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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
Thursday, 4 May 1972

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1 DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

2 PUBLIC HEALTH SERVICE

3 HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

4 REGIONAL MEDICAL PROGRAMS

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6 Review Committee

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

12 The meeting convened at 8:45 o'clock a.m., Dr.

13 William Mayer presiding.

14 Council Members Present:

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

24

25

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1 P R O C E E D I N G S

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

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

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

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

23 Harold.

24 DR. MARGULIES: Thank you very much.

25 The title of this presentation is "Present Shock."

1 There are a number of things I would like to go over with you,
2 but before I do and at the risk of saying the obvious, I would
3 like to comment on the fact that the end of the period of
4 activity of the four people who have been serving on the
5 review committee is a point of real concern for all of us.
6 I was just talking to Bill who confessed to something like
7 six years and six months with the Regional Medical Program
8 which should represent some kind of a badge of honor, purple
9 heart, or something of that kind or purple heart for each
10 year, but it is going to make a big change. And it is going
11 to be a notable loss when we see these very, very effective
12 people leave the committee.
13 And it does not mean, of course, that we won't
14 anticipate being able to call on them regularly as we have
15 with others who have served on both committee and Council.
16 And we don't expect to let them leave the program that
17 effectively.
18 I would like to bring you up to date on a series of
19 events which are not necessarily related, but all of which
20 have a heavy impact on our activities and on the Regional
21 Medical Programs.
22 First, let's start with the current legislative
23 interest which suddenly built into a point of great concern
24 and people realized that the Regional Medical Program
25 legislation along with just about every major legislative

1 program, legislative act, which supports programs in Health
2 Services and Mental Health Administration was up for extension
3 during the coming fiscal year. I think there are at least
4 14 major health legislative acts which have to be renewed by
5 June 30 of 1973. RMP is one of them.
6 I don't believe that the Administration has estab-
7 lished a clear position on the whole range of them, but it has
8 made it clear in the first response to Senator Kennedy's
9 bill that it hoped to address the legislation this time in a
10 much more inter-related fashion rather than having a separate
11 extension of Acts which have come to have a relationship with
12 one another, but were created at a different point in time
13 without that relationship clearly spelled out.
14 What did happen is that when Senator Kennedy intro-
15 duced his bill on Health Maintenance Organizations, he added
16 to it for purposes of opening the discussion the extension of
17 several of the legislative Acts. And Title IX for Regional
18 Medical Programs was one of them.
19 I believe that hearings are already underway and
20 will continue. I don't know the format in which they will be
21 carried out. There have been discussions inside HEW simply
22 leading up to what the legislative form of the RMP should be.
23 The coordinators independently have suggested certain legislative
24 bases for Regional Medical Programs so that this will have a

25 very clear-cut influence on what we do in the future.

1 The issues are all those which you have discussed
2 here in the review committee. They raise the questions of
3 how RMP relateds to comprehensive health planning. They
4 raise the question of the relationship of the National Medical
5 Programs to educational activities, to the implementation of
6 planning, to the categorical devices which have been a part
7 of RMP since its beginning, and to a number of other organiza-
8 tional issues which will probably carry the debate until well
9 after the election. I would be surprised if there is any
10 final action on our legislation until sometime after the next
11 Congress meets. But, of course, it is conceivable it could
12 be done in the present Congress. It is conceivable, but very
13 doubtful.
14 I also don't know how much the House and Senate
15 committees are going to call on other people to provide
16 testimony. And it is perfectly possible that if they have
17 not already, they may ask members of this committee to testify
18 regarding their recommendation on Regional Medical Programs.
19 While all that is going on, of course, there are
20 appropriation acts. We have had hearings before both the
21 House and the Senate Appropriations Subcommittees. They have
22 made every effort this year to complete the appropriations
23 actions prior to June. I don't know where the Senate stands
24 at this point, but the House has completed its actions.

25 What now is necessary is for the two chambers separately to

1 reach an agreement on what they believe the appropriations
2 should be to get those through the House and the Senate, then
3 to reconcile any differences.
4 The request on the part of the Administration for
5 RMP was, as I think we have already indicated at the last
6 meeting, one which would allow the Regional Medical Programs
7 to maintain their present level of grant support which is
8 in the general range of about $98 million. They indicated
9 during the testimony before both chambers that there would be
10 no special funds set aside in the coming fiscal year for
11 health maintenance organizations out of the RMP budget and
12 made it quite plain that the funds used this year for HMOs
13 were all that they had expected to use out of the RMP
14 appropriations.
15 They also indicated that the construction funds which
16 we will talk about in a moment for a cancer facility were one-
17 time funds in the Regional Medical Programs. And there would
18 be no further request for construction funds. They prefer to
19 keep those under other kinds of administrative authorities,
20 especially Hill-Burton. And I would assume some under the new
21 cancer authority and possibly some under the educational
22 institution support programs in the NIH.
23 There was an indication also by the Administration
24 that they wanted to raise the level of support for emergency
25 medical services from the current $8 million to $15 million in

1 the next fiscal year and that this would be all that would
2 be requested for special demonstration purposes which I will
3 refer to again in a moment.
4 There was no real discussion of the Area Health
5 Education Center concept during the appropriations deliberations,
6 but we will talk about that in a moment also. So that I would
7 anticipate some final action on our appropriation level in
8 the relatively near future which means one would guess by
9 midsummer which is far better than we had been doing during
10 the past several years.
11 Now, there is a word of warning on that. Although
12 the appropriations action was completed last year by August,
13 there was no final disbursement of funds until well into the --
14 well, it wasn't until after the beginning of the next fiscal
15 year. So completing appropriations action in Congress is not
16 enough to assure us that we will know our actual level of
17 funding. And as you will be hearing, this has produced some
18 specific problems for us during the present fiscal year.
19 Now, I have got several other items, but if there
20 are some questions about that, perhaps I should stop. That is
21 really fairly mechanical up to this point.
22 DR. MAYER: Harold, would you translate the appropria-
23 tions into dollars for RMP grants?
24 DR. MARGULIES: What has happened this year is that
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25 with the final resolution of carryover and so forth, we ended

1 up at about $98.3 million for RMP grant support. And that is
2 what we anticipate for the next fiscal year.
3 DR. MAYER: Other questions?
4 DR. SPELLMAN: You said the emergency medical
5 services grant funds are being increased to $10 million?
6 DR. MARGULIES: The emergency medical funds are going
7 to be increased from the $8 million of this year to $15 million
8 next year, but that gets a little bit more uncertain because
9 during the discussions of budgetary process, since that money is
10 being utilized not as an RMP activity, but rather as a
11 HSMHA-wide activity in the current fiscal year and probably will
12 be next fiscal year, it will very likely drop out of our
13 budget and become a separate item. So it will not be carried
14 as a part of the RMP budget, but this will not affect the
15 basic level of grant support for RMPs which will remain at least
16 constant. This is on the assumption that the Administration
17 recommendations are the same as Congress'. In the past, they
18 have not been. Congress has regularly increased the level.
19 DR. BESSON: To what extent does that apply to the
20 current $8 million, that same suggestion that you just
21 raised about the $15 million being HSMHA funds for emergency
22 medical services.
23 DR. MARGULIES: I will get to that in a moment.
24 But the question that is raised is how the current $8 million
25 for emergency medical services is being handled. And that is

1 being managed as a HSMHA-wide emergency medical service
2 activity with contracts out of the Office of the Administrator.
3 It is not being managed by the Regional Medical Program.
4 DR. BESSON: Is RMPS then not allocating money
5 separately for EMS activity?
6 DR. MARGULIES: I have that on my agenda to discuss.
7 This is as good a time as any if there are no other questions
8 about that.
9 All right, let's talk about the emergency medical
10 systems activities.
11 When the President indicated in the state of the
12 Union message and subsequently that he wanted to raise the
13 level of investment in emergency medical systems, there was
14 at the same time a decision made to do this in basically two
15 ways in HSMHA.
16 One of them was to develop some major emergency
17 medical systems demonstration activities with the emphasis
18 on it being a total system and to do this in such a manner
19 that the various emergency activities which are fairly
20 widespread in HSMHA could be well coordinated at one point.
21 There is, for example, in NIMH suicide prevention and
22 crises intervention emergency activities, maternal and child
23 health services, general pediatric and poison control centers.
24 There is a Division of Emergency Medical Services in HSMHA,
25 etc., a whole range of emergency activities. In order to bring

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

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

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

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

1 that these demonstrations did not simply be demonstrations
2 with no effect, which is too often the case, initiate and
3 encourage the development of emergency medical activities
4 to the RMPs as a separate grant activity eligible for
5 supplementary grant award. And we have done that. And so the
6 Regional Medical Programs have received and are responding
7 to a description of a well-coordinated total emergency medical
8 service to be supported by grants which is complementary to
9 the contract activity. And in fact, we exchange day to day
10 data between what we are doing in grants and what we are doing
11 in contracts with the hope that when the whole thing has been
12 completed, we will have a total body of knowledge and of
13 action which is effective in order to carry out that emergency
14 medical activity. As I think you know, we have set up a
15 separate special review body which is going to look at the
16 responses to our invitation to submit supplementary grant
17 requests.
18 DR. MAYER: This is within RMP?
19 DR. MARGULIES: This is within RMP.
20 DR. MAYER: And separate from the contract?
21 DR. MARGULIES: Quite distinct and separate from the
22 contract. The contract activity is another issue entirely.
23 In order to give enough time to the RMPs to
24 respond and to develop something which is meaningful, we have
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25 given them a fairly tight, but reasonably broad period of time

1 in which to work. The grant requests, applications, are
2 at the present time all in. They reach a fairly formidable
3 level, and they will have to be reviewed on May 15.
4 What we have done, in order to set up an effective
5 review mechanism for a kind of special action, was to ask
6 Dr. Besson, Dr. Toomey, Dr. Scherlis, who will act as
7 chairman from the review committee, Dr. MdPhedran and Dr. Roth
8 from the Council to act together for these two bodies and for
9 the RMPS in making a review of the Emergency Medical
10 Systems grants requests. When that occurs, we will give
11 them full information regarding the status of the contract
12 proposals so there is no confusion between the two. And we
13 will try to keep them as discrete as possible.
14 We would anticipate that the Emergency Medical
15 Systems activities would continue beyond this year. We have
16 not set aside a specific sum for that purpose, and I will get
17 into the funding aspects a little bit later. But you might
18 want to ask further questions about the Emergency Medical
19 Systems.
20 DR. SPELLMAN: When you say that the grant awards
21 will complement --
22 DR. MAYER: Mitch, could you use the speaker?
23 DR. SPELLMAN: My question is in making one of the
24 qualifications of grant awards for Emergency Medical Services
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25 projects funded by RMPS, does this mean then that the grant

1 awards are in effect supplements of contracts, or does the
2 complementary process occur in a way in which the contract
3 and grant awards are two different things, different
4 institutions or entities?
5 DR. MARGULIES: It is complementary in a conceptual
6 sense. What we are saying is we don't want to develop
7 contract activity which would represent a total approach to
8 a system and have some grant awards which have a piece of
9 equipment here and training program there. We want both of
10 them to represent an effective approach to organizing a total
11 emergency system. But with the RMP activities, I think we
12 have some laterality which may not be true of the contracts
13 because we are dealing with a Regional Medical Program in that
14 case.
15 Being very specific, if a contract is awarded,
16 contract this time is awarded, for an Emergency Medical System
17 to a unit of government in a community, it will be with the
18 understanding that this is a very time-limited and emergency-
19 related activity. It has to do with the moment at which an
20 emergency is identified until the point of resolution of what
21 you do with that emergency in the emergency room or whatever.
22 And beyond that, the contract activity doesn't apply.
23 It doesn't, for example, go to in-hospital
24 emergencies, to referral activities. It has to be that
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25 discrete.

1 We will be interested in the Regional Medical
2 Programs in this being more than an EMS carryout effectively,
3 but in addition to that being something which has an
4 influence on the rest of what that RMP does and on the rest of
5 the system which is around it such as the other ambulatory
6 care, the referral services. And, of course, with our special
7 interests in heart disease and in stroke, we would be
8 particularly sensitive to how effectively they include competence
9 to deal with acute infections, acute strokes and so on.
10 DR. MAYER: Two questions, Harold. One is you are
11 talking next year in terms of that move from $8 to $15 million
12 of the operation being there to start to develop centralized
13 information. Is it the intent to expand on those original
14 five contracts, to extend it to more or to expand on those
15 original five? What is the intent in terms of next year?
16 DR. MARGULIES: It is to expand it to more new
17 contracts, I am quite sure, because I believe what we will do
18 -- and this depends in part on the demand -- I just looked at
19 some of the contract reports, submissions, yesterday -- is
20 contract in such a way that we obligate funds which will carry
21 them over the full period of the three-year contract so that
22 they will be full funded contracts and the ones which we
23 would be looking at in the next round, therefore, would be
24 new contracts.

25 DR. MAYER: Jerry.

1 DR. BESSON: Maybe I can ask my question in a
2 different way. How much money would you anticipate would be
3 allowed for the five contracts?
4 DR. MARGULIES: The five contracts will for the most
5 part consume the $8 million.
6 DR. BESSON: Then, the moneys pertinent for RMPS-EMS
7 are outside of anything in --
8 DR. MARGULIES: Yes, they are separate.
9 DR. BESSON: And the only reason they are not being
10 considered by this committee is because of the lateness of
11 submission of the grant proposals.
12 DR. MARGULIES: We have the same problem with those
13 and with the community education activities which I can get to
14 in a moment also.
15 DR. BESSON: You previously have spoken of RMPS
16 money as maybe not being allocated, but somewhat sequestered
17 for kidney activities or other activities. Is there any
18 thought in RMPS about how much of the --
19 DR. MAYER: Can you hear him in the back?
20 They can't hear you, Jerry.
21 DR. BESSON: Is there any thought in RMPS as to how
22 much money would be allotted from RMPS funds for other
23 activities?
24 DR. MARGULIES: There is some thought about it, and
25 I will get back to that, Jerry, but it is wrapped up in several

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

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

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

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

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

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

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

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

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1 that is really the only issue.

2 DR. MAYER: Additional comments on EMS?

3 (No response.)

4 What would be the intent next year in terms of RMP

5 activity in EMS?

6 DR. MARGULIES: I think this is going to depend

7 pretty much on the total influence of the current round.

8 And there are really three things involved.

9 One is our general appropriation level.

10 The second is the final decision on what will be

11 done with the additional emergency medical activities in the

12 $15 million zone.

13 And the third will be some judgment about how ready

14 we are to do more emergency activities.

15 I told you I thought the $15 million would go in

16 that direction, Bill, but it really hasn't been formalized yet.

17 It is perfectly psssible the role of RMP in the EMS activity

18 will be redefined either by legislation or by something else

19 during the coming year. But assuming everything I have said

20 is true, I would anticipate we would continue to show a high

21 level of interest in the support of Emergency Medical System

22 activities in the next fiscal year as well.

23 DR. MAYER: Under RMP?

24 DR.MARGULIES: Yes.

25 DR. MAYER: Under separate kind of review effort?

1 DR. MARGULIES: No, we wouldn't do it separately
2 because this was a matter of duress. At that point, we could
3 enfold it into the regular review system.
4 DR. MAYER: I think that is an important concept for
5 this committee because it is the bits and pieces issue.
6 Slowly but surely you dissect everything off.
7 DR. MARGULIES: Well, let me deal with that issue now.
8 DR. MAYER: Before you do, let me make a comment as
9 someone who is absolutely and irrevocably addicted to
10 nicotine that as all of you are aware, the Secretary of this
11 superb organization known as HEW has indicated a mandate which
12 has come on down through this. I think everyone is on their
13 own in relationship to whether they feel the lightning bolt
14 coming down from downtown or not in regard to that issue.
15 I say that in preface to I have already made by
16 decision. I want to leave tomorrow, not today.
17 DR. MARGULIES: That statement is part of the
18 confidentiality of the meeting.
19 I think it might be easier for us to deal with the
20 budgetary issues because they keep coming up rather than with
21 such things as the area health education center concept. What
22 has happened in this fiscal year has been the appearance of
23 a funding pattern which might have embarrassed us badly, having
24 us reach the end of the fiscal year with more money than we had

25 anticipated and no way to spend it or the appearance of that

1 amount of money with us very well ready to spend it as we are
2 or no additional money whatsoever which might yet occur.
3 Now, in that range of possibilities here is about
4 what happened: We did not get a clear statement about our
5 total funds for this current fiscal year until after the end
6 of January. Even when we had received that information, there
7 was uncertainty about the funds which would be spent for Health
8 Maintenance Organizations, some $16.2 million, and the funds
9 which were set aside for Area Health Education Centers, some
10 $7.5 million.
11 Furthermore, the $8 million which had been identified
12 for Emergency Medical Services Systems had not yet been set
13 aside as they are now as I described to you for contract
14 activities. And so we had this range of uncertainties.
15 There was from the preceding fiscal year, you may
16 recall, approximately $44.5 million which was not released in
17 that fiscal year which we had been promised would be released
18 in this fiscal year. It was released, but only in part.
19 So we got to about March knowing that there were several
20 possibilities which gave us a range of difference in the month
21 of JUne which is turning out to be true of about $22.5 million
22 uncertainty.
23 Well, with $22.5 million uncertainty and the
24 desire to be able to use it effectively, you have to develop
25 some footwork. And so we developed some footwork. This

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

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

21 While all this was going on, the $7.5 million which
22 had been set aside for Area Health Education Centers was
23 kept back and remains back. So we still have the uncertainty
24 of whether we will have available $7.5 million for educational

25 activities, whether some of the HMO money will be returned to us

1 and whether we will have funds available at varying levels,
2 depending upon the grant requests from the Regional Medical
3 Programs in fiscal '72.
4 What we decided on is a rather simple maneuver to
5 give ourselves maximum flexibility. And the way it is going to
6 work out, we will be able to expend all our funds no matter
7 what the decisions are. We extended the fiscal years of each
8 of the programs in this review cycle, but we did not give
9 them grant awards to cover the whole period of time. So if
10 an RMP went from 12 months to 16 months, the grant award was
11 for 12 months. And what we told them was, "Show us what your
12 rquirements are for the full 16 months. And if you require
13 X level, you can be assured of getting that if that is an
14 appropriate level. But we can decide with you whether you
15 need it this fiscal year or next fiscal year." That meant that
16 in the majority of the program --
17 DR. MAYER: In terms of release, Harold.
18 DR. MARGULIES: In terms of release, yes.
19 It covers the same period of time, but this meant
20 that up to June 30, we had a liability just in grant award
21 for basic RMPs of something in the range of $8 million which
22 could go in one fiscal year or the other and produce the same
23 result. This is the only year we will ever be able to do that,
24 but it is also the year in which the uncertainties appear to
25 be maximal.

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1 That last statement, don't believe that for a moment,
2 but the flexibility is maximal.
3 (Laughter.)
4 So we are really trying to play these varying kinds
5 of games.
6 If you say in the middle of that, "Exactly how much
7 is it you are going to have for EMS and how much for educational
8 activities," I can just add to the fringe of interest by
9 telling you about what we are thinking about. We hope that we
10 can talk in the educational activities in the general range
11 of about $3 million. And in the EMS, we have had a greater
12 level of uncertainty because it has been awfully hard to
13 predict what might actually come in. But I would not be
14 surprised to see us working in the same general range for the
15 Emergency Medical Systems.
16 Now, this depends on an action which may be taking
17 place today, I am not sure. Part of it does. And that is that
18 we have gone through, and I will have to complete this, Bill --
19 I am sorry that this gets complex, but, damn it, all of it is
20 complex. It has been like that. We have gone through an
21 interesting tango -- you can't tango with four partners --
22 we have gone through an interesting square dance on the Area
23 Health Education Center activity trying to decide who does
24 what. And it has at least reached a point of some definition.

25 And that is that in the opinion of the Office of Management and

1 budget and of the Office of the Secretary, something called
2 an Area Health Education Center is related to the Carnegie
3 Commission model which is essentially an activity conducted
4 primarily under the auspices of a university health science
5 center with the Area Health Education Center a satellite
6 thereof. And this with some embellishments is the concept.
7 The essential ingredient is the extension of the
8 energies and interests of the university health science
9 center. That is not exactly what the Carnegie Commission report
10 said. It has become the general concept in the JAMA and the
11 article by Margaret Gordon and in the Office of the Secretary.
12 OMB and I believe the Office of the Secretary feel that that
13 is fit for NIH Bureau of Education and Manpower Training to do,
14 not for HSMHA RMP.
15 There was in the middle of this discussion of Area
16 Health Education circulated in among other places what is
17 known as the blue sheet a statement which said that General
18 Counsel opinion deleted RMP from educational activities. That
19 was in error. There had been at that time no General Counsel
20 opinion submitted to anybody. There had been some grants which
21 were incomplete and which we asked them to complete at a
22 later date.
23 The General Counsel opinion on educational activities
24 for RMP is quite clear-cut. It says that under 910(c), we

25 can indeed conduct educational activities which need not be

1 confined to the categories which are concerned with improving
2 the utilization of manpower, expanding their capacity, but they
3 added the comment that they felt clear that RMP should not be
4 involved through 910(c) in the support of training activities
5 which essentially changed the unskilled into skilled.
6 And to be definite about it, they said such as
7 training a high school graduate to be an RN, paying for that
8 or paying for the stipends or faculty for medical students and
9 so on, and that we were concerned with the community activity
10 which linked education to service. And they are quite com-
11 fortable with that differentiation.
12 Since that is basically the policy under which RMP
13 has been operating for some time and causes us no concern --
14 DR. MAYER: Since the beginning, Harold. CC and I
15 wrote those exact same guidelines five years ago.
16 DR. MARGULIES: This is buttressed, then, by the
17 General Counsel opinion, so we have no problems over it.
18 So what we had done without any of these decisions having been
19 made and without any General Counsel opinion is to run the risk
20 of circulating to the Regional Medical Programs the description
21 of a program community based education activity to which we
22 invited their attention and for which we are going to provide
23 supplementary grant awards. This is parallel to the Emergency
24 Medical System activity.
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25 We could not put this out with any term that said

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

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

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

1 Leonard.

2 DR. SCHERLIS: Have you distributed to the members

3 of this committee the same information you sent out to the

4 various regions as far as their coming in for EMS or these

5 educational centers?

