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# Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS

REVIEW COMMITTEE

Rockville, Maryland  
Friday, 5 May 1972

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PUBLIC HEALTH SERVICE  
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION  
REGIONAL MEDICAL PROGRAMS

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REVIEW COMMITTEE

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Conference Room G-H  
Parklawn Building  
Rockville, Maryland  
Friday, May 5, 1972

The meeting reconvened at 8:45 o'clock, a.m.,  
Dr. Alex M. Schmidt, presiding.

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P R O C E E D I N G S

1  
2 DR. SCHMIDT: Well, good morning. I think we might  
3 get started.

4 If it is acceptable to the review committee, I have  
5 been asked to chair this one session this morning and have been  
6 instructed to try to get the group through our last four propo-  
7 sals in time so that we might go on and discuss some of the gen-  
8 eral issues that our former chairman charged us with last night.

9 So let's begin with Oklahoma. We may have to re-  
10 arrange the order slightly as we go on. If someone would pass  
11 Dr. Scherlis the microphone down there, we will see if Oklahoma  
12 is okay.

13 DR. SCHERLIS: I had the opportunity of chairing a  
14 site visit to Oklahoma in July of 1971. There were many items  
15 which were pointed out at the time of the site visit, and these  
16 included comments as far as what areas particularly needed  
17 strengthening.

18 I will refer to what the status is now as best I  
19 know it in terms of the leadership.

20 Dr. Groom has been coordinator of the Oklahoma  
21 Regional Medical Program. When we had visited him, an assistant  
22 director, extremely active and very productive individual, had  
23 resigned. That was Mr. Hardin.

24 The previous leadership, as far as the RAG was con-  
25 cerned, was also subject to change. Dr. Johnson, who had been

1 a particularly strong individual, was leaving to be replaced by  
2 Dr. Strong, and there was some question as far as his ability  
3 and his interests as far as RAG went.

4 So there was a problem with the leadership from the  
5 point of view of Dr. Groom's general attitudes and interests  
6 from the point of view of staff which had been leaving and has  
7 continued to leave, problems in terms of RAG.

8 So this was a strong point of our concern and some-  
9 thing which we did discuss at great length at that time.

10 We were also concerned about the strength of the  
11 core. There was a problem as far as having adequate representa-  
12 tion on RAG and we had pointed out that it should be more in-  
13 volved as far as monitoring the program. There was very little  
14 indication, as far as its goals and objectives having to be in  
15 line with what are the present directions of RMPS.

16 There was a problem at that time of subregionaliza-  
17 tion, a problem of the Oklahoma Regional Medical Program working  
18 more closely with other Federal programs which were going on in  
19 that area. There were significant strengths. Their coronary  
20 project was one which spread pretty well throughout the State.  
21 There were subnetworks, and subregionalization at least in that  
22 particular program was really a very good one.

23 There was evidence of their working in a pretty good  
24 way with the medical school of the university. We met with  
25 Dr. Kelly West who did an excellent survey as far as health

1 needs in Oklahoma, but this had not been put into any discern-  
2 ible use as far as the Oklahoma Regional Medical Program was  
3 concerned.

4           Following the site visit, communication was made  
5 through the usual channels with Dr. Groom to indicate what some  
6 of the strengths and weaknesses of this program were. This,  
7 as I said, was through usual channels and followed by channel  
8 communication.

9           I received a letter, having chaired the site visit,  
10 from Dr. Groom, asking me if I shared the conclusions that Dr.  
11 Margulies had expressed in the analysis of our site visit report.  
12 I did not file a minority report at that time.

13           Following our meeting, there were certain changes  
14 which occurred which have been, I think, important as far as be-  
15 ing of a constructive nature is concerned. One was that there  
16 was a so-called Macer committee. This was a group from Colorado,  
17 Wyoming and elsewhere, that went into the region apparently at  
18 the invitation of the Oklahoma Regional Medical Program and went  
19 over some of the aspects of the Oklahoma Regional Medical Program  
20 which had been pointed out to the region in the site visit.

21           There have been other changes which appear to be, I  
22 think, helpful ones. First of all, as one looks at their present  
23 application, it is in much better form than their previous ones  
24 have been. At the present time, they are applying -- and it is  
25 a rather ambitious request, particularly in terms of what happened

1 as far as the recommendation of the last visit was concerned --  
2 for their 04 year for a total of \$1.5 million, out of which  
3 \$724,000 is for core, a continuation of some aspects of their  
4 coronary programs in the fourth year of some \$28,000, and the  
5 rest is a series of some 14 or 15 individual projects, many of  
6 which are related to subregionalization, Ada, and elsewhere in  
7 Oklahoma, \$35,000, \$40,000 to \$50,000 each; rehabilitation pro-  
8 gram in service education, a screening program, an educational  
9 program centered around the VA, an application for emergency  
10 medical service which will not be considered since that is being  
11 looked at in a separate way, pediatric nurse associate, and so  
12 on.

13 It is a large variety of programs which are not being  
14 submitted. Unfortunately, in reviewing their application, it  
15 is apparent that they have not really met the deficiencies which  
16 have been pointed out previously. This is apparent if anyone  
17 had been on the site visit. It is certainly well pointed out,  
18 I think, as far as the staff review is concerned, which I think  
19 is a very good document and really indicates what the strengths  
20 and weaknesses are.

21 They have, as I have said -- and this is on the  
22 positive side -- set up Tulsa as a subregion, and this had been  
23 of some concern. When we were there, of course, Tulsa did not  
24 seem to be adequately represented. Although the projects, they  
25 have shown ability to cut some off. They had originally had 11



1 projects implemented when the regions became operations. Three  
2 they terminated in two years, four at the end of three years,  
3 and as I have said, continue the coronary care and one or two  
4 core projects.

5           There has been some information which was just given  
6 to me yesterday. There had been some indications that Dr.  
7 Groom will probably resign, and it is my understanding he has  
8 now sent such a letter to RAG. And there is already, I under-  
9 stand, attempts being made to replace him and have a successor.

10           So I think in evaluating the region, we are in a  
11 peculiar position of, first of all, not knowing who the coordi-  
12 nator is. And recognizing the fact that while the goals and  
13 objectives previously were not really in line with what usually  
14 RMPS goals and objectives are, they have now drafted a complete  
15 series of new goals which have been approved and which I saw  
16 yesterday and seem to have adequately expressed the direction.

17           However, there is the problem as to what sort of  
18 leadership they will have from RAG because Dr. Strong has re-  
19 placed Dr. Johnson who is the new strong individual.

20           In terms of the actual support that they requested, I  
21 think one has to look at what should be done in Oklahoma which  
22 is to take some time for actual operational efforts and try to  
23 really reorganize their entire staff, and whoever replaces Dr.  
24 Groom will not alone have some problems but will have some, I  
25 think, strong points. Because in looking over their staff at

1 the present time there are several vacancies at a good profes-  
2 sional level which can be filled.

3 I think Oklahoma has a lot to build on in the sense  
4 that they do have a good record of an excellent coronary care  
5 program, one of the better ones which has spread out, so there  
6 is an active subregionalization evaluation.

7 Evaluation appears to be good. The methods of review  
8 are good. They have been hampered by a change in leadership.  
9 At the present time they are hampered by the loss of Mr. Hardin  
10 who has been extremely active.

11 The problems, I think, in not having moved into new  
12 directions -- Dr. Groom has very marked strengths in the area of  
13 continuing education but not in the outreach program that the  
14 Oklahoma Regional Medical Program really has required. I think  
15 whatever recommendations are made -- and I would like to with-  
16 hold those until there has been secondary review -- will have  
17 to be in terms of what is a rather fluid condition in that  
18 region at the present time.

19 So can I defer to the second reviewer before I make a  
20 recommendation as far as level of funding.

21 DR. SCHMIDT: Fine, thank you.

22 Dr. Ellis.

23 DR. ELLIS: Dr. Scherlis has gone over the program  
24 extremely well and had the advantage of making the site visit,  
25 and I didn't. But I concur with what he has said.

I would like to say that I am quite distressed that

1 much of the continuing education really is not educating the  
2 physicians and other professionals about the goals and objectives  
3 of the Regional Medical Programs. And I was just wondering --  
4 there is going to be a great need to strengthen the leadership,  
5 and I am wondering how, since a person who is not a physician  
6 seemed to have been the person who carried the program on, and  
7 we seem to be having such difficulty with these coordinators, if  
8 another administrative mechanism could not be worked out utilizing  
9 perhaps a physician as a consultant to -- could we not try -- an  
10 administrator who would have the capability of really planning  
11 things that would make the Regional Medical Program a meaningful  
12 part of the health delivery system there.

13 I get the impression that this is still a great lot  
14 of a university program that is not really moving, and I am not  
15 sure the people have heard the message which RMP has to give.

16 I really think that this program needs to have care-  
17 ful guidance and complete reorganization. I can't see that we  
18 can keep going on with these kinds of coordinators who really  
19 don't lend anything to the program, and I recognize that this is  
20 a conservative area. It has been repeated over and over again  
21 in the write-ups. But it seems to me with proper communication  
22 a different administrative mechanism could be set up which would  
23 be entirely acceptable to conservatives and also it would seem  
24 to me that part of the continuing education might be directed  
25 to the RAG.

1           This has been done in a few places, and to see the  
2 change in attitude when this type of thing goes on is good be-  
3 cause unless we get the other disciplines, the allied profes-  
4 sions, I can't feel that any real progress is going to be made.

5           Now, talking about the pediatric nurse practitioner  
6 program is fine, and I certainly am for this, but I was distressed  
7 to read that the nurse is not playing a really active role in  
8 the discussion, and this is nursing service in the main and I  
9 would wonder about that.

10           Also, I think that the core staff remains rather  
11 narrow in a large number of the programs because if real change  
12 is to be made in the lives of the individuals to be served  
13 directly and indirectly, I think we have to connect with social  
14 services in a way which is not clear to me here, and also it  
15 might be good to really talk about the health education in a  
16 little different way. And I think that this program could be  
17 reconstructed. And since its major leadership has not been from  
18 a physician but rather this has been a confirming kind of  
19 leadership, maybe the reorganization could be worked out along  
20 these particular lines.

21           DR. SCHERLIS: There has been a significant problem  
22 in leadership. I think Dr. Margulies and others who are familiar  
23 with the area understand I have understated it because it is a  
24 necessary thing to go into problems, particularly since Dr.  
25 Groom has just resigned.

1 I am concerned about RAG. We met separately with Dr.  
2 Johnson who is an extremely capable physician in Oklahoma who  
3 had been chairman of RAG. And in every way that he could, he  
4 both assured us and has assured the so-called Macer Committee  
5 that he would be very active.

6 The Macer Committee, I think, did an excellent job.  
7 It is a good example of how a region near-by can be a help to  
8 another one. They reviewed their problems and pretty much stated  
9 as you have, and as I have, what the problems are in that area.

10 Mr. Hardin, who has been extraordinarily strong and  
11 represented leadership that Dr. Groom didn't give, has accepted  
12 a position of responsibility with the university, administrative  
13 vice president or something of this sort, and is no longer  
14 available. And I think what this region has to find is a strong  
15 individual who will be active.

16 We did meet with the vice president of Health Sciences  
17 on the campus or university who I think has a real understanding  
18 of what the needs are of the Regional Medical Program, and I  
19 think has been helpful in getting them through some of their  
20 changing leadership at this time.

21 Looking at the core personnel, there are eight or  
22 nine vacancies, and there have been some resignations in addition  
23 to this. So a new coordinator has an opportunity to really  
24 restructure, as you pointed out, core and individual projects.

25 If I can make a formal recommendation at this time,

1 I don't think it should be supported. The core has a great many  
2 empty slots in it, and there is adequate room, by filling those  
3 slots, by using funds available, I think through taking a year  
4 off from just individual projects and doing some planning.

5 The level which staff review recommended has a good  
6 deal of logic behind it, but what they have suggested is they  
7 be given the funds they should have gotten for 03 year before  
8 they were cut, and this comes to something like \$839,000. It  
9 is significantly less than what they asked for, which is \$1.3  
10 million. But with a new coordinator coming in I would think  
11 the worst thing we could do would be to give them some of these  
12 projects on an operational level and review them separately. I  
13 don't think that's the way to go at this time.

14 I would therefore recommend a much reduced budget  
15 in the order of \$839,000 which would match their 03 year, with  
16 strong recommendations that they not only find a good coordi-  
17 nator but they give him the necessary support to restructure  
18 the Oklahoma program.

19 It has good strengths which can be utilized. But  
20 one of the problems has been that Dr. Groom has not been, I  
21 think, as involved as he should have been timewise, which has  
22 been a very significant problem and one of the reasons that  
23 a strong individual like Mr. Hardin could be the force that he  
24 was and, secondly, he came there at a time when RMP was basically  
25 interested in continuing education in that area. And this has

1 been the main thrust and that is where the thrust has remained.

2 Is there any staff comment on this?

3 DR. MARGULIES: I would like to comment just briefly.

4 We have met twice with the Vice President for Medical Affairs,  
5 Dr. Eliel. And he is a different kind of person who has  
6 been very busy trying to do some things in the university, has  
7 gone far enough so he understands the potentialities of Regional  
8 Medical Programs.

9 Interestingly enough, Dr. Ellis, he is thinking  
10 about what kind of leadership and organization that is needed  
11 there is very close to what you were talking about. They are  
12 on their research committee looking at competence which does  
13 not require an M.D. They are looking for someone who can give  
14 it a different sort of leadership.

15 I think possibly the most hopeful thing about Okla-  
16 home is that Dr. Eliel and the people in Oklahoma more and more  
17 define the role of the University Health Science Center as an  
18 institution to serve the State of Oklahoma, and he understands  
19 that, and he feels, as do other people, that the Regional  
20 Medical Program represents the kind of link they have to have  
21 if they are going to be an institution of community service.

22 I think in the best university RMP arrangements that  
23 is the concept which dominates events. Dr. Eliel understands it.  
24 He also wants to avoid having university dominance so that the  
25 environment, if the selection of the coordinator is successful,

1 is very promising.

2 This doesn't get around to the problem of the  
3 Regional Advisory Group but I think that when you get those two  
4 forces working effectively the Regional Advisory Group may  
5 function much more effectively.

6 DR. SCHERLIS: I think the other strengths are Dr.  
7 Kelly West who tends to maybe act as a consultant. His report  
8 on some of the health needs of Oklahoma is one of the best that  
9 we have seen and, interestingly enough, was never referred to  
10 in any of our formal meetings. We just happened to find out  
11 about it casually and could be one of the strong points of the  
12 entire site visit. He really defines what a lot of the health  
13 needs of the State are.

14 Also, another strong point is Dr. Johnson, and he  
15 again tends to remain active, but he is no longer head of RAG,  
16 but had assured us he would set up some form of advisory com-  
17 mittee ongoing activity as far as the group is concerned.

18 So there are significant areas that can be a real  
19 credit to the Oklahoma program. This is one reason why I hate  
20 to see a more drastic cut made. I think this cut is strong  
21 enough. I think there are enough funds for restructuring and  
22 replanning, yet at the same time giving them more would mean  
23 saddling them with projects they have to support for a few  
24 more years, and probably use good people. And they don't have  
25 that many available.



1 DR. SCHMIDT: We have a motion, Dr. Ellis. Do you  
2 second that?

3 DR. ELLIS: Yes, I do.

4 DR. SCHMIDT: All right. We have a second to the  
5 motion. Any discussion?

6 DR. KRALEWSKI: What is their organizational relation-  
7 ship to the medical school? Are they in a department or do they  
8 report to the vice president?

9 DR. SCHERLIS: You see, earlier, when Dr. Groom came  
10 there, he was essentially recruited by the medical school. This  
11 is where his strength was, as a cardiologist, and very active  
12 in teaching at the university, and he came essentially for that  
13 reason.

14 DR. KRALEWSKI: Well, the basis of my question is in  
15 terms of their ability to get a good coordinator, if they are  
16 going to have to get a guy who has certain academic qualifica-  
17 tions or are they --

18 DR. SCHERLIS: It is through the University of Okla-  
19 homa who is the grantee organization, but again I want to  
20 emphasize what Dr. Margulies said, the relationship is an ex-  
21 cellent one.

22 This is not going to be, as far as we can see,  
23 judging from Dr. Eliel's statements. This isn't going to be a  
24 program I think completely dominated by the medical school. The  
25 point you made, this is a very strong point as far as the vice

1 president of the university is concerned. I am not concerned  
2 about this being a dominated program.

3 DR. SCHMIDT: I remind everybody of the rating  
4 sheets. If anybody turned their's in and needs a fresh rating  
5 sheet, raise your hand.

6 Is there other discussion?

7 Joe.

8 DR. HESS: I would just like a little further  
9 clarification on the recommendation for \$839,000. If I under-  
10 stood you correctly, you were suggesting that there be relatively  
11 little funding for projects, is that correct?

12 DR. SCHERLIS: Yes.

13 DR. HESS: And as I look at the budget breakdown here,  
14 the 04 year request for Core is \$677,000. Their current year  
15 funding is \$354,000. And then there is the request for \$629,000  
16 in operational activities, the past year spending \$384,000.

17 Can you describe all these vacancies in the Core staff  
18 And what I am having trouble with is understanding why you  
19 justify that much money.

20 DR. SCHERLIS: You say your feeling is that that much  
21 is too high or too low.

22 DR. HESS: Too high.

23 DR. SCHERLIS: You think it's too high?

24 DR. HESS: Based on what you said before.

25 DR. SCHERLIS: I tried to use the following ground

1 obviously too much. I think to strip them so they can be essen-  
2 tially at the level where they were in the 03 year again is  
3 too restrictive. I think they have to be at about that level  
4 so they can restructure, and to have enough -- If we are going  
5 to talk about subregionalization in getting this started as a  
6 part of the reorganization, I think they have to put some money  
7 into that.

8           The number was derived from what they had been  
9 awarded before it was cut by the council, an across-the-board  
10 action. So what we did was restore the 03 year, knowing that  
11 since they don't have that many projects continuing they can  
12 hopefully support a couple of new ones in that, and to give the  
13 new coordinator something to work on, frankly.

14           I think if we begin by giving him very little, he  
15 isn't going to have a program that is feasible, nor could we  
16 attract a good coordinator to the area.

17           But I think there is enough in that so we could get  
18 a couple of good projects going and restructure the core. The  
19 number was derived from what they had in the 03 year prior to  
20 the cut.

21           DR. HESS: Is that different from the \$738,000 shown  
22 here on the sheet?

23           DR. SCHERLIS: Yes. They had originally been given  
24 \$839,000, and it was cut to \$738,000. It was cut at the council  
25 level across the board, is that right?

MR. SAYS: Twelve percent.

1 DR. SCHERLIS: So they had been given \$839,000, and  
2 it was cut across the board. Logically giving them that just  
3 indicates that's the level they had before and would continue  
4 for another year until such time as they have shown by their  
5 growth in program that they deserved or merited additional  
6 monies.

7 DR. HESS: If I understand it correctly, Dr. Groom  
8 has recently resigned. They don't have a new coordinator.

9 DR. SCHERLIS: He is going to stay on board, isn't  
10 this correct, until there is a replacement?

11 MR. SAYS: Yes. It is my understanding Dr. Groom  
12 has a contract with the university until the end of June. They  
13 have already interviewed at least two candidates, non-physicians  
14 at the doctoral level, but I don't anticipate a replacement on  
15 board until July 1.

16 I would like to throw out one comment that might  
17 help you some in terms of the funding.

18 DR. SPELLMAN: Could you speak a little louder?

19 MR. SAYS: As is indicated in the recommendation by  
20 the SARP, the action did not include consideration of Project  
21 25, the emergency medical system, which will be taken up on  
22 the 15th by an ad hoc group of the council, and that is  
23 \$140,000, which was their number one activity.

24 They will also be submitting supplemental applica-  
25 tions for several local health manpower systems, each for

1 \$50,000 or less, June 1. So there are some other proposals  
2 that will be in the hopper to be acted upon by the June council.

3 DR. SCHMIDT: Sister Ann Josephine.

4 SISTER ANN JOSEPHINE: Dr. Scherlis, you have indi-  
5 cated that you feel by putting the funding at the level of  
6 \$839,000 they'd have some money so that the new coordinator could  
7 continue a few projects.

8 I am beginning to wonder, as I listen to these re-  
9 views, whether we shouldn't feel that it is not only satisfac-  
10 tory but probably in many cases advisable where programs in the  
11 condition this program seems to be from the review, that a very  
12 worthwhile activity for a new coordinator is reorganization  
13 without the distraction of projects. And I would like to make  
14 a few points.

15 You know, you have to believe me, I love doctors, but  
16 I think that possibly in this program --

17 DR. SCHERLIS: I'm afraid to listen to what is going  
18 to follow.

19 (Laughter.)

20 DR. SPELLMAN: You protest too much.

21 SISTER ANN JOSEPHINE: I really do.

22 (Laughter.)

23 I have been grappling with this for some time and  
24 trying to relate from my daily experience some of the problems  
25 that I am seeing in this program. And I think that all of us,

1 while we talk about health care, are disease-oriented. And as  
2 we are disease-oriented, in the medical profession you are  
3 diagnosis-oriented and make the diagnosis and then move on from  
4 there.

5           And at the same time, within the last year we have  
6 been grappling with a total program evaluation, and I just don't  
7 think we feel real comfortable or flexible or probably are as  
8 able to handle this kind of concept as we can a task-oriented  
9 concept where we are looking at one thing at a time and making  
10 a decision, and moving on to the next.

