how much impact the RMP is having on use of those facilities. They have stimulated cooperative arrangements among hospitals. There is sharing going on as a result of these RMP projects. So we got the feeling that they have had some impact.

The improvement of care, I think what I have already said more or less summarizes what I want to say in this area.

Short-term payoff, I think there has been some with the coronary care learning resource center. They have plans for more regionalization in the sense they are developing area coordinators who are going to work in specific areas within the region to stimulate more cooperative arrangements and more joint activities in that area.

In summary, then, we felt that the region had seriously addressed all of the issues which have been raised as a result of the site visit of last year and has made very substantial progress in making the necessary changes in reorganization and changing the direction of the RMP.

As a result of this, we came up with a funding recommendation of $725,000.

Now, that is based in part on the recommendation of the Kidney Review Panel that neither of the kidney projects ought to be funded. And one of the important reasons is they had not developed a well-thought-out regional plan for kidney disease. So that accounts for one of the major reductions

below their request.

And we felt that there were some savings that they could make in terms of the mobile cancer unit and one or two of the other projects without hurting them and also that some cutbacks should be made in the funding of current projects to give them some seed money for feasibility studies and so on to start off and do some planning at least in the new directions which they want to go.

So that this was the rather simplistic rationale for arriving at the recommendation for $725,000. We recommend that they find within that budget about $25,000 for initiating some small planning feasibility studies, mentioned the two kidney disease activities, and we felt that they should be given the option to submit a triennial application next year, feeling that with another year to work and develop that they may be in a position to merit that.

DR. MAYER: Dorothy, comments?

MISS ANDERSON: I was amazed, just reading the materia I wasn't on the site visit -- at the progress they have made in just six months with this new coordinator. And I think this is a real good example where rather than getting the person to change their thinking in coordinators and changing their action that maybe we do need to look seriously and encourage some areas, regions, to get new coordinators.

Now, I was impressed by the involvement of the RAG

group. They really got involved in committee meetings. They were involved in site reviews and made recommendations for changes of budget and relocation and reallocation of money, as I understand.

They have also changed their by-laws and realigned budgets and did other things that really showed involvement of the group.

I was interested that the staff kept relating to a 1968 survey that was done. And I had a feeling that maybe if the staff had been out in the community more, they wouldn't have to wait for this new survey for some direction.

DR. HESS: I think maybe that is an unfair reflection of the report because the staff is out in the community. They get very high marks for being out and visiting around. They really ride the circuit.

MISS ANDERSON: It seems like they have quite a few things they are holding off until they get this new survey.

DR. HESS: That may be more a reflection of our report than it is in reality. I am not sure that is really fair.

MISS ANDERSON: Thank you.

Another area I thought was interesting was the development of the new goals in regard to the new direction that RMP is going in regard to health manpower, health care delivery and management and administration.

I think everything else we have touched as far as I can see.

DR. HESS: Just to elaborate on one point that you picked up and I forgot to mention is that the RAG is involved in the site visits to projects. I think this is a very tremendous thing. At least some member of the RAG has some detailed knowledge of nearly every project. And that is, I think, rather unique. I don't know. There may be some other regions, but offhand I can't recall others that have that degree of involvement of the RAG.

MISS ANDERSON: And I think another point I would like to support you in is in regard to representation on the RAG. They do need more minority people. There are many Indians as an example in this area. And blacks also.

And, also, they need more allied health people on their RAG from what they have had in the past to make it, if you are thinking of comprehensive health care.

DR. MAYER: Dr. Hinman, comments?

DR. HINMAN: Yes. This region had two applications in for support of kidney activities. They both had technical review in the region by people from within the region who made strong recommendations against the appropriateness of the proposals. And on that basis, it is the staff recommendation it not be approved even though the RAG sent them in.

One of them was to produce six films of teaching

tapes of undetermined type for an undetermined audience. And the other was to train some people for we didn't know exactly what in the application. So it was our recommendation that the region be given advice that there were existing guidelines that could have assisted them, staff could have assisted them, there were new guidelines coming out, and we recommended disapproval.

It was $48,838 requested.

DR. MAYER: Further comments?

DR. KRALEWSKI: I have a question about the core staff. How many people do they have and how was this affected when they split apart and all that? Are they saving any money or what is happening to the core?

DR. HESS: Well, you mean when South Dakota-Nebraska -

DR. KRALEWSKI: Yes.

DR. HESS: They decided there was a division of funds and so on that was negotiated with RMPS.

DR. SCHMIDT: I think the answer is in light of the activity, the core type of activity, was really Nebraska and South Dakota's problem is really to build up. The flow was into -- at least, I was representing South Dakota at that time - the flow was kind of into Nebraska. We had a core staff. I don't think they are cutting back any. The loss of South Dakota, there wasn't much in South Dakota there.

DR. KRALEWSKI: This budget expands that core now,

does it?

DR. HESS: I would have to go back and look at the figures a year ago versus now.

DR. MAYER: Yes, by about $140,000.

DR. HINMAN: $232,000 to $376,000.

MR. POSTA: I might make the statement here I think the core budget as outlined here for this upcoming year really indicates the inclusion of four new members to the staff. But in view of the fact that the drug information center and resource learning center that was appointed a project last year would be included under the core, I think would be increased for the next year total within core is about $115,000 rounded off. And that would take care of assuming those two new programs or the two old programs and a couple of new additions to the core staff.

DR. KRALEWSKI: How many vacancies do they have?