6 DR. MARGULIES: Yes.

7 DR. SCHERLIS: We had that?

8 DR. MAYER: No.

9 DR. MARGULIES: Didn't this go to review committee?

10 I am sorry, it should have gone to review committee.

11 I thought it went to review committee and Council. That was

12 an error on our part, then.

13 DR. SCHERLIS: Perhaps we can have those.

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

15 DR. SCHERLIS: Fine.

16 DR. MARGULIES: Let me add one more feature to it

17 which gives you an idea of some of the special procedures we

18 have to carry out regarding these two categories of interest,

19 the Area Education Service one and the EMS. If we get funds

20 released yet this fiscal year, and I think it is likely, which

21 the Office of Management and Budget does not intend to have

22 in continuing appropriations, we will have to provide evidence

23 that that money can be spent to support activities in RMP

24 without raising the level of commitment to individual programs.

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

1 for one choice the EMS activity as a discrete activity in a
2 program. If the program comes in and says, "We have a well
3 knit Emergency Medical System activitity, it will take three
4 years to complete, it will cost X amount of money," we can
5 award a grant based upon their total needs for three years
6 and reach an agreement for them to carry that as a separate
7 item in their budget. At the end of those three years, that
8 activity will have been completed and will not be part of
9 their basic commitment.
10 I think that the Office of Management and Budget will
11 accept that procedure.
12 DR. MAYER: With the commitment, however, for the
13 three years coming out of -- let us assume $3 million -- that
14 original $3 million.
15 DR. MARGULIES: That's right. It is essentially
16 forward funding for the line item in their own budget.
17 DR. MAYER: In other words, the commitment that would
18 be made, let us say.
19 DR. MARGULIES: We would release all the funds now.
20 DR. MAYER: There would be only a million dollars of
21 annualized commitment that would be made at this time, is that
22 what you are saying?
23 DR. MARGULIES: Yes, we would release the $3 million,
24 but at the end of that period.
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25 DR. MAYER: It would be spread over three years.

1 DR. MARGULIES: It would be spread out over three
2 years. If they were smart, they would probably handle it
3 through some kind of a contract to keep it separate. At the
4 end of the three years, their commitment level would be whatever
5 it had reached at that time exclusive of that $3 million which
6 then disappeared.
7 DR. SPELLMAN: You would make the three-year award
8 at one time, one sum?
9 DR. MARGULIES: To get the funds obligated.
10 DR. SPELLMAN: OMB will commit them?
11 DR. MARGULIES: We don't know yet. That is our plan.
12 DR. SPELLMAN: It is extraordinary.
13 DR. MARGULIES: It is not so extraordinary.
14 DR. MAYER: They have been doing that in construction
15 for years.
16 DR. MARGULIES: The reason they have to do that is
17 because they are committed to releasing all funds. It is
18 their -- their being downtown, whoever is downtown, it is always
19 they, all those people downtown with responsibility -- so the
20 fund was not released, and they have to devise a method of
21 releasing it and making it effective. I think they had
22 assumed we would not be in a position to respond as effectively
23 as we can. And we can do it because we will have reviewed
24 and approved and identified actions on that kind of a base

25 because I guess it was staff wisdom 8 months ago this is exactly

1 what would happen now.

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

3 (No response.)

4 That was the easy part. Have you got the hard

5 part, Harold?

6 DR. MARGULIES: Let me just run over two or three

7 other things quite quickly because they might take some further

8 time. We can come back to them because this gets to be quite

9 a long unifocal dialogue.

10 DR. MAYER: We are listening.

11 DR. MARGULIES: The Cancer Center proposal which was

12 reviewed by Council last time represents for your recollection

13 the investment based upon Congressional action of $5 million

14 for a cancer construction center in the Northeast part of the

15 United States. That was reviewed, and there has been favorable

16 action with certain requirements attached to it by the Council

17 for a cancer center in Seattle called the Fred Hutchinson

18 Cancer Research Center.

19 There were specific requirements by the Council and

20 some that we imposed which had to do with such regulations

21 as are in the legislation, in State regulation, certificate of

22 need and so on. They appear to be moving quite well to

23 complete their requirements.

24 We said that we would release the funds only when

25 all of these requirements were met. So that the award was made

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

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

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

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

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

21 DR. MARGULIES: For research purposes, yes.

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

1 with the meaning of the emergence of the new cancer
2 authority and of the new heart disease push in the form of
3 two major forms of legislation. You may recall that there was
4 new cancer authority passed to produce a special center for
5 cancer research and control. And there is a parallel bill for
6 management of heart disease.
7 This, of course, raises the question immediately of
8 what relationship either of these activities may have to the
9 Regional Medical Programs which are identified with the same
10 diseases.
11 It also raises the question of whether there will be
12 a continuation of this kind of special interest and special
13 disease categories, perhaps rejuvenation of interest in
14 neurological diseases or some of the others. I don't know
15 about that.
16 What has happened, however, has been a desire certainly
17 in the cancer bill to produce a consistent pathway from the
18 cancer laboratory research area to the delivery of good care
19 tothe public with prevention, diagnosis, treatment, rehabilita-
20 tion.
21 This could be done by establishing or re-establishing
22 the control programs which were carried under the Division of
23 Chronic Diseases in the past. It could be done by other
24 mechanisms. It could be done by the National Cancer Institute
25 managing the whole thing from the research end to the delivery

1 end. Or it could be done by arrangements which they work
2 out with programs like the Regional Medical Programs.
3 There has not been a decision made at present about
4 what our actual working relationship will be either with the
5 National Cancer Institute or the National Heart and Lung
6 Institute. Tomorrow I am to go over and talk with a group of
7 people in the National Heart and Lung Institute about heart
8 and stroke activities which we might be able to carry out in
9 common. But I think the negotiations are taking place
10 currently between the Office of the Administrator and with
11 Bob Marston at NIH to decide how best we can work this out.
12 What I hope for is a union of the special cancer
13 interests and special heart and lung interests which represent
14 NIH's major interest and constituency with those in the Regional
15 Medical Programs. And what many of us hope for would be if
16 there is a re-emergence of the control program that this be
17 designed in such a way that it improves the delivery system
18 rather than operating in isolated segments thereof.
19 But we will probably have a clearer answer to
20 that at some time in the future.
21 In the meantime, interestingly enough, just to
22 add to the confusion of the picture, when Senator Kennedy
23 extended our legislation, he dropped the categorical designation
24 out entirely and put his total emphasis on education, manpower,
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25 and the improvement of delivery of health services. So we are

1 in a continuing period of time of struggle between these
2 issues which, if you had thought would disappear with anticipating
3 events is not likely to occur in the next few years. I do not
4 know what final arrangements will be carried out.
5 In the meantime, it has caused us to look again
6 more sharply at how much of our activities are dealing with
7 heart disease, cancer, stroke, and kidney disease. And they
8 still remain a preponderant part of Regional Medical Programs.
9 What we have difficulty with, and it is distressing
10 that we do, is the idea thatyou can by improving -- well,
11 we talked about it earlier -- total emergency medical services
12 make a contribution to the control of heart disease. That
13 never emerges from the kind of data which are put together.
14 If you are talking about a categorical disease activity in the
15 way most of the people looking at it at the budget end like
16 to look at it, it has to be exclusively for a specific disease
17 within that category. If not, they can't recognize it.
18 If you improve basic primary care services in a rural area,
19 the assumption is, I guess, that somehow you do that and
20 exclude heart disease, cancer, stroke, and kidney disease and
21 related diseases when in fact that is an absurdity.
22 If you try to tote up what you are doing in some kind
23 of dollar terms to improve management of these diseases, it is
24 very difficult to do. And we are in that kind of a dialogue.
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25 I have no answers for you.

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

2 DR. MARGULIES: One other, and some of these others

3 will come up again.

4 We have issued the new kidney guidelines very recently,

5 and they are available to you. And I think rather than go

6 into detail at the present time, since we have been over quite

7 abit of ground already this morning, that we will bring up the

8 details of that at a point where you are actually going to

9 deal with the subject. Or we can do it now if you prefer,

10 Bill. It is up to you.

11 I have a more significant issue to deal with, though,

12 for the time being. And that is the nonpayment of consultants.

13 All I can do is read you the note.

14 What happened was that the central payroll converted

15 to a new system. An old consultant timekeeper number was

16 used which resulted in many consultant checks not being written.

17 Research has been conducted to double check on the consultants

18 not paid and to clear up other errors. Hopefully, all work

19 will be completed and checks written for the May 23, 1972, pay

20 day.

21 In other words, we operate our pay system when we

22 change from an old system to a new system just as others do --

23 ineffectively. So that those who have not been paid have not

24 been paid because they had wrong addresses, wrong numbers

25 which the switchover managed to produce. And we will, if we

1 can get the machine to listen to us, make sure everybody gets
2 paid as he should have.
3 Some people are in arrears clear back to last
4 October.
5 DR. SCHERLIS: It has been speculated that is a
6 source of funding for your expanding EMS programs.
7 DR. MARGULIES: As a matter of fact, we linked it up
8 to another failure in another subscriber system. And if you
9 don't get paid, you are going to get a 10-year subscription to
10 the National Geographic.
11 (Laughter.)
12 DR. MAYER: Other comments?
13 (No response.)
14 Thank you very much, Harold.
15 At the risk early in the meeting of fixing dates,
16 I would like to turn to the calendars which are contained in
17 your notebooks under the first tab which is labeled simply
18 "Calendar" in an attempt to get the link with Council or closer
19 link to Council at least temporally if not philosophically,
20 we need to pick two dates out of the following three weeks
21 in the subsequent year.
22 If you will put a circle around the September 17-23
23 week, a circle around the January 15-19 week and a circle
24 around the May 14-19 week, what we need to do is pick two
25 days in that period of time, each of those weeks, that you

1 would like to schedule for meeting. And this is part of that
2 going from four cycles to three cycle year.
3 Preference is in September? We are now on a
4 Thursday-Friday go. Is that good, bad, indifferent?
5 How about the 21st and 22nd of September as
6 possibilities?
7 Going once, twice, all right, gone.
8 In January, is the 18-19 appropriate?
9 All right, other time during that week?
10 DR. ANCRUM: Any day except that Friday. I have
11 to be back in Seattle.
12 DR. MAYER: O.K., 17-18.
13 DR. ANCRUM: That would be fine.
14 DR. MAYER: How is that, O.K.?
15 17-18, then, of January.
16 And in May 17-18 of May?
17 DR. ANCRUM: The third Friday is out for me.
18 DR. MAYER: Then what about the 16-17?
19 DR. ANCRUM: Am I the only one that has this
20 conflict?
21 DR. MAYER: I don't hear anybody moaning about the
22 other cycle. There is no magic about Thursday-Friday.
23 O.K., then the 16-17 of May.
24 O.K., then what we have said is 21-22 September,
25 17-18 January, and 16-17 May, as the next three go's.

1 I would like to turn now to some other additional
2 comments which I think are very pertinent to the review
3 process itself as we go through the review process from Dr.
4 Pahl.
5 Herb.
6 DR. PAHL: Thank you, Bill.
7 First of all, I would like to mention for you that
8 there is the dinner this evening at the Flagship Restaurant
9 close by here to the Parklawn Building.
10 And, Bob, perhaps you can give detail arrangements
11 later. But this is something that we are looking forward to
12 because we do have several of the members of the committee
13 leaving. And we believe that the other members of the committee
14 together with staff would like to meet together informally and
15 have an opportunity to socialize and wish those who are
16 departing well, although we do hope we have close and continuing
17 relationships with each and every one.
18 I have just a very few comments because I think Dr.
19 Margulies has indicated the complexities that we have been
20 going through. And you will again obviously have a very full
21 agenda of information items in September because the program
22 does continue to change. However, my remarks are much more
23 mundane and specific.
24 Specifically, I would like to indicate that the
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25 staff anniversary review panel is continuing to function very

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

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

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

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

1 would be presenting a summary, if you will, of what the staff
2 anniversary review panel concluded relative to the application
3 to reach that assigned priority.
4 You will also note that we have introduced certain
5 new formats in the paper work which has come to you both at the
6 time of site visits and in terms of primary and secondary
7 review of the applications. And I believe you will see very
8 readily that the purpose of this has been to try to tie into
9 our analysis of the application in question the review criteria
10 which have been developed and are increasingly being used not
11 only by RMPS, but by the RMPs themselves as they view the
12 progress of their programs.
13 There will be an opportunity provided to this
14 committee at the end of this meeting tomorrow to comment upon
15 and make constructive suggestions for modifications in these
16 new kinds of forms and so forth which we are using. We hope
17 that the information is being organized perhaps somewhat better
18 for you, particularly for comparison purposes between and
19 among programs since by having the items organized along the
20 lines of the review criteria it is more possible now to review
21 one program in comparison to another and look at the similar
22 items of information.
23 Internally, there certainly is not complete agreement
24 that this is the ultimate way to present information. We do

25 feel, however, that there is an opportunity here to improve

1 matters. At the same time, we feel that the information as
2 we are now receiving it and prsenting it to you does contain
3 perhaps less narrative and more pithy substance on the particular
4 points in question. However, we do look forward to your
5 comments at the end of the meeting as you have had an
6 opportunity to use these new forms.
7 DR. MAYER: I might just interject, Herb, each of
8 you, I think, at your desk had a long sheet which does have
9 the May-June review cycle, SARP recommendations on it which you
10 need to have for referral as we go through.
11 DR. PAHL: And it is the five applications at the
12 bottom of the sheet which are being brought to you for
13 information purposes only and are included behind that blue
14 tab in the back of your book.
15 In terms of the NIS printouts, in just a moment I
16 would like to ask Mr. Ichinowski to present very briefly for
17 you what the printouts are designed to do. And he has
18 distributed these large binders for you.
19 There is no intent to have you try to look at or
20 absorb any such information here at the table. Rather, those
21 of you who have been assigned primary and secondary review
22 of applications have already received the appropriate printout
23 packages. And this merely represents a compilation for
24 each application before you today so that you will have some
25 appreciation of how the NIS, National Information System, is

1 being utilized more and more to bring information to you,
2 site visitors, and the National Advisory Council, and to be
3 used more effectively by our own staff as we go through the
4 review process and analysis of regions.
5 I would indicate again that we look to this committee
6 and to our non-committee site visitors for constructive
7 suggestions as to how to bring to you those kinds of
8 information and present them to you in some organized fashion
9 that will be more effective in accomplishing both site visits
10 and the anlaysis and discussions of the regions' programs.
11 Now, with that slight introduction, I would like to
12 ask Mr. Ichinowski to take a few minutes and review for you
13 not any specific numbers within these printouts, but rather
14 what the nature of the format of each printout is designed to
15 do for you.
16 And, again, I will appreciate as well, particularly
17 at the end of tomorrow's meeting or at any time, of course,
18 that you so desire suggestions as to how this kind of
19 activity can be improved to serve your purposes better.
20 Frank.
21 MR. ICHINOWSKI: Thank you, Dr. Pahl.
22 We put together a number of printouts on each
23 region that is going to be discussed here today and tomorrow.
24 And these packages were previously sent to the primary and

25 secondary reviewers for those regions that they had under their

1 responsibility. So maybe they are not completely new to you.
2 We have, then, all 14 regions here with the exception
3 of the new Ohio RMP. We have six printouts for each RMP.
4 And if you would be so kind as just to take your big black
5 binder, maybe we could run through for a minute or two the
6 kinds of things we have there and perhaps how you could use
7 them in your determinations.
8 First of all, they are all alphabetical, the RMP,
9 starting with Kansas, Missouri, and so forth. We have
10 reduced the printouts, as you know, from the large size which
11 we found somewhat unwieldy to this reduced version that you
12 see in front of you.
13 If we could use perhaps the Kansas RMP as an example
14 and run through the printouts, maybe that would be of assistance.
15 The first printout is a funding history list which
16 identifies for you for each RMP all of the projects that
17 were ever supported by RMPS funds and then in each column by
18 year the moneys that were put into that activity.
19 For example, in the Kansas, you see there they have
20 it awarded for five years. So the first five columns are the
21 moneys that were awarded in each project and total at the bottom
22 for each of those five years.
23 To the right of the asterisk column are those
24 moneys that they are requesting at this time for subsequent
25 years. In the case of Kansas for years 06, 07, and 08. Again,

1 at the bottom, the totals that are being requested.

2 O.K. For the next printout, you flip over behind

3 the number one tab. The breakout of request which identifies

4 for each RMP by type of support being requested, whether it is

5 continuation within approved period of support, which is the

6 first column, continues beyond the approved period of support

7 which is the second column, and so forth, those moneys that are

8 being requested for a particular year.

9 Each page is a program period. The first page for

10 Kansas is their 06 year of request. The second page will be 07.

11 At the right of the page, you not only have the

12 direct cost being requested, but also the indirect and total

13 dollars.

14 Now, behind the number 4 tab, under Kansas, we have

15 an identification of the RMPS funds that are being requested

16 as a percentage of other sources of support.

17 Now, in the financial data record that the RMP

18 submits to us on each project, they identify if they are going

19 to be getting other sources of support for that activity.

20 And we have displayed this in terms of identifying in the first

21 column after the title the RMPS funds that are requested.

22 The second one is those funds that they have indicated will be

23 coming from other sources, with the total then in the third

24 column. And in the fourth column is that percentage of money

25 that RMPS would be contributing.

1 In the case of Kansas, as you can see, they have
2 not indicated any other sources of support for any of their
3 activities.
4 We can go, then, behind the number 9 tab of Kansas,
5 And these are printouts that come from the descriptor summaries
6 that had been submitted to us by the RMP. We have this
7 broken down into three major groupings.
8 The first groupings are operational components.
9 In the case of Kanasa, on the top left-hand corner, you can
10 see that they are requesting 12 operational components which
11 total $693,243. Within each of the 12 major groupings of
12 descriptor categories, we have broken those down to identify
13 for you the number of components that relate to that specific
14 element, the dollars that are related and then the percentage
15 of those dollars that that money identifies of the amount that
16 they are requesting.
17 There are four pages for that particular printout.
18 And then right behind the little yellow tab, we have a similar
19 type of display for the planning studies that they have
20 identified in their application which runs the same pattern, --
21 the number of programs that they are requesting and the amount
22 of dollars.
23 And the third batch are the program feasibility
24 studies and central services again in a similar arrangements
25 and array.

1 The next printout under Tab No. 11 is a repeat
2 of their page 7 of their application which identifies equal
3 employment opportunity data they have submitted to us. There
4 are four major columns, the first being core staff, again
5 broken down into professional, technical and secretarial
6 and clerical, the same breakdown for project staff.
7 The third major column is the regional advisory
8 group.
9 And the fourth one other committees.
10 The rows, I believe, are self-explanatory. The top
11 row is total which are members. Then you have the breakdown
12 between male and female. Then you have the breakdown under
13 minority groups, total minority, and those that are
14 appropriate to blacks, Indians, Spanish, oriental and others.
15 This is a direct take-off from page 7 of their application.
16 The 1st printout we have provided for each RMP
17 behind Tab 14 has been derived from the financial data
18 records where we have identified for those objects of expenditure
19 that are on page 16, moneys in each component that have been
20 reported to us. Each column is a particular component, the
21 first being core, the second one developmental, and then the
22 component numbers. The total in each object of expenditure
23 for each RMP would be the furthermost right-hand row of the
24 last page. In the case of Kansas, the last column on page 2.
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25 Now, there is one other set of printouts that we have

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

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

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

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

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

1 percent and so forth down the line.

2 Now, there are four printouts to this series. The

3 first page that we have gone over is total direct cost. The

4 second page has to do for core components, the third one for

5 project and the fourth for those that apply developmental

6 components.

7 Yes, Sister.

8 SISTER ANN JOSEPHINE: I am interested in this five

9 years.

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

11 SISTER ANN JOSEPHINE: In this five-year operational,

12 as you look at Kansas and Missouri, and you look at the current

13 budget and requested, immediately the question comes up what

14 is changing there? Because it is changing very rapidly.

15 MR. ICHINOWSKI: In the case of Kansas, they are

16 requesting $1.7 million. And they are currently being supported

17 at the $1.3 million level.

18 SISTER ANN JOSEPHINE: I am talking about Missouri.

19 As I look at these two, they are being funded at $1.9, and

20 they are requesting $4.4. There are some significant changes

21 taking place here.

22 MR. ICHINOWSKI: In Missouri? I believe you will

23 discuss that at the time the Missouri application is to be

24 presented.

25 SISTER ANN JOSEPHINE: This could highlight these

1 of things I suppose one would look at.

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

3 this.

4 SISTER ANN JOSEPHINE: I keep hoping we ask the right

5 questions because if we don't, we work on the wrong answers.

6 MR. ICHINOWSKI: Are there any other questions?

7 MR. HILTON: Yes.

8 DR. MAYER: Yes, Mr. Hilton.

9 MR. HILTON: Is the current plan to have these

10 printouts replace much of the reading material we have in the

11 other book? Is this the idea?

12 MR. ICHINOWSKI: Yes.

13 MR. HILTON: Is there some way to make this printout

14 clearer? Some of these figures are --

15 MR. ICHINOWSKI: Yes. We have just in this last cycle

16 made the decision to go from the large printout to the reduced

17 printout. It is an internal problem with the use of a Xarox

18 7000 machine in the building here. And if we can get to use

19 the Bruning or one of the other machines which we are negotiating

20 for right now and get it perhaps printed rather than xeroxed,

21 we can improve the quality significantly. And I believe by

22 the next time these printouts are presented to you, you will

23 note the difference in the quality.