11           And this may well be an inherent weakness in the  
12 program that maybe is supported to an unrealistic degree by the  
13 professional orientation of the leadership of the medical  
14 profession. And I just throw it out as a possibility.

15           DR. SCHMIDT: The only comment I have about that  
16 would be that in addition to the leadership of the Regional  
17 Medical Program, obviously there are some troops out there in  
18 the trenches that have been brought along by the coordinator.  
19 And when one talks about stopping the projects, he is talking  
20 about some of the people who have gotten up the projects in  
21 good faith, and sometimes at some expense to their own thing  
22 that they were doing.

23           So that there might be some breakage kind of acci-  
24 dently that would give a new leadership a lot of problems with  
25 loss of confidence in the people that he is going to have to

1 turn around and work with.

2 So if you do stop projects prematurely, some of the  
3 people who are the project types might suffer and may be less  
4 willing to come along with a new and strong leadership.

5 I would rather favor phasing out and giving people  
6 some time to fire their staff -- you know these sorts of things  
7 have to happen. So I think we should be cautious about this.  
8 I was just thinking, with apologies to Mitch, I suppose that a  
9 poor quality granting agency might be termed a sick provider.

10 SISTER ANN JOSEPHINE: Dr. Schmidt, as I say this I  
11 don't mean to do it in any one step and do anything drastic, but  
12 I think it is something maybe we need to consider as a group.  
13 Maybe we don't give sufficient recognition to the need for time  
14 to stop and maybe reorganize while business does go on.

15 And I think that the health of the program isn't in  
16 the number -- we all know this -- of projects and maybe sometime,  
17 even as we make the site visits, you know you have to plant the  
18 seed and change attitudes. And I feel the same way about the  
19 Federal Government. I think we rush from one program to another.  
20 And at the last meeting I was just forced to express again my  
21 concern that we destroy the possibility of continuity of pro-  
22 grams by this kind of thing. I get the feeling we may be doing  
23 the same thing here.

24 DR. SCHMIDT: The point of discussion, really, I  
25 think, is the level of funding. That is what we are on now.

1 DR. BESSON: I would like to reiterate what is im-  
2 plied in Sister Ann Josephine's comments by pointing out that  
3 there are some questions even in the area as to whether it is  
4 reasonable to support projects really because they represent  
5 the hard work of some people who develop them. And while I am  
6 sympathetic with the notion of providing some wherewithal for a  
7 new coordinator and, let's say, a refurbished outfit to work  
8 with, I think we run a little bit of a hazard in perpetuating  
9 mediocrity by providing funding for this kind of an organization.

10 I would just like to read to you some of the comments  
11 I noticed in SARP's comments, that they referred to a disparity  
12 between the A and B agency approaches to some of these projects.

13 And as I got the application to look at, what this  
14 disparity was, apparently, the Area Health and Hospital Planning  
15 Council had some question about viability of some of the pro-  
16 jects and the approach of the RMP toward approving these projects

17 Yesterday I made the comment that there was a built-  
18 in bias to having RAG approve of the labors of their own people,  
19 and I think that is so. We have seen constant evidence of it.

20 The A agency here apparently has that same bias.  
21 They are hardly going to be in a position to turn away funds  
22 if their approval would bring those funds into the area. So they  
23 are almost a pro forma review and common function.

24 But this particular group says in reviewing these  
projects they approve some and they approve others in principle



1 and reject others. And the comment here is in terms of the  
2 projects rejected. And I am reading from the B agency comments

3 DR. SCHERLIS: B agency from where?

4 DR. BESSON: Tulsa.

5 "Projects Rejected. The Board felt the health bene-  
6 fits likely to be accrued versus the expenditures anticipated  
7 were not compatible. It was also felt that communications be-  
8 tween the applicants and various interests within the region to  
9 be served were minimal; that the projects were by and large  
10 ill-defined in terms of methodology, and methods for evaluation  
11 were not in evidence.

12 "Also a major concern to the board was the failure to  
13 have proposal advocates in attendance to answer questions. The  
14 board recognized the imposition that would be placed on appli-  
15 cants but also noted its own imposition in terms of performing  
16 the review without sufficient information."

17 Then they go on to say that in the future they hope  
18 RMP would consult with them to keep the projects a little bit  
19 more relevant before they reach their decision.

20 That is the first time I have seen an honest comment  
21 in any of these pro forma approvals by any agency at the  
22 peripheral level. I think it's very much in keeping with  
23 the comments Sister just made, and I wonder whether the bolder  
24 approach that we had with Mr. Parks' comments about Northeast  
25 Ohio yesterday of just phasing them out isn't the other point of

1 view to the one that was presented by Dr. Scherlis.

2 DR. SCHERLIS: First, let me emphasize I have hardly  
3 been considered an advocate of the Oklahoma Regional Medical  
4 Program by the Oklahoma Regional Medical Program, so I am not  
5 appearing here from the point of view of advocate.

6 There are certain things I think should be pointed  
7 out. That is, that the Oklahoma Regional Medical Program has  
8 not had the active participation or cooperation of the Tulsa  
9 group -- bear me out on this. The distance between Oklahoma  
10 City and Tulsa has been a rather large one in terms of the Re-  
11 gional Medical Program.

12 Their new plan includes subregionalization with  
13 Tulsa being actively involved as part of the regional effort.  
14 So this is recognized, was talked to as a point by our site  
15 visit group. And looking at some of the projects that we are  
16 talking now about eliminating, one of them relates to programs  
17 for education in Tulsa.

18 I would not like to see the evidence that you have  
19 given submitted as a failure of the Oklahoma Regional Medical  
20 Program. I have to ask how many project directors appear before  
21 B agencies to discuss their projects, and I think you come up  
22 with a fraction of one percent. I think that would be a rather  
23 accurate estimate. Maybe a little bit more. I may have to  
24 move the decimal point over a bit, but I would hate to see that  
25 used, and particularly since there is the Tulsa-Oklahoma City

1 situation.

2 I would again submit I am not an advocate of Oklahoma  
3 except trying to look at it from the point of view of the  
4 strengths that they have and trying to build on them. I don't  
5 think a sum of \$800,000 is excessive in terms of core and in  
6 terms of subregionalization and in terms of a couple of projects  
7 which appear to be viable ones. I don't think this is a region  
8 where we can now say, "You have done an awful job. Get rid of  
9 your coordinator. Restructure and set up different relationships  
10 with the medical schools," and so on. They are getting a new  
11 coordinator.

12 Dr. Eliel, I think, is a real asset to the group. I  
13 think they have strengths that they can use. I think they are  
14 beyond getting a warning. They have had warnings for the last  
15 two years, and it is obvious they have finally moved in a very  
16 strong and positive direction. I don't think this is quite in  
17 the order of going to a group and saying, "You have an awful co-  
18 ordinator, you have poor structure, poor organization, and redo  
19 it completely." They are. And I think they need some help to  
20 accomplish it.

21 Do you want to comment on the Tulsa situation?

22 MR. SAYS: Yes. Since the site visit, the Tulsa  
23 subregional office was staffed and got into full swing. That  
24 office truly represents three CHP areas, each having their own  
25 council with pretty good consumer input. There is a local RAG,

1 a local advisory group to that RMP subregional group. And in  
2 looking at the analogy that we have done here of the ratings,  
3 there are four projects that relate to the subregional, the  
4 Tulsa area subregion, and they were all approved by the A and  
5 the appropriate B agencies.

6 Now, since the submission of this application, there  
7 has been a lot of work done out there, and mainly because of  
8 the efforts of Dr. Cooper, a young planner who recently came on  
9 board and is working out in the local level in Tulsa.

10 I have the minutes of a meeting that was held March  
11 18. It was initiated by the Oklahoma RMP. Without us calling  
12 their attention to the disparity in coming to grips with project  
13 activities to be supported by ORMP, they recognized this them-  
14 selves. And at least from the minutes that I received, I think  
15 they are attacking this problem. And by the time we site  
16 visited, it would be prior to the applications about a year-and-  
17 a-half, I guess, I think they will have solved many of these  
18 problems. Staff will be monitoring this operation in the mean-  
19 time.

20 I think their relationships, while not the best,  
21 have improved, and individuals on the core staff, I think, are  
22 very sensitive to this. And with a new coordinator, I think  
23 that much of it will be corrected.

24 DR. BESSON: I won't belabor this much. I know we  
25 are talking about a motion on funding level, but I think there

1 is a principle involved here I would like to explore a little  
2 bit further. And that is Dr. Scherlis has mentioned we have  
3 won them on more than one occasion. I think of the relationship  
4 between RMPS and the regions as being one of a limited leverage.  
5 We do have a leverage of funds, and we do have a leverage of  
6 education, and we are not going to make that core strength if  
7 we provide the water unless they have the same perspective  
8 about the problems that we do, let's say assuming that we are  
9 the enlightened ones, and there is some question about that, too.

10 But I think we have to accept the limitations of our  
11 leverage and say that unless there is a spontaneous generation  
12 of interest and organizational implementation of principles  
13 manifested in projects, we are just not going to be able to  
14 exert enough of the leverage from here on what is happening in  
15 Oklahoma. And I think we have to look at our methodologies for  
16 how we do exert that leverage, and maybe we are over-using our  
17 thinking about funding levels and what we can do by telling  
18 them, "Well, here's some money," or "We will withhold that money."

19 Maybe what we ought to do as an RMP is organization in  
20 relation to the regions so if there is a disparity in how they  
21 go about their business, if there is a disparity in the leader-  
22 ship that is available, maybe we are not doing our job educa-  
23 tionally rather than just from the point of view of funding.

24 DR. SCHERLIS: I think what should be emphasized is  
25 that their relationship hasn't only been with a letter. Two,

1 they had the Macer Committee which had a real impact on their  
2 group. Their leaders, not just their coordinator, but Dr.  
3 Eliel -- they have recognized, as attested to by their change  
4 of coordinators, what one of the basic problems has been. But  
5 he provided what has been referred to by many of the people  
6 there as absentee leadership. And the whole feeling when you  
7 dealt with the Regional Medical Program was a pessimistic one,  
8 the whole aspect of this was a rather gloomy one.

9           This has been altered, as I have said. In that area  
10 there has been utilization in terms of projects, in terms of  
11 involving Tulsa, Ada and other health centers programs which  
12 really give a great deal to build on, and they have gotten the  
13 message. I don't think we are in a position of saying they will  
14 understand if we cut their money. It was cut at the site visit  
15 drastically. They applied for a triennium. They were given a  
16 one-year support at a very, very drastically reduced level. So  
17 they have gotten the message, I think. Their change of leader-  
18 ship is an indication.

19           DR. SCHMIDT: Phil, do you have a comment?

20           DR. WHITE: I was going to ask how many dollars were  
21 involved in the projects?

22           DR. SPELLMAN: And how many vacancies are there in  
23 the core and how many projects will be phased out in this?  
24 Maybe this will give you some idea of how much money there is  
25 involved.

1 DR. SCHERLIS: There is only one project that is  
2 continuing, and that is in the fourth year, and that is \$27,000  
3 for some aspects of coronary care, case records, and evaluation.  
4 So after that, there are zero projects, isn't that correct?  
5 Everyone they have applied for is beginning a fourth year.

6 MR. SAYS: No.

7 DR. HESS: On the sheet here there are four continu-  
8 ing projects.

9 DR. SCHERLIS: That's right. There are four.

10 DR. HESS: And the amount is something like \$103,000  
11 continuing projects.

12 DR. SCHERLIS: Right. There are two educational  
13 ones, there's a rehab, aid to continuing education. There are  
14 three or four continuing education programs in that. These are  
15 subregionalization programs.

16 DR. HESS: But if you add that to their current  
17 budget which includes eight vacancies, that adds up to \$506,000,  
18 if my arithmetic is correct.

19 DR. SCHMIDT: They are looking at page 7 of the  
20 salmon sheets. Just keep flipping your salmon sheets to page 7  
21 and you will see the budget breakdown.

22 DR. HESS: The core request is \$724,000. The current  
23 year's expenditure of \$354,000, if I understand you correctly,  
24 includes eight vacancies which are not going to be filled  
25 immediately July 1.

1 DR. HESS: They are funded at the level of \$354,000,  
2 and did you say they have --

3 DR. SCHERLIS: I am looking at Form 6 in the applica-  
4 tion.

5 DR. HESS: I am looking at this previous 03 year  
6 operational award which says \$354,000.

7 DR. SCHERLIS: Which page are you on?

8 DR. HESS: Page 6 on the salmon sheets it says  
9 "Previous Yr's Award 03 Operational Year," Core is \$354,000,  
10 and I assume that is what they are funded at. And within that  
11 \$354,000 there are eight vacancies.

12 DR. WHITE: That doesn't seem reasonable.

13 DR. SCHERLIS: I am sorry I misquoted. Looking at  
14 the vacancies, the turnover has been very rapid. Do you know  
15 what the vacancy figure is?

16 MR. SAYS: No, I don't. I think the current profes-  
17 sional staff number of positions is 15 or 16 or 17. Those are  
18 the type people.

19 DR. HESS: Is this \$354,000 what they are awarded for  
20 the 03 year?

21 DR. SCHERLIS: Yes, that is the 03 year, that's  
22 right.

23 DR. HESS: That is accurate. So what you are saying  
24 is that the eight vacancies perhaps is not accurate but there  
25 are some vacancies.



1 DR. SCHERLIS: That's right.

2 DR. HESS: Within that \$354,000.

3 DR. SCHMIDT: Dr. Ellis.

4 DR. ELLIS: I would like to say if we are going to  
5 do a good job of reorganization and restart and possibly have  
6 a non-medical coordinator, he should have the same opportunity  
7 that the other people have had before, or she, as the case may  
8 be, to try to be innovative and to get a staff which will  
9 solidify.

10 In my mind, unless there is some money there for  
11 this to have him look at the needs of the people, he will be  
12 so handicapped that he will not be able to even begin to build  
13 a permanent structure.

14 We have heard that the vice president is willing,  
15 and is anxious, in fact, to try to go along with this, and I  
16 suggested before that it is necessary to look at the kinds of  
17 educational activity, continuing educational activity which is  
18 going on.

19 I notice that in other connections, much of the con-  
20 tinuing education that is going on has been the same thing we  
21 have been doing for 25 years, really, not involving anybody  
22 except one discipline, not one cross-discipline at all, not  
23 explaining concept at all. And I am just hopeful that as we  
24 do this it will have real meaning for the Regional Medical  
25 Programs and for their ability to really structure programs of

1 service to people. And I think if we reduce this to an extent  
2 where they cannot get some guarantee of staff where people do  
3 not feel that they are in a permanent situation that we will  
4 defeat our purpose.

5 DR. SCHMIDT: I believe that the issues are drawn  
6 fairly clearly here. There is a principle involved. There is  
7 also the level of funding that I think has been discussed enough  
8 to at least test the sense of the committee.

9 Joe, I would like to limit this to new issues, new  
10 comments. We are beginning to circle a little bit.

11 DR. HESS: I just wanted to emphase that the funding  
12 level which would permit continuation of core staff out of the  
13 current level of funding, plus continuation of the projects,  
14 is \$506,000. I think we need that as background information to  
15 any action on the recommendation.

16 DR. SCHMIDT: Fine. The motion on the floor is for  
17 approval at reduced rate. They ask for 1.75 total. The motion  
18 on the floor is confirmation of the SARP's recommendation of  
19 \$839,000.

20 Unless there is an objection, I will ask for a vote  
21 on this motion. If you wish to reduce the level of funding, you  
22 will vote no to the motion. A vote "yes" would mean a level of  
23 \$839,000.

24 MR. PARKS: Wait a minute. We may not be for it at  
25 all, so I think a negative vote should be presumed just to reduce

1 DR. SCHMIDT: A negative vote defeats the motion,  
2 and we will need a new motion on the floor which could include  
3 zero level funding.

4 DR. BESSON: I know you are looking at the clock and  
5 ready to vote on this motion, but I would like to just on this  
6 motion again refer to the principle. And that is now, as I read  
7 the application further -- and I apologize to Dr. Scherlis be-  
8 cause he has been on the site visit and knows the area very  
9 well and I am just speed-reading now -- but in reading the  
10 comments of the RAG chairman about the direction of ORMP, it  
11 may be that the problems that they are having --

12 DR. SCHERLIS: Which chairman is this? Dr. Johnson  
13 or Dr. Strong? It is very relevant. These are two totally  
14 different individuals.

15 DR. BESSON: Dr. Johnson. Is that good or bad?

16 DR. SCHERLIS: Dr. Johnson is one of the strongest  
17 features of RAG. Of the whole program in the State, he is one  
18 of the strongest features.

19 DR. BESSON: Well, the question I am raising is  
20 whether what we are seeing here in the difficulty that the  
21 Oklahoma region is having is not symptomatic of a national prob-  
22 lem, and that is the demand that we've made on the regions to  
23 shift their emphasis out of category and continuing education  
24 to a whole new ball game. And maybe the anxiety that is being  
25 produced in the regions is being manifest in the disorganization

1 and lack of leadership. And in reading this summary by the RAG  
2 chairman, apparently they have had a great deal of dispute in  
3 their discussions about what direction Oklahoma Regional Medical  
4 Program will take.

5 Dr. Groom is a cardiologist. He said, in your site  
6 visit you reported he felt the function of the Oklahoma RMP  
7 was continuing education and categorical, and he just didn't  
8 understand public health and didn't have anything to do with it.

9 Now, this is reiterated apparently at the conclusion  
10 of their discussions where the RAG chairman says it all boils  
11 down to the fact that Oklahoma Regional Medical Program has  
12 elected to continue its relatively direct pursuits of its origi-  
13 nal purpose.

14 Now, that means that there is a paradox in what we  
15 are asking them to do and faulting them for and what their per-  
16 ceptions are and what their aims are. Or it may be, therefore,  
17 that they really, in spite of the fact that we think that every-  
18 body should have gotten the message by now, they really haven't  
19 accepted this new role.

20 DR. SCHERLIS: When I began my introduction several  
21 hours ago, I commented on the fact that they just recently  
22 accepted completely reoriented goals and objectives and said  
23 these were much more in direction as far as RMPS is concerned.  
24 This just happened how long ago?

25 MR. SAYS: We just received them this week.

1 DR. BESSON: So this is out of date.

2 DR. SCHERLIS: Yes, I said that since the time of  
3 this submission, two important events have occurred. One, the  
4 resignation of Dr. Groom; two, the drafting of new goals and  
5 objectives by the Oklahoma Regional Medical Program.

6 DR. THURMAN: A whole new issue. Could you clarify  
7 for us one thing and that is how strong --

8 DR. SCHERLIS: I am having difficulty with anything.  
9 I would like doctor's assistance.

10 DR. THURMAN: I still refuse to step down. Can you  
11 clarify for us how strong really Dr. Groom's resignation is --  
12 I'm looking beyond you, Len -- because he has resigned before.

13 (Laughter.)

14 Going back to what Dr. Besson said, I would be a  
15 little more comfortable if I really knew the day he was out  
16 of the ball game. I don't mean to be ugly. I'm just asking  
17 for information.

18 MR. SAYS: I think his letter to the RAG, which we  
19 have a copy of, carries no doubt he will be leaving. Dr.  
20 Margulies may have more input.

21 DR. MARGULIES: I think there is no question that he  
22 has resigned. We pursued that with some vigor and it is formal  
23 and final.

24 I might just comment in terms of what kind of in-  
25 fluence this type of review has on accepting new directions

1 without the necessary club of money, full review some time, or  
2 we could do it for you. What has happened to a long list of  
3 traditionally unacceptable coordinators in the last year-and-a-  
4 half, especially those who reached prominence during the period  
5 of earlier development of RMP which was categorical and project  
6 dominated, and who were dealt with with regularity, you will  
7 find that with the exception of one or two they have resigned.

8 DR. SCHMIDT: I know that I can't go into the State  
9 of Indiana for a little while. I asked one of my department  
10 chairmen for his resignation by letter. He gave it to me with  
11 an effective date of 31 July 1978.

12 (Laughter.)

13 I am trying to figure out what to do with that.

14 Let's test the sense of the committee then. I think  
15 everyone has an understanding of the motion. Unless there is  
16 strenuous objection, I will call for a vote.

17 All in favor of the motion please say, "aye."

18 (Chorus of "ayes.")

19 Opposed, "no."

20 (Chorus of "noes.")

21 All in favor, please raise your hand.

22 (Show of hands.)

23 I get seven.

24 Opposed?

25 (Show of hands.)

1 Six.

2 DR. SCHERLIS: The chairman has a right to vote. I  
3 don't think you should be deprived of a vote because you're  
4 really a member of the group.

5 DR. SCHMIDT: All right. The chairman in this in-  
6 stance exercises his right to vote or not to vote. He votes  
7 to create a tie, and thus defeats the motion, and I will not  
8 vote, so the motion is carried.

9 Are there other comments?

10 One thing I learned I had to do was memorize Robert's  
11 Rules of Order. I'm assuming this committee operates by Robert's  
12 Rules of order, is that correct?

13 DR. MARGULIES: As long as you are in the chair, yes.

14 DR. SCHERLIS: As interpreted individually.

15 DR. SCHMIDT: There is a new edition of Robert's  
16 Rules out that is a most excellent book in case anyone hasn't  
17 seen it.

18 We will move on then from Oklahoma to Puerto Rico.  
19 Miss Anderson.

20 MISS ANDERSON: I will try and make this brief. We  
21 are talking about Puerto Rico now.

22 I have a problem, not being on a site visit, to talk  
23 to the RAG members and the coordinator and staff about the pro-  
24 gram, so I was dependent upon the written reports of the staff  
25 and the previous site visit in 1970 by Dr. Lemon.