MR. POSTA: Frank.

MR. ZIZLAVSKY: They are requesting four full-time positions -- deputy coordinator, associate coordinator for evaluation, and two additional area consultants. And this totals about $70,000. $20,000 increases for fringe benefits. Previously under the previous coordinator, fringe benefits were non-existent. This is something they have been fighting for three years. They have finally established it.

That speaks to about $100,000. They have a couple of

pharmacy students on part time answering the phones 24 hours a day which speaks to about $10,000. That accounts for about $110,000.

We have got a little bit more money in travel, a little additional money in equipment.

DR. HESS: I think you are asking how many existing vacancies.

DR. KRALEWSKI: Right.

DR. HESS: And I don't believe there are any. They are all new ones that they are asking money for.

DR. MAYER: Four new professional positions, is that what you are saying?

MR. ZIZLAVSKY: Right.

DR. MAYER: Further comments?

DR. HESS: I would move formally, then, they be approved at $725,000, and we also felt we ought to make a tentative recommendation for $700,000 for the second year so they have something to plan on, but with the understanding --

DR. MAYER: They will probably be coming in with a triennium.

DR. HESS: That's right.

DR. MAYER: But in case they don't, we are recommendi $700,000.

DR. HESS: Yes, some sort of assurance for them.

DR. MAYER: O.K., is there a second to that?

MISS ANDERSON: I second it.

DR. MAYER: Further comments?

Yes, John.

DR. KRALEWSKI: A point of clarification. That $25,000 is included?

DR. HESS: In the $725,000.

DR. SCHMIDT: I am curious about this renal business, Dr. Hinman. You said that the RAG approved it, but that people within Nebraska recommended disapproval?

DR. HINMAN: There was a technical review by three physicians from within the State who had adverse comments the program was not adequately documented, adequately structured, and they still sent it.

DR. SCHMIDT: From the university or Creighton or --

DR. HESS: One was Dr. Holmes from Colorado. They were experts, kidney experts, that were called in. But they were not all from without Nebraska.

DR. HINMAN: Two of them were, weren't they? You are right about Dr. Holmes, but I thought the majority were from within Nebraska. But either way.

DR. SCHMIDT: It was on technical grounds that it was turned down, then?

DR. HINMAN: Yes.

DR. MAYER: Technical plus regionalization, I was hearing, Mac.

DR. SCHMIDT: I know, but you see the RAG approved it.

DR. HINMAN: That is correct.

DR. MAYER: In spite of the negative comments.

DR. HINMAN: Yes, sir.

DR. MAYER: Which makes the point we were trying to make earlier.

O.K., further comments.

(No response.)

All those in favor of the motion?

(Chorus of ayes.)

Opposed?

(No response.)

Before we break, I have got a couple of issues I want to comment about. The first relates to this evening's activities, to make sure we all understand where we are going and how we are going to get there.

(Announcements were made.)

DR. MAYER: One of the individuals who has been participating in RMP applications as long as anyone, including maybe myself, Lorraine Kyttle, who is on my right, who has been serving us very effectively for the last three years, four sessions of this committee, this is also her last review committee session. She is going to be assuming responsibility for South Central Operations Areas which will include Memphis,

Illinois and South Carolina as her activities, but will not be serving in the capacity she has. So I just wanted to indicate to you this evening while we are there that it is also her last go with the committee.

On the agenda for time, I will not be with you tomorrow. My chancellor has called a budget session which I have to be at if I hope to survive for tomorrow. And I will have to go back tomorrow. But there were two items or three items that were on the suggested items for the agenda that I wanted to remind you all about so that you didn't forget them.

One was the, if I may call it that, emasculation issue which Jerry had raised and others had raised that we needed to talk about a little further.

The second was Mr. Parks raised the question appropriately about several of the questions that we sent up to the Council at the last meeting, and we need to discuss a feedback of those. And I assume, Mr. Parks, you will raise those tomorrow.

And then thirdly, there was some discussion of at least some of the people at lunchtime about new members of the committee and new chairmen, vice chairmen, etc. And I think that issue needs to be raised.

And with that, I would like to say it has been my very real pleasure having an opportunity of participating in this committee over the many years and chairing it the last

two years almost in toto. I appreciate all the efforts that have gone on in terms of helping us get through and the job done. It has been done very well.

DR. SCHERLIS: I think somebody should recognize the fact that you are not being here tomorrow, this is our last opportunity to formally thank you for, I think, what has been not just superb direction, but maintaining our good humor and I think giving us a sense of at least thinking we know where we are going. And I want to on behalf certainly of the committee extend to you our thanks for having been such an excellent chairman over the years.

DR. MAYER: Thank you very much.

DR. KRALEWSKI: I would like to formally move that into the minutes.

DR. BRINDLEY: Second.

DR. BESSON: I move it up to the Council.

(Laughter.)

DR. MAYER: That is really a policy issue.

Well, I hope to see most of you this evening at 6:30.

I would also like to remind you do not forget those of you because I didn't remind you in Nassau-Suffolk as well as Nebraska in terms of your rating sheets. And I would assume that if you held onto those, fold it up neatly at your place so people aren't seeing them. I think you are probably

in good shape. We can leave the materials here.

What time, 8:30 in the morning? I think we can probably appropriately move it along.

(Whereupon, at 5:10 o'clock p.m., the meeting recessed, to reconvene at 8:30 p.m. on Friday, May 5, 1972.)