24 DR. MAYER: That is extremely helpful data. When I

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25 tried to dissect out that "new" Ohio program, I would have

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

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

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

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

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

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

1 And the whites are generally the back-up information.

2 And Lorraine, do we have another color?

3 MRS. KYTTLE: No, sir, only one little thing that

4 jarred us, and that is that the printer contracted out and,

5 therefore, we have several shades of the same color. A pink

6 is a pink, no matter what its shade is. It depends on what

7 contractor printed it.

8 MR. HILTON: What is a salmon?

9 MRS. KYTTLE: Mr. Hilton, the salmon indicates materials

10 generated by staff or the initial review of the Staff Anniver-

11 sary Review Panel.

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

13 MRS. KYTTLE: We are all swimming upstream.

14 DR. MAYER: Other comments?

15 DR. PAHL: I do have one or two points of information

16 for you. And then I have something to state about the kidney

17 proposals. So let me take up the first two points relative

18 to information at this time.

19 There has been over many months now an increasing

20 need by RMPs for a clear statement from RMPs relative to the

21 responsibilities and relationships of the grantee, the RAG and

22 the coordinator. And many months of staff work have now gone

23 into a statement which has been looked at by the steering

24 committee of the coordinators and has received the approval

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25 of the HSMHA grants policy office. And we will be getting out

1 hopefully within the next week or two weeks a statement on
2 responsibilities and relationships of RAG, grantee and
3 coordinator.
4 Now, we are aware that by making this statement,
5 and it will be policy, there will have to be some modifications
6 in some of the RMP regions' by-laws and relationships. But in
7 general this is what the director and HSMHA and the steering
8 committee of the coordinator believe is appropriate. And
9 since it is rather lengthy, I won't read it into the record.
10 We do not have it for you today. We have been
11 working intensively to make such a deadline, but have been
12 unable to get the HSMHA clearance in order to do so.
13 The value of this, I think, will be that for once
14 there will be an opportunity for both the regions and their
15 organizational groups and ours to have a common document to
16 look at as we discuss problems which do arise in the various
17 regions.
18 In general, the key statement which has been itself
19 so easy to read and has taken so long to get clearance on, I
20 would like to read into the record because I think the rest of
21 it amplifies this statement.
22 The grantee organization shall manage the grant of
23 the Regional Medical Program in a manner which will implement
24 the program established by the Regional Advisory Group in
25 accordance with Federal regulations and policies.

1 And then there are a number of items describing in
2 detail the role and responsibilities of the grantee, the
3 Regional Advisory Group and the coordinator who in this document
4 is also identified as the chief executive officer. And it
5 represents, I think, a major step forward. And there will be
6 some specific, isolated problems, but most of the problems
7 which have arisen are because of misunderstandings and lack
8 of agreement as to a common theme.
9 So we do hope that this results in better understandings
10 and relationships. And over the course of the year, I am sure
11 the few specific problems will be able to be worked out on a
12 negotiable basis.
13 MISS ANDERSON: Are you going to include the make-up
14 of the RAG and definitions of what consumer is?
15 DR. PAHL: Not in this document. As we have brought
16 before you at earlier times, there is a requirement by the
17 Department that more aspects of all HEW programs be put into
18 regulations. This is a mandate by the Secretary's office,
19 and we are proceeding as we develop these documents to then
20 couch them in broader, more general language in terms of
21 regulations. We are trying to keep the formal regulations
22 as broad as possible to provide maximum flexibility to both the
23 regions and ourselves and to use these statements to make
24 explicit what is understood and intended and HSMHA policy.

25 But the points you mentioned are not in this

1 document and probably will be the subject of further work.
2 These take quite a while to get everybody to come to some
3 agreement on.
4 DR. MAYER: When will these be released, Herb?
5 DR. PAHL: It has been cleared by HSMHA. I would
6 expect in the next two weeks we would be able to begin
7 mechanically getting them printed and out.
8 The second point I would mention is that HSMHA has
9 now established a policy effective April 11 -- and this is only
10 for your information -- which now makes it a requirement,
11 places it as a requirement, on all HSMHA programs to inform
12 the appropriate regional health director of any proposed grant
13 or contract to be made by HMSHA in that HEW region and to give
14 to that regional health director the opportunity to comment
15 upon prior to the final decision either grant or contract.
16 He is not required to submit comment, but he must be provided
17 the opportunity to make comment.
18 It also is a requirement that once the disposition
19 has been made, either approval or disapproval and award level,
20 this information must be given back to the regional health
21 director. Obviously, this is in the interest of keeping him
22 better informed about all activities, whether they are managed
23 in his office or not, but which come from HSMHA. And we have
24 already implemented this relative to our grant activity in that
25 we are soliciting for current applications to go to the June

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

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

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

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

1 There has been a very great amount of effort in
2 trying to develop this issuance and without going into that,
3 let me read to you, then, what the summary of the review
4 process at the local and the national level is which is
5 effective now and, therefore, pertains to the activities of
6 the meeting of this committee.
7 Starting off with the technical review process at
8 the local level and forgetting about initial discussions which
9 may occur between the region and RMPS staff as a concept for
10 a kidney proposal develops, but starting with the technical
11 review process at the local level, the issuance reads:
12 Prior to submitting application for a renal
13 disease program, the RMP is expected to obtain a technical
14 review of the proposal by a group which has not participated in
15 the program's development. The technical review group must
16 be comprised of at least three renal authorities from outside
17 the geographic area served by the region. Payment of the costs
18 of such consultant services will be made by the requesting RMP.
19 The region may obtain the names of consulting renal
20 experts by calling the appropriate Operations Branch for
21 assistance. The Division of Professional and Technical
22 Development maintains a list of renal consultants, and is
23 responsible for coordinating their assignment. Should the RMP
24 desire to choose its own review panel, the names and curriculum
25 vitae of prospective consultants must be cleared with the

1 Division of Professional and Technical Development.

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

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

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

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

25 The complete comments of the members of the technical

1 review committee, and any CHP agency comments, must be included
2 in the forwarded proposal.
3 RMPS Staff Review - the initial review at RMPS shall
4 include:
5 a. The contribution of the project toward kidney
6 program objectives.
7 b. The completeness and nature of the comments of
8 the RAG.
9 c. Comments of CHP agencies.
10 d. The preferred method of funding.
11 RMPS Review Committee - RMPS staff will summarize for
12 the RMPS review committee available information as to how each
13 kidney proposal proposes to support the National Kidney Program
14 objectives, and the substantive points developed through local
15 review processes by the Technical Review Committee, the RAG, and
16 the CHP agency. For those applications for which the RAG;
17 CHP agency; director, RMPS, or RMPS Review Committee has
18 indicated a concern apart from the technical merits of the
19 project, the RMPS Review Committee will be asked to make a
20 recommendation to the National Advisory Council.
21 The RMPS Review Committee specifically will not
22 review on a technical basis the merit of the proposal, or
23 establish formal numerical ratings for individual proposals.
24 And, finally, section 6, Council Review - all kidney
25 proposals shall be submitted to the National Advisory Council

1 for final recommendation. In keeping with the categorical
2 nature of the kidney disease program within RMPS, the Council
3 will review and recommend funding levels for kidney proposals
4 separately from the funding level of the specific RMP. Kidney
5 program funding will be in addition to other RMP program funding.
6 Now, those are pages 3 and 4 of this issuance. And
7 I would like before we entertain discussion, because I think
8 this is not in the complete framework, to have Dr. Hinman
9 have distributed to you these which were just issued and perhaps
10 comment on some of the other features of this -- namely, the
11 framework of kidney program objectives.
12 DR. MAYER: Before we do that, could we talk about
13 the specific role of this review committee --
14 DR. PAHL: Of course.
15 DR. MAYER: -- to make sure we have got that under-
16 stood?
17 DR. PAHL: Of course, Bill.
18 Perhaps what I should do is indicate to you that the
19 review committee responsibilities are on page 4, item 5, and
20 if we can have Dr. Hinman come up perhaps the two of us
21 can try to respond together with Dr. Margulies to the
22 questions that may be raised.
23 DR. MAYER: I guess my problem relates to how we
24 deal with this. We are not dealing with the technical aspects
25 of it. We are dealing with its presumed relationship to the

1 rest of the regional activities. Is that correct?

2 I am trying to get a feel for what is our role

3 vis-a-vis the kidney projects.

4 DR. PAHL: Well, this issuance came about as a result

5 of the extended discussion at the last committee meeting and

6 at the Council subsequent to that meeting. And perhaps in

7 order to abbreviate it, Dr. Margulies can reiterate, I think,

8 what was a statement to the committee that afternoon of the

9 second day and which has been embodied in the principles

10 enunciated here.

11 So let me ask Harold --

12 DR. MAYER: I need to have a positive statement,

13 perhaps with examples of concerns apart from technical merits

14 which is what it defines as this and what kind of range is that.

15 DR. MARGULIES: I think the most important issue here

16 is the one that we wrestled with over quite a period of time.

17 And that is the relationship between a proposed kidney activity

18 which may be technically satisfactory and a Regional Medical

19 Program which may have some problems with it.

20 At one time, we had been operating with, at least,

21 the implicit assumption that an RMP which was in real trouble

22 was probably not a very good site for the establishment of an

23 effective categorical kidney program. That appeared in many

24 ways to be as a general principle unacceptable and unworkable.

25 So what we would ask the review committee to do with that kind

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

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

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

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

1 And that is exactly the kind of situation we are talking about.
2 One of them is a possibility that the kidney program
3 will be the only thing in the activity which is any good.
4 It will be relatively large. It will not involve the Regional
5 Medical Program in any kind of regionalizing activity and
6 under some circumstances, based upon your judgment of those
7 circumstances, might serve as an excuse for the RMP to go on
8 doing a bad job because they are doing something good with the
9 kidney activity, in which case you might decide no matter how
10 good the kidney activity is,the total result for the whole
11 region will be made worse rather than better.
12 The alternative probability is that a kidney program
13 which is put together which is truly regionalized and which is
14 designed to meet the needs of the population in the best
15 possible way may prove a good vehicle in a weak program for
16 learning how to do things in an integrated, effective fashion,
17 and might be an additive stimulus to it.
18 There aren't any specific rules on that. Those are
19 the kinds of events you have to examine on an individual
20 basis. And it is exactly that kind of dilemma which the review
21 committee, I am afraid, is going to have to deal with. I don't
22 know any sharp rules for it.
23 DR. MAYER: Sister Ann Josephine.
24 SISTER ANN JOSEPHINE: I can anticipate another problem
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25 where the consultants do not have to examine the project on

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

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

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

11 DR. MARGULIES: It doesn't?

12 SISTER ANN JOSEPHINE: No.

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

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

1 the region, whether this would suffice or not.

2 It is very similar in the anniversary applications.

3 This body sits in review without having physically gone to the

4 region to site visit.

5 DR. PAHL: Sister Ann, I believe that both of the

6 questions that have already been raised and those that will

7 come up, you really have the answer couched in this statement

8 by exception which is as broad as we could conceive it to be

9 and yet be helpful. And that is, where the RAG, where the

10 CHP agency, where the Director and his staff, or where the

11 review committee has a concern apart from the actual technical

12 merit of the proposal, then this review committee is asked to

13 review the data and to make a recommendation.

14 Now, the concern can be on any point. We felt there

15 were occasions when it would not be necessary to make a full

16 site visit because of recent actions by staff or knowledge.

17 And we were trying not to bind every applicant into a specific.

18 We would imagine that most activities would involve site

19 visits, but we wanted to be free on that. But if there were

20 a concern by any party to this review process that it weren't

21 an adequate, valid review, this committee is given the full

22 responsibility for raising that concern, having full information

23 from the staff, and making whatever recommendation it so

24 desires to the Council.

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

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

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

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

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

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

24 DR. MARGULIES: That is right.

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

1 pertinent one.

2 DR. MARGULIES: I think it is a pertinent one.

3 The difficulty we find ourselves in in following your

4 suggestion is that we are still trying to maintain some reasonable

5 balance even in the categorical activities between a centrally

6 controlled activity and one which is locally developed.

7 You might raise the same question about technical

8 review for all activities in a Regional Medical Program.

9 The basic plan for non-kidney activities is the technical

10 review is carried out under the purview of the local Regional

11 Medical Programs selecting its own specialists and its own

12 consultants, its own advisers.

13 The reason we have made an exception in the kidney

14 activity is no more complicated than the fact it is almost

15 impossible to get technical review by people within the RMP

16 without involving those who will be in fact in the project.

17 And all we are really aiming for is to make sure that those

18 who are not actively personally interested are involved in the

19 review. And so long as they select competent people, the

20 individual selection, it would seem to us, is reasonably

21 left in the region as it is with all other technical review.

22 DR. SCHERLIS: Then you are particularly exempting

23 any technical review by this committee, are you not?

24 DR. MARGULIES: That's right.

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

1 as our chairman does.

2 DR. MAYER: Let me make a suggestion, and I am not

3 sure what your time is and Dr. Hinman's time, but we have been

4 at it two hours in terms of time sequence. And I have a

5 feeling we are getting a little heavy sitting. And let me

6 suggest we take a 15-minute break at this point in time and

7 then come back.

8 (Whereupon, a recess was taken.)

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

10 We would like to go back to pick up where we were

11 on the kidney proposal issue and see if there is further

12 discussion about that.

13 Yes, Phil.

14 DR. WHITE: It is with some degree of pleasure that

15 I can make this comment without fear of the future, but it

16 has been interesting to watch the gradual emasculation process

17 that goes on in the sense that we were never allowed to drink

18 coffee in these conference rooms, some short time ago,

19 we were told not to look at projects, today we are prohibited

20 from smoking. And in view of the new guidelines, it probably

21 will be unnecessary for us to make any decisions in the near

22 future.

23 I hope that the remaining members of the committee

24 can be comfortable with this gradual process.

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

1 I wanted to ask a question. How many renal consultants
2 are there to draw from? I asked because I got the impression
3 the numbers are so small, so-called qualified ones, that it
4 ends up in a sense of a kind of round robbin in which the
5 same persons are repetitively looking at them. And I ask
6 that because then it would bring some reality to the question
7 if, indeed, the region can select its own consultant and
8 there are precious few of them, what liberty is this in the
9 final analysis?
10 DR. MAYER: Does someone have information? Ed, do
11 you have information on it?
12 Did you all hear the question?
13 DR. HINMAN: The question revolved around the number
14 of consultants we would keep available, the names we would
15 keep available here to assist the region.
16 At the time that decision was made to proceed in
17 this direction, we mailed out requests to approximately 55
18 different experts in the field we felt could be of use in this
19 activity. I don't know exactly how many responded yet, but
20 we would anticipate having a list of about 50 people regularly
21 who could be used by the regions in the review process.
22 I would like to address this issue of the reviewers
23 a little more since it was the subject upon which the coffee
24 break was taken. It is sort of appropriate the coffee break

25 was taken during the kidney discussion. I assume that a

1 bladder break is involved, too.

2 The issue of who does the technical review is one

3 that has been of major concern. The point that Dr. Spellman

4 just raised about the number of consultants was the reason that

5 prompted us to insist upon there being people from outside

6 the region. Because if you can imagine within any one RMP,

7 the total number of consultants that could be available and

8 would have the competency to do the kind of review we are

9 looking for is such that they almost undoubtedly will be

10 involved in the projects initially.

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

12 it.

13 DR. HINMAN: That's right. Or if they are not, it

14 is because they are from another medical school and have

15 the scratch-each-other's-back approach.

16 So what we were concerned about was attempting to

17 assure there will not be a casual or cavalier approach to the

18 technical review. So the decision was made to insist upon

19 three people from outside the region.

20 Now, it is impossible for us to keep up with who

21 might qualify on a monthly basis or semi-annual basis. And this

22 was the reason why there was the freedom for the region to come

23 to us and say, "May we constitute our review committee from

24 someone other than those on your list?"

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

1 "Who is on your list we can call," they have not proposed
2 ringers from the outside.
3 The criteria we would be concerned about is that it
4 be someone who has technical knowledge in the area, i.e., if
5 it would be a pediatric nephrology type of application, one
6 dealing with children only, I would be very distressed if the
7 technical review were done only by physicians treating adults
8 only because the problems of children with kidney disease are
9 different than those of adults with renal disease. So we do
10 have the right to say that this is not an adequate review
11 committee.
12 We also have added the requirement that the written
13 reviews be sent to the national level, be available for
14 perusal either by this group or advisory council or by staff.
15 This will tend to limit again people giving a very superficial
16 review, I would think. And it is conceivable some people would,
17 but again the number of potential consultants being, as I
18 said, in the 50 to 70 range, the number of potential applications
19 being in a similar range, possibly if each region had
20 applications in, again I would be surprised if someone who
21 is potential applicant from Region A would gloss over a poor
22 application of Region B because he in turn is going to be
23 submitting an application somewhere along the line. So I think
24 it will be somewhat of a policing activity.

25 Of the reviews that have come in so far since the

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

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

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

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

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

24 DR. HINMAN: Content if it is disparate from the

25 national priority. This is one other area, thank you, that I

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

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

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

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

2 DR. MAYER: Let me ask one more, and I will stop.

3 And that is the concern -- and this is an issue I was trying

4 to get out but doing it poorly before the break, let's see if

5 I can do it better after -- about the issue of regionalization

6 process.

7 One of the things I commented on is a good region

8 that is going through that process or a poor region that

9 isn't and a kidney program that is. And my problem is who is

10 looking at that regionalization process? In other words, you

11 can have the greatest technical competence in the world across

12 the street from one another who are not interrelating in a

13 regionalized effort in kidney disease.

14 Now, I guess I need to have a feel for who is looking

15 at that. And if I am not out there to sample that and if that

16 is a part of the responsibility of this committee, somebody

17 has got to be out there to see about that issue. Or is it

18 a responsibility of technical review? Who has that responsi-

19 bility?

20 DR. HINMAN: The basic responsibility for regionaliza-

21 tion rests in the hands of the regional advisory group in

22 each RMP. We see our staff role, my staff sees its role,

23 here to again watch behind this. As you know, there are the

24 regular review processes, verification review process, which

25 goes on which attempts to look at these issues of regionalization

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

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

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

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

23 DR. MAYER: Well, O.K.

24 DR. PAHL: Bill, let me try a statement. I think

25 this will be a continuing staff concern because it is one of

1 the basic themes of RMPS is to promote regionalization. The
2 responsibility for carrying out regionalization lies within
3 the local RMP, but this would be a point that staff would be
4 looking at and comes under the point of if the Director, RMPS
5 has a concern apart from the technical merits of the project,
6 it comes to this committee or if anyone on this committee has
7 such a concern. So that I don't think it is pinpointed to
8 just staff. But certainly it would be a responsibility of
9 staff to look at this and bring information to this committee.
10 DR. MAYER: Bill, you had a comment?
11 DR. THURMAN: Let's take a very specific example,
12 one you were recently on with us. And that was the Greater
13 Delaware Valley.
14 Going back to Bill Mayer's question, that regionaliza-
15 tion was not approved by the RAG. There are good facilities
16 across the street from each other which don't need to be there.
17 Who does have the responsibility for looking at the Delaware
18 Valley? Is that supposed to be the RAG? And if so, it certainly
19 doesn't work.
20 That is what Bill is really asking in a way.
21 DR. MARGULIES: This is a very key question. It
22 involves the whole change in structure.
23 One of the things that we have done in the process of
24 changing the review cycle from four to three is free a

25 considerable amount of staff time from the review process and

1 spend more time in the region.

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

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

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

16 DR. MARGULIES: Not technical review.

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

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

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

1 DR. MAYER: You should have used castration. That
2 goes either sex.
3 DR. MARGULIES: That's a little broader. It is a
4 little better.
5 (Laughter.)
6 There is no evading the fact that when you are
7 running a program as we are which is dealing 95 percent of the
8 time with Regional Medical Programs and the way in which they
9 function that you cannot at the same time use the same processes
10 on what is a narrow categorical project kind of activity.
11 And there is little doubt but that the review committee's role
12 with kidney review does not have the same penetration and the
13 same meaning as it does with triannual review, anniversary
14 review, and total attention which it gives to Regional
15 Medical Programs. And we have been saying that now for some
16 time.
17 What we are asking you to do is to look at the kidney
18 proposals in terms of the Regional Medical Program when
19 appropriate, but not ask yourselves to be technical review
20 people and not ask yourselves to be fiscal people in determining
21 what the actual budgetary level should be.
22 DR. MAYER: Leonard.
23 DR. SCHERLIS: I guess having started the problem
24 this far as the discussion of consultants, I would like to

25 pursue that further.

1 After carefully listening to you, Dr. Hinman, I
2 see no reason for --
3 DR. MAYER: Jerry, could you hand him the microphone?
4 DR. SCHERLIS: After listening to your comments as to
5 why the regions should select their own consultants, I can't
6 really discern the point you made. The mere fact that the
7 lists change, they change locally as well as nationally. And
8 I would think if a technical review is indeed to come to us
9 with all of its finality, as we have been told, that I would
10 much prefer that the technical review be done by consultants
11 wh are indeed selected nationally.
12 I see no reason for having local option on the
13 selection of consultants. And I would indicate that if the
14 review committee -- What is our responsibility? Do we have
15 any at all? In other words, if it goes from here to the
16 Advisory Council, is it assumed that we have made some action
17 upon it or do we just sort of ignore the fact there is a
18 kidney proposal?
19 The point I am going to make is if we have any
20 action whatsoever on this, I would find it impossible to make
21 such action unless the consultants are indeed appointed from
22 the national office and not selected locally. I would like
23 that point pursued in some detail. I have rather strong
24 feelings about it, and I would like to either have them altered
25 by your comments or carry it further to an action by the

1 committee.

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

3 DR. SCHMIDT: Yes.

4 It seems to me there is an inconsistency in what I

5 have heard about the reasoning for the local people to select

6 technical review locally and yet have them approve somehow

7 at national. There are national constraints to be placed

8 on the technical review process. There are few people to be

9 called upon. They have to be expert, I would think, not only

10 in the technical aspects of the renal programs, but also hope-

11 fully at least something also concerning Regional Medical

12 Programs and its purposes in funding these. The site visitors

13 have to be educated at least to some extent beyond simple

14 technical aspects of the renal program.