1 I didn't have a chance to talk to Jessie Salazar but  
2 I did talk to George Hinkle and I appreciate his comments re-  
3 garding their recent visit there in December to assist the new  
4 coordinator in developing his anniversary review application.

5 Apparently Dr. Fields and Jessie Salazar and George  
6 Hinkle and Robert Shaw did a very good job as the anniversary  
7 review report is quite complete and up to date.

8 Briefly, the profile of Puerto Rico is as you have  
9 in your book. It's a small island with a heavy census of over  
10 2.7 million, and the health statistics in regard to mortality  
11 rates is a fairly healthy place to be in regard to heart disease,  
12 cancer and stroke.

13 Fortunately, they seem to have some very good educa-  
14 tional facilities and institutions. They have a school of  
15 medicine. They have a school of public health that is accredited  
16 They have ten schools of nursing, five at universities, one at  
17 junior college and four at hospitals.

18 There are two schools of medical technology, and that  
19 pretty well completes the educational aspects. They do have  
20 18 nursing homes, and the American Hospital Association reports  
21 59 acute care and long-term hospitals in the area.

22 But in addition to this, they also have municipal  
23 hospitals and district hospitals. And there are 78 of those.  
24 And as I understand, some of those are just one- and two-bed  
25 affairs, but they are considered hospitals and they do give care.



1 I do not know the staffing patterns of these smaller places.  
2 Incidentally, Puerto Rico is made up of 75 municipalities, and  
3 of the 75, 73 of them have hospitals of some sort. So there is  
4 some type of public care.

5 The private hospitals are mainly in the cities and  
6 they have 50 percent of the beds. And the public hospitals, as  
7 I mentioned, are in the various municipalities also.

8 Now, in the coordinator's report he really spelled  
9 out the new goals and objectives as clearly as possible and they  
10 do go into the direction of RMPS planning. The main thrust is  
11 in regard to education and health manpower, health delivery ser-  
12 vices systems, and the collection of data and statistics. He  
13 emphasized increasing availability of care and enhancing the  
14 quality and moderating the cost of health care.

15 Now, some of the accomplishments they have done in  
16 this short period of time are quite dramatic. And I would like  
17 to mention a few of them to you. They are all listed on page 5  
18 of the salmon report. But they have been very much involved  
19 with other official agencies, governmental and also non-profit  
20 organizations, in cooperating and developing proposals and pro-  
21 jects.

22 They have expanded their services not only in San  
23 Juan and the bigger cities but also in the rural areas and  
24 villages. They have had active participation in their program  
25 from the Health Department, Department of Labor, labor unions,

1 community and civic organizations, as well as related health  
2 organizations. They are trying to obtain funds from various  
3 resources in the community. There is a problem. This area has  
4 quite a bit of poverty, and they do not have the resources that  
5 many other States of the Union have. So I think they are a  
6 little slower in doing these things.

7           The region's continued active involvement and  
8 emphasis devoted to looking for other sources of support is on-  
9 going. A point I was impressed with was the comprehensiveness  
10 of the educational aspects of ongoing activities that include  
11 education not only for the provider but also the community, the  
12 patients and their families.

13           Also another plus is the fact that they are trying  
14 to develop leadership roles for paramedical type persons and  
15 people.

16           The continued support, as was mentioned here, is  
17 being established as part of their policy and is included in  
18 all the proposals that they are planning. Actually, to date  
19 there has just been one proposal that has been discontinued and  
20 is being carried on by the health department.

21           As far as minority concerns, I would like to state  
22 the goals and objectives are directed to all the people in  
23 Puerto Rico. Through intensive efforts toward regionalization,  
24 decentralization of treatment centers, continuation of health  
25 providers in isolated areas and educational programs directed at

1 both the patient and the patient's family, all interests are  
2 considered to be served.

3 I was interested in and requested the interest of  
4 minorities on the staff. All of the staff is made up of  
5 Spanish surnames, and as Puerto Rico has a few other minority  
6 groups which are the other side of the coin, such as black  
7 people from the Virgin Islands and Caucasians living in the  
8 community.

9 Also they have other minority interests such as  
10 allied health and nursing who are not recognized on their staff  
11 or their RAG. But I think this is the area that they are working  
12 on. I was surprised this is the first review I have seen in  
13 which the females are not minorities on the core program staff.  
14 On this program staff the females are a majority, 8 to 6.

15 The coordinator, as I mentioned, is a newly appointed  
16 coordinator as of December '71, and he is a dentist and is  
17 apparently very aggressive and very progressive. His special  
18 interest is in education and he has had experience in health  
19 manpower and is on some national committees with the National  
20 Institutes of Health. So I think he has a feeling now of local  
21 needs but also national trends and interests.

22 He has reorganized the program staff and and is more  
23 closely allying the staff's missions and responsibility to the  
24 new direction.

25 He has been involved in revising the RAG by-laws to

1 increase the consumer representation at all socioeconomic  
2 levels. He realizes that the RAG has been inadequate in the  
3 past, and he is getting more involved in the activities of the  
4 program. As the staff reports, he has gained the confidence of  
5 the staff and the community, and they feel that he is really  
6 moving the program along very nicely.

7           The program staff is almost new. There are many  
8 resignations due to reduced funding, and the demoralization in  
9 regard to their feelings of not being so optimistic about RMP's  
10 future, but now they are developing their staff again.

11           And the staff is being focused on three main areas:  
12 health, education and manpower; administration and health  
13 services, and planning and evaluation. We hope to have them  
14 add more allied health people in nursing to their staff and  
15 nursing. At the present time they have 32 positions budgeted  
16 and only 21 filled.

17           A staff person is assigned to the RAG in order to  
18 support their various task forces and also to help them in de-  
19 veloping plans of action.

20           On the RAG there are currently 28 members. There  
21 are 4 vacancies. And of the RAG, 4 of the members are women,  
22 and they are pretty well spaced, with 20 people from the north-  
23 east, 2 from the south and 1 from the west, and they are plan-  
24 ning now to add better geographic representation.

1 the public and consumer categories which shall include at least  
2 ten health services for consumers proportionately representative  
3 of all socioeconomic levels of Puerto Rico.

4           The RAG used to have two meetings a year and atten-  
5 dance was very, very poor. Now they are scheduled for four  
6 meetings a year and the meetings are going to be rotated around  
7 the island in order to have better attendance and representa-  
8 tion.

9           It is understood that the RAG has accepted their new  
10 roles and responsibility and are willing to move ahead.

11           The RAG has twelve standing committees, and in re-  
12 viewing the literature I found that only three of these com-  
13 mittees have met during the past year. The one committee that  
14 was most active is one on continuing education and has 15 members  
15 and met 10 times.

16           The project directors committee, which is a new com-  
17 mittee, has 13 people who are involved as project directors,  
18 and they have met nine times recently. And this is a new inno-  
19 vative program that has been established by the coordinator to  
20 help the project directors to understand more about RMP and the  
21 goals of RMP and helping these coordinators to work together  
22 and possibly do more coordinating of their programs and projects  
23 and in exchange of information, and that I thought was a very  
24 big step forward.

1 the enthusiasm and dedication that the various proposers seem  
2 to have toward RMP and their projects.

3           There is another committee, the planning committee,  
4 of 13 people, and that met 3 times recently in regard to short-  
5 term and long-term planning for the region. The remainder of  
6 the committees were just on paper and were not active.

7           The grantee organization, according to the report,  
8 is the University of Puerto Rico, and apparently the relation-  
9 ships are very cordial and the university does not add any  
10 pressure or direct guidance to the group. They are quite inde-  
11 pendent.

12           The participation of the RMP is that there is very  
13 active participation of the various health agencies on the RAG.  
14 The program staff planning studies are planned in cooperation  
15 with the State Department, prepaid health insurance organiza-  
16 tion, the Puerto Rico Hospital Association, the Department of  
17 Health, and the San Juan Municipal Government and other municipi-  
18 pal governments.

19           The Veterans Administration there is active in doing  
20 continuing education programs and other programs in the com-  
21 munity, and they are working closely with the VA in regard to  
22 this. They have joint activities with the Puerto Rico Medical  
23 Association, and the coordinator is a member of the Committee for  
24 Medical Education.

25           Local planning -- they have regular meetings, as we

1 mentioned, not only of the RAG but of the Department of Health  
2 Communications, with the RMP staff, to avoid duplication of  
3 activities. Also CHP and RMP are meeting together at regular  
4 intervals.

5 RMP has been appointed a member to the Municipal  
6 Advisory Board of the planning office for the area of San Juan.

7 The Central Program Staff Planning and Evaluation  
8 Section has served as a consultant and taken steps to provide  
9 requested consultation services to the Planning Board and  
10 Department of Health in Puerto Rico.

11 They are also planning to develop a consortium of  
12 the various health agencies in the island, and to combine their  
13 efforts in regard to data collection and interpretation.

14 And another recognition of their local planning is  
15 a development of conferences and seminars with the various  
16 health agencies and groups in the island. And what they are  
17 trying to do now is to classify the various health service per-  
18 sonnel and reorganize the educational system to meet the new  
19 types of health delivery. Also they are planning an Area  
20 Community Health Education Center.

21 The assessment of needs and resources is reflected in  
22 the health professions human resources inventory that has been  
23 completed and is transferred to the local Comprehensive Health  
24 Planning for sharing with them and RMP and they plan for regular  
25 up-dating of this material. I mentioned to you earlier that

1 they are developing a consortium of health educational agencies.

2           The core staff has planned activities and studies to  
3 gather additional basic information for the development of the  
4 operational plan for the next triennium. Many of these studies  
5 are referred to and a direct result of the Program Master Plan  
6 developed for the region.

7           Some of the things that they are planning to do in  
8 their studies are to survey the number of licensing, the problems  
9 of licensing and health professions, the planning cost study  
10 and outpatient clinics. They are planning a study on inventory  
11 audio-visual resources in Puerto Rico and listing hospitals that  
12 are accredited. And they have quite a list of things that they  
13 are planning to do in this coming year.

14           Now, in regard to management, it appears to be pretty  
15 well organized, well managed. The staff is assigned to moni-  
16 toring the various proposals and provide support to the projects.  
17 They have monthly meetings of the project directors, as I men-  
18 tioned to you earlier, with the coordinator and the staff.

19           Also progress reports and expenditure reports are  
20 reviewed, mainly the expenditure reports are reviewed, by the  
21 RAG annually and by the staff quarterly, and project reports  
22 are reviewed by the staff bi-monthly.

23           As far as evaluation is concerned, evaluation pro-  
24 cedures are required for each project. And they are well written  
25 into the project. All projects are evaluated by the program



1 staff and consultants, and evaluation is of both a qualitative  
2 and quantitative nature.

3           During the past year evaluation reports have been  
4 completed on six projects. The program staff is actively work-  
5 ing towards completion of the development and implementation of  
6 the total program evaluation plan. And it is anticipated this  
7 plan will be completed during the coming year.

8           Now, the action plan has been established and is  
9 considered to be consonant with the national goals and the goals  
10 of the region. The region plans to continue currently on-going  
11 categorical activities and has restated its goals and objectives  
12 in terminology agreeable to the RMPs published missions. It  
13 is noted the activities appear to be in complete agreement with  
14 these goals. The new proposals are going in the new directions.

15           The on-going activities are most comprehensive with  
16 respect to patient services, education of health providers,  
17 patients and families and community health manpower utilization  
18 and establishment of new skills and new types of personnel.

19           Their dissemination of knowledge is being extended  
20 into the community, and we mentioned this earlier about not  
21 only the professionals but also the consumers and patients and  
22 their families. And they are planning in the coming year to  
23 have post-testing for all the continuing education programs, to  
24 have pretesting and post-testing, in regard to the knowledge,  
25 attitudes and any change in practice that occurs.

1           The utilization of manpower facilities seem to be  
2 improving and they are interested in developing health per-  
3 sonnel in new skills and training. The health assistants and  
4 family health workers are being used in the community in rural  
5 areas and are recognized as being valuable in increasing the  
6 productivity of the physicians and other health manpower.

7           The improvement in care, I think, in reviewing some  
8 of the proposals, you will find the pediatric cardiovascular  
9 program, they have been testing children from prekindergarten  
10 age to sixth grade, and have developed clinics and areas through-  
11 out the island. They usually start out with one clinic or one  
12 area, and then after that proves to be successful they multiply  
13 themselves in other areas.

14           The hematology and chemotherapy and blood banking  
15 program has developed monthly clinics in various parts of the  
16 island, and other parts, more inhabited parts, weekly visits  
17 to areas for examination, teaching and treatment of these  
18 children.

19           Another example is pediatric pulmonary center has  
20 developed continuing education for health professionals,  
21 community people and family conferences. And you just go down the  
22 list of their other proposals, and these just naturally fall into  
23 the area of improving patient care.

24           Now, the short-term payoff, as far as activities are  
25 concerned, are the courses for the development of professional

1 and community leaders in the areas. I think it is one very  
2 good example. Also the training of local health education  
3 coordinators in the rural areas and the training of health con-  
4 sumer orientation.

5 The regionalization is with the staff located in  
6 San Juan, and the new coordinator wants the staff there at the  
7 present time. They are establishing subregional offices in  
8 other towns.

9 The project activities are located in many other  
10 areas throughout the island. They do consultation and give  
11 help to the Virgin Islands in regard to their RMP program.

12 As we mentioned earlier, the other funding is being  
13 included in their plans and at the present time only one proposal  
14 has been funded by another agency.

15 I was wondering, maybe Dr. Spellman would like to  
16 add some more.

17 DR. SPELLMAN: Very little. I think Miss Anderson  
18 has given a very comprehensive report and I have very little  
19 else to add. I think that the picture I get from reviewing this  
20 is that the new coordinator is a young, energetic, ambitious  
21 man who is obviously committing full-time to his task. And I  
22 think his report is an excellent one and he projects optimism.

23 The supposition that essentially each of these  
24 projects will be on-going and supported largely by the government  
25 each enterprise he proposes will be sustained by government

1 support, and that projects already have budgetary allocations,  
2 for example, to absorb the new health careers training.

3           Everyone of the projects, whether they are inven-  
4 tories of health facilities or whether they are continuing edu-  
5 cation for nurses or physicians or new health careers, are de-  
6 signed to have a rapid, almost immediate impact on provision of  
7 health services even if they aren't in the first instance  
8 directly measurable.

9           There is the implication that subregionalization  
10 will be effectively implemented through these district hospitals  
11 which are physically spread throughout the island, although he  
12 doesn't specifically define this as regionalization strategy.

13           I think that virtually all of this reflects the im-  
14 pact of Dr. Fernandez, and I gather essentially the entire staff  
15 is new because the old staff resigned with the cutting of the  
16 RMP budget. So in a real sense it's a highly promising new  
17 program which is going to be essentially dependent more than  
18 most on his leadership.

19           The only other comment I'd like to make is the  
20 composition of RAG. In his report he recognizes the inadequate  
21 representation of consumers. The fact that all of them have  
22 Spanish surnames throughout this is a kind of a nationalist  
23 pride, I think, and a certain degree of innocence in which it  
24 expresses, I think, excessive optimism. But I think that this  
25 under-represents, obviously, ethnic and population groups in the

1 island that have some interest besides their origins in the  
2 Spanish culture.

3 I think he acknowledges this and has promised once  
4 again that the expansion of this will be truly representative  
5 of the whole island.

6 I think all of this is consonant with the new goals  
7 and objectives of RMP, and I think the whole restructuring in  
8 this rapid period of his on-coming is, I repeat, highly com-  
9 mendable of what he is likely to achieve.

10 I don't think I have anything else to add.

11 DR. SCHMIDT: Do you have a recommendation?

12 MISS ANDERSON: Well, the staff recommended a budget  
13 of \$1,496,631 as direct cost amount. It was recommended the  
14 funds be provided to support for the program staff at an in-  
15 creased level for eight ongoing operational projects and two  
16 previously approved but unfunded projects and one new proposal.

17 Also the increase of geographic scope of new activi-  
18 ties to be initiated is concentrated in the south and west  
19 health regions of the island.

20 Maybe some member of the staff may want to clarify  
21 this some more.

22 DR. SPELLMAN: I would like to make one other comment.  
23 Maybe the staff could enlarge on this.

24 I sense that the hope for comprehensive accessible  
25 health services in Puerto Rico are going to be dependent on

1 governmental sponsorship.

2           You also get the impression the ownership of these  
3 hospitals by private physicians create very little contribution  
4 from the private sector to a really enlightened kind of health  
5 care system.

6           And taking up what Sister has just mentioned, my  
7 guess is that much of the hope of this may be the fact that  
8 Fernandez is a dentist and young and not afflicted with much of  
9 the preoccupations of the private sector in Puerto Rico, and in  
10 this sense I would think that they have got a better chance than  
11 they would if the leadership were much more dependent on its  
12 support from existing health components.

13           I have never been there; I have never site-visited;  
14 so I don't know.

15           DR. SCHMIDT: Am I correct in assuming that the recom-  
16 mendation is for the level of funding requested?

17           MISS ANDERSON: Yes.

18           DR. SCHMIDT: All right. That would be an increase  
19 in Core from \$248,370 to \$447,597, and operations from \$594,000  
20 to \$1.04 million. Is there staff comment?

21           MR. HINKLE: The budget aspects of it -- I might  
22 first speak to Dr. Spellman's concern about the private sector.  
23 That is one of the concerns of past reviewers, and I think Dr.  
24 Fernandez is pretty much aware of these. And as I read some of  
25 the on-going projects for the third year, they are planning to

1 move from the health center where they were initially set up  
2 out into more isolated areas, and some of the private hospitals  
3 are also mentioned. And I feel as they move out into these  
4 more isolated areas, they will bring in the private physicians.

5           Currently they start with the project in the health  
6 centers, which are mostly government supported. Once they  
7 get their base established, they move out into isolated rural  
8 areas.

9           But Dr. Fernandez seems to be aware of all the  
10 past criticisms, and in his brief term he has initiated some  
11 proposed amendments to the by-laws, some of which were referred  
12 to, and these were also taken into consideration in the past  
13 criticism. He is aware that the RAG in his opinion hasn't been  
14 as active as it should be. He has set up a liaison person on  
15 his program staff to more actively work with the RAG and bring  
16 them into daily operation.

17           He has also set up his committee of project directors  
18 so that they can get a more overall view of the total Puerto  
19 Rican RMP program instead of just their own.

20           I believe what I am trying to say here is that based  
21 on his reaction to past criticism in the brief time he has been  
22 on board, I feel he would also move these things out more into  
23 the private sector.

24           I have only been to Puerto Rico one time myself, and  
25 just in December, and reading this application, most of the

1 comments reflected here came direct from the application at  
2 face value. As I read it, as I'm sure some of you did, there  
3 are many areas I would like to delve into much more deeply when  
4 I get an opportunity to go down there.

5 DR. SCHMIDT: I detect a very wistful note in all  
6 of these plaintive statements that I am just reviewing this  
7 from paper and I've not been down to Puerto Rico. We maybe  
8 should have the committee convene in San Juan in order to give  
9 this program a good going over it obviously needs.

10 Is there a second to the motion that we had? I  
11 didn't hear one.

12 DR. SPELLMAN: I second it.

13 My only question about the level of funding is whether  
14 or not this rather striking increase of operation of activity is  
15 warranted. I just don't know. There are a large number of  
16 projects.

17 DR. SCHMIDT: The first sheet in this big black book  
18 full of computer printouts that you were briefed on before, the  
19 first quarter's sheet from Puerto Rico -- it's tabbed just  
20 behind Puerto Rico '65 -- does give a nice breakdown of the  
21 funds awarded in 01-02, and requested in 03, and one or two of  
22 the projects do go up considerably. For example, Project No.  
23 010, the request goes from \$107,400 to \$148,900, and I assume  
24 that this is because of expansion into other areas of the  
25 island.



1           So they are asking for increased funding of their  
2 ongoing projects. I suppose the only thing that bothers me a  
3 little bit is that they aren't aggressively moving these pro-  
4 jects out into other sources of funding. But on the other hand,  
5 there aren't any other sources of funding in the island for  
6 these projects to go to, and I think there is somewhat of a  
7 peculiar personality of the island that must be taken into  
8 account here. I have visited it, not under RMP auspices but  
9 under others, and would make that comment.

10           Sister Ann Josephine.

11           SISTER ANN JOSEPHINE: Dr. Schmidt, I wonder if some-  
12 one would talk to this project they are apparently asking to be  
13 funded, computerization of dose distribution.

14           DR. SCHMIDT: The question is the computerization of  
15 dose project.

16           Bill.

17           DR. THURMAN: Sister, the major basis for this is  
18 that Puerto Rico from the standpoint of cancer has been an un-  
19 tapped resource for research and development. What they have  
20 done, as indicated in the past, is they have had a cancer hos-  
21 pital and a university hospital, and the two have never seen  
22 eye to eye about the price of anything. And what they are trying  
23 to do -- the project has always been in the cancer hospital --  
24 they are trying to bring it more into the university hospital,  
25 and in so doing they are bringing on people who will be better

1 then be put into the periphery and delivered into outlying  
2 area units as well, primarily in radiation therapy but also  
3 chemotherapy and related things.

4           It's over-priced for its effectiveness. I would  
5 make that as a very critical judgment with no basis in fact.  
6 But it is over-priced in its effectiveness, as are several other  
7 of these projects. And I think that basically their concern is  
8 that they need to have the money in case they do get the job  
9 done. I don't believe that they will have the money. I don't  
10 believe they will get the job done. But this one is over-  
11 priced. We have seen units like this in several institutions in  
12 this country, and all of them have contributed. Puerto Rico  
13 has been a real ideal spot for us in the field of cancer because  
14 it has been so untouched in so many ways.