15 And the policy would be far more consistent and

16 understandable to me if regions could ask for people to be

17 placed on a national panel and thus the national panel broadened

18 by nominations, if you like, from regions of experts that they

19 would like to see and then have the technical review team

20 picked nationally and sent to a region. This would be a

21 consistent policy, at least, and would meet the desires as

22 I have heard them expressed.

23 And I believe as written up here, it is inconsistent

24 at some point. So I won't ask for comment.

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25 Again, I would like somebody to explain to me the

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

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

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

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

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

1 as too difficult a thing to achieve. And I think your points
2 are well taken.
3 DR. MAYER: Jerry.
4 DR. BESSON: If we can formalize that, then, and
5 bring it to Council so we can have an opinion rendered by
6 Council on that question, I would like for us to do that.
7 Because I would like to enlarge the question from that specific
8 point to the fact that that particular point is one manifesta-
9 tion of a much larger question that I think we should be dealing
10 with. And that is somewhere along the line we have got to
11 look at the whole concept of RAG review and local review and
12 wonder whether there isn't some kind of a built-in bias,
13 a kind of a Parkinson's law of making sure that anything that
14 you submit has local RAG approval that tends to remove this
15 committee's function of making some larger decision about
16 prioties. that I see in the rhetoric everywhere, but the word
17 "emasculation"is very appropriate. I think that function is
18 being removed from this committee's activities. And I wonder
19 whether anybody is assuming responsibility for it other than
20 someunknown, nameless, faceless people who are called vague.
21 Maybe we ought to dispose of this question first,
22 Len, and then get to the larger question that I think is a
23 very important part of it.
24 DR. MAYER: Would someone care to frame a motion
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25 relative to -- I gather the key issues are that the experts that

1 are brought into the technical program review at the local
2 level be selected by RMPS rather than by the individual region.
3 Is that the essence of it?
4 DR. SCHERLIS: Yes.
5 I would move that item 2 on page 3 be altered as
6 follows:
7 DR. MAYER: I think probably it is a recommendation
8 to Council that we are making, then.
9 DR. SCHERLIS: Yes, to Council be altered as follows:
10 That the technical review group must be comprised of at least
11 three renal authorities from outside the geographic area
12 served by the region, said authorities to be appointed by
13 RMPS.
14 Is there a second to that?
15 DR. THURMAN: Second.
16 DR. MAYER: Further discussionof that motion?
17 (No response.)
18 All those in favor?
19 (Chorus of ayes.)
20 Opposed?
21 (No response.)
22 O.K.
23 DR. THURMAN: At the risk of being called dense,
24 could I ask Dr. Margulies to say one more time what our
25 responsibility is. Because I didn't catch it when it went by.

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1 DR. MARGULIES: The responsibility for this
2 technical review is primarily by exception. Since it is a
3 technical review, it will be brought to your attention that
4 a kidney review has been completed. If the recommendation is
5 that it meets with the national priorities which are described
6 in the way that Dr. Hinman laid them out and which go back to
7 an earlier document which is an effort to have a national
8 network of kidney dialysis centers, if all the technical
9 requirements are met and the Regional Medical Program is a
10 good, sound program and we bring to your attention the fact
11 that the regionalization aspects are adequate, there really
12 isn't any need for you to take action on it.
13 When, however, these things are not true or when
14 there is a challenge which is brought up at any point in this
15 range of activities, then you do come into action.
16 DR. SCHMIDT: Is it implied by that that this
17 committee cannot raise an exception?
18 DR. MARGULIES: The committee can always raise an
19 exception. That is in the document .
20 DR. SCHERLIS: It specifically states on page whatever
21 it is -- 4 -- "Those applications for which the RAG, CHP agency,
22 Director RMPS, or RMPS Review Committee has indicated a
23 concern apart from the technical merits of the project, the
24 RMPS Review Committee will be asked to make a recommendation."
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25 So since technical is not clearly defined, I would

1 assume these are very restrictive definitions of that term
2 as far as raising an objection.
3 DR. MARGULIES: We would think that probably the
4 whole committee would not want to debate whether one form of
5 dialysis or another is better, but you certainly want to get
6 into the question of whether what is being proposed is going
7 to meet the regional needs.
8 DR. MAYER: Jerry.
9 DR. BESSON: Perhaps, then, if we disposed of that,
10 we can get to the larger question of emasculation. And it is
11 interesting, Phil, that at our break, I used practically the
12 same terminology in discussing with Len about a function of
13 this review committee. So I guess as incoming members emeriti
14 of this committee that our thoughts are not too far apart.
15 I would like to pursue this question if this is
16 an appropriate time.
17 DR. MAYER: Could I suggest, Jerry, that that is
18 a major, broad issue which I think is going to lead, appropriatel
19 should lead, to half an hour or more of discussion. And what
20 I would like to do is to red flag it, see how we are progressing
21 in terms of time, in terms of meeting our goals, and then come
22 back to it, if I could.
23 DR. BESSON: Sure.
24 DR.MAYER: To get a very real red flag on the agenda
25 to deal with it. Because I think it is an important issue.

1 We discussed it, as you know, at some length at the last
2 meeting and I think left feeling we had made some progress
3 in understanding that issue. Obviously there are still
4 concerns, and I think they ought to be discussed.
5 O.K., other items on the renal issue?
6 DR. HINMAN: Dr. Schmidt had raised another question
7 that was never answered on page 4, the second paragraph.
8 And what it was referring to was the fact that other parts of
9 the RMP applications are looked at as a whole and considered.
10 In other words, when you review any one of the ones that are
11 here today, the RMPS discusses as a whole, but the kidney is
12 notdiscussed with that application. And that is what those
13 two sentences refer to -- the first sentence.
14 The second sentence refers to the attempted process
15 to prevent having an application that is technically
16 meritorious passed in by a RAG, but does not reach toward the
17 goal of regionalized kidney resources throughout the country,
18 i.e., several regions are further along in provision of
19 treatment facilities than other regions.
20 It would seem that the regions that do not have
21 these facilities should have a higher priority than a screening
22 program, for instance, in a region that already has the
23 treatment facilities. A treating program may be very meritorious
24 but it is one of the ones that are not a topic of priority
25 list until we have the country better covered with facilities

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1 for the treatment of end stage renal disease patients.

2 DR. MAYER: Other comments on the renal issue?

3 Sister?

4 SISTER ANN JOSEPHINE: May I ask a question? I

5 notice on page 3 at the bottom which says, "Forwarding

6 proposals," it indicates the technical review committee and

7 then the RAG and then the CHP agency. Would there be any merit

8 in having the Division of Internal Medicine of the Medical

9 Association in its appropriate committee make some comment on

10 this? If the majority of the renologists were in the Medical

11 Association and in practice and weren't with the particular

12 group who were submitting the proposal, I would think that

13 their input would be rather significant in a case like this.

14 And this would be by exception, probably. I don't know.

15 DR. HINMAN: Sister, the proposals dealing with

16 transplantation, dealing with children, would not fit under

17 internal medicine. Proposals in which a large element is

18 public education, again, there would be other groups that would

19 feel they should have the same right to comment if it is

20 given to a single part of the Medical Society group.

21 SISTER ANN JOSEPHINE: I would like to think that

22 all the children would be the same, just by pediatricians.

23 But this is truly not the case.

24 DR. THURMAN: The majority are not.

25 SISTER ANN JOSEPHINE: Realistically, they are not.

1 DR. MAYER: Other comments?

2 DR. HINMAN: I would like if there are no comments

3 about kidney in general to get down to kidney specifically.

4 DR. MAYER: All right.

5 DR. HINMAN: There are nine regions that have

6 applications containing some element of kidney involved in

7 them, eight of which are in your folder and one which is

8 outside. There are two types of applications before the blue

9 tab and after the blue tab.

10 Before the blue tab, the first region having an

11 application is Nassau-Suffolk. Nassau-Suffolk has submitted

12 two requests for kidney activities.

13 The first is a donor program. And the purpose was

14 to procure cadaver kidneys from at least 24 donors each year

15 from seven named hospitals in which there is a physician

16 committed to the program.

17 The application further states they are working with

18 Metropolitan New York and New Jersey in an effort to design

19 a tri-region 910 application for organ procurement for the

20 entire area, but that pending the negotiation between the RAGS

21 and the staff and the individual RMPs, they would like to get

22 started.

23 The total amount requested was $27,060 for the first

24 year. This would be used to develop and train procurement

25 teams.

1 DR. MAYER: Let's see if I am clear on where we are.
2 Are we going to go through the renal applications separately
3 at this point in time? Is that the intent?
4 DR. HINMAN: Yes, sir.
5 DR. MAYER: All right, I guess I need to be referred
6 to what kind of material and where is it in the mass that I
7 may be making reference to.
8 DR. HINMAN: Well, there are some comments in the
9 Nassau-Suffolk on a white sheet, I believe, not having a
10 folder.
11 They are there, I see. It is right behind the yellow
12 one in Nassau-Suffolk.
13 DR. MAYER: Could I just make sure the committee has
14 where we are? Nassau-Suffolk, white tab, March 31, 1972,
15 Post-Mini SARP .
16 DR. HINMAN: Of the nine regions with kidney requests,
17 using the general guidelines Dr. Margulies had laid down,
18 eight of them are for your information. One of them is for
19 your advice and recommendations.
20 Nassau-Suffolk is in the former group. In other
21 words, my comments are informational to the review committee.
22 Unfortunately, as I also indicated a little earlier,
23 some of these decisions were arrived at during this week so
24 that the supporting material is not at the level that would be
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25 desirable either by my staff or by the review committee. We

1 are still going through what has been known for the last
2 several months as the transition period. And I would hope that
3 by the next meeting of this group, there will be tabs and
4 information that are easier to refer to than what you have
5 today.
6 This part of the renal organ procurement program
7 had been reviewed locally and approved by the RAG. The staff
8 review concurred in the reviews and is recommending approval
9 of this part of the application.
10 The second part of the application, a home dialysis
11 training program, the stated purpose was to develop 50 validated
12 modular single concept lessons for home dialysis. And in looking
13 at this part of the program, the investigators did not seem
14 to be aware of the fact that there were several home dialysis
15 training programs throughout the country that had already
16 succeeded in doing this quite well. They were requesting
17 $31,200 for this, and it was the recommendation that this be
18 disapproved and not funded and strong advice back to the region
19 which, incidentally, had been given to the region nearly a
20 year before, that in home dialysis training programs, names of
21 individuals who knew how to do it and advice to them as to how
22 to go about it, and they seemed to have ignored this.
23 DR. BESSON: Mr. Chairman, are we going to be talking
24 about these individually or are we talking about Nassau-Suffolk
25 now?

1 DR. HINMAN: No, sir. I was requested to present
2 sequentially in an abbreviated fashion the nine kidney
3 proposals that are in this review cycle.
4 DR. BESSON: Will they be reviewed as part of the
5 regional review?
6 DR. HINMAN: The reason for bringing them up ahead
7 of time is so when you did get to Nassau-Suffolk, for instance,
8 you would already be aware of what the recommendations were
9 on it.
10 DR. BESSON: They might be a little bit more in
11 context. Excuse me, Dr. Hinman, but I find myself not really
12 listening to what you are saying because it is totally out of
13 context with what our job is which is to look over individual
14 areas in the context of everything that is happening here.
15 Now, maybe that is my own inadequacy. But I just
16 mention that. If this is the procedure that is going to be
17 established, fine, we will do it.
18 DR. HINMAN: Whatever you all want. I have no
19 vested interest.
20 DR. BESSON: I would rather look at Nassau-Suffolk
21 in context so we would know what is happening there.
22 DR. MAYER: Yes, Mac.
23 DR. SCHMIDT: Bill, I believe strongly that castrated
24 is as castrated does. I support Jerry and believe these should
25 be looked at as we look at the regions.

1 DR. MAYER: O.K. Is that the consensus of the
2 committee?
3 I would feel more comfortable. That is why I asked
4 the question what is it that we are doing at this point in
5 time.
6 DR. HINMAN: Before I relinquish the chair --
7 (Laughter.)
8 -- my staff assures me these items I distributed
9 during the break were indeed mailed to the committee members.
10 One of them is a package dated February 25, 1972, and is the
11 guidelines for the EMS applications that Dr. Scherlis or Dr.
12 Besson, I am not sure which, referred to.
13 And the other is a series of three documents, one
14 dated March 13, one dated March 15, and one dated April 7,
15 that were sent out concerning the community-based manpower
16 development program. This was mailed just Tuesday night.
17 That is why many of you probably did not receive it. We
18 distributed that a little earlier.
19 DR. MAYER: I would be delighted to talk to whoever
20 your staff is who has got some validation that this material
21 was mailed.
22 DR. HINMAN: Believe me, as confusing as things
23 have been, I cannot be certain. That is why I gave them back
24 to you.

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

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

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

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

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

17 Nothing other than that, Bill.

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

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

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

1 so sometime today, since I am reviewing Ohio, I would like to
2 have the opportunity of taking that one up as primary reviewer.
3 And that is very intimately linked -- well, that is the wrong
4 statement. It ought to be, but isn't intimately linked to
5 Northeast Ohio. But the discussion ought to go on back to back,
6 I think, on those two.
7 Are there other specific problems?
8 John Kralewski will be in hopefully this afternoon,
9 and Dr. Brindley ought to be in this afternoon to pick up.
10 Is there anyone else with problems?
11 Phil?
12 DR. WHITE: I must leave by noon tomorrow.
13 DR. MAYER: Well, if there are no other major
14 conflict time scheduling problems, then what I would propose
15 to do would be to start out with the triennial review of
16 Oregon which has been site visited, which Dr. White does have
17 responsibility for.
18 Phil, it is all yours.
19 DR. WHITE: One is supposed never to preface comments
20 with an apology so I shall not, but I would like to explain
21 something to you as my presentation may be less than sparkling.
22 It relates to an experience which was somewhat distressing
23 which has left me distraught and discombobulated. It is a
24 comment on our health care system which perhaps RMPS may
25 eventually influence.

1 Tuesday, I arrived in Detroit because my father-in-law
2 broke his hip. This is not why I arrived in Detroit, it is
3 why I went to Detroit.
4 He was taken to a local hospital at 4:30 in the
5 afternoon. At 10 o'clock or shortly thereafter, he was
6 finally put in bed. He in the meantime occupied a corridor
7 along with a number of other elderly gentlemen who were also
8 apparently emergencies of one sort or another.
9 And I thought this was appropriate in view of the
10 emergency system which is being discussed.
11 In the course of his experiences there, he was taken
12 up to X-ray, presumably because this is essential to the
13 diagnosis of a broken hip or at least helpful. While there
14 he had an urge which perhaps relates to the renal problems we
15 have been talking about.
16 To my surprise, there was no urinal anywhere in that
17 vicinity, and no one who seemed to have the authority to
18 indicate where one could be procured. So I went down to the
19 emergency room myself. And being familiar with hospitals, knew
20 that they would usually be in a closet and procured one and
21 took it up. Someone was a little aghast that someone without
22 a white coat was carrying a urinal around.
23 While up in X-ray, during which time we saw very
24 few people, one of the other elderly gentlemen there had a
25 cardiac arrest. And suddenly, all of the doctors which were

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

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

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

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

24 And I am not picking on Detroit, Joe.

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25 (Laughter.)

1 Be that as it may, in March we did visit the Oregon
2 Regional Medical Program. And Dr. Thurman was with us as well
3 as Mr. Russell and Mr. Moore. And I understand Dr. Blomquist
4 isback there today looking at their kidney program.
5 There has been a turnover of coordinators in this
6 region over the years. I think this is, what, the fourth
7 different coordinator. And the present one has been on board
8 something about a year.
9 In the past, the activities of the Oregon Regional
10 Medical Program were largely educationally oriented. They had
11 circuit-riding teams going about talking about heart, cancer,
12 and stroke. They had coronary care training units and
13 other similar educational activities. They have an understanding
14 of the new mission of the Regional Medical Program Service
15 and have adopted objectives and goals which seem consonant with
16 those which have been suggested from Washington.
17 They have involved their regional advisory board,
18 as they call it, in this planning for the next three years.
19 And it seemed to us that they were deeply involved and did
20 participate. Their staff is involved. And Dr. Reinschmidt
21 who is the new coordinator is a seemingly capable man who has
22 spurred them on to changing their goals and objectives and
23 to participating in the development of these goals and
24 objectives.

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25 They are, as you can imagine, related to improving

1 accessibility of primary health services, improving the
2 quality of care and containing the costs, which are those
3 which are relevant these days.
4 They felt that these were in keeping with the
5 national guidelines and goals and were relevant to the needs
6 in Oregon.
7 They had different methods by which these goals
8 were to be achieved. They had different subsets of objectives
9 and goals which related to the primary ones.
10 We felt in reviewing this program that they had
11 given considerable thought and were realistic in their plans
12 and in the adoption of these goals and objectives.
13 The one perhaps weak area would relate to the fact
14 that their health data were weak, that there was some intuitive
15 process involved in the development of their goals and
16 objectives, although it would seem unlikely that Oregon's
17 problems were greatly different from those of the rest of the
18 country. Nevertheless, it was recommended that some effort be
19 undertaken to strengthen their data base so that they could
20 indeed determine whether or not their new activities would have
21 an impact on the problems in Oregon.
22 In the past as I mentioned, they have emphasized
23 educational activities. Nevertheless, they were also very
24 active staff people, and they were out stirring up interest,

25 developing relationships, and a highly qualified and dedicated

1 staff had been developed.

2 There needs to be a continuing effort to relate to

3 the community so that the new ORMP goals are more completely

4 understood and accepted by the community and so that the

5 community will have an understanding as to how they can best

6 use the Oregon Regional Medical Program. This is in the

7 planning stages. This is in themind of Dr. Reinschmidt, and

8 he has plans to increase the staff with this in mind.

9 Some of the projects that have been undertaken in the

10 past have been phased out. They have attempted to develop

11 other funding for these, and indeed, in the acceptance of the

12 project, there is clear understanding that funding by RMP

13 will be discontinued at the end of three years.

14 In some instances, at least, some of the projects

15 have been taken over by other funding mechanisms. Some of the

16 educational processes, for example, by tuition payments or

17 underwriting by some of the institutions benefiting from the

18 educational activities. Not all of their projects have

19 continued, however.

20 You might note in the printouts on the management

21 assessment sheets that there is some sharing of project

22 funding by other sources. In contrast to Kansas who said 100

23 percent of the projects were funded by RMPS money, you will

24 note that there is a variable percentage in Oregon.

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25 We looked at the minority interest. It is interesting

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

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

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

23 The core staff is made up of professionals. We
24 reviewed each person's credentials. We asked them to outline

25 their background and training for us. It seems that they were

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

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

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

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

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

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

1 There are no problems to speak of with the grantee
2 organization. The University of Oregon School of Medicine
3 is that organization. It adopted a hands-off policy from the
4 very beginning, acting only as the fiscal agent, and I think,
5 Dr. Pahl, completely conforming to the guidelines which you
6 read to us earlier about the relationships between a regional
7 advisory group and grantee organization.
8 We did note one problem in that the salary scale of
9 the University of Oregon School of Medicine was low. Dr.
10 Reinschmidt has had some difficulty in recruiting certain
11 kinds of people to his staff because he is not competitive.
12 They are examining the alternatives that are available to them,
13 and they may choose to go to the route of an independent
14 corporation. However, the services provided by the University
15 have value, and they do not want to undertake this change
16 lightly.
17 We recommend that they do give this serious thought
18 and look at the alternatives available to them.
19 During the site visit, we had a number of presentations
20 by other people from other health agencies, including a number
21 from the CHP B agencies, volunteer health associations,
22 Model Cities people, the president of the State Medical
23 Association, and so on. It was apparent that there was
24 cooperation and participation both by the RMP in those
25 activities and by them in RMP activities.

1 The RMP and the Oregon Medical Association are and
2 will continue working closely together to develop a peer
3 review system or some other quality assessment system that is
4 pertinent to the needs of Oregon. To some extent, through the
5 efforts of ORMP, there had already been developed by the
6 Oregon Medical Association a requirement that their members
7 take certain hours of post graduate education in order to be
8 eligible for membership in that body. And indeed I have
9 forgotten the exact number -- I think it was 11 -- members
10 of that society had been dropped from membership because
11 they failed to meet these requirements.
12 It was apparent, than, that the agencies in the Oregon
13 region called upon the ORMP for expertise and advice and
14 assistance, although perhaps there was a need for them to more
15 clearly understand what ORMP was all about. And we recommended
16 that there should be further elaboration of ORMP's role to the
17 other health agencies in the area.
18 There are comprehensive health planning agencies in
19 Oregon. There is a CHP statewide organization. Not all of the
20 B agencies are functioning well. However, there is a close
21 relationship between what does exist in the CHP and the ORMP.
22 They abide by the policies which require joint review and
23 comment where applicable.
24 I referred earlier to the fact that there was a
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25 relative lack of hard data in terms of health needs. And they

1 understand this. They have established what is called a
2 needs assessment unit as part of their new organizational
3 structure. And this presumably in cooperation with the
4 health resources unit in the CHP agencies where they exist in
5 the area will be undertaking some studies of what is necessary
6 in Oregon to develop a quality health care system, not just
7 only from the standpoint of defining where there is a lack of
8 anything, but perhaps more from the standpoint of the provider
9 defining what needs to be done, what process should be under-
10 taken, to meet the needs. This needs assessment committee
11 will overlook and guide the development of, they tell me,
12 17 different groups around the State consisting of physicians,
13 and I think 12 or 14 nurse groups of a similar type.
14 They will be directed by coordinators. It will be
15 their responsibility to determine and define what is required
16 in a particular area of the State. We felt that this was a
17 healthy change of direction.
18 We have little or no question about the quality of
19 management of this region. The staff was good. As I mentioned,
20 the fiscal agent was good. We found no evidence that there was
21 any problem with the way they managed their funds or kept a
22 handle on what was going on in the region.
23 However, related to this was the evaluation process..
24 I guess there have been some problems here in the sense that

25 with budget restrictions, Dr. Yagi was put on half-time rather

1 than full time as an evaluator. Now, he will be going back
2 full time, presuming this committee's favorable review.
3 And we suggested that they need to look at some
4 other kind of evaluation. They have been looking at process
5 evaluation rather than evaluation as to whether they have
6 achieved their goals or objectives. And I guess as somebody
7 has said, they have an H & H type of evaluation process, a
8 head count and a happiness index sort of evaluation.
9 Dr. Yagi, however, seemed a capable sort of person,
10 well organized, disciplined man, and we are hopeful that
11 something more will come from his full-time employment by the
12 Oregon Regional Medical Program. We are confident that he
13 will develop the techniques appropriate to assessment of
14 their achievement of goals and objectives.
15 Well, the action plan, I need not go into a great
16 deal more because I think I have covered it to some extent in
17 my previous comments. They are developing projects which will
18 be programmatically oriented, which will be consonant with
19 their goals and objectives. They are, indeed, looking at some
20 of the needs. They are, I think, action oriented.
21 We did have one question about action, and I guess
22 that relates to funding. You may note that in their request,
23 they have asked for growth funds. We had a little bit of
24 difficulty grappling with this because I wasn't clear in my

25 mind at the onset of the difference between growth funds and

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

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

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

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1 technological process rather than by transporting the
2 patient or the expert.
3 The family practice clinic was also a little bit
4 nebulous, I felt, in the sense that they were presuming that
5 with appropriate financial underwriting, they could establish
6 family practice clinics in areas where doctors had not
7 previously chosen to practice. We reminded them that Sears
8 Roebuck had not had favorable experiences along these lines.
9 They felt that perhaps this was more than just building a
10 building for someone to practice in; that they were going to
11 make an effort to develop teams to locate in these areas.
12 And if this is possible, then this would seem to be appropriate.
13 You may recall that in the Journal of Medical
14 Education a few months ago, and I can't remember the citation
15 specifically, there was a study of why people left practice
16 in rural areas. And it was clearly related to the fact that
17 doctors feel lonely when they are by themselves and that they
18 do need some kind of health professional team about them.
19 And if the Oregon Regional Medical Program can indeed generate
20 teams in remote areas, it might be a worthwhile experience.
21 So it is with reference to these sorts of activities
22 that they have asked for growth funds.
23 We feel that the Oregon Regional Medical Program is
24 strong. We feel that with some of these projected activities,

25 the development of the needs assessment unit and the health

1 resources unit, that the strengthening of the core, there will
2 indeed be improvement in their programs and projects.
3 I shall not, I think, go further at this point and
4 simply indicate that in general the team was impressed that
5 this was a good region and that it was making attempts at
6 strengthening regionalization, that it was trying to reach out
7 into the totality of the State in spite of the fact that about
8 70 percent of the population resides in Willamette Valley.
9 And I would like Dr. Thurman to make some comments at this
10 time if he wishes to do so before we talk about the funding.
11 DR. MAYER: Bill, comments?
12 DR. THURMAN: There is little to say. I agree with
13 everything that Phil has said. I think one of our major
14 concerns was that core staff is too small to do particularly
15 with the new thrust job that they are trying to do.
16 We were all impressed with one new man that they
17 had added recently and how much time he is spending on the
18 road and bringing things in.
19 I would underline one point that he made and that is
20 that their coordinator is so strong that if he had a coronary
21 tomorrow, they might be in trouble really because there is
22 no depth. So that all of us brought over to him again the
23 business of needing a deputy coordinator to pick up some of
24 these things.
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25 I think the only other two points I would underline

1 about what Phil said was that they really don't understand
2 what consumers are or have not understood what consumers are
3 and had not made a truly honest effort despite the fact that
4 one of their core staff was specifically assigned this
5 responsibility. I believe that our site visit was very
6 useful to them from that standpoint and that they understood
7 what we were trying to say, they thought we were saying it
8 reasonably nicely. And I believe that they intend to move
9 on with that relationship.
10 The other point was the one he made about a fair
11 amount of their money goes to help develop programs for
12 other agencies. And despite that, there are a great many
13 people who do not see any visibility for the Oregon Regional
14 Medical Program. Dr. Reinschmidt recognizes this. I am not
15 so sure that he knows how to correct it. I am not so sure that
16 anybody knows how to correct it. But it is interesting how
17 well he has done with his money in helping other people get
18 their programs off the ground. But it has not provided the
19 visibility for RMP in Oregon that it might have otherwise.
20 I close all that by saying I was very impressed with
21 this program.
22 DR. MAYER: Mr. Moore, do you have additional comments?
23 MR. MOORE: No.
24 DR. MAYER: Phil, your recommendation?

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

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

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

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

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

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

21 DR. THURMAN: Second.

22 DR.MAYER: Questions or comments by the committee?

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

1 DR. HINMAN: Because that is included in that.

2 DR. MAYER: The only reason I didn't mention it was

3 simply because I had heard somebody say that there was somebody

4 out there today.

5 DR. HINMAN: Part of this application from Oregon

6 includes a cadaver organ procurement application. At the time

7 that the CHP A agency established its health plan for the

8 State, kidney was a major activity and was a well-outlined

9 plan for entry points into dialysis and to transplantation

10 which design was accepted by the Governor. Parts of it,

11 particularly the dialysis aspects, have been implemented

12 to date.

13 Their application requests funding to enlarge organ

14 procurement activities throughout the State, particularly in

15 this valley right here where most of the population resides

16 and in which there is an interstate highway and a lot of

17 carthage on the road. So that the availability of organs

18 is right in this particular area.

19 They also are requesting funds to expand their

20 transplant capabilities. The VA hospital in Portland has been

21 approved to increase its transplant capabilities. It is targeted

22 to procure sufficient organs for the needs of all the residents

23 in the State, both the veterans and non-veterans.

24 This was reviewed locally by the RAG and by a

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25 staff group. There was some concern about some of the budgetary

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

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

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

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

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

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

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

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25 DR. MAYER: Comments on the motion?

1 Jerry?

2 DR. BESSON: Phil, do I understand then for this

3 fifth year, you are recommending no growth funds?

4 DR. WHITE: No, we are recommending growth funds,

5 but substantially reduced from their request, Jerry.

6 DR MAYER: Not in the fifth year.

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

8 fifth year.

9 DR. BESSON: I see.

10 In this summary sheet of what they plan to do with

11 their growth funds -- Oh, I see, they have just begun with the

12 sixth, used for the sixth year.

13 DR. WHITE: Yes.

14 DR. BESSON: In reading at least your reiteration

15 of their goals and priorities, and you mentioned the holy

16 trinity of cost containment,the quality improvement, and what

17 was the third?

18 DR. MAYER: Accessibility.

19 DR. WHITE: Accessibility.

20 DR. BESSON: Increased access to care -- that

21 they have some money set aside in their growth fund for the

22 additional funding of the establishment of a peer review

23 organization on a statewide basis. $50,000 was set aside for

24 the second year. And since they are being funded currently

25 by the National Center for the development of such an organizatio

1 and if these goals are going to be more than just rhetoric
2 as far as Oregon is concerned, I wonder if in our letter to
3 them explaining the action of Council, whether it might not
4 be appropriate for us to encourage them in the use of their
5 growth funds for this kind of activity.
6 There is precious little that review committee can
7 do. Perhaps this might be one thing they can do. And there
8 is no need to make a motion, but I would just like to call
9 attention to that use of growth funds and encourage it.
10 DR. MAYER: Phil, would you care to comment on that?
11 DR. WHITE: I am sure that they would welcome this
12 recommendation. They are highly interested in this area,
13 and I think if we were to encourage them, they would become
14 more active.
15 DR. MAYER: Could I raise a comment about the
16 growth funds and the principles inherent therein?
17 As we move toward anniversary review, triennial
18 review, whatever you want to call it, it said that each
19 program would hae the option of and has the responsibility
20 of coming in annually for an update of their requests. It was
21 my understanding when we did that that that provided a
22 mechanism for requests for new project proposals of the individua
23 regions once they have been fully formulated, fully approved by
24 the Regional Advisory Group, to find their way to Washington.
25 And I guess I am caught on the horns of a dilemma

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

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

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

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

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

25 DR. WHITE: Surely. I think they do.

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

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

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

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

1 very appropriate way for Oregon to be moving in contrast to
2 some others that we will discuss over the next couple of days
3 that are going in the totally opposite direction, and we
4 would discourage by turning off funds.
5 This is a way of supplementing their request. I
6 like the idea. I have not encountered it before. But I think
7 it is a good one.
8 DR. MAYER: O.K., further comments?
9 MR. HILTON: Just a question, really. I am going to
10 take advantage of my newness to this committee.
11 Is there still a distinction between this term
12 "growth funds" which is new to me and the developmental
13 component?
14 DR. MAYER: I have no problem with that because I
15 think that what they are saying is in terms of the developmental
16 component that that is priming, catalytic kind of dollars.
17 And they are saying that growth fund, if I understand it, Phil,
18 are dollars for new projects --
19 DR. WHITE: That's about right.
20 DR. MAYER: -- as yet not formulated in final form,
21 but have at least come along far enough so that they can see
22 that they are going to be in final form within a finite period
23 of time.
24 DR. WHITE: That is essentially correct. And they
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25 justified this in a sense that in the past they have gone

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

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

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

25 MRS. KYTTLE: Dr. Mayer.

1 DR. MAYER: Yes. Mrs. Kyttle.

2 MRS. KYTTLE: In back of the tab labeled "Council

3 Highlights" in your books is a resolution passed last Council

4 that says unless the review procedures have stipulated to the

5 contrary when regions enter a triennium, the approved levels

6 of the first year will hold for the remaining two approved

7 years of the triennium.

8 We had to move to that because Oregon, like several

9 other regions, proposing a triennium, particularly in your

10 fifth year, and it catches you betwixt and between with a

11 program that is ongoing and yet in the next year it will drop,

12 was attempting to establish a level for its triennial period

13 within which it could move in its triennium. That is the

14 concept of the approved triennium.

15 And yet, these regions when they map out their second

16 and third year of the triennium are not in a position at that

17 time to specify the exact projects and the exact budget that

18 will preserve a level. So with last Council's action that

19 unless there is a certain reason for a decreasing level in

20 the triennium, the first year's level of the triennium will be

21 the approved level, not necessarily the funding level, but the

22 approved level for the remaining years of the triennium.

23 DR. MAYER: Well, where does that then relate to the

24 annual review within the triennium? They are saying is that

25 option now no longer possible vis-a-vis the action of the

1 Council?

2 MRS. KYTTLE: O.K., within the action of the Council

3 establishing a level for the triennium, at the anniversary

4 a region may come in and propose uses of the dollars up to

5 the approved level by Council. And that is an action that

6 staff anniversary review panel considers and reports to you

7 about.

8 Should they request the use of dollars beyond that

9 level, then that would come to committee for action.

10 DR. MAYER: But that option is still available.

11 MRS. KYTTLE: Oh, yes, indeed. They may request a

12 second year triennium budget that is over the level of the

13 approved level for that year of the triennium if the staff

14 anniversary review panel recommends that that level be

15 increased. And I think last time Tri-State was one that came

16 to committee because staff was recommending the second year

17 of the triennium level be increased, but there was no other

18 way for regions other than to forecast a program three years

19 ahead that might radically change than to either do as Oregon

20 did, provide growth funds, you remember Western Pennsylvania

21 did it when they went to triennium. They were trying to

22 preserve a level, give you inklings of what they would go into.

23 But they are not yet ready to be specific about it. And it

24 led to the policy from the Council last time.

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

1 that I have raised, though.

2 DR. WHITE: No, I am not sure that is correct. At

3 least my understanding is that the second and third year budget

4 shall be not less than the --

5 DR. MAYER: Let me try it again.

6 MRS. KYTTLE: I was waiting for your action because

7 this one increases.

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

9 DR. SPELLMAN: Is that what you said?

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

11 MRS. KYTTLE: It would not be less than the level

12 established for the first year unless committee said, "Yes,

13 we want this decreasing because we don't like that."

14 DR. MAYER: But that doesn't answer the question which

15 I raised which is what is existing policy of the Council in

16 terms of this group taking action on providing contingency

17 funds for growth. You know, without clear-cut evidence of

18 what it is going to be used for.

19 DR. SCHMIDT: You are saying it is a new way to get

20 money. Is that what you are saying?

21 DR. MAYER: No. I am saying is it consistent with

22 existing policy of the Council and in that sense legal?

23 DR. PAHL: Bill, we don't have a clearly formulated

24 Council policy on the point that you are raising. And at this

25 point in time, the concept of developmental components and growth

1 funds which has been coming into it has not been fully assessed
2 by staff. This is one of our agenda items because we are
3 getting into various ways of providing flexibility to the
4 region. So it is appropriate at this committee meeting to
5 make whatever recommendation you want to the Council, and they
6 will be asked to establish a policy in connection with these
7 various ways of funding.
8 But you are not inhibited at this point in time
9 from recommending favorable action on growth funds if you so
10 desire and to recommend different levels of funding for the
11 different years requested.
12 Nothing in the Council policy that Lorraine mentioned
13 is restrictive. Both this committee and the Council may set
14 whatever levels for the individual years are decided upon.
15 It is just thatunless special action is taken by the Council,
16 then a level is fixed.
17 DR. MAYER: Let me try it once more with my problem.
18 My problem is I sit here knowing a year and a half of effort
19 and energy of a lot ofpeople went into establishing the
20 policy of the developmental component. And I think that was
21 appropriate because out of that came some guidelines that were
22 known to everyone in the world about what developmental
23 component is.
24 We are now talking about growth funds. And all I am
25 saying is to me that sounds like it is as every bit as big, if

1 not a larger, policy issue than the developmental component.
2 And rather than deal with that on an ad hoc basis, I would
3 just want to get it flagged as an issue that ought to be
4 looked at and guidelines established rather than doing it on
5 a hit and miss kind of ad hoc sort of basis.
6 DR. PAHL: There is complete concurrence. It is
7 just a question of priorities. We haven't had an opportunity
8 to do this.
9 I should say that although the concept of developmental
10 component was clear at one time which meant that there would
11 be additional funds as a reward, it turns out that as one
12 moves into the triennial period and where there has been
13 responsibility delegated to the region for funding projects
14 within the Council-approved program without coming back and
15 looking on a project-by-project basis and where no additional
16 funds are being provided because the developmental component is
17 awarded, the concept of developmental component has been
18 changing. And right now, I don't think it is as clear as you
19 have indicated it was when it was first enunciated.
20 Many times we approve the developmental component
21 without additional funds which gives them a flexibility within
22 their program. But by now, going on to a three-year basis,
23 they have practically all the flexibility that they need
24 within their program. And the whole concept of what develop-

25 mental component is actually accomplishing under a level budget

1 is quite different than what it was under a rising budget.
2 And this is the question that staff and Council must discuss.
3 And it is further complicated by this new concept of
4 growth funding that has come in.
5 So we are not in a position to say there is a
6 Council policy or that there has been a staff analysis and
7 clear statement policy. These things have yet to be done.
8 So you are free to flag the issue, and we will be coming to
9 this as quickly as we can. But we don't have a policy for
10 you, and Council doesn't have a policy that I know of at this
11 particular point in time.
12 DR. MAYER: Phil.
13 DR. WHITE: I think it is worth bringing to Council's
14 attention, and I think it is worth pointing out that this region
15 and I hope all, are full of integrity and honesty, but they
16 could have said these are projects we are going to undertake,
17 that we have them fully developed and planned, and we know
18 precisely what we are going to do, and put down a budget and
19 say, "This is it." This way they were honest with us at least
20 and said, "We are going to move in these directions, we don't
21 yet know what it is going to cost, and this is our estimate."
22 Their estimate varies from ours a bit, but I think
23 something ought to be done to deal with these sets of
24 circumstances.

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

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

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

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

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

13 Yes, Mrs. Silsbee.

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

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

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

23 Jerry?

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

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

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

11 DR. BESSON: Yes.

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

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1 So I think you might consider now adopting a
2 single term and that you look at it only in terms of the
3 increment above the first level of funding. It wouldn't make
4 any difference there, and that would take care of what everybody
5 is talking about.
6 DR. MAYER: Could the chair try to separate these
7 two out? They are linked, but I would like to deal with
8 the individual proposal and then deal with the policy issue
9 if we could.
10 DR. BESSON: Then I will withdraw.
11 DR. MAYER: Because you may find yourself in a
12 position of having to vote against the recommendation that
13 you might agree with because you are disagreeing with the
14 principle. And I think that would be inappropriate.
15 DR. BESSON: O.K.
16 DR. MAYER: Further comment on the recommendation
17 of the site visitors relative to the funding and level of
18 funding for the Oregon RMP?
19 MR. MOORE: I would like to add one point.
20 DR. MAYER: Yes, Mr. Moore.
21 MR. MOORE: Of the seven growth fund activities they
22 are presently participating in five as a part of planning
23 feasibility and core activities. So these are not new
24 activities per se. And the use of the term "growth" that
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25 should the feasibility planning studies grow to a point of

1 projects in the following years, then they would be
2 submitting such projects.
3 DR. MAYER: Further comments?
4 (No response.)
5 Everyone clear on the motion and recommendation?
6 All those in favor say, "Aye."
7 (Chorus of ayes.)
8 Opposed?
9 (No response.)
10 Now, the question is how do we deal with the issue.
11 I think it needs to be flagged, obviously, as a policy issue.
12 And maybe, Jerry, the approach that you are taking is the
13 obvious one. I just have a feeling that the implications
14 of that are moderately significant in terms of how people change
15 in approach. And having been in on that discussion on a
16 developmental thing as many of us were, that got to be pretty
17 sticky. And I am not sure that it isn't just raising the
18 flag of the policy issue in suggesting that an appropriate
19 group be called upon to look at that issue and to insist or at
20 least to suggest that representation on that group come off
21 of this review committee as well as off of staff and Council.
22 I am just suggesting that as an approach. Maybe it
23 is as simple as you say.
24 DR. BESSON: In the interests of being even-handed
25 with the bandying about of the notion of emasculation, I think

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1 putting some -- I will block that metaphor that just came to
2 mind -- but getting the review committee back in the saddle --
3 (laughter) -- that I would like to keep this idea of a growth
4 fund separate.
5 Let me reintroduce my motion. But I would like to
6 keep it separate from the developmental component mentioned
7 because I think it really says something different.
8 If there is some merit to the idea that the review
9 committee by its action can tend to move this ponderous
10 machine in one direction or another, then the use of growth
11 funds can be what we used to do many years ago in awarding
12 funds for projects -- encouraging those that we said yea to
13 and discouraging those that we say no to. But now we can no
14 longer do. All we can do is award a lump sum and approve
15 general principles and process.
16 But this might allow us to indicate to a region that,
17 yes, they are doing what they should be doing and to other
18 regions that get zero growth funds, that can be a very obvious
19 sign to them that maybe this review committee and the general
20 direction therefore for how RMPs should develop may be somewhat
21 more re-established.
22 DR. SPELLMAN: I would just answer that by saying
23 that I think the differences between what the growth fund
24 and the developmental component are going to be used for in
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25 the future could be increasingly artificial. If you look at

1 that, it is only 13 percent different between the first and
2 second year.
3 What this means is this is just an assurance to
4 Oregon that they have a level of funding higher in the second
5 and third year with a wider latitude to determine what they
6 are going to do with that increment. That is all it is. And
7 I wonder, what Herb said, if people are already doing this
8 with the developmental component anyway, what is going to be
9 done with growth funds? It just doesn't seem to me any longer
10 to have any merit by creating two kinds of instruments which
11 in the final analysis are used for the same thing. That is
12 the only point I make.
13 DR. MAYER: Joe.
14 DR. HESS: As I have listened to this discussion
15 here, I have wondered how much of this problem would have been
16 eliminated if they had just not put in those two words "growth
17 funds," and left those projects listed under the headings and the
18 money attached to it and left the developmental component just
19 sitting there and get those two words out of there. How much
20 of this discussion we had had in the last few minutes would have
21 gone on?
22 DR. MAYER: If you are saying if they had formulated
23 projects that were there that the site visitors felt were
24 consistent with their goals and it was clear that they had
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25 gone through the internal review process, I would have no

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

2 DR. HESS: But what they are saying here, it seems

3 to me, is these are areas in which we want to develop

4 projects. This is not completely flexible money that can be

5 used for anything that happens to come along, but these are

6 ideas that we have that are partially formulated that we

7 think are appropriate to be in the regions that we are going

8 tofund. And they are projects in process which to me is a

9 different thing than developmental component which is sort of

10 flexible money that could be used for something that hasn't

11 even been thought about yet.

12 DR. SPELLMAN: But the evidence I gather is that

13 the differences between these are rapidly fading and indis-

14 tinguishable from what he tells me. The question is really

15 two years from now whether we will be able to tell them in

16 Oregon what is the difference between the way they use the

17 $75,000 and the $250,000. They may lose their definition. That

18 is all.

19 But I am in agreement with the principle that they

20 ought to have $75,000 plus the $250,000. I was just suggesting

21 that it be done in a way which in the future would make it a

22 lot less complicated than inventing nomenclature that is just

23 meaningless. It is the way of getting more money for the

24 second and third year.