15           MR. HINKLE: May I make a comment, please.

16           Dr. Spellman, this dose distribution, one of their  
17 previous, I believe, projects when we had project review.  
18 When the region came in they asked for \$89,000 for the first  
19 year, \$57,000 for the second, and \$58,000 for the third. The  
20 National Advisory Council increased their first request from  
21 \$89,000 to \$160,00. The second year will drop down. They felt  
22 they needed a little more money for equipment the first year.

23           DR. THURMAN: I don't mean to stand in the face of  
24 the National Advisory Council, but on the other hand, almost all  
25 of these projects have been over-priced for what was necessary

1 to be done. Puerto Rico -- I have site visited this for the  
2 National Cancer Institute. That is the only reason I am speaking  
3 with some degree of assurance. But the Puerto Rico idea is to  
4 put it into this component of hospitals. Dr. Spellman has in-  
5 dicated there's real concern about many of these private hospi-  
6 tals. And if you go back to this specific project, there's a  
7 request for a terminal in one of these private hospitals that  
8 has three beds. I don't believe that's too rational, and I  
9 think this is why in general it's over-priced.

10 DR. SPELLMAN: That's my feeling. I think they should  
11 be supported, and generously supported. I just wonder, really,  
12 though, whether they are going to be able to spend that much  
13 money operationally, given the jump they are making, and that  
14 is why I was hoping staff would give us some idea. He has only  
15 been there a very short time. This is a substantial increase in  
16 operational projects.

17 DR. KRALEWSKI: I have several concerns. I sympa-  
18 thize with the economy of the area, and I recognize that every-  
19 one is backing this leadership, and the fact is that the guy  
20 might do a really good job.

21 But what we are doing here is substantially increas-  
22 ing the budget of this program at a time where they will be  
23 coming in for a three-year application next year. So we are  
24 giving them all this right now, and next year they will be  
25 coming in for a three-year program. And if they tie into all of

1 these projects, they are going to be tied into a lot of activity  
2 here at a time when they are supposed to be outlining a three-  
3 year plan.

4           It seems to me that is going somewhat in the wrong  
5 direction.

6           Secondly, these projects that they have outlined here  
7 don't appear to be terribly exciting. And when reviewed in the  
8 context of their economy with a great deal of poverty, the fact  
9 that they have many underserved areas that really need help.  
10 What they are doing here is dealing with continuing education  
11 similar to that, but really nothing terribly innovative.

12           And then thirdly, along the lines that have been  
13 mentioned, I don't know if they will be able to spend this kind  
14 of money. You mentioned that they have some agencies in the core  
15 staff now and they are going to expand that tremendously. I  
16 wonder if they are going to be able to handle this kind of in-  
17 crease to be able to do justice with it at this time in their  
18 development.

19           DR. SCHMIDT: Joe.

20           DR. HESS: I had a somewhat related concern. I was  
21 trying to harmonize the project titles, at least -- we don't  
22 have descriptions of the projects available -- the project  
23 titles and the budget, and the action, brief description of  
24 their action plan. Some of the other things described here  
25 is the direction in which they are going in the budget. And

1 look at the essentially doubling of the operational activities  
2 and what that is going for. And I assume that much of these  
3 new kinds of things that are talked about are subsumed under  
4 the core budget which again is not clear.

5 But I have a similar kind of uneasiness about where  
6 the program is going as shown on these projects that they are  
7 wanting to fund versus what it says in the descriptive material.

8 DR. SCHMIDT: Len.

9 DR. SCHERLIS: I guess there's such a thing as a  
10 halo effect. If you have a good coordinator everything takes  
11 on a glow, and if you have no coordinator or changing coordina-  
12 tor things don't look quite as well. I can comment on that  
13 further, but that is apparent.

14 (Laughter.)

15 Strength of this committee, I will word it that way.

16 In looking at the new projects, if they reflect any-  
17 thing they reflect committee retrenchment of what were the good  
18 approaches of categorical grant requests three or four years  
19 ago. As I add this up, of the new funds requested, some  
20 \$339,000 go into the following: dose determination, for  
21 malignancy, screening and early diagnosis. This is a public  
22 education project to teach 300,000 men and women how to look for  
23 cancer. That is project No. 17 which is \$78,000. And Project  
24 12 is prevention diagnosis and treatment. This is to establish  
25 a cancer information center, and that comes to a sum of \$100,000.

1 I just question if this new direction really reflects  
2 any impact he has been able to have yet. It is too early to do  
3 that. But I think \$360,000 for such cancer-oriented activities  
4 and what I think -- what little I know about Puerto Rico --  
5 would be a great area to do more imaginative things.

6 I wonder if you might just speak to the value of the  
7 two programs, one in public education and the other one, not  
8 just in terms of what it would accomplish but mostly in terms  
9 of the health dollar that could be best expended in Puerto Rico.

10 I have a gut reaction that Puerto Rico looks good  
11 RMP-wise, but at the same time it isn't such a warm glow in my  
12 abdominal area. It is an occasional pang of consciousness.

13 As the chairman said yesterday, it's good and it's  
14 bad.

15 DR. SPELLMAN: I agree. I think these new projects  
16 are the least relevant. The ones that I was speaking about are  
17 really the ones which are ongoing, and I would agree they have  
18 the least applicability to the goals and objectives of the program.

19 DR. THURMAN: Sister, let me go back and say all my  
20 comments were predicated on -- I thought the computerized dose  
21 was \$89,000, and actually it's \$160,000, and that therefore  
22 makes my comments much worse, not better.

23 I think, Leon, in answer to your feeling about why  
24 they have gone so strong in cancer is that everyone in the United  
25 States has faced the fact that Puerto Rico is our last untapped

1 frontier in many of the areas that we should have tapped before  
2 in cancer detection and treatment. This is an improper term at  
3 the Federal level, but they have a pipeline to the National  
4 Cancer Institute, and I think that this in many ways is re-  
5 flected in their interest in having RMP money take on some of  
6 these projects. I think that it is an overweight, yes, and they  
7 do have a considerable amount of money from other sources.

8           SISTER ANN JOSEPHINE: You know, it's interesting  
9 in the statistics of the area that the median age is 18.5, and  
10 it would seem to me it would be an exciting area to develop  
11 education programs so we could begin the intervention thrust be-  
12 fore we're treating disease.

13           DR. SCHMIDT: We have a seconded motion on the floor  
14 for a level of \$1,496,631. The chair would accept a substitute  
15 motion.

16           DR. SPELLMAN: I am trying to add up the sum of these  
17 new ones, and the ones related to cancer, and I am going to just  
18 produce one in a minute.

19           DR. SCHMIDT: We have a little bit of a time problem  
20 here, and I think we do want to take about a very quick ten-  
21 minute coffee break, so we will declare a recess and I will  
22 appoint a committee of the primary and secondary reviewer over  
23 coffee to come up with a level after the presentation of Missouri  
24 We will table this for the time being.

DR. SPELLMAN: I think we have one. \$1.1 would, I

1 think, do it.

2 DR. SCHMIDT: All right, \$1.1, and this is generally  
3 acceptable. You know, it's marvelous. You mention coffee and  
4 things move right along.

5 All right, then, the primary mover has amended the  
6 motion to include approval at a level of \$1.1. Are we ready for  
7 a vote on the motion then? I see assent.

8 All in favor, please say "aye."

9 (Chorus of "ayes.")

10 Opposed, "no."

11 (No response.)

12 DR. MARGULIES: I just wanted to make one quick  
13 comment. We won't hold you up very long. It has nothing to do  
14 with this particular application, but another activity of Puerto  
15 Rico which I think you would all find interesting.

16 Some years ago they became particularly alarmed in  
17 Puerto Rico with a number of physicians who could not pass local  
18 examinations or the ECFMG. They have been educated primarily in  
19 Latin America and Spain. This was three-and-a-half or four  
20 years ago, and I suggested a plan of action which they then  
21 followed through on and got a contract from the National Center  
22 for Health Services R&D to involve the medical school in a pro-  
23 gram of supplementary education for these physicians who had  
24 gone to great personal expense and a lot of deprivation to get  
25 their MD's and couldn't practice. And the results have been



1 excellent. They have been retested, with a special test set up  
2 by the Educational Testing Service that has been cross-checked  
3 against the ECFMG examination. And when I last heard, they had  
4 salvaged about 64 physicians who are now available to practice  
5 in Puerto Rico who otherwise would not have been. They are now  
6 going to expand that program which I think is a heartening kind  
7 of an activity.

8 DR. SCHMIDT: We will reconvene for Missouri -- Dr.  
9 Besson has to leave early -- sharply at 10:45.

10 (Whereupon, a short recess was taken.)

11 DR. SCHMIDT: Dr. Brindley is ready to begin with  
12 Missouri, if we could take our seats and begin.

13 To relieve anybody's anxiety, I will be prepared to  
14 do South Dakota in one minute 32 seconds. I timed my presenta-  
15 tion. And South Dakota should be relatively easy to do, I think.

16 DR. SPELLMAN: Is that what you are going to do now?

17 DR. SCHMIDT: No, we'll do Missouri. Dr. Besson has  
18 a time constraint.

19 DR. BRINDLEY: Okay, Missouri. I will try to give  
20 you a reduced summary.

21 As you know, Missouri has been a complicated region.  
22 It was started off with the expectation that the level of  
23 funding would be higher than later proved to be realistic. They  
24 did make commitments in large amounts to computer and bio-  
25 engineering projects. They have continued to support those.

1 They now have asked for some more monies. A site review has  
2 been made to evaluate these programs and to see should these  
3 monies be made available, should the level of funding be in-  
4 creased, and should the developmental component be added.

5 The current year's award is \$1,947,417. They had  
6 requested \$5,061,962. Council had a recommended level of the  
7 06 year of \$2.5 million. The committed level is \$1,825,417.  
8 It is of interest that of this committed level of \$1.8 million,  
9 the Missouri RMP did allocate \$300,000 to the computer and bio-  
10 engineering projects.

11 Three months after they received their funds, they  
12 made the decision to continue to support the automated physician's  
13 assistant proposal in Dr. Bass' office rather than to phase it  
14 out, even though the council had recommended that it should be  
15 phased out.

16 Missouri RMP then requested a supplement of  
17 \$122,092 to permit the continued operation of the automated  
18 physician's assistant project for the six-month period, January  
19 1 through June 30, and council disapproved this request.  
20 I won't give you all those reasons right now.

21 They considered then the contract mechanism, as to  
22 whether this might be a good way in order to support this. And  
23 subsequently, a contract was let by RMPS for support of this  
24 because they felt at that time that redeployment of Federal  
25 resources allocated to aerospace and military technology would  
soon initiate new programs in this field and that some monies

1 were justified in this area. So a six months' contract was  
2 made for approximately \$122,000.

3 Also they submitted the automated physician's assis-  
4 tant project of the National Center for Health Services R&D and  
5 subsequently a study section of this organization considered the  
6 request and disapproved the APA proposal.

7 I want to go over a few things quickly with you, if  
8 I may.

9 We received from the study group letters from each  
10 one of the reviewers in which they gave their opinions. And in  
11 summary, they were all pretty much against it. As a matter of  
12 fact, they recommended that funds not be allocated, and that a  
13 developmental component not be allowed.

14 Now, to hastily review the things we are talking  
15 about, a site visit was held on April 4 and 5 to review the  
16 technical activities for the Missouri RMP. And these projects  
17 included the automated ECG in the rural areas, the biomedical  
18 information services, the automated physician's assistant, and  
19 the development of these activities have been supported by the  
20 Missouri RMP already for five years, an expenditure level of  
21 approximately \$7.5 million. They are presently being supported  
22 through grant and contract funds at a level of approximately  
23 \$422,000.

24 The reviewers were critical of the project progress  
25 and recommended reduction of RMPS support.

1           If you look at the automated ECG in the rural area,  
2 this has been supported by RMPS for five years. It is focused  
3 on making remote electrocardiographic interpretation available  
4 to small hospitals located in rural areas of Missouri.

5           Now, they purchased 17 carts that would make the ECG's  
6 transmit them to the University of Missouri who would interpret  
7 them, and the reports be given back to these peoples. And now  
8 they have reduced this to 9 carts, and they felt this was an  
9 important thing to them. I talked to Bill Mayer. He feels that  
10 if this were supported for one more year, they could then become  
11 self-supporting.

12           Now, the reviewers didn't share that conviction.  
13 They were concerned, did not think it could become self-supporting.

14           The carts rent for approximately \$300 a month which  
15 is paid for out of Regional Medical Program grants. It is  
16 presently supported by more than one source. They get \$96,000  
17 from RMPS, \$40,000 from the University of Missouri, and a con-  
18 tract for translation of the program into Fortran from the  
19 National Center for Health Services Research and Development.

20           Now, there are a lot of interesting things. When  
21 they talked to the cardiologist, Dr. Sandberg, he admitted  
22 there were errors in the interpretation in about half of the  
23 cases, and then about 20 percent of these that the error would  
24 be of clinical significance. He thought they could achieve  
25 economic viability if they added some other tests that could be

1 obtained at the same time.

2 So he talked about exercise ECG, phonocardiogram,  
3 spirometry and pacemaker analysis.

4 The consultants had reviewed it, looked into this,  
5 went over there and went over it. They felt that the spiro-  
6 grams probably would add very little useful information in the  
7 communities if this information would be utilized, and that  
8 actually a time vital capacity test would probably be just about  
9 as good.

10 As a thoracic surgeon, I might add I don't think  
11 that's always true, but those are probably not thoracic surgeons  
12 that are interpreting the spiograms.

13 Phonocardiogram, they thought it would be difficult  
14 to record, and that the local physician would have some diffi-  
15 culty interpreting it, and it probably wouldn't have a great  
16 deal of clinical significance.

17 The exercise ECG that was used in preparation for  
18 coronary artery surgery, and pacemaker analysis would not help  
19 the cost effectiveness, and they didn't feel there was very much  
20 of a reasonable market for it.

21 Now, they intended to spread this responsibility out  
22 and probably use some more cardiologists. There are three  
23 cardiologists in the University of Missouri that interpret these,  
24 and one proposal was maybe we should use some more cardiologists  
25 throughout the State. They haven't really done much of that

1 yet but that is one proposal that has been considered.

2           They felt it was probably not of much value in inter-  
3 pretation of arrhythmias, and at the time of the last visit  
4 there was great doubt as to whether this ever would become  
5 economically feasible.

6           They thought about charging a fee of \$5 for each one  
7 of the ECG's, and this \$5 might or might not include the fee  
8 for the cardiology interpretation. It wasn't very clear in any  
9 of the information we had.

10           In conclusion, they really thought probably this could  
11 be done better and for less money with some of the commercial  
12 services that already are available where they could use analog  
13 transmitter services through the telephone and have the cardi-  
14 ology interpretation, and if this was an excessive amount of  
15 money that was being used, and they weren't getting their dollar's  
16 worth of value out of it. They concluded that the present mode  
17 of computerized interpretation of ECG's is neither particularly  
18 useful nor economically viable.

19           Each one of the consultants that wrote back a letter  
20 about this was really very critical and apparently unanimous in  
21 their concept that this should not be supported.

22           They did make another suggestion that perhaps it  
23 might be well to consider an allocation of some monies possibly  
24 around the \$60,000 range to see if a less expensive method could  
25 be devised where they could make available to the smaller

1 communities ECG consultation and review of ECG's.

2 A biomedical information service is a fact bank and  
3 it's operated by the Missouri RMP in conjunction with the Uni-  
4 versity of Missouri Medical School Library and the School of  
5 Engineering. It is designed to provide specific disease infor-  
6 mation from recent journals and texts. It has continued in  
7 operation for the past nine months. Also I think connected by  
8 phone line with the University School of Pharmacy in Kansas  
9 City as a resource on drug reaction and also with Mercy  
10 Children's Hospital in Kansas City for poison control advice.

11 They estimate that it costs about \$100,000 a year to  
12 support this. At the present time, the University of Missouri  
13 has been contributing around \$2500 a month in support of the  
14 fact bank. They made a survey to try to find out how many folks  
15 were using this. You might criticize the survey since they  
16 only asked 59 physicians out of the 6,000 in the State, but they  
17 did use that as an index. And they concluded that 58 percent  
18 of the physicians might accept it. Five hundred doctors have  
19 used the service so far.

20 The supporters of the project have inferred they be-  
21 lieve this could be paid for by physicians subscribing to it at  
22 the rate of \$60 per physician per year. The reviewers felt that  
23 this was an optimistic conclusion and did have some difficulty  
24 in obtaining this many people that would provide the \$60.

25 It was interesting that most of the inquiries were

1 received from physicians in Columbia, and very few from the  
2 outlying areas of the State.

3           It was the consensus of the site visit team that  
4 there was very little insight concerning the difficulties of  
5 marketing a fact bank on a break-even basis and very little  
6 comprehension of all of the technical difficulties of indexing  
7 a large library. They concluded that it was too expensive for  
8 the output, and the physicians of the State would be much better  
9 served by using the National Library of Medicine assets.

10           The also stated they felt that no RMP support was  
11 justified by this activity.

12           The automated physician's assistant is something we  
13 have talked about every time we have talked about Missouri. We  
14 are up to bat one more time. And this is a five-year request  
15 for \$3 million for a one-year funding level of \$538,000. And  
16 this is to develop and use technological innovations to improve  
17 medical care delivery in a rural area through the use of an  
18 automated system of patient data handling.

19           This is in the office of a private practitioner by  
20 the name of Dr. Bass in a relatively small community. He  
21 apparently does have a large amount of very sophisticated equip-  
22 ment. It is used primarily in evaluation of patients that are  
23 seen for the first time. There's a lot of data here saying how  
24 many patients that that consists, but it is actually not very  
25 many, probably not more than two a week.



1           The cost is quite excessive. There's a great deal of  
2 doubt about how much good it helps anybody, either the patient  
3 or the physician.

4           I won't go over again the things that are recorded  
5 unless you wish to, but the major thrust involves automation of  
6 collection of certain information components at the time of the  
7 first visit. It includes an automated medical history, the  
8 entry of physical examination findings from a structured check  
9 list. The nurses actually record this data after Dr. Bass has  
10 seen the patient. The entry of clinical laboratory data which  
11 consists primarily of an SMA-12, and X-rays reports which are  
12 sent back from the University of Missouri. Automated ECG. He  
13 also has access to the fact bank in helping him with diagnosis  
14 and recommendations of treatment.

15           It has been proposed that perhaps it might be well  
16 to expand this program in the University of Missouri in two  
17 areas: One into a family practice type clinic, and the other  
18 one into a thoracic surgery clinic.

19           The reviewers that saw it were not too impressed.  
20 If you want to know the details of the technical parts I can  
21 give them to you. They screen their patients for vision,  
22 hearing, breathing function, blood pressure and electrocardiogram  
23 The vision is evaluated by a Titmus vision tester, hearing with  
24 a Tracor audiometer, breathing with a spirometer. All of them  
25 have been modified for digital recording. They do record the

1 blood pressure by an air shield method and found it wasn't very  
2 good, so now they take the blood pressure manually.

3           The electrocardiograms are done with the Marquette  
4 Electronics cart. They do use the SMA-12. There is very little  
5 method in there to record any subsequent visits. There is very  
6 little effort about correction of any data.

7           I can give you the names of the investigators but  
8 I don't think they would change your conclusions any. But they  
9 see about two patients a week. It's very rudimentary in nature.  
10 To make a long story short --

11           DR. BESSON: Did you say \$3 million?

12           DR. BRINDLEY: They estimated it cost \$60,000 a year  
13 just for the computer time, and that the total technological cost  
14 might be as much as five times that. And the cost of the patient  
15 would be somewhere between \$165 and \$175 per patient. You could  
16 do a pretty good examination for that.

17           They suggested maybe there might be two others things  
18 that might be tried, neither one of which sounded very good.  
19 They might make a satellite station similar to Dr. Bass' clinic  
20 in another area without a physician. And it wasn't very good  
21 in Dr. Bass' clinic, and it is hard to see how it would be any  
22 good anywhere else.

23           They also suggested that you might develop a modular  
24 system for \$180,000 and use an IBM System 7. But the reviewers  
25 never did get a very clear answer about what the goals were, how

1 you were trying to go about it, how you might achieve these  
2 goals, and how it would actually improve health care. It would  
3 cost at least \$2,000 a month to keep it up.

4           So the conclusions of the reviewers was that these  
5 were not good proposals. Technologically they were not well  
6 conceived. The medical supervision was not good, that it  
7 had not been as useful as it would need to be to justify this  
8 cost, and they did not recommend that we give any funds for  
9 Project 72 which is the automated physician's assistant, or to  
10 75 which is biomedical information service.

11           There was a difference of opinion as to whether any  
12 money should be given for the automated ECG in the rural area.  
13 There has been a suggestion that we might consider the \$60,000  
14 to see if a less expensive method could be devised to provide  
15 this assistance to the rural communities.

16           And as you know, a second request was for an in-  
17 creased level of funding from the \$1,904,417 to \$4,460,852.

18           When we made a site visit to Missouri, we found their  
19 goals to be very broad and vague, poorly defined, that they  
20 largely were related to projects rather than to programs, that  
21 they largely depended upon interested physicians, mostly  
22 physicians, in communities to submit plans for projects, and if  
23 they proved to be good ones and the idea to obtain regionali-  
24 zation was to use a similar thought and see if you could set it  
25 in another area.

1           That program consists primarily of accumulation of  
2 projects. Evaluation was largely evaluation of projects, and  
3 they had a great deal of difficulty in phasing our or modifying  
4 poor projects. Sometimes it would take them three or four or  
5 more years to do this, and they were very reluctant to change  
6 them once they had accepted them.

7           The coordinator seemed to be a fine man, but actually  
8 his administrative ability was not as good as it might be. He  
9 is not a very strong administrator.

10           The staff is large, maybe too large, for what they  
11 should be doing. It largely is related to projects that have  
12 been developed in the past for which they felt some commitment.  
13 The staff review when they saw them did not feel that they had  
14 improved this enough to where they would be justified in the  
15 greatly increased level of funding, nor did they think we were  
16 justified in recommending a developmental component.

17           I did speak to Bill Mayer -- off the record.

18           (Discussion off the record.)

19           DR. SCHMIDT: Dr. Brindley, I will apologize to you,  
20 and I will also apologize to Jerry because he does have a time  
21 constraint.

22           DR. BESSON: Let's leave that flexible. I think this  
23 is much more important.

24           DR. SCHMIDT: I was trying to read where you were  
25 approaching you might make a recommendation. Are you approaching

1 that point?

2 DR. BRINDLEY: Yes.

3 DR. SCHMIDT: Would you object if I turned to Dr.  
4 Besson who does have a time constraint, and let's get his  
5 overview on this and then we'll come back to you.

6 DR. BRINDLEY: Right.

7 DR. BESSON: Getting out of Missouri is like getting  
8 out of Vietnam, except that we can make the decision right here.

9 DR. SCHMIDT: Can we make an assumption of what is  
10 coming from that?

11 (Laughter.)

12 DR. BESSON: There are two parts to this request.  
13 One is the bioengineering and the other is continued support  
14 in the deveopmental component.

15 The bioengineering is very simple. The technical site  
16 visit said no, and the only disagreement is whether they should  
17 get \$60,000 or not for the automated ECG. And as I went through  
18 a careful analysis to try to justify the \$60,000, I must agree  
19 with SARP and say that that's not justified either.

20 So my general impression is that as much as we could  
21 phase out of the ridiculous kinds of requests that we keep  
22 getting from Missouri, the more we should.

23 As far as committed support is concerned, they present  
24 two plans, Plan A and Plan B. Plan A is \$1.8 million, and Plan  
25 B is for \$4.4 million. They ask for a developmental component

1 as well, and part of our decision as to which plan to support  
2 involves our approach towards whether they are ready for a de-  
3 velopmental component. And as I went over the individual pro-  
4 jects to assess that, I came up with a very negative opinion as  
5 to their readiness to have a developmental component. I could  
6 bore you with the details, but I think just their approach to  
7 the bioengineering phase itself should be sufficient indication  
8 of their lack of maturity, at least so far as not only the new  
9 direction of RMP but even the old one. And with all due respect  
10 to our recently eulogized chairman, I must disagree with him and  
11 perhaps his paranoia is only because he is so deeply involved  
12 in the program.

13           But I would then not be in favor of awarding the  
14 developmental component, and of the two plans that they offer,  
15 under Plan A there is a commitment of \$1.825 million that has  
16 already been made. Plan B, the \$4.46 million, I think should  
17 be outrightly rejected. If we accept Plan A, that gives them --  
18 and we also reject the bioengineering -- there is an additional  
19 million under Plan A that would not be funded therefore. That  
20 would give them an additional \$1 million to use for other pro-  
21 jects.

22           MISS HOUSEAL: That's inaccurate. There would be  
23 approximately \$200,000 to \$300,000 under Plan A that would be  
24 freed up. The \$1 million is out of Plan B, and that was the  
25 plan presented to the site visitors.

1 DR. BESSON: That's right, Donna. The \$1 million  
2 would be what they were requesting under Plan B of the \$4.4  
3 million, but if we accept their Plan A but deny them their bio-  
4 engineering, those three plans, 69, 72 and 75, come to a sum  
5 total of \$200,000.

6 We cannot deny them that \$200,000, though, because  
7 that is already committed. Therefore, they would have the  
8 option of using that \$200,000 for other projects. But never-  
9 theless, in keeping their funding at \$1.8 million instead of  
10 the \$4.4 million that they request, we are in effect cutting  
11 them down about an additional 40 percent from the request from  
12 the \$4.4 million to the \$1.8 million by keeping them at a level  
13 funding.

14 So in effect, the suggestion would be to reject the  
15 bioengineering request, to reject the developmental component  
16 request, and by keeping them at a level funding, indicate the  
17 displeasure of this committee and our hope that they might  
18 terminate the bioengineering activity.

19 DR. SCHMIDT: Thank you.

20 Are there any staff comments on that?

21 MISS HOUSEAL: There are a couple of corrections to  
22 the record. The \$3 million request for five years of computer  
23 activities was what was presented to the National Center for  
24 R&D. The request to RMP was for one year only at this point.

25 So that the R&D, what they reviewed at their study section

1 about a month ago was the \$3 million, five year request.

2 With regard to the EKG, the site visitors felt that  
3 on the basis of what the region was charging now and the number  
4 of subscribers they had, that they could not reach a level where  
5 they would become self-supporting in another year. The site  
6 visitors felt that the most valuable thing they could provide  
7 would be an overread or a consultation service to the rural  
8 physicians. And they thought if the project were totally re-  
9 directed that this would be worthwhile or worthy of support.  
10 They felt that the region had the resources to do this, and it  
11 would be something that would be worthwhile.

12 DR. SCHMIDT: Thank you. Dr. Brindley then.

13 DR. BRINDLEY: Yes, sir, I was going to get around  
14 to that and I think that's good. I would move that we recommend  
15 \$1,825,417 as our funding, that we deny the developmental com-  
16 ponent.

17 DR. SCHMIDT: All right. This is consistent then with  
18 what Dr. Besson outlined, is that correct? So that you second,  
19 Jerry?

20 DR. BESSON: Yes.

21 DR. JOSLYN: May I ask, does that motion include a  
22 denial of the three projects that are now within the \$1.8  
23 budget? In other words, the computer projects, that \$200,000  
24 could not be used for the computer projects but could be used  
25 elsewhere. That was stated in what you were saying but not in



1 what Dr. Brindley was saying.

2 DR. SPELLMAN: I think the implication is there but  
3 I don't think you could deny them.

4 DR. BESSON: I think we could disapprove of those  
5 projects which is what I think the question was.

6 DR. JOSLYN: I think the site visit committee felt  
7 that a disapproval of those specific projects was needed in  
8 order to change the direction of those projects. In other  
9 words, just allowing the funding that even remains in the A  
10 budget would allow a continuation of the projects in the direc-  
11 tion they are going.

12 DR. SCHMIDT: Then the specific question would be  
13 the disapproval of which projects then?

14 DR. BESSON: Projects 69, 72 and 75.

15 DR. JOSLYN: Those projects are the automated EKG,  
16 the biomedical information system, and the automated physician's  
17 assistant.

18 DR. SCHMIDT: Dr. Brindley is primary mover. What  
19 is the intent of the motion?

20 DR. BRINDLEY: I would like to include that in the  
21 motion.

22 DR. SCHMIDT: That is included in the motion. Is  
23 that acceptable to the seconder?

24 DR. BESSON: Yes.

25 DR. SCHMIDT: Is there further discussion then?

1 MR. PARKS: My unreadiness goes to the whole project,  
2 I guess, because I have some questions about what it is that  
3 we are doing here and what is it that apparently RMP is committed  
4 to.

5 I happened to run a scan of the full application here  
6 and it raises some very real questions. First of all, I find  
7 the so-called minority participation to be so small as to be  
8 totally nonexistent. With respect to that I would say directly  
9 and frankly it is a shame, and a shambles.

10 On the other hand, the participation of the grantee  
11 in the operation of this with respect to the staff listing of  
12 positions, which is on Form 6 which lists the core personnel, I  
13 would daresay with a scan like this that the personnel is close  
14 to the 90th percentile from the University of Missouri. This  
15 is highly suspect. Yet, when I look at the report of the RAG,  
16 the very first thing that they outline with respect to their  
17 programmatic relevance is the fact that they have addressed  
18 themselves with a high blood pressure program, which is a  
19 serious problem primarily among the black population of Kansas  
20 City. And then the rest of it goes off into a number of other  
21 projects.

22 Again I find in the opening page of the application  
23 an announcement that this is the Missouri Regional Medical Program  
24 heart disease, cancer and stroke. Going back into the programs  
25 that they intend to continue, I am not sure that I find that

1 there is a shift in emphasis that corresponds to the so-called  
2 change or new national emphasis.

3           So with respect to this, I understand that we are  
4 committed to them at this point on some kind of a continuing  
5 or triennial commitment. But I raise some very serious ques-  
6 tion as to whether there is minimal compliance with those basic  
7 conditions that are necessary not only to obtain but to sustain  
8 the eligibility as a grantee or regional medical program operated  
9 as this one is.

10           DR. SCHMIDT: I think it would be appropriate for  
11 staff to note these particular comments very, very strongly, in  
12 that they be conveyed and the concern of this committee in this  
13 area be conveyed very strongly to the region.

14           Jerry.

15           DR. BESSON: I would like to respond to Mr. Parks'  
16 comments because I think again they raise a principle that  
17 disturbs me personally greatly in our relationship with a totally  
18 untenable region such as Missouri is. And that is how we have  
19 managed to remove ourselves from the decision-making process.  
20 Three years is a long time, and if change is occurring as ex-  
21 ponentially as it is currently to have committed ourselves a  
22 year ago when we may have just felt in a more salubrious mood  
23 and maybe a little more generous to this level of funding, and  
24 now coming back to see the intemperance of the region and  
25 funding the program in the face of council disapproval, and

1 their cheek in presenting a budget like this with obvious  
2 changes in national mood, yet we are left powerless to do any-  
3 thing about it. We have to fund them at a level of \$1.8 million  
4 because that was committed a year ago.

5 Our only action on this application, Mr. Parks, can  
6 be to disapprove the request for these three projects, disapprove  
7 the developmental compent, period. We can't do anything more,  
8 but you raise the fundamental question, I think, of the in-  
9 appropriate stance that this review committee and therefore  
10 council has now placed itself in relation to a rapidly changing  
11 program by fixing itself to a three-year commitment with periph-  
12 eral decision and no decision-making power left at this level.

13 DR. SCHMIDT: Sister Ann.

14 SISTER ANN JOSEPHINE: I would like, in conjunction  
15 with Mr. Parks' question, to raise a question that probably  
16 we are going to be facing -- maybe we won't be on the committee  
17 any more, but we will be facing it somewhere down the pike. And  
18 that is the total funding of medical education as it relates  
19 to the faculty.

20 Mr. Parks points out that 90 percent of the personnel  
21 on the program, on the RMP program, are from the university.  
22 I think that it would behoove all of us to read the recent  
23 Millis report on irrational public policy for medical education  
24 and its financing, or somewhere down the line we are going  
25 to be sorry we permitted this type of investment in underwriting

1 faculty salaries, and the unrealistic development of faculties  
2 beyond the financial capability of funding them when the  
3 Regional Medical Program is phased out into another type of  
4 program. And as we know historically what Federal programs do,  
5 this is going to happen, and I think it is terribly important  
6 that we realize we are contributing now to a stance that has to  
7 be taken on medical education. It has to be adequately funded  
8 but from the right sources so we are going to have a continuity  
9 of funding.

10 DR. SCHMIDT: Staff?

11 DR. JOSLYN: I have been with RMPS for less than a  
12 year, and I am not knowledgeable of all the politics and con-  
13 straints and all, but I would hope that this review committee  
14 or National Advisory Council or some board would have the power  
15 to have some effect in Missouri, and I think this is what I hear  
16 people saying, particularly Dr. Besson, at the table. And I  
17 think that something needs to be said besides a letter of  
18 recommendation which has gone out the last four years. I don't  
19 know whether this takes this committee having its next meeting  
20 in Missouri with national television coverage, or what, but I  
21 guess I'm just asking: Is there any way this committee -- and  
22 Dr. Margulies and I have talked about it, and I don't want to  
23 bate it if it's not appropriate, but I would hope that the  
24 committee can move this region. It has some positive aspects.  
25 Some of these have not been brought out. But it does have some

1 positive aspects, but it is misguided in other areas, and I  
2 think those have been brought out and they have not been moved  
3 in the past. I would like some innovative way to move them, and  
4 hopefully this committee might do that.

5 DR. SCHMIDT: I'm sorry we can't. We're committed  
6 to meet next in Puerto Rico.

7 (Laughter.)

8 Joe.

9 DR. HESS: I would just like to say that I share the  
10 concerns being expressed around the table. One of my early  
11 site visits was to the Missouri region, and I see that many of  
12 the things we identified then were matters of concern are matters  
13 of continuing concern and nothing much has happened.

14 And in connection with this discussion, I wonder if  
15 it is possible under current policy, or if a new policy should  
16 be created to make it possible, to put a very large red flag on  
17 this anniversary approval and say that if certain actions are  
18 not taken by next year, that in spite of the triennial status  
19 that there will be funding cut-backs.

20 Now, that may or may not be a new policy, but if it  
21 requires new policy, I think perhaps this is an issue we ought  
22 to raise for discussion here and pass on to council.

23 DR. MARGULIES: I'm in full sympathy with your con-  
24 cern, but I just have a trace of the historical perspective in  
25 this, too. I would like to point out to you that this program

1 reached zenith of its categorical activities under the old  
2 processes under which this review committee operated, and it was  
3 this committee that put them at the extraordinary level of  
4 hardware activity which has generally dominated it. And it is  
5 only now, under these circumstances, that you first begin to  
6 look at the program. It is only now that you begin to raise  
7 questions about minority representation. It is only now that you  
8 begin to look at the grantee structure. It is only now that  
9 you look at the question of university domination and of the  
10 presence of RMP paid people on the faculty. It's now that you  
11 can begin to deal with it as a total structure. And what you're  
12 hesitating about I don't understand. In the past all you did was  
13 go from project to project, and under those circumstances it  
14 reached a total hardware level of something in the range of what?  
15 \$4.5 million, \$5 million, \$6 million?

16 DR. JOSLYN: Yes.

17 DR. MARGULIES: And it was recently that you began to  
18 look at it as a programmatic structure. You are in a much better  
19 position to act on this as a total program than you have been at  
20 any time in the past.

21 DR. BESSON: Except that we are constrained totally  
22 by the triennial review process and the fact that we can say  
23 nothing about this program except within the limits of denying  
24 developmental component and denying these bioengineering processes  
25 And I say that's not enough. I think the program is changing

1 too rapidly for us to be tied in to a three-year anniversary  
2 review. And I think that policy must be reexamined in the light  
3 of rapidly changing events. It's inappropriate. It's unre-  
4 sponsive. It leaves the change lag too great. If you are  
5 chastising this group for reaping the fruits of some action it  
6 took a year or two ago, I'm making the bid for making this  
7 organization much more responsive, and immediately so.

8 DR. MARGULIES: And I'm asking you why you don't  
9 just take the action you keep talking about. What are you  
10 hesitating about? There is nothing special about a triennial  
11 review. You have this program to look at now. Why are you  
12 leaning back?

13 DR. BESSON: Well, maybe we should have some more  
14 information. Could you outline for us what we can do about  
15 Missouri other than the motion?

16 DR. MARGULIES: You have a full range of recommenda-  
17 tions. You can do what you think is best.

18 DR. BESSON: Are we not enjoined from interfering  
19 with the committed support?

20 DR. MARGULIES: The support is committed on a year-  
21 by-year basis. The triennial review anticipates a continuing  
22 level of commitment if the program meets its responsibilities.  
23 If it does not, then it does not get the level. It's merely a  
24 matter of continuing it under those circumstances.

25 DR. BESSON: Okay.



1 DR. SCHMIDT: Len.

2 DR. SCHERLIS: Several things. One is that several  
3 of us have over the past several years been very concerned about  
4 the involvement of the Regional Medical Program in computer  
5 activities which appeared to be looking for programs so that one  
6 could use tools rather than trying to meet health needs and  
7 finding that computers were of assistance in this regard.

8 Several years ago -- I guess it was several, when  
9 we had categorical review by a heart committee that looked at  
10 all the heart programs and cancer committee -- at that time I  
11 was a member of a committee chaired by Paul Hugh, and subse-  
12 quently I chaired a committee. And on each occasion we wrote a  
13 letter to the council -- I don't think you have a review com-  
14 mittee at that time -- saying we wished to have the council have  
15 an ad hoc committee formed to draft a statement on computer EKG  
16 because we felt frankly this was very much at that time being  
17 misused. The committee finally met a few months ago. And this  
18 was an action we had requested because we were very concerned  
19 about the involvement of RMP in hardware at that time.

20 We also sent a statement asking for mobile ambulance  
21 units in coronary disease, and that one I guess never quite got  
22 help. But the feeling we had in the area of cardiology was  
23 there was a gross misuse as far as computer equipment was con-  
24 cerned.

25 I completely share the recommendations as far as EKG

1 here is concerned. They could do the same thing as far as  
2 helping some rural physicians by having a telephone at one end  
3 and sending the EKG directly to a physician or Xeroxing it and  
4 sending it over. The use of a computer here is a Cadillac to  
5 do the work that somebody could do on foot. And I think it's an  
6 expensive example.

7           So I think as far as the excessive hardware in  
8 Missouri, we all bear responsibility for it, but all of us had  
9 seen this coming and had tried to get some directions about how  
10 much hardware was going to be purchased.

11           I would hope the committee at this point -- and I  
12 would lean back to the original recommendations and think in  
13 terms of cutting that recommendation financially, significantly,  
14 even beyond the limit that was suggested.

15           DR. SCHMIDT: Dr. Thurman.

16           DR. THURMAN: In view of the discussion, I would like  
17 to offer a substitute motion, and that is that we disapprove  
18 this application with the intent that there be a site visit  
19 within the very near future, disapprove it with the understand-  
20 ing that Dr. Margulies would agree to continue to fund it at the  
21 present level until such time as that site visit could be car-  
22 ried off, and many of the apprehensions that have been listed  
23 here today be specifically charged to that site visit group.

24           DR. SCHMIDT: And the site visit would be charged  
25 with making recommendation then for funding level, and so on?

1 DR. THURMAN: It's my understanding it is within  
2 Dr. Margulies' power to continue funding this at the present  
3 level to let them go on until such time as the site visit could  
4 be organized to address many of these problems. And therefore  
5 we would not be jeopardizing the eventual future of the Missouri  
6 Regional Medical Program should it adhere to many of the things  
7 we might suggest at that time.

8 DR. SCHMIDT: We have a substitute motion on the  
9 floor, then, for disapproval with funding maintained adminis-  
10 tratively.

11 DR. THURMAN: Excuse me one second. Miss Anderson  
12 had an addition to my substitute motion.

13 DR. SCHMIDT: I'm sorry, that is out of order.

14 DR. SCHERLIS: Point of information. My reading of  
15 that would be that you would be including ongoing support for  
16 the very projects we suggested they not fund, if you make it  
17 at the same level. Would it be feasible to drop that level down  
18 excluding the support of the automated EKG processes?

19 DR. THURMAN: As a discipline of Robert, I can also  
20 say I can accept that in my substitute motion, and would expand  
21 my substitute motion to include the recommendations previously  
22 listed. And that is that none of these three projects be  
23 permitted continuing operating money at Dr. Margulies' discre-  
24 tion.

25 DR. SCHMIDT: Is there a second to that motion then?

1 MISS ANDERSON: I will second it.

2 DR. SCHMIDT: The motion is seconded, and I presume  
3 understood. Would you like to modify it further?

4 MISS ANDERSON: No.

5 DR. SCHMIDT: That incorporates it.

6 MISS ANDERSON: Yes.

7 DR. BESSON: Perhaps we can have a clarification that  
8 this is an action that cannot be, because of Catch 22, rejected  
9 by council.

10 DR. SCHMIDT: Was that a question?

11 DR. BESSON: No, I would like to have a comment by  
12 Dr. Margulies that what we are doing is not going to be hung  
13 up on a technicality.

14 DR. SCHMIDT: I presume this could be rejected by  
15 council.

16 DR. MARGULIES: Of course.

17 DR. BESSON: Barring that, is there any reason why  
18 what we propose is going to be rejected by council for some  
19 technicality. If they reject it on principle, then that's  
20 debatable, but if it's rejected on a technicality that we can't  
21 do this --

22 DR. MARGULIES: The only technicality which might  
23 arise would be the need, because I cannot do exactly what you  
24 said. I cannot continue the program beyond its fiscal year  
25 without the council giving approval of an award level. So that

1 they would have to set some level at which they would operate.  
2 I don't have the authority to continue to award a grant unless  
3 the council has approved, but that would be the only technicality  
4 As a matter of principle, they can endorse this action, or  
5 reject it, of course, because that's their legislative preroga-  
6 tive.

7 DR. BESSON: So we have a level of \$1,625,417, is  
8 that correct, Donna?

9 MISS HOUSEAL: Yes.

10 DR. SPELLMAN: But I think the rejection and the  
11 prospects of rejection in principle would be diminished to the  
12 extent that the report to the council clearly states all of  
13 the considerations which have gone about. The only one I would  
14 add to that, I think this kind of unreal commitment, to Kansas  
15 City on the one hand, and clearly a system of program that has  
16 throughout responded to an essentially rural constituency,  
17 using urban methods, hardware, extraordinarily expensive pro-  
18 grams where an individual physician almost operates a multi-  
19 phasic screening operation at an enormous cost.

20 DR. SCHMIDT: A brief staff comment?

21 DR. JOSLYN: In light of the many past site visits  
22 and the data you have, I would just like to question what data  
23 you expect to gain from a site visit that will alter your  
24 position. And secondly, I would like to ask whether or not  
25 behind the recommendation for the site visit is a hope to move

1 the region, which is what I was addressing before. And I think  
2 merely requesting a site visit is another long chain of site  
3 visits.