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

1 me try it and see if this is acceptable: That the committee
2 is in favor of the conceptualization of the growth fund issue;
3 that if definitive policies are to be established relative to
4 growth funds and how they might appropriately be done, that
5 the committee expresses its desire to participate in those
6 decision-making processes.
7 DR. BESSON: But they can't do it because once the
8 anniversary review, once you fall into that slot, then you
9 no longer have control.
10 DR. MAYER: No, no. You are missing what I have
11 said, Jerry. I am sorry. What I am saying is if the Council
12 in its infinite wisdom listens to the fact that we think the
13 growth funds are good, they think it is appropriate, but it
14 finally dawns on them that unless they start as in all things
15 to further define what the boundaries of growth funds are,
16 what percentages might be appropriate, da-da, da-da, da-da,
17 when they do that, all I am saying is we ought to participate
18 or representatives of this committee in the future ought to
19 participate in those discussions.
20 Yes, Leonard.
21 DR. SCHERLIS: Maybe I am hypoglycemic, and I don't
22 quite know why I feel as I do about it, but I really think we
23 are raising issues that we are looking to raise in this regard.
24 I would much prefer that the site visitors give us a
25 recommendation that certain priorities have been set up which

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1 obviously require certain funds of money. And it is
2 apparent that the money will be spent in that area.
3 I don't like the term "growth" now. We are going to
4 have to define it as distinguished from developmental.
5 Maybe I am the only one who has the limitation of
6 trying to distinguish between these two terms. I would much
7 prefer we keep the developmental as it is and just ask for
8 a little better definition of how they are spending the money.
9 You have defined it. You said seven areas they are
10 moving into. They have already moved into five, they need
11 the funds to move into the other two. After all, I would just
12 say they found some money, that is what they are going to do,
13 and they defined it pretty well.
14 I would hate to see us telling Council when they have
15 reached a decision they have got to come back to us, and we will
16 discuss it further. I don't think a decision is necessary in
17 this regard.
18 I would move to strike out the last ten minutes of
19 discussion.
20 DR. MAYER: Joe.
21 DR. HESS: I think we may well be creating an
22 issue that doesn't need to be created here. If we understand
23 what they want to do, because they happen to use a couple of
24 words that were unfamiliar to us, let's not get hung up on
25 formulating a brand new policy. It seems to me this could be

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1 handled under existing policy of a region who has reached
2 the triennial status.
3 DR. MAYER: There is more than just the words, Joe.
4 There is some substantive difference between this approach
5 and other approaches of definitive projects. And I won't say
6 anything more about it.
7 DR. SPELLMAN: If it is that simple, you can predict
8 that everybody will do that.
9 DR. BESSON: I think everybody else might have the
10 option of doing it.
11 At the risk of prolonging this discussion at an
12 inappropriate blood sugar level time, and many decisions we
13 may make are based on no more influence than that, I would
14 say that I see a difference. And I think that a 13 percent
15 increment you referred to, implying that therefore it is not
16 very different from the developmental component, I think I
17 read somewhat differently here, Mitch, because I see that that
18 13 percent increase is a result of a 24 percent decrease in
19 projects and an 18 percent decrease in core, but 100 percent
20 increase in growth funds.
21 Now, that gives you a figure which is not far from
22 the developmental component. But the point is I don't think
23 that 10 percent is adequate enough for what some regions want
24 to do in an expansioning fashion. The growth fund concept,
25 I think without putting a percentage figure on it, allows

1 a region that is moving in the right direction to really
2 blossom.
3 Right now it is constrained from so doing by having
4 a limitation of 10 percent on it.
5 DR. MAYER: O.K., I guess the question I have to
6 ask is, we have taken an action on one which does have this
7 principle that would suggest we are in favor of it, at least
8 as it relates to Oregon, and we have no objections to the
9 principle at least as it applies to Oregon. I guess the
10 question I want to raise is do we want to make any comments
11 above and beyond that of a more generic nature to Council?
12 And if we do, what is it? And if we don't, then, fine, let's
13 end the discussion.
14 Mac.
15 DR. SCHMIDT: I believe we should comment that it
16 seems apparent there is some change in the concept behind the
17 developmental component and the growth fund concept is worthy
18 of study in relation to the other. And the staff and Council
19 should take this under advisement and so on.
20 I think both of them have to be looked at in relation
21 to each other and something new developed.
22 I personally favor a single type of dollar. And I am
23 really closer, I think, with Leonard than anybody else.
24 DR. BESSON: I withdraw my motion in favor of that.
25 DR. SCHMIDT: I would move the sense of whatever it

1 was I said be conveyed.

2 (Laughter.)

3 DR. MAYER: All right, is that clear?

4 DR. ELLIS: Second that.

5 DR. MAYER: Further comment?

6 DR. SCHERLIS: You have dismounted, is that correct?

7 DR. MAYER: All those in favor?

8 (Chorus of ayes.)

9 Opposed?

10 (No response.)

11 Why don't we break for lunch? Try and be back at

12 1:30.

13 Do not forget during that 45 minutes that you have

14 an obligation to score this region.

15 (Whereupon, at 12:45 o'clock p.m., the meeting

16 recessed, to reconvene at 1:30 p.m. the same day.)

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1 AFTERNOON SESSION

2 (1:40 p.m.)

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

9 DR. KRALEWSKI: Thank you.

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

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

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

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

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

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

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

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

1 this. And so I really think it is going to be, "Mayer goes
2 down alone in flames on final mission."
3 So I commence this review knowing I picked up an
4 assignment befitting a chapter in "Mission Impossible," and
5 wishing that not only my instructions might have self-destructed,
6 but the whole region from Athens to Zanesville.
7 As a background, you will know, as you recall in
8 previous meetings, we felt that although the State of Ohio
9 might be the mother of Presidents, we hardly felt it was the
10 father of RMPs. There were four RMPs involved in the State --
11 the Ohio State RMP which was focused out of Columbus, the
12 Northwest Ohio RMP focused out of Toledo, Northeast Ohio RMP
13 focused out of Cleveland, and then the Ohio Valley-Kentucky
14 RMP focused in Kentucky and including Cincinnati and the
15 several-county area in southwest Ohio.
16 The first three, to put it mildly, had a great deal
17 to be desired. And it was suggested by staff and by ourselves
18 and Council that we might be able to put some bad apples
19 together and with appropriate aging come up with a vintage
20 wine rather than some sour cider. I am not sure how
21 appropriate that decision was, but that was the decision we
22 made.
23 Accordingly, in the April-May review cycle of last
24 year when we had all of the bad apples together from Ohio in
25 the review process, we extended their funding for an abbreviated

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1 period from July of last year to January to provide them the
2 opportunity to get together. This they did with the following
3 results:
4 It looked like the Ohio State -- I think if you
5 will take your yellow sheets, page 7, there is a map which
6 outlines the region. It gives you some feel for the geography.
7 What appeared was that the Ohio State RMP which is central and
8 southeast Ohio and the Northwest Ohio RMP were making music
9 together, but the Northeast RMP really was keeping out and
10 saying they wanted no part of those other two. And really,
11 the Ohio Valley RMP which incorporated the southwest component
12 of it was never really a major part of the issue, feeling
13 they probably were a functional RMP and it may not be
14 appropriate to try to get them involved.
15 So we extended them for six more months from
16 January to July after having extended them six months from
17 July to January to try to work that out, then extended them
18 another six months and then sent the shock troops of Millikan,
19 Everist, and staff in on January 10 and 11 as a fact-finding
20 activity relative to the three regions.
21 The results of that visit are outlined in the
22 very poignant comments of Millikan and Everist on pages 27 to
23 35 of the yellow sheets. I recommend those to you as reading
24 programs tonight because I think they are classic examples

25 of what two pros can surface in just two days in a region.

1 In brief, they, however, discovered the following:
2 That Ohio State and Northwest Ohio RMPs were making progress
3 towards union and Northeast Ohio in its pristine purity was
4 having none of it. And although they had invited the Ohio
5 Valley-Kentucky groups to participate, they felt that it was
6 probably not appropriate to incorporate them in it.
7 The end result was a series of recommendations that
8 came out of the February '72 issues of Council which are on
9 page 2 of your yellow sheets. And I will not go through those
10 in any detail, but essentially I think did recommend the
11 formation of a new RMP which combined the Ohio State with
12 Northwestern regions and that the effective date of merger
13 be September 1 and that this application of that merged, two
14 merged RMPs, are to be brought back to this particular review
15 cycle.
16 Well, that is the background of this particular
17 application. And what do we have in it? We have a proposal
18 then to merge previously existing Ohio State and Northwest
19 Ohio RMPs into the Ohio Regional Medical Program.
20 We have a request for $2,082,000 in direct costs for
21 one year activity when as near as I can figure out from data
22 which are not totally complete, they are roughly at a $1.4 millio
23 level of activity in that.
24 The request includes a request for $1.2 million of
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25 program staff, a core, compared to a current combined total

1 of about $800,000 now in core.

2 We have a request of approximately $800,000 of

3 project funding which include the following:

4 One, two projects, the first and second ones there

5 which have previous Council support for approval for support

6 for an additional year.

7 Two, a kidney project in the amount of $201,000 --

8 that is project three -- which will be reviewed on May 8.

9 And since this is May 4, I don't know what that review has

10 in common.

11 And thirdly, there are 12 other new projects, nine

12 of which are from the previously existing Northwest Ohio

13 RMP and three from the previously existing activity in the

14 Ohio State RMP. And when I am saying nine in that Northwest

15 Ohio RMP, I have to comment parenthetically there has been

16 a considerable amount of concern that previous activities in

17 the Northwest Ohio RMP were moving towards the funding of the

18 newly developed medical school at Toledo with emphasis on that

19 rather than to a greater degree on the RMP component.

20 And, finally, one out of the 12 that is a health

21 careers program of Ohio in the amount of $171,000 outside of

22 RMP guidelines. And that is contained on page 17 of the

23 yellow sheets as to why.

24 In my opinion, then, they have made progress in

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25 merger. They did attempt as requested by Council to move the

1 Northeast Ohio and Ohio Valley RMP. However, this whole
2 application has the flavor of a new and developing region.
3 And it kind of has the deja vu of four to five years ago.
4 William Pace, the Dr. William Pace at Ohio State
5 who is the acting coordinator, obviously has had a great
6 impact in trying to bring this merger about and has obviously
7 been helpful in effecting it. However, he is pulling out or
8 resigning on June 30 of this year, and they are looqing for
9 a new coordinator. The reasons why Dr. Pace is leaving that
10 responsibility aren't clear, and perhaps staff may have some
11 comment on that that may be helpful to us.
12 Secondly, in terms of the review process at the
13 regional level, this appliation is acknowledged by them to
14 essentially having been nonreviewed in the kind of review
15 process that they would hope to ultimately accomplish in a
16 combined region due to the newness of the effort.
17 Thirdly, the goals and priorities of the group are
18 general, not specific, but they do have a mechanism and are
19 actively, I gather, working on them.
20 Fourthly, the advisory council is temporary and is
21 in the process of -- this is the combined advisory council --
22 expansion in organization.
23 Fifthly, the staff is not yet fully formulated or
24 organized, although there is a fairly good proposal for
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25 organization that is contained in the application activity

1 materials. They now have, as I gather, 19 professionals in
2 the two pre-existing programs, 13 in Ohio State and 6 in
3 Northwest Ohio, and are requesting 32 professionals in the
4 core staff and the new development, an increase of 13.
5 Sixthly, they have agreed on a grantee and a fiscal
6 agent, the Ohio State University Research Foundation, which
7 is evidently a private corporation which is handling the
8 research funds of Ohio State in the amount this year of
9 around $20 million and obviously have competency at the
10 fiscal level to handle the activity.
11 And, finally, they evidently have settled in a
12 positive light on a relatively strong RAG chairman in the form
13 of Dr. Brain Bradford of Toledo.
14 So that's where we are. And I suspect you can
15 understand part of my problem that I tried to outline at the
16 beginning of the presentation. When I got to this stage of
17 the report, debating about what to conclude about all of this
18 in light of the newness of the activity when most programs
19 have moved on in a far more sophisticated fashion, I recall
20 John Gardner's beautiful essay on the anti-leadership vaccine
21 which some of you may have read. And it is in the part when
22 he was describing one of the great dilemmas of the day and
23 problems of today is the lack of any real confidence in the
24 leaders of today -- that is, confidence in their capacity to
25 perform and assume responsibility.

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1 When he was talking about it, he described the
2 story of the little girl in the third grade art class who was
3 asked by the teacher, "What are you drawing, Mary?" To which
4 Mary replied, "I am drawing a picture of God." And the
5 teacher then said, "But, Mary, no one knows what God looks
6 like." Mary simply said, "They will when I get through."
7 So what I am about to tell you is I have no idea
8 in my own mind really what is the appropriate way of going
9 about evaluating this activity. We have an example of two
10 regions which have a poor track record in terms of what they
11 have accomplished in the past. We have told them to merge.
12 They have done that and have done that with, as I gather
13 reading between the lines, a fair amount of pain, but neverthe-
14 less have accomplished it and do look like they are beginning
15 to move in appropriate directions.
16 So that is where it is. And I guess it is out of
17 that kind of anxiety and concern that I will blithely go
18 ahead and give some conclusions about recommendations about the
19 activity.
20 As I indicated before, the funding, as near as we
21 can get an estimate of the program support of core staff
22 of the two programs together, is about $811,000 on an annual
23 basis. I would recommend funding them at about $900,000 for
24 the first year which is roughly a 10 percent increase with
25 recommendation for second year funding about 10 percent above

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1 that or at the roughly $990,000 level. This does, then,
2 at least give them an opportunity to try to take the steps
3 of putting the two programs together and building a strong
4 and effective core staff.
5 They are currently funded at about $583,000 in terms
6 of individual projects and are asking approximately $800,000
7 for individual projects in this. And I would recommend a
8 level not to exceed $500,000 in project activity with a
9 minimum of 5 percent increase in the second year.
10 Included in that funding of individual projects
11 obviously is the continuing commitment of the funding of
12 projects 1 and 2 which have already been approved if they so
13 desire. And included in 2, is the funding of the renal
14 project if approved by the ad hoc panel. And if it is not
15 approved by the ad hoc panel, then I would suggest a reduction
16 of that amount from the $500,000 that I recommended above.
17 And then, fifthly, obviously excluded from approval
18 for them to spend any of their money on what would be project 8
19 which is outside the guidelines of the RMP.
20 And, finally, I would suggest that we indicate to
21 Clark Millikan and Bruce Everist at Council level that I reviewed
22 this project for the review committee and suggest at least
23 that my tour of duty with RMP, at least at this point in time,
24 at least equals or exceeds theirs, so when they get to alter
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25 these recommendations at the Council level they at least know

1 whose recommendations they altered.

2 Mr. Hilton, comment?

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

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

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

21 They face a problem, looking to this first year, I
22 think, a dilemma which was described in one of the documents
23 I read whether they should devote themselves aggressively to
24 planning and development activities in light of this new

25 consolidation effort or whether they should launch apparently

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

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

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

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

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25 On the matter of minority interests, the Statewide

1 statistics suggest some 9 percent nonwhite population in Ohio.
2 And for this region, this new consolidated region in particular,
3 it would probably somewhere in the neighborhood of at least
4 6 percent minority overall. But on the staff, some 19
5 professionals, there are 2 black professional staff. There
6 are no other nonwhite minorities indicated in any of the
7 reports. And there are 2 blacks on the clerical staff. I am
8 uncertain as to the minority input into the RAG. And planning
9 committee, I get numbers that range from 8 to 11 in terms of
10 participation and no clarity on the degree of participation.
11 Nor are there any statements indicating any move at
12 this point to act on that problem.
13 The new projects, 9 new projects that were submitted
14 aside from the legal point on project No. 8 seem to have
15 been heavily designed by Northwestern Ohio which originally
16 covered only 12 counties. I was concerned whether the smaller
17 number of counties to the extent that these projects might be
18 based in those counties should dominate the entire Ohio
19 Regional Medical Program which the other part of it is 49
20 counties and really the larger part of the area in question.
21 So I had some concerns about that.
22 Aside from that, I think we are put in the position
23 that we have to accept a good deal on faith at this point in
24 time due to incomplete information and the expectation of
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25 new leadership in this region. And on that matter, I would

1 have to join Dr. Mayer in the uncertainty, but I would agree
2 perfectly with the recommendations on funding.
3 DR. MAYER: O.K., additional comments or
4 questions.
5 DR. ELLIS: I would like to ask a question. Are
6 they working very closely with Comprehensive Planning A
7 agency? And how are they working with the section in north-
8 western Ohio?
9 DR. MAYER: Well, I gather from the information that
10 there is a very direct linkage with the B agencies. I missed
11 where that link was with the A agencies. In other words,
12 they are actually planning to subregionalize the area in accord
13 with the B agency geographic boundaries and linked to the B
14 agencies. That is part of their whole organizational chart.
15 You all got it.
16 DR. ELLIS: I just wondered what you thought about it.
17 DR. MARGULIES: Could I comment on that? Because
18 Ohio is a rather unusual situation for CHP. The director of
19 Comprehensive Health Planning is Sewell Millikan who is on
20 the National Advisory Council. And he has played one of the
21 key roles in trying to carry this merger through and in fact
22 in trying to get what we initially were trying to achieve which
23 was a merger of all three of the programs which was so far
24 ineffective. So that the relationship with the A agency is
25 unusually strong.

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1 And then added to that is the fact that the director
2 of the State Department of Health is John Cashman who was
3 formerly the head of Community Health Services in HSMHA and
4 has had unusually strong interest in uniting these activities
5 in Ohio.
6 So that we are favored regardless of where they are
7 at the present time with some unusually strong elements to
8 pull them together better than they would under ordinary
9 circumstances.
10 DR. MAYER: What they have programmed, they have
11 programmed a major build-up in the core staff of the total
12 region. They have developed two subregional groups with the
13 pre-existing ones, but with small staffs there, two people, I
14 think, in each one.
15 And they are proposing then they branch out from
16 that. For example, the Northwest Ohio Region covers two CHP
17 B agencies. And they are actually going to put their staffing
18 in those two B agencies. And the proposal is that there are
19 five B agencies relative to the Central Ohio one with a link
20 to those five agencies. Actually it is right on the
21 organizational chart.
22 Now, how far they have gone, I don't have a feel for.
23 But they are at least thinking about those issues.
24 MISS ANDERSON: Do they have a competent deputy
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25 coordinator there?

1 DR. MAYER: Well, all I can comment is what I read.
2 And the opinion evidently of Millikan and Everist was that
3 the Northwest Ohio existing coordinator was not very effective
4 and that Pace had proven to be moderately effective. And the
5 problem is that they are now looking for a leader.
6 And this is one of the reasons why I personally
7 suggested that two-year funding for them as a mechanism of
8 at least providing an option for a guy to have two years of
9 assurance of a chance to build a program.
10 John.
11 DR. KRALEWSKI: Are they actively looking for a --
12 DR. MAYER: Yes.
13 DR. KRALEWSKI: Everyone that is there knows that?
14 DR. MAYER: Yes.
15 Does staff have any further information?
16 MR. VAN WINKLE: They have a search committee, and
17 they actively now have 42 possible candidates for that position,
18 a sum of 42. Some of them are existing coordinators in other
19 RMPs who have shown an interest, one being an ex-Ohio State
20 or graduate of Ohio State, I might say. And I believe he is
21 an Ohio boy.
22 They have hired, it is not really a deputy coordinator.
23 They have a three-pronged organizational chart there. And
24 they call them associate coordinators. And they have just

25 hired Mr. Al Deitz who was the Deputy Commissioner of Health

1 under the Rhodes administration. And I believe Dr. Ellis
2 is quite familiar with him.
3 DR. ELLIS: Yes, he is good.
4 MR. VAN WINKLE: He is quite an effective administra-
5 tor. And he is due to come aboard the first of June.
6 And Dr. Pace's reason for his stepping out is that
7 he said that he had 21 years commitment to Ohio State
8 University, and when it came to making a decision as to
9 whether we were insistent upon 100 percent coordinator, he had
10 to go and stay with Ohio State rather than stay with the RMP.
11 It was his election that he do that.
12 DR. MAYER: John, I think their problem is no one
13 in their right mind until the Council takes some sort of
14 action in this sequence, I think would dive into that. Because
15 the message that is there is that there have been two weak
16 programs, and we have told them to do something about it in
17 terms of merging them. But they don't have any answer back
18 about whether we think there is a chance.
19 So I think what is done as action in this next step
20 is important. And this is why I put the emphasis on core
21 staff support as part of the planning and build-up of the
22 region as opposed to individual project support.
23 DR. KRALEWSKI: That funding that you are suggesting,
24 what does that allow them to do? I am sorry, but I didn't
25 follow that very well.

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

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

12 Now, if the renal disease program is not approved,
13 that produces an operating budget for next year of about
14 $1.2 million as opposed to an existing operating budget of
15 about $1.4 million.

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

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

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25 Sister Ann.

1 SISTER ANN JOSEPHINE: I think it is significant
2 they are looking for a coordinator of the Regional Medical
3 Program. And I think there are several other programs that
4 are probably in that same position. And I think it is not
5 unrealistic to expect it is going to be difficult from here
6 on out to get good coordinators of programs. There is going
7 to be a lot of interprogram pirating.
8 And so I think that the national trend that we are
9 seeing in mergers and consolidations certainly should hold
10 on a State level. You know, in California, we could be looking
11 for eight coordinators.
12 DR. MAYER: Other comments?
13 (No response.)
14 Any additional comments of staff who were on the
15 site visit in January?
16 DR. SPELLMAN: Is it appropriate to include in the
17 level of funding a sum which includes the renal project given
18 the guidelines we have just had set? Can we do that?
19 DR. MAYER: Well, it was included in their total
20 tab.
21 DR. SPELLMAN: O.K.
22 DR. MAYER: Since that $200,000 was a part of the
23 $800,000 requested for projects, I dealt with it in that
24 context.
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25 DR. HINMAN: Do you want any comment on the kidney?