4 DR. SCHMIDT: There are site visits and site visits,  
5 and I believe that some of the site visits we have made have  
6 not really been so much to gather data as to provide data. And  
7 we go back to what we were talking about before, that there  
8 have been a number of site visits, and my most recent one, I  
9 suppose, being an example that resulted in quite an upheaval  
10 and change of direction in the region and so on. I believe it  
11 is this sort of site visit that was recommended.

12 Joe.

13 DR. HESS: I would just like to get some clarifica-  
14 tion on when that site visit was projected and what it was de-  
15 signed to accomplish.

16 DR. THURMAN: I think it's projected as soon as the  
17 staff can arrange it, Joe, because I think basically by not  
18 approving continuation of the triennium, I share Jerry's concern  
19 about what the council is going to say about that, but in not  
20 approving that we are creating a little bit of an administrative  
21 morass, and therefore the site visit would have to come as  
22 quickly as staff could arrange it. And specifically the site  
23 visit would be as Mac has indicated, to approach the problems  
24 of why they weren't approved. And I think that in that light  
25 the site visit will be a fairly critical site visit.

1 DR. HESS: My question, then, is this a better way  
2 of trying to accomplish our goal than cutting back the funding,  
3 having the advice letter and staff contact and so on, the message  
4 carried that way, with the provision that there be a site visit  
5 a year from now after the message was carried back and they have  
6 had some time to reorient. And then a site visit team would  
7 go in with the purpose of seeing what they've done about the  
8 advice that they were given.

9 I'm wondering if that wouldn't be a better use of  
10 the site visit mechanism?

11 DR. BESSON: When you made the motion, Bill, I  
12 deferred to you, but I had a different approach to this other  
13 than a site visit, which would accomplish what Joe has now  
14 raised. And I thought, well, a site visit may act as our  
15 way of telling them directly face to face just what RMP is  
16 concerned with. But it may be that if we let them know by the  
17 funding mechanism, and my motion was to have been to cut them  
18 down not from \$1.8, minus the \$200,000, which was the bio-  
19 engineering, but down to an arbitrary lower figure, \$1.5 million,  
20 let's say, which would have given them a message that we are  
21 objecting not only to their bioengineering, and therefore  
22 cutting down \$200,000, but we are objecting over and above that.

23 Now, if that can be done with an advice letter, and  
24 then tell them this region would be reevaluated by a site visit  
25 after you have had time to reassess the impact of this change

1 in RMPS policy about the triennium review, then that might give  
2 the council an opportunity to establish an entirely new approach  
3 to triennial review which we haven't taken yet. But deferring  
4 it to a site visit, it almost implies we are not meeting the  
5 problem in a head-on fashion; we are not doing anything. Well,  
6 I guess in cutting down the \$200,000 in funding level --

7 DR. SCHMIDT: Jerry, we are also disapproving the  
8 application.

9 DR. BESSON: No, we are disapproving the application  
10 entirely.

11 DR. THURMAN: That was implicit in the motion, and  
12 Dr. Ellis and I were raised to use the term, I think if we did  
13 an advice letter we would be patting them on the fanny, and  
14 that's all we would be doing.

15 DR. SCHMIDT: The motion is for disapproval of the  
16 application, with just funding being sufficient to keep them  
17 from going down the tube completely.

18 DR. BESSON: But the application is what? For  
19 developmental component and these three projects. Is that  
20 right? That's all that the application is. And an increased  
21 funding level.

22 Well, we are denying the increased funding level;  
23 we are denying the developmental component; we are denying the  
24 bioengineering. But we are saying more than that. Disapproval  
25 of this application doesn't get to the heart of what's wrong



1 with Missouri.

2 DR. THURMAN: I think if the site visitors had the  
3 courage of their convictions, and the wisdom of this review  
4 committee behind them, they would get to the heart of Missouri.

5 DR. BESSON: But you reassured me by disapproving  
6 this application that we are changing policy, and we are telling  
7 them that we disapprove of Missouri's general program. But we  
8 are not doing that by disapproval of this application because  
9 this is an interim application that only asks for three addi-  
10 tional bioengineering projects, plus a developmental component.  
11 Is that correct?

12 MISS HOUSEAL: When you say interim, I'm not sure  
13 what you mean. This is an application for the next year's support  
14 that includes funding for core and their projects, including the  
15 support for the three computer activities and the developmental  
16 component. It's for one additional year, the second year of  
17 their triennium.

18 DR. BESSON: It's a different impact, though, in  
19 keeping them at a level funding, and in concomitantly disapprov-  
20 ing this application, than in disapproving what they are  
21 doing which doesn't appear on this.

22 MISS HOUSEAL: Do you want an application before the  
23 site visit goes out, or do you just want the site visit team to  
24 go out and get further information and then carry a message to  
25 the region?

1 DR. MARGULIES: I think what you're doing in effect,  
2 if I may say so, is saying that you are withdrawing the previous  
3 approval of a triennial award, and that what you want to do is  
4 send some people out there who know what they are talking about  
5 to give them an understanding of why. And the site visit is  
6 sort of broad term, and what you are really advising is that  
7 they be given straight information on what they are going to have  
8 to do to have a Regional Medical Program.

9 DR. BESSON: If those words are included in the sub-  
10 stitute motion, disapproval of the previously approved tri-  
11 ennial award, then there's no problem, I think.

12 DR. THURMAN: Them I'm perfectly willing to accept  
13 it as Dr. Margulies has phrased it, because that was my intent.

14 DR. SCHMIDT: Do you have a comment?

15 MR. GARDELL: If you disapprove the application, re-  
16 gardless of what council does, we cannot make an award without  
17 an approved application. So we would have to get something from  
18 them between now and September 1 to make an official award.

19 DR. BESSON: I like the most recent wording better.

20 DR. SCHMIDT: All right, the most recent wording is  
21 adopted by the mover and the seconder as part of the motion.

22 Now, the funding level we are talking about is  
23 \$1,625,000.

24 I think we are in a sense moving toward testing the  
25 question.

1 John.

2 DR. KRALEWSKI: Let me see if I understand this. We  
3 are suggesting now \$1.6 million, a site visit, a new application  
4 which we possibly will deal with before September.

5 DR. MARGULIES: No.

6 DR. KRALEWSKI: And that funding level is going to  
7 be \$1.6 regardless of the site visit, or would you clarify that  
8 for me?

9 DR. MARGULIES: The point is good, because you are  
10 going to have to decide at what point you want to reconsider.  
11 If you withdraw triennial approval, and if you say there must be  
12 a site visit and a new application, then you may want to set a  
13 time for a subsequent meeting which is out of phase, if necessary  
14 to see if they can come back with some reconciliation in it and  
15 new directions. Otherwise, it is pretty infeasible to ask them  
16 to come in with a totally new application with about two to three  
17 months to do it. It wouldn't be realistic. You wouldn't get  
18 anything good out of it.

19 DR. THURMAN: May I ask the question for information?  
20 What good would a new application do at this point in time? My  
21 intent was that we would visit to do what you said in your last  
22 statement. A lot more information on paper that is garbage is  
23 still more garbage. So it would do us no good to have another  
24 application, and if nothing else would raise their frustration  
25 level almost beyond acceptance.

1           So my intent in the motion, which obviously has  
2 never been clear, was that we would have a site visit reasonably  
3 soon, and that in that interim there would not be a new applica-  
4 tion, but that instead, within the power of your office and  
5 the council, that funding at the previously approved level,  
6 1.6, not the 1.8, would continue until that site visit could be  
7 again reviewed by this committee which would then be in September.

8           DR. SCHERLIS: That is my understanding.

9           DR. MARGULIES: If you don't include an application,  
10 then it could be done.

11           DR. THURMAN: I am perfectly willing to have the  
12 motion voted on on whether everybody wants another application,  
13 but to commit more words to paper doesn't change the course of  
14 the program.

15           DR. BESSON: I think as far as John's comment is  
16 concerned, I think the words Harold used "as soon as feasible,"  
17 is the only reasonable approach; staff should arrange it at the  
18 earliest opportunity, and we should visit, and then give them  
19 an opportunity to resubmit a new application after that  
20 message is clearly verbally given.

21           DR. SCHMIDT: We could withdraw triennial status,  
22 and then set a lower level for the second year, 1.6. And  
23 that's what we're doing.

24           DR. BESSON: When is their anniversary?

25           MISS HOUSEAL: Their year starts September 1, 1972.

1 They would then be coming in with another application, a year  
2 from now.

3 DR. SCHMIDT: That's reasonable, then.

4 DR. BESSON: So the new level of 1.6 would begin  
5 September 1972. The site visit can be held at any time. They  
6 would have ample time then for a new application.

7 DR. SCHMIDT: That's correct.

8 DR. SPELLMAN: A year hence.

9 DR. SCHMIDT: Joe.

10 DR. HESS: I would again like to raise the question,  
11 and perhaps direct this to Dr. Margulies. Do you feel that it  
12 takes a site visit to get the message across to Missouri, or  
13 are there other established administrative mechanisms that can  
14 be just as effective in getting the message to Missouri without  
15 a site visit?

16 DR. MARGULIES: I think it takes at least a site  
17 visit, and a very carefully selected one. Yes, I think that  
18 could be helpful, particularly if it is in the framework of re-  
19 form. And it has worked in the past. There are unusually  
20 resistant factors that we are dealing with here, but we will  
21 deal with them as best we can.

22 DR. SCHMIDT: All right. It's getting on. I believe  
23 we are ready to test the substitute motion then. Unless there  
24 is strenuous objection, I will put the question.

25 All in favor of the motion please say "aye."

1 (Chorus of "ayes.")

2 Opposed, "no."

3 (No response.)

4 All in favor of Sister Ann chairing the site visit  
5 say "aye."

6 (Laughter.)

7 MRS. KYTTLE: Donna, are we thinking alike on what  
8 we have written here, withdrawal of the triennial status,  
9 funding level for the upcoming year of \$1,625 million, an early  
10 site visit, rejection of developmental component, and rejection  
11 of the bioengineering proposal.

12 DR. MARGULIES: Could I make one comment. This is  
13 a very convenient time for me to do it -- we should have done it  
14 the very first -- which is to let you all know what I hope you  
15 do know, and that is the newly appointed Deputy Director of the  
16 Operations Division is Judy Silsbee. This is a notable achievement.  
17 I bring it up at the present time, not because I just  
18 thought of it, but because it seems to me that one of the things  
19 she could do to really contribute and show how wise we were in  
20 choosing her is to lead us out of the Missouri wilderness.

21 That's combined with the announcement of the fact  
22 that we're awfully happy to have her in this job.

23 MISS ANDERSON: Mr. Chairman, I hope that in this  
24 next site team the members would be selected to reflect the new  
25 direction of RMP.

1 DR. SCHMIDT: I think there is a lot hidden in that  
2 remark. I'm not sure I understand the full flavor of it.

3 DR. BESSON: Mr. Chairman, one other thing. Now  
4 that we are through with Missouri, I wonder whether this would  
5 not be an appropriate time, since we obviously have been operat-  
6 ing under inadequate information as to what our responsibili-  
7 ties as a review committee could entail, to ask whether we  
8 couldn't have a staff clarification by memo to review committee  
9 perhaps council, outlining exactly what your prerogatives are  
10 currently. We've got kidney, emergency medical services, anni-  
11 versary review, our relationships with SARP and staff, the  
12 regions. I think that would be very helpful to delineate our  
13 areas of responsibility.

14 DR. MARGULIES: I think that is a very good point  
15 because these have accumulated, and to put them all together in  
16 one document would be very appropriate.

17 DR. SCHERLIS: We have a manual of operations.

18 DR. WHITE: I would think it terrible if we had to  
19 have guidelines as to what we can do and can't do. What we can  
20 influence or not influence may be a different thing. But  
21 council has to abide by whatever its decisions are going to be  
22 and they must adhere, presumably, to whatever policy it estab-  
23 lishes to guide its function. But I would hope this committee  
24 could remain totally independent and recommend to council  
25 anything it pleased to recommend. Whether they accept it or

1 not is a different proposition. We may be speaking in an in-  
2 creasingly higher-pitched voice, but we've got to be heard.

3 DR. SCHMIDT: I think I can read Harold better than  
4 I can from previous doctor associations, and so on, but I think  
5 that was the message he was giving us earlier today, and was  
6 sort of behind my comment yesterday, that you are what you do.  
7 And I think Harold is saying that this committee really should  
8 not hold back from doing what it feels is right and proper in  
9 flexing its muscle. I don't think anybody has taken our muscle  
10 away legally.

11 If the thrust of Jerry's request is to get a clari-  
12 fication of the charge to this committee, rather than guidelines  
13 or constraints or whatever, I believe that that would be a fair  
14 request. I occasionally get requests from committees to re-  
15 charge them or clarify their charge.

16 Len.

17 DR. SCHERLIS: Two brief points. The reason I was  
18 agreeing with what Jerry said was more in line with a definition  
19 of terms, particularly with new members, and what it means to  
20 a region to be told they have a triennium. I am not talking  
21 about proscribing the limitations of activities of this committee  
22 but just getting down the jargon on what this means in terms of  
23 whether these are contracts or not.

24 The other point I wanted to raise was that while this  
25 is valuable, I find it less value to me than would be another,



1 either substitutive or additional form of information. When  
2 you are constricted to a certain number of letters to describe  
3 a project, even the title doesn't come through completely.  
4 While we don't look at individual projects, the flavor to me  
5 of whether a region has certain directions lies in a little  
6 paragraph discussing each individual project. Now, this doesn't  
7 mean the entire project or anything else.

8           But the former yellow sheets I found to be invaluable,  
9 and frankly I got lost in a lot of material which I find less  
10 clear and more obfuscating than helpful in terms of the follow-  
11 ing.

12           I would like to see, for example, as far as Missouri  
13 is concerned, a paragraph about each one of the projects that  
14 they have which I find difficult to obtain even from the total  
15 application from the terms of their descriptions. What I am  
16 asking for is what is present in only a few of these regions  
17 at this time, a small paragraph describing the individual pro-  
18 ject.

19           I wish there could be some staff comment on this be-  
20 cause I find the flavor of a region lies in what it is doing,  
21 not what it tells me it's going to do. Its goals and objec-  
22 tives, they all read alike now, they've got this clearly, but  
23 as far as the projects, this is how they translate it.

24           Is this a fair statement?

25           DR. SCHMIDT: There are many heads nodding in assent

1 around the table.

2 Bill, do you have a comment?

3 MR. HILTON: Yes, I have a concern closely related  
4 to that one. I was interested in background information, and I  
5 know that going through the various briefing documents provided  
6 on each of the regions, they vary somewhat in quality, and  
7 while there appears to be a move to uniformize at least certain  
8 of the material in accord with our criteria for evaluation, I  
9 find it helpful to be able to refer to background, demographic,  
10 geographical information. I find that is not consistently rep-  
11 resented and not always presented with equal thoroughness.

12 Missouri's happens to be one of the better ones I  
13 have seen. It provides me with some information. It helps me  
14 assess how well the region has made its plans in light of the  
15 regional needs.

16 And I would like to make a bid for staff making a  
17 more standard approach in that area, too, everybody provide  
18 certain background data on each of the regions, in addition to  
19 this additional information about progress.

20 DR. SCHMIDT: I would agree in many respects the  
21 old yellow sheets were a little more helpful to evaluate the  
22 summary of the projects rather than to be one more time removed  
23 in evaluating the evaluation of a summary of the project.

24 Before we move to South Dakota, then, there is this  
25 issue we have surfaced. Is there any other comment on this

1 particular one?

2 All in favor of the motion, say "aye" again.

3 (Chorus of "ayes.")

4 Opposed, "no."

5 (No response.)

6 The motion is carried.

7 We will move on then to South Dakota.

8 I said that I did have a 1 minute, 33 second version  
9 of a review, and was sort of planning on this a week ago, and  
10 then McGovern started to win more, and I thought better of this  
11 and will give a 5 minute, 21 second version.

12 This region is not ratable on your sheets this time  
13 because what we are reviewing is an application for a planning  
14 grant, and the review criteria, et cetera, are so much oriented  
15 toward operational that I agree with the staff it's essentially  
16 unratable.

17 South Dakota used to be married to Nebraska, as was  
18 brought out yesterday, and early on it was a happy marriage with  
19 good potential, and most people agreed that the couple should  
20 produce marvelous projects together.

21 But South Dakota became a little unhappy. She began  
22 to feel that the marriage was an unfair partnership. She did a  
23 lot of drudgery without getting too much glory, had a lot of  
24 ideas. The good ideas seemed to be implemented in Nebraska and  
25 not in South Dakota. She felt neglected and suffered from lack

1 of affection and attention. Core staff seemed to be developed  
2 more in Western Nebraska. All the meetings are Eastern Nebras-  
3 ka. All the meetings were held there and not in South Dakota,  
4 which forced South Dakota to come always to Nebraska. Only a  
5 few projects got going in South Dakota, and she just felt she  
6 wasn't fulfilling her potential as an individual program.

7 She asked to change the marriage vows more to a  
8 partnership contract, and there was some attempt to work this  
9 out but it didn't really come to any good end. She did not  
10 feel liberated and filed for divorce.

11 There was a site visit mounted in October of '70 by  
12 council to South Dakota to look at this. And the site visit  
13 recognized that the RAG for the combined region was too large,  
14 was not functioning well, particularly for South Dakota. There  
15 were problems with the dean of the two-year school of medicine  
16 in South Dakota. There was no full-time coordinator for that  
17 subregion, and very little staff expertise in a relatively  
18 have-not state. The State had become disenchanted and, save for  
19 a coronary care unit training projects, which they are very  
20 enthusiastic about, have lost enthusiasm for the activities  
21 there.

22 The recommendation of council was a new region be  
23 established, that they be given planning funds, that the coronary  
24 care training projects which were considered valuable by both the  
25 site visitors and the region be continued.

1           So that on 1 January 1971 South Dakota was officially  
2 designated a region. However, they were not funded independent-  
3 ly until 1 July '71, and a new and very good coordinator did  
4 not come on board until 1 September 1971, and within six months  
5 they were charged with coming in with their application.

6           This planning application, which is asking for very  
7 modest levels of support, they seemingly have a good start with  
8 some good people. And my recommendation will be the same as  
9 the staff's, and that is that the application be approved at  
10 the funding level requested.

11           The coordinator I mentioned is good. They have  
12 structured a Regional Advisory Group that is interesting. It  
13 is 41 members, 21 being consumers, and serves as the governing  
14 body for both CHPA in the State, as well as the Regional  
15 Advisory Group. They have worked out a sort of a common cause  
16 in which the CHP will be dealing with conceptual planning and  
17 general strategical affairs, and the RMP will be implementing  
18 and more concerned with tactical aspects.

19           The two directors, the directors of CHP and RMP are  
20 different individuals and they work well together and are com-  
21 municating well.

22           The core staff is small but dedicated and competent,  
23 and they are building a good staff. South Dakota needs more or  
24 less one of everything, and they are trying to bring in com-  
25 petencies needed in the State.

1           They are somewhat weak now as an organization. They  
2 have very little bench strength, as I have intimated. There is  
3 no evaluation competence on board right now and an inadequate  
4 field staff, but they have plans to obtain these.

5           The Chairman of the RAG is an excellent person about  
6 whom this committee will learn much more in the future.

7           They have accepted a problem orientation way of plan-  
8 ning and have established some early-on goals and priorities  
9 listing emergency health service as number one, and this seems  
10 appropriate for South Dakota; chronic care, number two; acute  
11 care, three; preventive care, four; subacute care, five; and  
12 custodial services, six.

13           They aren't quite sure why they chose these. Some  
14 of it obviously is guessing at what the Federal Government wants,  
15 and yet they have done some good thought in these areas, and  
16 again under the planning grant will be refining these and  
17 coming up with a program.

18           Dr. Lowe has an evaluation letter in the application,  
19 and one is impressed reading the letter. He makes cases well.  
20 He has gotten around the State. Just for one example, he has  
21 visited every hospital in the State at least twice already.  
22 He has been an aggressive, active person, and I think has great  
23 promise for becoming a leader in that area of the country.

24           The reconstituted Regional Advisory Group is quite  
25 engaged in the program. They have more than 80 percent attending

1 their meetings. And interestingly enough, the divorced partners  
2 are seeing each other frequently. They are still dating on  
3 occasion and are talking about cooperative efforts between South  
4 Dakota and Nebraska where these are appropriate. They are  
5 having development meetings for the Regional Advisory Group,  
6 even giving them training sessions in management, and this sort  
7 of thing that is interesting and kind of acute.

8           They have some problems, and I have a few questions  
9 about what they are doing, but I really don't fear that they  
10 will recognize their problems and move to correct them.

11           I believe that their request for funds to support  
12 planning studies and feasibility studies is very reasonable.  
13 They seem to have structured a good review system of activities  
14 less than \$1,000. The coordinator will be free to make commit-  
15 ments of funds. The executive committee of the RAG must be in-  
16 volved in projects between \$1000 and \$2500, and anything costing  
17 more than \$2500 will be evaluated by the whole Regional Advisory  
18 Group.

19           They need to develop a program. I think they can.  
20 The coordinator comes through, on paper at least -- I have not  
21 visited there -- he seems so potentially attractive that I hope  
22 that he is used in site visits and brought in here to head-  
23 quarters and oriented well and supported by staff. I believe  
24 they need help from good regions in setting up their processes,  
25 but I am kind of excited about what they have the potential for

1 doing.

2 My recommendation, therefore, is strongly for  
3 approval of this planning application at the level requested,  
4 with continuation of the one tripartite project for the remain-  
5 ing year of this project, the coronary care unit, nurse training  
6 and other training activities.

7 The secondary reviewer, Dr. Ancrum.

8 DR. ANCRUM: Well, only having the same material that  
9 Dr. Schmidt reported on, there isn't too much that I can add to  
10 it. By and large I concur with all the things that he said  
11 about the program.

12 Looking at the time that they have had to plan and  
13 develop potential programs, they have done a fairly good job  
14 on it, and I think with realistic approaches. When I first read  
15 it, I had questions about the small feasibility studies for  
16 developing the programs, but then after reconsidering the man-  
17 power available and the population characteristics and density,  
18 that this probably was the best way to go about it.

19 In terms of their minority structure, they seem to be  
20 moving toward this direction. They have a small staff now  
21 both for their RAG and for their core staff, and they do have  
22 two Indians, I believe, on the core staff. And they are making  
23 an attempt to get other minorities involved in the program.

24 DR. SCHMIDT: Thank you. Would you second the motion  
25 that was made?



1 DR. ANCRUM: Yes, I'll second it.

2 DR. SCHMIDT: The motion is seconded. Are there  
3 questions, comments?

4 Bill.

5 MR. HILTON: I don't see any mortality data on this  
6 region, but I assume with the emphasis on coronary care, that  
7 would be the major concern of this region? There are no other  
8 area focuses that --

9 DR. SCHMIDT: I don't believe that's entirely accurate  
10 This project is a hang-over in a way from the early days a  
11 couple of years ago when these were the things to do. It was  
12 really the one attractive type of regionalization type of getting  
13 across the State type of project that was mounted in South  
14 Dakota, and was considered to be a very good thing to do. And  
15 it has been supplying a great need for the hospitals in South  
16 Dakota to at least get nurses in that know what to do in certain  
17 emergency situations. But this is really not their top need or  
18 their top priority, which they have given, at least initially,  
19 as emergency health services. You see, this is a planning  
20 application, and they will be coming in with the sorts of data  
21 that will back up their program in a year when they apply for an  
22 operational program. So this is not even in an operational  
23 status as yet.

24 SISTER ANN JOSEPHINE: Dr. Schmidt, I wonder if  
25 Harold might want to comment from staff.

1 DR. SCHMIDT: Harold made a most recent visit out  
2 there. Harold?

3 MR. O'FLAHERTY: I would only echo the sentiments  
4 that have been expressed here, particularly with respect to the  
5 coronary care unit nurse training project. This was the rem-  
6 nant left over from the bi-State region, and it has been the  
7 major entree into South Dakota at this juncture in giving them  
8 some continuing visibility. The program has put together what  
9 appears to be a good staff. They have set direction. They have  
10 set a somewhat unique approach to planning which you may find  
11 interesting in that they have established what they call the  
12 problems in delivering health care. And related to these  
13 problems is the resources that will be necessary to augment  
14 present facilities and resources in order that the present  
15 delivery system may be enhanced. And it may be more capable  
16 of providing better health care.

17 So they are extremely sensitive to the needs of the  
18 health care system. They are working consistently with them.

19 Given the fact that Dr. Lowe came on board September 1, they  
20 are moving systematically, albeit deliberately, to develop a  
21 three-year plan that is reflective of the needs of the region  
22 with a couple of major programmatic thrusts that have been  
23 reduced to time phase objectives which would include the  
24 terminal points for evaluation. This is the kind of consulta-  
25 tion and guidance we have been providing them. This is the

1 type of thing they see to be their need to develop real pro-  
2 grams instead of a conglomerate of disparate projects.

3 DR. SCHMIDT: Thank you.

4 Mr. Parks.

5 MR. PARKS: I wanted to get some clarification on a  
6 few things. Dr. Ancrum, I think, according to the report I  
7 have here, there are two Indians on the Regional Advisory Group  
8 and none on either core or project staff, unless there has been  
9 some change.

10 I think -- well, let me ask a question. Is there  
11 some reason why the university medical school is the total  
12 source of personnel for this particular project?

13 MR. O'FLAHERTY: Do you mean, sir, the program staff  
14 or coronary care unit project?

15 MR. PARKS: The program staff for personnel.

16 MR. O'FLAHERTY: In fact, they have not really been  
17 the total support. They have brought on some people that have  
18 heretofore not been associated with the university. The  
19 director principally was the assistant commissioner of health.

20 We have addressed this issue with them, of the  
21 minority group interests, and you may find this interesting, that  
22 Mr. Abel Redfish, who is a member of their Regional Advisory  
23 Group, of the Sioux tribe, has been recently appointed as the  
24 chief executive officer in the Governor's cabinet for Indian  
25 affairs. I had the occasion to spend some time with him

1 personally two or three weeks ago in South Dakota, and he feels  
2 that the region is somewhat sensitive to the needs of the  
3 Indians. But he is preparing for me his own independent assess-  
4 ment of the health care status and sensitivity of this program  
5 and other related programs to the needs of Indians.

6 MR. PARKS: That's sort of like the black that they  
7 appoint to a government position who is in charge of the black  
8 problem. He certainly should address it in a way that is going  
9 to be salutary for whatever is going on.

10 But my question is: You tell me, for example, that  
11 Dr. Lowe is connected with, what was it?

12 MR. O'FLAHERTY: State Department of Health.

13 MR. PARKS: He is listed her as being affiliated  
14 with the University of South Dakota.

15 MR. O'FLAHERTY: They're the grantee.

16 DR. SCHMIDT: There's a chance for confusion here.  
17 This is a two-year medical school. They do not have clinical  
18 departments. The people that get engaged in the projects, be-  
19 cause the medical school is the grantee, and pays them, get  
20 listed -- and I believe the problem is that these are listed  
21 as being associated or affiliated or something with the school,  
22 but there really isn't a clinical school, and I believe that  
23 the impression that's being given these are all from the school  
24 is incorrect by the table that you're looking at.

25 MR. PARKS: Is that right? Then this is inaccurate.

1 MR. O'FLAHERTY: Yes.

2 MRS. KYTTLE: Mr. Parks, it's that the university  
3 is the grantee, and when these people join this program they  
4 become the employee in that light of the university, because  
5 the university receives the funds and pays them, and therefore  
6 in that sense they become an employee of the university.  
7 I think Jerry Gardell could probably give you --

8 MR. PARKS: Is it that the program is not a body  
9 corporate politic. Is that what you're saying? And the uni-  
10 versity is and handles it for payroll purposes?

11 MRS. KYTTLE: Yes. And that's why that column  
12 comes up listing them as affiliated with the university, because  
13 indeed they are for payroll purposes.

14 MR. PARKS: Okay. Then your form should be modified,  
15 I think, to reflect that kind of thing.

16 DR. SCHERLIS: Look at the front. You will see that.

17 MRS. KYTTLE: That is not to say, Mr. Parks, in some  
18 programs there are people who are giving x percent of their  
19 time to RMP.

20 MR. PARKS: Well, my question has been answered.  
21 And that is that there is a reason why the core staff is  
22 listed as university personnel, which was my question.

23 The next question that I would want to address goes  
24 to a comment that Dr. Spellman mentioned yesterday, and that  
25 was the fact that a sick physician was a sick provider. And in

1 the report of the principal reviewer, the suggestion was that  
2 there was an adequate and substantial consumer participation on  
3 the RAG. And I would like to know just how that's determined.

4 DR. SCHMIDT: I am not sure I understand the ques-  
5 tion.

6 MR. PARKS: I believe you gave a figure --

7 DR. SCHMIDT: Yes, 21 of 41 people on this body that  
8 serves both CHP and RMP are listed as consumers.

9 MR. PARKS: I was wondering how you determined that  
10 they were consumers. When I see categories of representation,  
11 I am not able to just gather how that is determined. For  
12 example, we have the sales manager for the Black Hills Clay  
13 Products, and he is listed as a public member. Is that a con-  
14 sumer? And the retired banker who is a public member. And  
15 then the retired Indian agent. I take it these are consumers.

16 DR. SCHMIDT: The CHP has rules about determining  
17 and guidelines for determining consumers or public members, and  
18 we accepted their review and designation of this.

19 MR. PARKS: The reason why I asked was because in  
20 scanning this, there is an almost direct connection with what  
21 in an urban area would be called a board of trade. For example,  
22 the retired farmer, it turns out, is listed as the public member,  
23 but he is the President of FEM Electric Association, Director  
24 and Past President of the Rural Electric Association, and so on.  
25 It goes down in here. For example, there's a farmer here who

1 is listed as a public member. He's the chairman of the Miner  
2 County Board of Commissioners.

3 I am just looking in terms of so-called programmatic  
4 direction with respect to attention upon under-served people  
5 and populations, whether in fact you have a "consumer" that is  
6 representative of that group.

7 DR. SCHMIDT: I looked through this, and my answer  
8 to this, being quite familiar with South Dakota, is that the  
9 answer that I accepted was to look at where these people are  
10 from. And he is chairman of the Miner County Board of Commis-  
11 sioners, and in Miner County the Chairman of the Board of  
12 Commissioners is someone who can read and write and has some  
13 free time, and so on, from his farm. He's in Carthage. And  
14 if you look at the geographic distribution of these people,  
15 they are from Bell Fourche and Mission and Carthage and Rapid  
16 City and Brookings and Phillip and Mitchell. They are well-  
17 distributed people across the State.

18 MR. PARKS: The reason I raise the question is that  
19 a program in this stage of development which is planning need  
20 not get into an operational or formalized state by a body  
21 like this condoning the development of the processes which we  
22 find in older and more sophisticated programs, to be now in a  
23 state of rigor mortis concretized. For example, the question  
24 about your minority involvement ought to be raised, and it  
25 ought to be monitored very carefully while this is in the

1 planning stage.

2 With respect to the composition of the RAG, it ought  
3 to be examined very carefully as to the genuineness of the  
4 interests that are supposedly represented there.

5 I think we would be doing, I would say, great  
6 honor to the purpose for which we are serving here if, in this  
7 planning stage, we did work with them to prevent error rather  
8 than a year or so hence, looking at them with a microscope  
9 saying that they have --

10 DR. SCHMIDT: I certainly agree with you and would  
11 accept your statements as something that should be conveyed  
12 back to the region. I can't probably put my finger right now  
13 on why I was led by the reading material to believe that they  
14 are very aware of the minority representation problem that they  
15 have. There are positive statements that they will involve  
16 minority groups in the workings of the program. I think it's  
17 in the coordinator's letter.

18 DR. ANCRUM: It was in some of the material I re-  
19 ceived, and I don't have it right now, that this was something  
20 that had been discussed and there were efforts being made to  
21 correct this.

22 Also, some of the things you brought out about the  
23 participation, I was going to point out about the large rural  
24 population and the inability of some of these people to par-  
25 ticipate because of this. I don't know very much about South



1 Dakota.

2 DR. SCHMIDT: I hesitate to say why I know a lot  
3 about South Dakota because I am ashamed of it. Why I know a  
4 lot about it, I spent many years hunting pheasants there, and  
5 now there aren't any pheasants left, and I left lead scattered  
6 all over the State.

7 DR. KRALEWSKI: Do you have a lead poisoning problem  
8 there?

9 MR. O'FLAHERTY: Dr. Schmidt, at their recent  
10 April 13 meeting of the Regional Advisory Group they revamped  
11 the by-laws governing the program. They have specifically  
12 delineated groups from which consumers would come. They have  
13 established a nominating committee which would be comprised of  
14 a majority of consumers. The same nominating committee will  
15 now appoint providers or recommend to the Regional Advisory  
16 Group that providers be appointed in that manner. They were  
17 sensitive to our recommendation that this be taken out of the  
18 realm of the speculative and put in the realm of performance to  
19 meet these kinds of specifications.

20 DR. SCHMIDT: All right, are there any other com-  
21 ments, questions?

22 MR. HILTON: This is not with respect to the  
23 motion, but I wanted to mention, before I forget: Lorraine,  
24 do we have any guidelines, or anything asked for in any of the  
25 forms, to give us any idea what percentage of time is given to

1 RMP? I know on some of the sheets, in the kind of situation  
2 that was discussed earlier, the possibility of there being some  
3 confusion of the affiliations of the granting organization.

4 DR. SCHMIDT: Yes, the budget sheets list the people  
5 and their percent of time.

6 MR. HILTON: And the other concern I just want to  
7 kind of amplify -- and I notice it has come up with other  
8 regions -- the definition of consumer. I think what many of us  
9 feel a real need for is to have representative consumership,  
10 that is economic cross-section of each area, and a tendency to  
11 elect as chairman of the board -- and in not all instance is it  
12 just the guy who can read and write. In the larger urban set-  
13 tings it becomes a guy who is very far removed from the popula-  
14 tions that are supposedly being served in some indirect way  
15 through all this. And I wondered if there were any guidelines,  
16 through CHP or RMPS, that specifically designates -- I don't know  
17 how you would go about it, by annual income or what have you --  
18 that there be a cross-section in the consumer body.

19 DR. SCHMIDT: There have been guidelines promul-  
20 gated for choosing RAG members. I think probably historically  
21 people who were chosen were non-physicians with clout. And we  
22 have been moving away from that in many of the programs. But  
23 the criticism is a very valid one. It's the same thing that is  
24 being faced all over the country by hospital boards of trus-  
25 tees that generally have corporation presidents on them and

1 nobody from the community on them. This is changing, and I  
2 think this will change, too.

3 All right. Are there other comments?

4 I would interpret most of the things that have been  
5 said as being advisory to the region and concerns. I would  
6 ask before putting the question to the vote whether anyone was  
7 concerned with the level of funding or giving them this amount  
8 of money. It's a moderate amount.

9 Unless there's strenuous objection, I'll call the  
10 question.

11 All in favor please say "aye."

12 (Chorus of "ayes.")

13 Opposed, "no."

14 (No response.)

15 That concludes the formal part of the actions of  
16 this committee. It is now 12:30, and I think we should decide  
17 what we want to do at this point. There are two or three things  
18 that we ought to do, I think. Bill Mayer left us with a list  
19 of two or three things. One we have talked about during the  
20 morning. It's the emasculation issue that I think probably may  
21 not be as vital an issue as before. There were questions that  
22 Mr. Parks had relating to council feedback, and there was the  
23 issue of a chairman for this committee.

24 If the committee wished, Mr. Dick Clanton could make  
25 a report to us concerning civil rights. This could be left to

1 the next meeting. So we could go for a little while and then  
2 break up. We could have lunch and come back for a little while.  
3 We could stop now.

4 What is the desire of the committee?

5 DR. SCHERLIS: I would suggest we remain here and  
6 finish. I don't think that there is that prolonged a discussion  
7 required unless it is the view of the chairman otherwise.

8 Is Dr. Margulies free?

9 DR. PAHL: I think he had to leave for an NIH  
10 meeting.

11 DR. SCHMIDT: Harold told me earlier he would be here  
12 until about noon, and then I missed him when he got up and left.  
13 So that I can't answer that.

14 DR. PAHL: Let's call upstairs and find out.

15 DR. SCHERLIS: I would suggest maybe we could stay  
16 and finish. Is this an open session or executive session or  
17 what?

18 DR. HESS: Before staff leaves, there is an issue,  
19 a question I would like to raise, apart from these three issues.

20 DR. SCHMIDT: The floor is yours. Would you talk  
21 into the mike, please.

22 DR. HESS: We have for a number of years now been  
23 placing emphasis on the gathering of evaluative data that would  
24 assist in decision making. And one of the problems which I find  
25 in looking at the applications and progress reports, and so on,

1 is that that data is almost uniformly missing. We see des-  
2 criptions of the process, and summary statements that evalua-  
3 tion is being carried out, but very little of the results of  
4 that evaluation. And I am wondering if staff might give some  
5 attention to seeing that that data appears in the applications  
6 and that selected parts of it might appear in the summaries we  
7 get so we can begin to get a little better feel of some of the  
8 outcomes of the results of all the money we are putting in. I  
9 realize I am asking a difficult question. It's a difficult  
10 request. But I think that all the years we have been talking  
11 about, we ought to begin to see some results surfacing here.

12 DR. SCHMIDT: Dr. Margulies is coming down and will  
13 be available until 1:10, is the answer to that question.

14 Does the staff or anyone have a comment, or is there  
15 supplementary comment to what Joe said?

16 Pete.

17 MR. PETERSON: I think staff has been concerned with  
18 this same problem. It is a long-standing problem. It doesn't  
19 even get around to what I think you're talking about in the way  
20 of evaluation. So for example, recently we have been looking,  
21 just as an activity which is an intermediate step, and we find  
22 that these are often lacking in and of themselves.

23 It is a concern at the regional level, too -- at  
24 least in some of the regions they feel that some of the evalua-  
25 tion activities that have been undertaken don't allow themselves

1 to be reflected adequately in the present application. On the  
2 other hand, a number of regions have begun as a course of sub-  
3 mitting some of that as a supplemental to the application.

4 I think from looking at it, Dr. Hess, some of it, at  
5 least some of the more recent ones, I think it's a problem that  
6 has to be worked at and is one -- and I know you and I have  
7 talked about this a little -- that particularly in relation to  
8 triennial review in connection with site visits -- and I go back  
9 to, for example, the site visit you and I participated in, the  
10 Greater Delaware Valley -- if you really highlight it in those  
11 instances, I think often we are faced with a lack rather than  
12 the presence of it.

13 DR. HESS: My point is that if we continue to be  
14 content to just having the process described and not seeing the  
15 results, that it means that we continue to have shoddy evalua-  
16 tions. On the other hand, I think perhaps there is some data  
17 which is available which may be worth seeing, but we never  
18 asked for it. It is not required. And I am just suggesting we  
19 begin to require the inclusion of outcome type evaluation in  
20 fact on health care in the applications.

21 MR. PETERSON: One of the things we have discussed  
22 in connection with the present application form is the possi-  
23 bility for some other additional information. One specific,  
24 and it is only one of several things, is perhaps the desirability  
25 of seeing, on activities that have been constantly completed, at

1 least with the RMP supported and placed out, something in the  
2 nature of a termination report some time after the activity  
3 has really been completed that would provide some of the infor-  
4 mation I think you are talking about, as well as information  
5 which I think is critical in terms of the sustaining of an  
6 activity once RMP support has been phased out.

7 That is one of the few areas in which I think we can  
8 present some fairly hard data. That doesn't tell you anything  
9 about the impact of the activity, but at least it begins to  
10 speak to the success, whether it is a categorical activity or  
11 something quite comprehensive, success with which a region can  
12 initiate efforts and can see them carried on within the  
13 regular health care planning.

14 So I think there are points with which we can begin  
15 to present some valid data, and I think this has been an area  
16 in which the committee has begun to make gross judgments, the  
17 inability to get out from underneath activities. It doesn't  
18 say anything about how meritorious they are.

19 DR.HESS: Well, I just feel we don't --

20 DR. SCHMIDT: Joe, the stenotypist simply cannot  
21 hear you. Would you speak into a mike, please?

22 DR.HESS: I just want to reemphasize that if we  
23 don't start insisting on seeing it, I don't think we are ever  
24 going to get it. I just feel that we've got to take a much  
25 firmer stand on this than we have in the past.

1 DR. SCHMIDT: All right. Other comments?

2 I would guess that the committee would agree with  
3 you in those comments.

4 All right. Does anyone wish to pursue the issue of  
5 the charge to the committee or the actions of the committee,  
6 the constraints on them? Are we agreed, Harold, that there will  
7 be some clarification of these issues coming from your office  
8 or staff?

9 DR. MARGULIES: Yes.

10 DR. SCHMIDT: Mr. Parks, you had some queries.

11 MR. PARKS: I had a request for answers. At the last  
12 meeting of the committee, we formulated several questions which  
13 were supposed to have been put to the council. And I have not  
14 been informed that the council either entertained them or acted  
15 on them. I do not have the specific articulation of them, but  
16 the one that I'm particularly concerned about did have to do  
17 with civil rights.

18 And my questions are, first of all, did the council  
19 receive it, did they act on it and, if so, what action? What  
20 was the result.

21 DR. SPELLMAN: I wasn't at the last meeting. What  
22 was the question, more specifically?

23 MR. PARKS: There should be a stenotype report of the  
24 last proceedings, and it might be well and helpful, I would  
25 think, if the proposition was stated as it was put to council.



1 DR. SCHMIDT: I'm afraid I can't be helpful because  
2 I was not at the last meeting myself.

3 DR. MARGULIES: We had intended to bring this up on  
4 the agenda yesterday, but Mr. Clanton couldn't be here. We  
5 have asked him to be here today, and I think he can be respon-  
6 sive.

7 MR. CLANTON: Let me just say at the outset that  
8 since assuming the position of EEO officer for RMPS, I share  
9 the concerns that I've heard in the past few minutes of some  
10 of the committee members. As I look at the ethnic profile of  
11 many of our RMP's across the country, as I look at the profile  
12 of our program staffs, of our Regional Advisory Groups, and of  
13 our local advisory groups as well as committees, I certainly  
14 share the concerns that I've heard in the past few minutes.

15 Since you last met, the RMPS EEO office has been  
16 reorganized. We have broadened the scope of activities to in-  
17 clude addressing the issue of civil rights in the RMP's. We  
18 are still in the process of recruiting staff, and we are  
19 hoping that in the not too far distant future we will have our  
20 full complement of staff.