1 DR. MAYER: Fine. I would love to have some comment.
2 I had assumed because it was being dealt with on
3 the 8th.
4 DR. HINMAN: Just to set the background, all the
5 kidney documents did not arrive here until Tuesday which is
6 why it is being dealt with on the 8th.
7 But Ohio in January of 1971 established a planning
8 group on renal disease that is statewide. It includes
9 representatives from Cleveland as well as the major cities in
10 the new merged area.
11 They have had adult type kidney doctors, and they are
12 appointing, either have or will be appointing, pediatric
13 type doctors as well. And they are starting an organ sharing
14 program within the various centers that will be in the State of
15 Ohio.
16 There are three applications in for reveiw at the
17 present time. One is to support a pediatric nephrology
18 program. That lost its pediatric nephrologist, and it is
19 basically geared around acquisition of said pediatric
20 nephrologist and funding him.
21 The other two are organ procurement and transplant
22 expansion programs, one for Toledo and one for Columbus.
23 Those two organ procurement programs have had very critical
24 technical review. Interestingly enough, one of them, the
25 investigators took into account -- at least the RMP did --

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1 and the applicantion as submitted has incorporated the critical
2 review, the things that needed to be straightened out.
3 The other does not. But it does begin to address
4 the issues of dialysis and organ procurement throughout the
5 State as a whole.
6 DR. MAYER: It does, you say?
7 DR. HINMAN: It does begin to, yes, sir.
8 DR. MAYER: Including the troops in Cleveland?
9 DR. HINMAN: A little bit. They are still pretty
10 independent in Cleveland.
11 This overall planning group has the sanction of the
12 Governor's office. He in turn delegated to the Commissioner
13 of Health, Dr. Cashman, to pull the committee together. And
14 it appears as if there would be some State legislation sought
15 by this group. And they are beginning to talk together.
16 DR. MAYER: Other comments?
17 (No response.)
18 Is everybody clear on the recommendations? Staff
19 clear?
20 All those in favor say, "Aye."
21 (Chorus of ayes.)
22 Opposed?
23 (No response.)
24 I would recommend to you that it might be worth taking

25 10 minutes tonight to read through those pages of 27 through 34

1 in the yellow sheets of the Millikan-Everist comments about
2 the situation that exists there.
3 DR. SCHERLIS: Pertinent to that, who is now head of
4 their RAG? Is it the physician Dr. Hudson who was mentioned
5 or who is his latest successor?
6 DR. MAYER: No. Brain Bradford who is evidently
7 a physician in Toledo who I gather from their comments and
8 other comments of staff is showing some fairly dynamic
9 leadership to it. In fact, the comment was made he knew
10 more about what was happening than the coordinator which was
11 an interesting comment.
12 DR. SCHERLIS: One other comment. Suppose elsewhere
13 in Ohio a regional program comes in for funding. Is there any
14 potential for a technical review group or that group charged
15 with "regionalization" saying that there has to be an entire
16 Ohio renal program and not a particulated one?
17 DR. HINMAN: You mean as far as the statewide committee
18 that is --
19 DR. MAYER: No, as far as RMP is concerned.
20 DR.HINMAN: The local RMP or RMPS?
21 As far as the local RMP is concerned, they have been
22 an active supporter of this Ohio Renal Disease Planning
23 Committee as I believe is its formal name.
24 Technically speaking, they could address themselves
25 only to the areas that are in the map shown as being the Ohio

1 RMP. I would assume in looking at the guidelines, the blue
2 sheets that were discussed for a while this morning and in
3 what I am hopeful will be further issuances coming from here,
4 they will understand that the whole area needs to be looked
5 at and not just their part of the State.
6 DR. SCHERLIS: I hope this is the message that this
7 committee can help implement. And that is that even if
8 technical review is satisfactory, if all of these areas come
9 up with nice technical reviews, I would assume looking at the
10 total national program, we would want to have evidence that
11 this is an integrated program. And I think this should be
12 noted.
13 DR. HINMAN: The Ohio Valley RMP out of Cincinnati
14 also has some kidney areas of concern. And we are attempting
15 to get into this total planning process as well.
16 DR. SCHERLIS: Of course, you are in a very fortunate
17 position in that you either do or do not recommend funding.
18 And you wouldn't have to be anything more than clear in your
19 direction as far as regionalization is concerned, particularly
20 if you are talking about a national network. Is that clear?
21 DR. HINMAN: I would hope to be able to be specific,
22 yes, sir.
23 DR. MAYER: Sister Ann.
24 SISTER ANN JOSEPHINE: Has Western Reserve been
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25 brought into these plans?

1 DR. HINMAN: The Cleveland Clinic is involved, but
2 I just don't recall about Case Western Reserve, Sister.
3 DR. MARGULIES: The Northeast Ohio Program is very
4 closely tied in with Western Reserve. That is the most
5 intimate part of their educational base.
6 When we were attempting to get a total Ohio program,
7 they were one of the principal actors in the discussion.
8 But their area of concern involved in regionalization is
9 not East Ohio centered around Cleveland.
10 DR. HINMAN: The kidney area specifically, though,
11 there is already some organ sharing going on between Cleveland
12 and some of the other cities. Whether it is only from the
13 clinic or Western Reserve, too, I just don't know the
14 specifics. But I think both are involved.
15 DR. MARGULIES: I should tell you that the system
16 they are using for coordinating things in Cleveland is not the
17 same system they used for handling the poling booths.
18 (Laughter.)
19 DR. MAYER: Yes, Lee.
20 MR. VAN WINKLE: The kidney committee, I would say
21 the head of the RMPs in the State in terms of taking a look
22 at the total picture and true regionalization, they have
23 representatives from the Cincinnati area, the Toledo area,
24 the Cleveland area, the Columbus are. They are fully
25 represented throughout the State on this committee. And that

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1 also becomes their technical review body for any proposal
2 that comes in to any RMP within the State -- representatives,
3 you know, from that State committee.
4 DR. MAYER: On renal disease.
5 MR. VAN WINKLE: Renal disease only.
6 DR. MAYER: O.K., I would like to move on now to
7 Northeast Ohio.
8 We will need to give some thoughts to the degree to
9 which we feel comfortable about rating or nonrating of this
10 proposal. I am in the comparison of apples and oranges kind
11 of issue myself which was part of my dilemma on it. And as I
12 go through it, I am at the one, two, three end of the spectrum
13 relative to this.
14 But I would have to say given the circumstances,
15 I don't know how they could be at other than the one, two,
16 three edge of the spectrum in terms of trying to develop a
17 new RMP. So the question is do we want to rate it and what
18 are the potential implications of that.
19 Lorraine, any comments on it?
20 MRS. KYTTLE: No, sir.
21 DR. SPELLMAN: I don't think I could rate it if it
22 is going to be commensurate with the decision to fund it.
23 I don't see how to translate into this. So I just couldn't
24 rate it.

25 MR. CHAMBLISS: May I comment there?

1 DR. MAYER: Yes.

2 MR. CHAMBLISS: You asked what are the implications
3 of rating, and you had suggested some numbers. Whereas I
4 would not suggest numbers, I would say whatever rating this
5 committee may place on that region would certainly give it
6 some indication as to where it stands. It would give it some
7 water line as to where it stands as a region based on the
8 action of this committee.

9 MR. HILTON: Are we talking about rating the
10 internal structures now, the internal coordinator and internal
11 advisory committee, as opposed to region?

12 DR. MAYER: Well, I guess the question of the
13 committee is do you want to rate it or not.

14 DR. SPELLMAN: Let's have a motion.

15 DR. SCHERLIS: Again, I am in a dilemma in that I
16 don't see why we should rate it. We are rating all regions on
17 the basis of a lot of extenuating circumstances, some more
18 extenuating than others.

19 I would think that the numbers that we come up with,
20 and I assume you do as chairman misuse your prerogative in
21 telling us how you rated it.

22 DR. MAYER: I am sorry about that. Like Mr. Nixon,
23 I occasionally forget.

24 DR. SCHERLIS: I would think we should rate it just
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25 to make matters clear.

1 DR. MAYER: All right, fine.

2 Before we do that, I had promised Mr. Ichinowski

3 we would comment briefly about the rating sheets before we

4 did Oregon, and then I flunked again.

5 Would you care to comment?

6 Lee, you have another comment?

7 MR. VAN WINKLE: I think we are rating something that

8 doesn't exist, sir. This new organization that you are taking

9 a look at is not even legal until September 1. So are you now

10 rating the two old regions?

11 DR. SCHLERIS: Then we are funding a non-existent

12 organization.

13 MR. VAN WINKLE: That is an application for

14 September 1.

15 DR. MAYER: Subject to.

16 DR. SCHLERIS: I think we hve to view the combination

17 of the two and come up with some evaluating system. We

18 reach the evaluation by the level of funding that we gave it.

19 I assume there is something objective behind that.

20 DR. MAYER: Comments on the rating system.

21 MR. ICHINOWSKI: I have a couple of notes I would

22 like to pass on to you which could help us as you do the

23 scoring and some problems that we had with the rating sheets

24 that we received from the review committee last time.

25 The key to remember, of course, is the one to five

1 rating. That second column with the numbers running down it
2 is the weights. And regardless of whether a criterion has
3 15 points, the scoring still goes from one to five. We did
4 get them running up to 10 and 15.
5 We would request that each criterion do receive a
6 score because if you leave one of the criterion blank, that
7 negates the weight. And this causes difficulty in calculation.
8 We also ask that you do not score, even if the
9 region is in your opinion not worthy of but one, that criterion
10 as a zero. Because that also causes us some problems.
11 With some of the raters last time wishing for some
12 more expansion in terms of identifying a region other than
13 1, 2, 3, 4, or 5, we notice that some were scoring 2 plus or
14 3 minus. The scoring system has now been expanded to include
15 1 decimal such that if you want to score a region 3.2 or
16 2.5, you can do this in each of the criterion. But try to
17 stay away from something like 2-1/4 because then that causes
18 another problem with two decimal places.
19 MR. PARKS: Would you go over again the problem
20 a zero gives you? I really didn't get that.
21 MR. ICHINOWSKI: A zero, when we multiply by the
22 weight that criteria has just multiplies out to zero. I would
23 suggest if you feel a region should be given a very low
24 figure for that particular criterion, maybe give it a .1 rather
25 than a zero because then, let's say the criterion you select

1 happens to be number 2, accomplishments and implementation,
2 which is worth 15 points, by you scoring a 0 on that element,
3 your actual output of that is 0 times 15 or 0.
4 MR. PARKS: That is accurate.
5 DR. SCHMIDT: But we don't want it that way.
6 MR. ICHINOWSKI: That's accurate in terms of maybe
7 what you want to give, but in terms of then compiling it by
8 some automated calculation technique we are using, it throws
9 it out as a reject.
10 DR. MARGULIES: It is really conformity to the
11 machinery we are asking.
12 DR. MAYER: No.
13 DR. MARGULIES: Not quite, but actually it throws
14 off the total calculation if there is a non-entity in there.
15 DR. MAYER: Dr. Hess.
16 DR. HESS: I have a question. If I understood you
17 correctly, you want some number of some sort other than zero
18 in every one of those boxes, right?
19 MR. ICHINOWSKI: That's correct.
20 DR. HESS: One of the principles of rating is that
21 you try not to halo, and you try to be as specific as you can
22 on every point. If you don't have data upon which to base a
23 judgment, you are better off not making any judgment.
24 DR. MAYER: I thought we arrived at we would circle
25 those.

1 MR. ICHINOWSKI: What we have done in the past is
2 we have circled those to indicate that the reviewer had
3 some concern or no data regarding his rating.
4 DR. HESS: For example, regarding Ohio, there are
5 many of these categories we essentially have no information on.
6 MR. ICHINOWSKI: That is a tough region.
7 DR. HESS: It seems to me it is very unfair and
8 illegal to make judgments on the basis of no data. We have
9 data on certain of those categories, but others we have
10 nothing.
11 DR. MAYER: Joe, I suggest you circle them and say
12 that the primary reviewer didn't provide you the information.
13 DR. WHITE: What if we should happen to say we cannot
14 rate this? Does this make the machine angry at one of us?
15 (Laughter.)
16 DR. ICHINOWSKI: If you do not rate the region, we
17 have provision for excluding all your dta elements in that
18 particular region.
19 DR. SCHERLIS: If I follow you correctly, then,
20 if we exclude some, you are going to exclude it all?
21 MR. ICHINOWSKI: Or else try to come up with some
22 provision for filling in the blanks that seems reasonable.
23 DR. MAYER: The issue is, Leonard, your opinion is
24 probably better than his about it even though you feel
25 uncomfortable with it.

1 DR. SCHERLIS: But in reality, if you get down to
2 what we really do is we put down these numbers after we have
3 such a forceful, lucid presentation as we just had by our
4 chairman. We attempt to really extrapolate what he is thinking
5 in terms of numerical value. And in case we don't follow the
6 directions, he lets us know what his numbers are.
7 (Laughter.)
8 DR. MAYER: In advance.
9 DR. SCHERLIS: It proves very helpful.
10 DR. MAYER: Other comments?
11 (No response.)
12 Has everyone who intends to rate the Ohio Region
13 rated the Ohio Region?
14 (Laughter.)
15 DR. SPELLMAN: Yes.
16 DR. MAYER: Let's move on to the Northeast Ohio.
17 Sister Ann.
18 SISTER ANN JOSEPHINE: I have some of the same
19 difficulties in providing information on this particular region
20 as Dr. Mayer did. The one contact I had with the data from
21 the region was as a member of this committee at which time it
22 was the decision of the group that rather than have three
23 very weak programs, there would be advantage in making a
24 recommendation that there be consolidation in the development
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25 of one strong program.

1 However, as Dr. Mayer indicated and the
2 material that is in your book gives the details of this,
3 the Northeastern groups strongly based in Cleveland decided
4 not to go along with this recommendation and at the present
5 time are submitting a request for funding of an individual
6 Regional Medical Program.
7 In assessing this particular program, one has
8 to keep in mind that for 17 months, no coordinator was
9 present during which time there was not an entire lack of
10 leadership, however the leadership was shared by many people.
11 And as a result, the total effort was not coordinated.
12 More recently, Dr. Gibbons has been brought in as
13 the coordinator of the program. And in reading some of the
14 descriptive material concerning the new coordinator, apparently
15 he has been in the Cleveland area for many years. He is very
16 well acquainted with the medical community and is able to
17 work very well with the diversified components there.
18 However, one of the concerns I personally would have
19 would be with the fact that here we a coordinator who is 76
20 years old. And this is not saying he can't be innovative and
21 all these things, but certainly the possibility of his availabili
22 over a period of time doesn't exist at the same degree as it
23 might if he were younger. And besides that, he has no assistant
24 coordinator to work with him in this program.

25 And one of the weaknesses of the program as it was

1 described by the site visit team chaired by Dr. White in 1970
2 was the fact that core staff at that time needed additional
3 development. I think the situation still exists. And I
4 think that in this particular area of responsibility of a
5 coordinator in the absence of adequate core staff, we are
6 probably going to encounter a great many problems.
7 The operational projects, four in number, are
8 in no way related to the objectives that are stated for the
9 region. This was true in 1970 and apparently it hasn't been
10 changed in the intervening time.
11 In 1970, concern was expressed concerning the
12 composition of RAG. I believe some changes were made. Additional
13 "consumer representatives" were added to the group. However
14 there is strong domination by the executive committee which
15 originates from the board of trustees. And in reading over
16 the material provided, I would get the impression that RAG
17 simply passes judgments on the kinds of recommendations that
18 the executive committee and the board choose to submit to RAG.
19 I believe, Mr. Parks, would you want to give some
20 of your other impressions?
21 DR. MAYER: Mr. Parks is secondary reviewer on the
22 project.
23 MR. PARKS: Sister, I concur largely in what you
24 have said. As a matter of fact, totally. And, again, I think

25 the predicament here highlights a situation which is incapable

1 of evaluation.

2 The predicament does not lend itself certainly to

3 any of the factors which we have on our evaluation sheets.

4 We are faced with a situation where we have a new coordinator

5 who did not participate, I understand, in development of this

6 particular application that we have here and a rather sparkling

7 record of failure in this case.

8 I know of no other way to present it accurately.

9 My basic inclination is that assuming it would be

10 an appropriate remedy for this committee, I would recommend

11 that this program be shut down.

12 The situation is tempered somewhat by some information

13 that was delivered to us today and by some previous action of

14 the National Advisory Council which would appear to pre-empt

15 the action by this particular committee. And that is contained,

16 I believe, in the papers which you have. It is a letter

17 dated February 10, 1972, from Dr. Margulies which transmits

18 to Dr. Glover the action of the National Advisory Committee

19 which is to the effect that the program be retained at its

20 present level of funding.

21 And so it would seem, then, that anything that we

22 might have to recommend to this committee with respect to either

23 continued funding or level of funding would be superfluous at

24 this time.

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25 It does, I think, relate to the larger question of the

1 role of this committee and especially in a situation where
2 the National Advisory Council has spoken on the matter previously
3 There was, I think, in this case as in the other
4 Ohio situation a site visit conducted by some members of the
5 Council.
6 There are some items about which we might particularize
7 with respect to the Regional Advisory Group, its make-up and
8 composition, the distribution and participation that is
9 effective participation of minority persons, the participation
10 of minorities on the staff, the non-application of priorities
11 which are established to program activities.
12 For example, they indicate that their top priority
13 is meeting some of the needs of the people in the urban areas.
14 And certainly running down those four priorities, I find none
15 of the operational effort directed to this. I find certainly
16 again with the exception of the Urban League director, I
17 don't find among the members of the Regional Advisory Group
18 or the trustees the kind of participation from among the
19 consumer element that you would expect to find in a situation
20 like this based in an urban setting such as Cleveland.
21 I think there is something to be said for having
22 engaged a coordinator who has the historical qualifications
23 that Dr. Glover presents. Among the papers which were
24 presented to us was a statement indicating that he has trained
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25 the majority of the practitioners within this region's scope

1 of activity. And it is largely through his standing within
2 the medical profession and his personal acquaintance with
3 the principal actors that he is able to bring together and
4 perhaps to effectuate some change.

5 The papers that were handed over just momentarily --
6 I think Sister has those -- may throw some light on it as to
7 prospective activity. But if what we are rating covers
8 the period in the past, I would say that this program is
9 questionable and based on its past performance, I would say
10 that it was of doubtful prognosis for the future.

11 Nonetheless, we are advised, I am advised, that the
12 new director, despite his years, and possibly because of it,
13 has, I guess accentuated change and is currently developing and
14 restructuring this particular program.

15 But for those qualifications, I would say, first of
16 all, there is a very real question as to whether this business
17 is appropriately before this committee.

18 The second thing is if it is an appropriate remedy
19 for this committee to recommend, I would be for recommending
20 the money for this program be withdrawn.

21 DR. MAYER: Could we deal with the question that
22 is being raised? Because I have a little trouble with
23 substantial inconsistency of the letter of February 10, Harold,
24 in which it implies that the National Advisory Council
25 recommended at this time, presumably in the February Council,

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1 a continuation of supprt for one year at a basis not to
2 exceed the existing level funding. And then in the concluding
3 paragraph, it says, change in review cycle will start date
4 for Northeast Ohio program from June to September 1, 1972.
5 Therefore, the present grant period for Northeast Ohio will
6 extend through August 31, 1972.
7 And presumably, this application deals with that
8 period after August 31, 1972. And yet presumably there is
9 some kind of commitment for funding in the region through to
10 what -- February of 1973?
11 I understand the issue you are raising because I can't
12 see it.
13 DR. MARGULIES: What happened earlier when we reached
14 the same conclusion you did about the program which is that
15 both Northwest Ohio and Northeast Ohio were of such doubtful
16 quality that there was serious consideration about whether they
17 should be continued at all, we did put considerable pressure
18 on them to make some basic alterations. We, in fact, limited
19 their funding during that period of time to six months and
20 then gave them an extension of six months to see how effectively
21 they could work out their plans.
22 And when they reached a tentative agreement which
23 required the Council to act on whether or not they should continue
24 the decision was made they should have funding for one year.
25 What you are addressing would affect their activities

1 thereafter. And so if you were to make a recommendation here
2 that this program should no longer be continued, it would be
3 a matter of phasing out their activities with existing funds
4 and then closing it down.

5 MR. PARKS: When would be the date that their
6 current funding would terminate?

7 DR. MARGULIES: Their current funding under this
8 one-year extension -- I will have to ask for some help on
9 that.

10 MRS. KYTTLE: August 31.

11 DR. MARGULIES: August 31 of this year as far as
12 I know, '72.

13 DR. MAYER: Except there is an implied commitment by
14 Council until February, at least one year from February 10,
15 in your letter.

16 DR. MARGULIES: Well, I am sorry because the letter
17 was confusing. That referred to the six months and then
18 six-month extension so that so far as I know they are funded
19 only through August 31 of '72.

20 DR. SPELLMAN: Was one of the clear alternatives
21 merger or abandonment, so to speak?

22 DR. MARGULIES: No. We did not require them to merge.
23 What we did was lay out to all three programs their deficiencies
24 and recommend they give merger serious consideration. And
25 that's why we had members of the Council go out to see what

1 progress they had made.

2 The efforts to consolidate were partially effective.

3 So you see two programs instead of three. But we still have

4 the problem of Cleveland and the rest of Ohio. And the

5 viability of the program is one to be judged at the present

6 time.

7 SISTER ANN JOSEPHINE: This morning when I said we

8 have to be sure we ask the right questions, I was thinking

9 in terms of this report. And I personally don't feel that the

10 question is at what level shall we fund them,but I think the

11 question is should we fund this program. Should we continue

12 to fund this program?

13 DR. MAYER: Comment, Phil?

14 DR. WHITE: I don't understand this concern in

15 reading this. Some of the comments by Drs. Millikan and

16 Everist suggest that in spite of his age, Dr. Glover seems to

17 have some leadership qualities. What has happened since that

18 time? Has he made any move?

19 Is Dr. Hudson still a thorn in their side?

20 Has there been no progress at all since that visit by Dr.

21 Millikan and Dr. Everist, or has there been?

22 DR. MARGULIES: Do you want to comment on this?

23 DR. MAYER: Mr. Ashby, comment?

24 MR. ASHBY: Actually, Dr. Glover is able to contain

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25 even Dr. Hudson. He does a good job of that.

1 And, yes, he has been very busy. The program staff,
2 at this time, morale is much higher. They seem to be working
3 harder, although it is just observation. Everyone that has
4 met him seems to be impressed. Even though he is 76, he is
5 a young 76. He realizes his age is a limiting factor as far
6 as being able to be around in that program for a long period
7 of time.