21 We did get involved -- I got involved -- at the  
22 point when I was asked to make a presentation to the National  
23 Advisory Council to reflect the committee recommendation at  
24 your last meeting. I talked to the council in terms of civil  
25 rights compliance of grantee institutions, the requirement to

1 complete the Form 441, which guarantees in so many words that  
2 a grantee will be in compliance with the Civil Rights Act of  
3 1964.

4 In addition, I pointed out to them some of the  
5 activities which we would be proposing in the coming year.

6 I also presented them with your recommendations, and  
7 I now read that to you.

8 "The review committee recommends to council that  
9 council establish a policy in which they instruct those par-  
10 ticipating in the review process, whether that be site visit or  
11 this review activity, that a special interest be given to and  
12 attention to the issue of compliance of the individual regions  
13 with the Civil Rights Act. And that as a part of the review,  
14 that documentation occur in each and every instance that has in  
15 fact occurred in the review process. And if in fact the re-  
16 viewers felt that there was some question of compliance, that  
17 they would have the right and responsibility to request that  
18 appropriate review of that issue occur."

19 This was presented to the National Advisory Council.  
20 The council endorsed this recommendation and approved it, which  
21 I feel gives us the leverage that we need to go about the  
22 business at hand.

23 In addition, I would call to your attention the  
24 RMPS affirmative action plan which, incidentally, is considered  
25 in many circles as the best affirmative action plan in this

1 agency. And incidentally, I will be mailing copies of the plan  
2 to each of you. I call to your attention page 40 of the plan  
3 which deals and addresses the issue of civil rights in the  
4 Regional Medical Programs, and I read to you some of the action  
5 steps:

6 "1. The Director, RMPS, will appoint a study group  
7 composed of, but not limited to, representatives from the  
8 Operations Division, the Youth Advisory Council, RMPS Minority  
9 Caucus, RMPS Women's Group, Office of Communications and Public  
10 Information, the EEO Council, and resource people from outside  
11 of RMPS, to define the responsibilities for implementing and  
12 monitoring an EEO program in the 56 RMP's."

13 This is one of the activities which we will be about  
14 in the very near future.

15 "2. Site visit teams will be constructed in such a  
16 manner that the objectives listed above are dealt with on all  
17 site visits.

18 "3. Site visit reports will include a comprehensive  
19 section regarding progress toward effective implementation of  
20 RMPS EEO goals and objectives.

21 "4. The Director, Operations Division, will review  
22 the EEO Section of the site visit report, and quarterly report  
23 to the Council on the EEO progress in the 56 RMP's."

24 Again, I say the Director, Operations Division.

25 "5. After the completion of the study group's

1 report, an abridged version of the RMPS affirmative action  
2 plan will be distributed to the RMP's.

3 "6. The Office of Communication and Public Informa-  
4 tion will regularly distribute EEO information to the RMP's."

5 Now, this plan has the endorsement of top management  
6 at the agency level, and has been endorsed by the program  
7 director. And we feel this, in addition to the council approval  
8 of your recommendation, gives us the leverage that we need to  
9 go about the business of EEO within the RMP's.

10 I would close by saying that we solicit your support,  
11 we solicit your suggestions and your recommendations in improv-  
12 ing our efforts here in helping us in these efforts. We will  
13 need your help, certainly. We are in room 11A16. If you want  
14 to write to us individually, feel free to do so. Call us. We  
15 need your help in the effort.

16 DR. SCHMIDT: I would like to request that copies of  
17 the plan be sent to review committee members. I think it would  
18 be imperative we be familiar with this.

19 MR. HILTON: May I ask what is the expected size of  
20 your staff?

21 MR. CLANTON: The staff will be three people, as it  
22 currently stands. Of course, we are hoping for more.

23 DR. SCHMIDT: All right. Are there questions?

24 Mr. Parks.

25 MR. PARKS: Mr. Clanton, you have just announced

1 something to us. It would be helpful to me if you could get  
2 the exact wording of the action of the council. That would be  
3 very helpful to me.

4 The other thing that I would ask, beyond the announce-  
5 ment you have just made here today, has this been brought to  
6 the attention of the staff that is involved with these particular  
7 programs? That is the first question.

8 Secondly, will it be in the immediate future com-  
9 municated to the various RMP's so they would be on notice.

10 Third, could you provide us with the information  
11 pertaining to the various civil rights acts and the provisions  
12 which HEW has published in the Federal Register with respect  
13 to programs funded by HEW which are found not to be in compli-  
14 ance with the several civil rights acts and regulations.

15 MR. CLANTON: Gladly.

16 MR. PARKS: Thank you, sir.

17 MR. CLANTON: In answer to your second question,  
18 which had to do with communication to the staffs of RMP's, we  
19 have begun to interact with several of the RMP's, not all, to  
20 date, several who have indicated an interest in recruiting in-  
21 dividuals for their program staffs. We did distribute to  
22 the council members, as well as a number of consultants to the  
23 program, copies of the affirmative action plan. A number of  
24 the RMP's now have the affirmative action plan. As a matter  
25 of fact, as the representatives from the program staffs come

1 in to visit us, we provide them on the spot with a copy of the  
2 plan. So there has been some communication to some of the  
3 RMP's, not all.

4 DR. SCHMIDT: Bill.

5 MR. HILTON: I was simply going to suggest, Mr.  
6 Chairman, that as a national commitment, and as the opportunity  
7 now presents itself with the unfortunate departure of four of  
8 our members, we possibly ought to consider those areas that  
9 are served by RMP where we have large Spanish-speaking popula-  
10 tions in the country that are served by RMP's, I would hope  
11 whoever it is that replaces those of us who retire or pass on  
12 or something would consider having Spanish-speaking representa-  
13 tion on the review committee in the future.

14 MR. CLANTON: It might be interesting for you to know  
15 your request has gone forward for Spanish-speaking representa-  
16 tion on this committee at this point. I believe for some  
17 reason or another it has been tabled. But the request has  
18 come from the program to include Spanish-speaking representa-  
19 tion on this committee.

20 It would seem to me a statement from the committee  
21 would certainly help us in this effort, some kind of a state-  
22 ment to the agency.

23 DR. SPELLMAN: I submitted a name this morning of a  
24 Spanish-speaking representative from the University of Puerto  
25 Rico who I think would make an excellent addition.

1 DR. MARGULIES: I think the word "tabled" is  
2 probably a little misleading, Dick. What we have done is to  
3 provide names of people who we thought would very well serve  
4 the interests of Spanish-speaking people, which is not just a  
5 single interest. If you have someone from the Southwest United  
6 States, that's not the same as a Puerto Rican from New York,  
7 or not the same as a Mexican-American from California.

8 We have run into a conflict of priorities for the  
9 time being which we simply have to sort out, because we also  
10 have to meet geographic needs, we have to meet the legitimate  
11 and very pressing needs of representation by women, and there  
12 is a requirement we have representation by people under the  
13 age of 30. We also have a requirement to try to find some  
14 people who have certain kinds of professional skills and educa-  
15 tional skills and educational interest to balance the whole  
16 committee structure.

17 So it's a matter of trying to maneuver through that  
18 and still come up with what we need. I recently had a rather  
19 acid discussion on a related subject coming out of a Chicano  
20 conference -- and incidentally, we are in the process of  
21 sponsoring another one -- in which there was an insistence  
22 that people dealing with Chicano affairs on committees be com-  
23 petent to deal with them, and that there should be representa-  
24 tion from the Chicanos on all their councils.

25 Some bright person in HSMHA said that's fine but we

1 must have evidence of competence.

2           And I said, "Well, that's all right, we'll have the  
3 same evidence of competence we require for all of our com-  
4 mittees, and what is that?"

5           Well, there wasn't any answer because we don't re-  
6 quire that kind of thing in migrant health councils, and so  
7 forth.

8           I suggested that one of the better qualifications  
9 for sitting on a committee to deal with Chicanos was to be a  
10 Chicano, and I continue to believe that's a pretty good idea.  
11 Interestingly enough, I met an argument on that one as well.  
12 I really did. I had a very severe argument over that.

13           But that's what we are trying to get done. I think  
14 we will succeed in getting that kind of representation on the  
15 committee. I cannot speak for the council. That gets into  
16 another area.

17           DR. SCHERLIS: How are you progressing as far as  
18 replacements of this committee are concerned?

19           DR. MARGULIES: That's a part of the whole thing.  
20 What we'd like to do, of course, is maintain the high level of  
21 competence that the committee has. And when you have people  
22 like Bill Mayer leaving, you would like to have a replacement  
23 somewhere near his qualifications. And then when you try at  
24 the same time to meet the other requirements, the choices get  
25 constricted and it becomes a matter of priorities. So far as



1 I am concerned, representation of women and of Spanish-speaking  
2 or Spanish surname people is the top priority, regardless of  
3 other factors, but we have to deal with all of them. I think  
4 we can manage all of them, but it requires a very careful kind  
5 of analysis.

6 MR. HILTON: Is it your judgment, Harold, that we  
7 need to make a motion officially on this matter, or could it  
8 be left at a suggestion?

9 DR. MARGULIES: I think we understand the committee's  
10 desires in this. As a matter of fact, it is a part of the  
11 official policy of HEW, and as I'm sure Mr. Parks can tell you,  
12 it also represents civil rights legislation, so that I think  
13 we can pursue it along those lines. It is really more a matter  
14 of sticky process than anything else.

15 On this subject, if you would like any further  
16 comment, Joe de la Puente -- I don't know whether Jessie is here  
17 or not -- but the two of them have been dealing with this par-  
18 ticular issue, and we have set up a number of activities outside  
19 of review committee and outside of RMP to foster our involvement  
20 with the Spanish surname group.

21 MR. DE LA PUENTE: I must say our activity has been  
22 very intense since the recent Southwest conference for Chicanos  
23 in San Antonio, which was sponsored by Dr. Du Val's office and  
24 paid by RMP, partly.

25 As a result of this conference and a positive response

1 for this conference, several activities took place.

2 First and foremost, we are going to have a conference  
3 north of Albuquerque run by the Cultural Awareness Center of  
4 the University of New Mexico. In this conference we will have  
5 all the coordinators of the seven Southwest States, the nine  
6 coordinators of the different areas in California and appro-  
7 priate staff, and pertinent staff here in RMP. We are looking  
8 forward to this conference. I think it's very timely.

9 From then on, there will be several activities that  
10 will take place concerning the effective participation of  
11 Chicano consumers in the decision-making and program planning  
12 throughout those regions. We are looking forward to this  
13 activity, and we are working very closely with Mr. Chambliss  
14 in these efforts, because that division concerns itself not  
15 only with the minorities in the Southwest, the Spanish-speaking  
16 people in the Southwest, but also the Spanish-speaking people  
17 throughout. And we are also working very closely with an urban  
18 group that we will have some urban health conferences in which  
19 these issues are going to be arranged. As a matter of fact,  
20 Mr. Wood from the New Jersey RMP is going to be at the confer-  
21 ence in New Mexico as the liaison with the urban group. So  
22 things are starting to percolate and we are looking forward  
23 to it.

24 DR. SCHMIDT: Thank you.

25 Jerry, did you have a comment?

1 DR. BESSON: Yes, and I hope my comments are mis-  
2 understood. I've been a critic so often of the way things are  
3 done, it is delightful to see the alacrity with which there is  
4 a response to this comment made at the last meeting, and I  
5 must say, since I'm not going to be here again, that although at  
6 this end of the table I have appeared to be critical of RMPS  
7 and its seeming lack of responsiveness, I would like to say that  
8 that is certainly more than balanced by the sense of responsive-  
9 ness that I have felt emerging at this meeting. And it was  
10 probably there right along.

11 DR. SCHMIDT: All right. Thank you. Are there  
12 other questions or reports? I have an uneasy feeling that  
13 this was one of a number of questions that were posed, Mr.  
14 Parks, is that correct?

15 MR. PARKS: I don't recall specifically what they  
16 were, but as I recall, there may have been another question. It  
17 wasn't on this particular issue, but as I recall there was at  
18 least one other question that I think was referred to. I  
19 don't recall what it was.

20 DR. SCHMIDT: Can staff help here? The discussion  
21 at the last meeting.

22 DR. MARGULES: I think what happened is there was  
23 a very good discussion about it, and unless I am confused in my  
24 memory, Mr. Parks, there was a movement in one direction which  
25 was then altered to produce the statement which went from here

1 to council, and you may be thinking about both. But I am  
2 really not sure, but that is what our record shows.

3 Maybe I should comment to you about what our hopes  
4 are for continuation of chairmanship and of vice chairmanship  
5 of this committee. What I would like to do, as long as we are  
6 able to keep him active on the council, is have Mack Schmidt  
7 continue as chairman, and John Kralewski as the vice chairman  
8 with the understanding he will assume the role at the time Dr.  
9 Schmidt finds he also succumbs to time in the rules and regu-  
10 lations of the committee membership.

11 DR. KRALEWSKI: That calls for comment. In keeping  
12 with our institution here, I would say that in that statement  
13 there is some good news and bad news.

14 (Laughter.)

15 I'm not sure which is which.

16 DR. SCHMIDT: All right. My leading instinct is  
17 that we are coming to closure here.

18 John.

19 DR. KRALEWSKI: If we are off of that topic, I have  
20 one other question I wanted to raise. Maybe you talked about  
21 this yesterday morning when I wasn't here, and if you did,  
22 please forgive me. But since you are going to be reviewing  
23 some substantial applications separate from this review commit-  
24 tee, such as the emergency health service programs, et cetera,  
25 what mechanisms have you developed so that this committee will

1 be on top of the results of those reviews when we look at  
2 regions and look at their total program and try to come to  
3 grips with a total funding package.

4 DR. MARGULIES: Very briefly, we did discuss this  
5 at length yesterday. What I explained was that we had to set  
6 up a special review mechanism for both of these activities.  
7 In other to meet that requirement, we established a review  
8 committee for each of them made up of a combination of members  
9 of this committee and members of council, and these will be  
10 processed in time to go through the council. The results will  
11 immediately come back to you so you know what action took place  
12 and it will become part of the record of what is going on in  
13 each Regional Medical Program.

14 DR. SCHMIDT: All right. Sister Ann.

15 SISTER ANN JOSEPHINE: I would like to follow through  
16 on a comment that Dr. Hess made earlier, and that is on the  
17 material that is provided us for review.

18 The reason I feel that if we could develop a more  
19 meaningful format of information we would possibly be able to  
20 make better judgments and ask more correct questions is because  
21 recently at the hospital I am affiliated with we developed a  
22 patient drug profile, and it is interesting now that the  
23 doctors look at the drug profile. It is making an impact on  
24 the ordering of drugs for the patient.

25 So I feel if we could develop -- and maybe staff

1 needs to brainstorm this, and we have capable people on the  
2 staff who have expertise in this area-- the kinds of profiles  
3 that will be meaningless at this point in time when we are not  
4 only identifying the programs as A, B and C level, but we are  
5 having an interesting opportunity where South Dakota, of course,  
6 doesn't have the problem of large programs, where there are  
7 conflicts between universities and schools of medicine, such  
8 as we find, for instance, in Ohio where the conflict is between  
9 Western and Ohio State. But we have a program that is still  
10 in the planning stage that has some of these obscuring areas re-  
11 moved from the picture, and whereas Mr. Parks indicated we can  
12 begin to concentrate and not keep on repeating the problems that  
13 we see are emerging in other programs and have caused problems.  
14 And I think we are fortunate to have a staff, Harold, who has  
15 expertise in evaluation, and with this expertise will be able to  
16 give them the kinds of help that a program in a planning stage  
17 in moving toward an operational stage needs.

18           So I think that we are coming into a time when  
19 there are many very basic things we can begin to identify, maybe  
20 regroup and provide a kind of new viability to programs as we  
21 begin to look at a new direction, which is to insure the via-  
22 bility of the total program.

23           DR. MARGULIES: I would just like to make one com-  
24 ment about that which is in support but which also carries with  
25 it some very frank expressions of concern for our present

1 problems and problems that will persist. And these are in  
2 violation of my basic principle which is that there is no point  
3 in sharing my problems with you if you can't do anything about  
4 it; they're my problems.

5           Nevertheless, the pillaging of staff in all of the  
6 programs in HSMHA has been tremendous. We just put together  
7 a list of people who have been taken away from us. Of course,  
8 when someone takes someone away to do something else, he always  
9 wants the best possible person. So we have lost people on  
10 detail after detail. We have tried to remodel the system of  
11 review for the Operations Division so that their time is not  
12 totally consumed with the review process because the other  
13 thing we most want them to do is to serve as technical assis-  
14 tants and deal with the kinds of issues particularly which we  
15 just discussed, those which have to do with the interests of  
16 minorities, and those who are deprived.

17           So there is an extremely heavy demand on staff, and  
18 at some points in the game, as a management principle, we have  
19 to do some things better and some things less well.

20           I would be misleading you if I were to suggest that  
21 we are going to amplify very rapidly or in great depth some of  
22 the kinds of information which we would like to have in everyone  
23 of the programs. Instead, what we will have to do is manage  
24 this so we can concentrate as much as feasible on problem areas  
25 in the Regional Medical Programs with all the risks that that

1 entails, and I don't see any alternative. To suggest that  
2 we can do it all is to send this staff, which is sitting around  
3 here and some who aren't here, into a state of collapse because  
4 they work extremely hard.

5 I have to go over and negotiate with the National  
6 Heart and Lung Institute right now, and I see my companion is  
7 waiting for me to go, but before I do I would like to say again,  
8 without overstating it in any sense, that the people who are  
9 leaving this committee are leaving the committee with some  
10 holes that just can't be filled no matter how well we do.  
11 They are remarkably good contributors. It is going to change  
12 things permanently. I know that you have said things to them  
13 already, but whatever was said that was nice I support, and if  
14 you thought anything bad I don't support it. They go with my  
15 very deep thanks and with my blessings. And again my affirma-  
16 tion of what I said yesterday, we aren't really going to let  
17 them get away entirely.

18 DR. SCHMIDT: Thank you very much, Harold. We  
19 appreciate your time that you've spent with us these last two  
20 days.

21 Any closing comments? Jerry.

22 DR. BESSON: I'm sorry Harold left, and I really  
23 should not usurp his last word, but I did want to follow up  
24 on the comment Sister made and he responded to, because this is  
25 one subject that we have skirted around but haven't really



1 discussed, and I don't think it's appropriate at this time to  
2 get into a long discussion of it, but I would like to raise it  
3 for the review committee's consideration at a future time.

4           The sense of what I gathered that Sister has said on  
5 more than one occasion at this meeting is that we are some-  
6 times not asking the right questions, and that sometimes we  
7 become so involved in the trees that we are not looking at the  
8 forest. And this is something that has disturbed me a great  
9 deal about the way the RMPS seems to be operating currently.

10           About a year ago the National Center asked me if I  
11 would serve on a committee to evaluate the Center. And I was  
12 privileged to do so and it was an outside look by people who  
13 are not involved at all with the National Center. I know that  
14 the Arthur D. Little Corporation did such a study for RMPS  
15 about a year-and-a-half or two ago, and that was a remarkable  
16 document in many ways and probably formed some of the basis for  
17 the shift in direction of RMPS. It served a useful function but  
18 in many ways it was too ponderous to be helpful to the rank and  
19 file. The summary was very helpful. But I think that that  
20 kind of ongoing outside evaluation of RMPS is probably going to  
21 be continually necessary if RMPS can maintain its viable and  
22 responsive posture. I sense in many of the applications that  
23 we've discussed over the past two days, Northeast Ohio, Okla-  
24 homa, and I know even though we haven't talked about California  
25 that a recent action in the California Committee for Regional

1 Medical programs has for the first time created a breach be-  
2 tween the practicing physician, as represented by California  
3 Medical Association, and the entire Regional Medical Programs,  
4 in that California Medical Association Council, reaffirmed by  
5 House of Delegates, indicated to California Regional Medical  
6 Programs that they would only continue to cooperate with  
7 Regional Medical Programs if Regional Medical Programs stuck to  
8 its original charge, which was continuing education and cate-  
9 gorical interests, and did not begin to meddle in delivery.

10 Now, that may be symptomatic of what we're seeing in  
11 the statements of Dale Groom, perhaps, and in the statements  
12 of Charlie Hudson in Northeast Ohio and various places, which  
13 may not be quite articulated. But I think that it does repre-  
14 sent a potential problem for RMP and should be surfaced, this  
15 committee should be aware of its extent and the extent of the  
16 breach that may be developing, or maybe there was never really  
17 close communication with the practicing physician, as I some-  
18 times suspect, and this kind of information should be brought  
19 back to review committee so that in dealing with the individual  
20 regions and in dealing with the individual decisions that we  
21 have to make about the nitty-gritty, we can do it in the con-  
22 text of viewing the entire program as serving a national pur-  
23 pose. Is it on target? And if not, what are the impediments?

24 Unless we can do that, I think we can very often  
25 be wide of the mark and spend much of our time fruitlessly in

1 discussing details that may be totally irrelevant.

2           So I would suggest that this review committee, per-  
3 haps at later deliberations somewhere along the line, or perhaps  
4 they might consider presenting to council the notion of doing  
5 this on an ongoing basis for review committee and council's  
6 advice, to have an outside group -- maybe not as ponderous as  
7 Arthur D. Little -- but to have some outside group put itself  
8 in a position of continually evaluating philosophy, purpose,  
9 meeting of goals of the program nationally, rather than any  
10 individual area.

11           DR. SCHMIDT: I suppose this is akin to a lot of the  
12 universities that have visitors' committees, the same type of  
13 function.

14           All right. Other comments?

15           (No response.)

16           Are we ready to adjourn then?

17           All right. With great thanks, we will stand  
18 adjourned.

19           (Whereupon, at 1:15 p.m., the meeting was adjourned.)

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