8 He impresses me as a mover, and I don't believe he
9 would have taken the position at all if he hadn't thought he
10 could do something with the program. He was one of the
11 biggest critics the program had prior to his acceptance as
12 coordinator.

13 DR. WHITE: I gather Dr. Robbins --

14 DR. MAYER: Phil, we couldn't hear you.

15 DR. WHITE: I was asking if Dr. Robbins, the dean
16 of the school, was in favor of RMP.

17 DR. MAYER: That to me is one of the great unknowns.
18 Fred Robbins, in spite of his research background and his
19 Nobel-laureacy is really committed to community health action
20 efforts. And yet here sat that RMP all this time without
21 movement. And I can't put those two facts together in my
22 mind. If anybody can help me with that out of staff or
23 elsewhere --

24 DR. ELLIS: I can.

25 DR. MAYER: All right, Effie.

1 DR. ELLIS: His philosophy was a little bit out of
2 line with that of the rest of the people at the time. And I
3 think the Midwest is pretty conservative. And this accounts
4 probably for the fact that it would take a little while to get
5 the show on the road.
6 DR. MARGULIES: Fred has been very deeply involved
7 in the efforts to rebuild this program. When we first tried
8 to have a merger of all three, he was one of the leading
9 voices for a true merger.
10 The problem, on the other hand, getting back to
11 Northeast and the question of why didn't it go, Bill, so far
12 as I could tell, it was the inability of the people in
13 Cleveland to resolve their own internal differences. It is the
14 old issue of Western Reserve and the Academy of Medicine and
15 the local politics. And about the time he would make a
16 move in one direction, he would run into Charlie Hudson coming
17 from the other direction. And he has not really been able to
18 overcome some of the resistance.
19 I think if he had had a free hand and if there had
20 been a coordinator -- You may remember when this program was
21 first developed, the coordinator was a fellow named Barry
22 Decker who was a very vigorous, imaginative, hard-working guy
23 who got the program through the planning stage and promptly
24 was recruited away. And they then were unable to get a
25 coordinator. And I think the main reason they couldn't get one,

1 and this is the real stalling point is because they couldn't
2 reach a resolution between the vying medical-political forces
3 within the Cleveland area. They would get somebody, and if
4 it was all right with Western Reserve, it wasn't all right
5 with the Academy. And sometimes they would say, "Maybe we
6 better go out of state to get somebody who is neutral." And
7 they were really hung up on their own internal differences
8 while Fred was trying to get something reasonable accomplished.
9 He is still actively interested. He still gives
10 strong support to the new coordinator. I don't know that they
11 have resolved those problems.
12 SISTER ANN JOSEPHINE: The question that arises
13 in my mind is would it be and it would seem to me that it might
14 well be to the interest of the total State to take a stand
15 that might give a little more encouragement to this merger.
16 DR. MARGULIES: I quite agree. What we have said
17 is that we accepted the present arrangement as a tentative
18 one, but we insisted they continue to work toward a final
19 resolution of a total State system. But that is sort of good
20 advice. I don't know how strongly it is accepted or how much
21 meaning it has. They are meeting together. They will talk
22 with one another more and more, but it is not quite what you are
23 talking about.
24 DR. MAYER: Yes, Leonard.
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25 DR. SCHERLIS: Do I read correctly the printout their

1 budget essentially is divided between the four, the hospital
2 librarian, coronary care unit training, strep culture, and
3 strong rehab? Is this the total program?
4 SISTER ANN JOSEPHINE: It is really not. It is a
5 very difficult program. They call it program.
6 DR. SCHERLIS: That comes to something like
7 $800-some thousand.
8 SISTER ANN JOSEPHINE: Actually, I think we are
9 describing a planning component and calling it an operational
10 program.
11 DR. MARGULIES: We have had repeatedly from that
12 program whenever we have leaned on them hard, particularly
13 about the coordinator, the complaint that there is so much
14 national instability in the Regional Medical Program that it
15 is impossible to get a coordinator. And we keep telling them
16 it is like arguing that you lost the ball game because it
17 rained. The other team is in the same rain. Other programs
18 have developed, have had strong coordinators, have replaced
19 them and got good people, and they haven't been able to.
20 But they have used this as a kind of a defense for not doing
21 anything.
22 When you look at how long that program has been
23 without a coordinator, it has been ever since they became
24 operational up to the present time when they have gotten Dr.

25 Glover in. And that has only been within a matter of a few

1 months. I think he came on board in January.

2 DR.MAYER: Yes, Joe.

3 DR. HESS: It seems to me we have to look, if we

4 accept Mr. Parks' and Sister's --

5 DR. MAYER: Could you use the mike? We really

6 can't hear you.

7 DR. HESS: If we accept Mr. Parks' and Sister's

8 feeling perhaps the thing to do might be to recommend the

9 phaseout of this program, then we have to look at what happens

10 if that actually is taken.

11 I think we would be in a better position or at least

12 I would feel more comfortable about being in favor of that if

13 the Ohio program were in a more stable state itself. But I am

14 just wondering if that wouldn't add an additional burden to

15 two regions that are already trying to merge and a coordinator

16 that is only there for another month or two. And how much can

17 it take? What are we going to do to RMP in that whole State

18 if we do this all at once?

19 Maybe one way out of this dilemma is perhaps delay

20 this for a year and give the Ohio RMP a chance to see what it

21 is going to be able to do and then take another look at it.

22 And maybe merger would be appropriate at that time.

23 But I must say I am worried about wiping this one

24 out and saying merge with Ohio right now in their current state

25 of flux.

1 DR. MAYER: Sister Ann.

2 SISTER ANN JOSEPHINE: I wonder if in line with this
3 February 10 letter which could well give us a position that we
4 could continue the funding until February of '73 which would
5 be nine months and say by this time, you know, we would hope
6 you would be able to work out these differences, that would
7 provide that leeway in keeping with something that we made
8 some kind of a commitment to.

9 DR. MAYER: Well, what would we expect? I guess I
10 need to have some feel in terms of the new cycle, what that
11 would mean. Presumably, that would mean that would have to be
12 reviewed in January which says that whatever new application
13 would have to be inhouse when?

14 I am trying to get a feel for what kind of time is
15 that.

16 DR. MARGULIES: November.

17 MRS. KYTTLE: I think we ought to look at Ohio's
18 schedule more than this region's schedule. If we want them
19 to think about effecting a merger within a certain period of
20 time, should we not be looking at the place with whom they
21 will merge rather than this place?

22 DR. MAYER: I am not sure I was hearing a clear-cut
23 call for merger. I think what I was hearing was a clear-cut
24 call for turning it around or else. That is what I was hearing.

25 SISTER ANN JOSEPHINE: No. I think we are moving

1 toward merger in this.

2 Really, it is very difficult to motivate any other

3 way in some cases. I mean, it is a matter of really the funds

4 are the strong point you have. And as I read all this, it is

5 not just an arbitrary decision. It is really in the best

6 interests of the total program for the people.

7 MR. PARKS: With respect to merger, if you allow this

8 program to survive, I think the question of merger is an

9 appropriate local decision. I think it is an especially

10 important one. I think we should be careful not to get into

11 a posture where we begin to dictate what ultimately ought to be

12 a local decision because we also would be the ones who will

13 come along and evaluate them. And we may have forced them into

14 an unnatural situation.

15 And I would certainly hope that even though that may

16 be something of a tactical guess as the appropriate direction,

17 I certainly would dissent from any decision that would indicate

18 to them that we expected or would expect as a factor of

19 evaluation to have these programs merged into a single unit.

20 I think more important that we have an effective

21 unit that meets with your broad national priorities. And as

22 long as it is operational and if you can ascertain that it is

23 moving effectively in that direction, if you can find a mechanism

24 to close the book on a bad chapter and rate that chapter for

25 precisely what it is and then the next time you take a look at

1 it, measure it from this time forward, I am not so sure I
2 would want to be in a position of this place and with the
3 information that we have indicating to them that they must
4 merge or else.
5 I really don't have the information to make that
6 decision.
7 SISTER ANN JOSEPHINE: I agree.
8 DR. MAYER: Let me see. To me, it seems like we have
9 roughly three options given the kind of tenor of the discussion.
10 One option is that we say effective August 31, they
11 are out of business. And they can come back in and reapply
12 for a new RMP if they want to do that in some form at some
13 future date. That's one step we can take.
14 The second step we can take is extend them to the
15 February period and say that by November you must have a
16 program in here developed for review or you will be out of
17 business effective February 28.
18 Or, thirdly, we could say, all right, we are extending
19 them at some level from now, from August of this year, to
20 August or September 1 of next year with the same kinds of
21 constraints on it.
22 Now, those to me seem to be the three options.
23 SISTER ANN JOSEPHINE: And if we did No. 2, what
24 would be our expectations at the end of that time?

25 DR. MAYER: That is up to us, the committee. And we

1 need to have those laid out more precisely.

2 Yes, Joe.

3 DR. HESS: In connection with your third option,

4 might we consider recommending what in essence would be

5 reversion to a kind of a planning phase? Phase out many of

6 these activities and ask them to take a good, hard look and

7 come in a year from now, fund them for sort of a planning year,

8 come back in with a better plan which reflects some very

9 serious rethinking of where they are going to go and how they

10 are going to get there. And this would keep them in phase with

11 the Ohio, and that would provide an opportunity for them to

12 look at this question of merger as well as to look at the

13 strengths they have to pull the program together.

14 Is that possible?

15 DR. MAYER: Sister Ann, comment?

16 SISTER ANN JOSEPHINE: Is Ohio in a planning stage

17 now, planning phase?

18 DR.MARGULIES: No.

19 SISTER ANN JOSEPHINE: It is operational?

20 DR. MAYER: Except that the recommendation we made

21 vis-a-vis the new Ohio RMP was most of the dollars in the core

22 staff to support that planning group and evaluation group that

23 they are proposing for the two combined regions with very

24 little money in terms of operation. The money that we

25 suggested was roughly two to one, three to one, in terms of

1 staff as opposed to projects which is the reverse of the
2 usual situation.
3 So in that sense, we have moved them in that
4 direction.
5 SISTER ANN JOSEPHINE: Then, what Dr. Hess is
6 suggesting would enable us at the end of the year to
7 evaluate the region's capability of planning and ability to
8 become operational or not. Is that what you are saying?
9 DR. HESS: Right. Cut them back, phase out the
10 project funding or reduce it substantially.
11 SISTER ANN JOSEPHINE: And it might even be that
12 during this period of time, they could begin to look toward
13 maybe working more closely with the other Regional Medical
14 Program in the State. Maybe that is the way they can take their
15 first step. Maybe it isn't the most desirable way to go.
16 And then if their planning stage, if at the end of the
17 planning period, the group felt that they were ready for
18 operational funds, then we could move in this direction.
19 Is it just one year for planning?
20 DR. MARGULIES: Technically, we would not put them
21 into the planning stage because that has too many legal
22 complications. Functionally, in a planning stage, which works
23 out the same way.
24 The only comment I would like to make regardless of

25 your decision is I think this extraordinary attention to the

1 program is well deserved. If they get through the present
2 period of pressure and emerge as Northeast Ohio feeling
3 that they can now feel as though they are on sound ground, they
4 will be making a very bad mistake, and so will we. Because
5 what has come out of it is anything but satisfactory up to the
6 present time.

7 But we do feel the potentials are there. But potentials
8 aren't enough.

9 DR. SPELLMAN: Which means at the end of that year
10 they would if they had not merged or had not made progress,
11 you would have to phase them out. That would have to be clear.
12 Otherwise, you would just be repeating the same.

13 DR. MARGULIES: That's right.

14 SISTER ANN JOSEPHINE: And the success that has been
15 subscribed for this program rather recently is all bound up
16 with one particular person, not a program.

17 DR. MAYER: Am I clear that their current level of
18 direct cost funding is in fact $690,000? I am looking on, I
19 guess it is pink. I am not sure whether it is pink or salmon,
20 but it has an asterisk and says "Does not include 24-month
21 extension for 01 year of $2,376,000." I don't understand it.

22 What level of funding are they currently at?

23 Let me make a suggestion in terms of staff. At least
24 what I need or what I needed when I reviewed programs is to
25 have a fix on what the current annualized, most up-to-date

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1 operating costs are of the program as it is then functioning.

2 Now, maybe we have got in here that data, but if

3 somebody said to me what are they currently functioning on

4 an annual rate basis in terms of core staff and in terms of

5 project -- that is the information we need to have in terms of

6 where they are. I don't know where they are. They are somewhere

7 between $2.3 million and $690,000 on an annual basis. I don't

8 know where they are.

9 Can staff help?

10 MRS. KYTTLE: We don't have their current expenditure

11 rate in here because we don't have it. We get expenditure

12 rates 120 days after a program year is ended. And then they

13 are negotiated and audited. And it is quite a while before

14 the review system gets that information. By the time we get

15 it, the review system has traditionally felt it was so old

16 that it was not applicable to the year that we are considering.

17 DR. MAYER: Let me ask the question a different way.

18 We must have some idea of what their anticipated expenditure

19 is from September 1, 1971, to August 31, 1972, which is when

20 the thing runs out. Or don't we even have that?

21 MRS. KYTTLE: Their anticipated expenditure?

22 DR. MAYER: How many dollars have they got to deal

23 with?

24 MRS. KYTTLE: You mean their award?

25 DR. MAYER: Yes.

1 MRS. KYTTLE: This region had so many extensions
2 that it had a 24-month 01 year. And their 690 is a 12-month
3 proration of that 24-month money.
4 DR. SPELLMAN: That 831?
5 MRS. KYTTLE: Where is Vernon? Did I say that right,
6 Vernon?
7 MR. ASHBY: No, it is not. The $786,187, they are
8 funded now for an 8-month period. I was trying to figure it
9 out here. It is 5 something. And it was divided by 8 and
10 multiplied by 12 to give you the figure out here on the right-
11 hand column.
12 DR. MAYER: So the ball park is $786,000, then. That
13 is the level they are functioning at.
14 MR. ASHBY: Yes.
15 DR. MAYER: O.K.
16 DR. SCHERLIS: May I have some other clarification
17 on funding? We have used the terms growth and development and
18 found that somewhat confusing.
19 Doctor, looking at the record, would you give me a
20 guess as to what you would think a reasonable amount of funds
21 that a region of this size with a core of $540,000 to allocate
22 feasibility studies -- that is somewhat development and growth --
23 DR. MAYER: I don't understand the question, Leonard.
24 DR. SCHERLIS: I guess what I am driving at is
25 looking at their summaries of core, the $539,000 for core

1 activities, they spent $246,000 for feasibility studies which
2 core activity in an area that has had so much difficulty with
3 looking for programs seems to me an excessive amount of money,
4 particularly since their entire project support is less than
5 that.

6 What I am making is obviously the one I don't know
7 how they manage it. Is there any review of RMPS of those
8 expenditures as they go on?

9 SISTER ANN JOSEPHINE: I don't have any data.

10 MRS. SILSBEE: As a member of SARP, we looked at
11 the money they were spending for those kinds of things under
12 core as being the only hope for this program. It was small
13 studies that were going on under the core staff.

14 DR. SCHERLIS: It must have been a lot of small
15 studies.

16 DR. MAYER: Dr. Hinman.

17 DR. HINMAN: One of these feasibility grants was to
18 the Youngstown Warren area which is one of their regionalized
19 areas and has developed into a community-based manpower
20 development proposal which will be reviewed on the 21st. But
21 the planning group and the concerns of the group seem most
22 appropriate in Youngstown and Warren. So there has been some
23 payoff for these dollars.

24 SISTER ANN JOSEPHINE: Were they specific about what
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25 the payoff was?

1 DR. HINMAN: Well, I visited with them in one of
2 their planning sessions, and they had brought together the
3 people from the three counties in Ohio and the two in
4 Pennsylvania that were contiguous that are in this medical
5 trade area -- consumer representatives, medical society
6 representatives, education representatives -- to sit down and
7 talk about whether or not they wish to try to do something
8 together along the model of either the Carnegie Commission
9 mental health education center or the RMP defined community-
10 based manpower development.

11 The total dollar investment, I think, was in the
12 neighborhood of $12,000 or $14,000. And it was basically in
13 the salary of Mrs. Baird, the area coordinator, who was
14 spending the time and effort in developing this program.

15 DR. SCHERLIS: It was $26,000.

16 SISTER ANN JOSEPHINE: One of the strengths of this
17 program, if I were to try to identify a strength, has been the
18 ability to get different groups together. You know, without
19 going into this as a feasibility study. At least this would be
20 my feeling.

21 DR. MAYER: Well, let me go back. I think we have
22 got the three possibilities. And then under those three, we
23 have to arrive at a level of funding with some principles
24 hooked to it that people can understand and rationalize.

25 Yes.

1 MR. GARDELL: I just say the funding, then, is
2 $781,000 we are working with. We had no Council level, approved
3 level, of record because that was the end of its program period.
4 And so we were just working on an extension basis. That was
5 the level prior to the cut in '71. And it is the figure we
6 have been working with all along.
7 DR. MAYER: The $781,000 which has roughly $500,000
8 or $600,000 of core and a couple hundred thousand of projects.
9 MR. GARDELL: I don't know what the breakout is.
10 All I know is the total figure.
11 I also should say to you we don't have any expenditure
12 reports from that year. We are still extending that'71 grant.
13 And it is running 26 months. And you don't get an expenditure
14 report until 120 days afterward.
15 DR. MAYER: Leonard.
16 DR. SCHERLIS: I would suggest that they spend some
17 of their feasibility funds to learn how to write grants. I
18 could make absolutely no sense out of that document.
19 What you are telling me about the length of year one,
20 I have always looked at year one rather conservatively as
21 being roughly 12 months, as I understand it. I don't accept
22 220 percent year one unless it is clearly stated in the
23 record.
24 And to pick up that blue book, I want to congratulate
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25 the two of you who reviewed it for making any sense out of it.

1 I find it completely lacking as far as any history or what
2 went on. Was I short-sighted when I looked at it or were there
3 pages that were missing? Because there was absolutely no
4 history. And I tried to figure out how they did everything
5 they did in one year.

6 How they can get this bad a record in one year is
7 something I could not figure out. It was a rather long year.

8 DR. MAYER: Dr. Schmidt.

9 DR. SCHMIDT: I don't think it would be appropriate
10 to close them down. And I think what we ought to do is approve
11 them for a period of time that would be approximately a year
12 or whatever it would be to get the end of their time matching
13 the end of the time of the Ohio program, whatever that is.

14 DR. MAYER: That is, I gather, August 30.

15 DR. SCHMIDT: And they should be instructed that the
16 options at that point would either be that they make the case
17 for an independent Northeast Regional Medical Program or they
18 are merged or they will be shut down and that the level of
19 funding be someplace around $500,000 or $600,000, something
20 that will get them down so that they have to start shutting
21 down their projects and enter a planning phase and come back
22 up again. And the funds should be limited to the extent that
23 this will force this, maybe $500,000 or $600,000 to do that
24 with the instructions stating in effect what we are asking for
25 is a plan for this Regional Medical Program that we would look

1 at and evaluate.

2 They have either got it or have to throw in with the
3 other one or they have got to quit. Having the end point
4 being the date --

5 DR. MAYER: Which is August 31, 1973, which is what
6 it would be.

7 DR. SCHMIDT: If there is a sense to that, I would
8 so move.

9 DR. SCHERLIS: Second.

10 DR. SPELLMAN: This August or next August?

11 DR. MAYER: This August there is no way they can
12 comply with what he is asking.

13 DR. MARGULIES: He is talking about '73.

14 DR. MAYER: So what Mac is talking about is recommend-
15 ing funding at a level which is kind of fuzzy, and we will
16 have to sharpen that up, from September 1, 1972, to August 31,
17 1973, which is one year and does include 12 months, Leonard,
18 with explicit instructions that at the end of that period of
19 time, they ought to have inhouse a grant application which either
20 justifies their continuation as an RMP, as Northeast Ohio or
21 merged or some other effective thing or their funding is going
22 to be discontinued.

23 DR. ELLIS: May I ask a question?

24 DR. MAYER: Yes, Effie.

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25 DR. ELLIS: I want to ask one question. I want to

1 ask Dr. Margulies do you think if staff works with them more
2 closely as they are set up, they will improve and their
3 horizons can broaden? If you could get a younger person
4 with newer ideas to work under Dr. Glover if he is going to
5 be there for a few years or more or something like that,
6 this would be helpful.
7 It doesn't sound to me as if merger would be possible --
8 that is, a real sound merger -- within the period of a year
9 or even two or three. Perhaps it would be better to say move
10 toward that if this seems likely.
11 But I don't know if they are going to be able to
12 do too much unless they do have someone kind of really helping
13 them and monitoring very closely what they are doing and
14 suggesting a way.
15 DR. MARGULIES: Well, so far as staff capacity to
16 improve the program is concerned, I guess my best response
17 is God willing. They are there. In fact, I think probably
18 staff in that part of the RMP, DOD, has spent more time on the
19 Ohio programs than any other. And the major benefit has been
20 in the other part of it where a merger has occurred. And in
21 the process of merger, some real new thinking has gone on.
22 Staff at the present time, as I indicated, has some
23 hope for the Cleveland end of it doing well. But I think it
24 will not do well unless the kind of very specific action which
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25 you are talking about does come out. So they don't think that

1 this is just a mild gesture, but it carries with it not a
2 veiled, but an open threat, fish or cut bait. I don't see any
3 other way in which staff will have the backing to have an
4 impression on what goes on.
5 MISS ANDERSON: Somebody mentioned their relation-
6 ship with Pennsylvania. Is that a reality? Could they
7 possibly merge with that group?
8 DR. MARGULIES: No, this was just on the local basis.
9 MR. HILTON: I was just going to ask simply on the
10 discussion stage on this motion, I wondered if there is a
11 possibility or the danger that this action might be interpreted
12 by those on the receiving end as indeed somewhat vindictive
13 on the part of RMPS --
14 DR. MAYER: Somewhat what?
15 MR. HILTON: Vindictive, punishment for them for
16 not -- Because it seemed there is no concept of merger.
17 The seed has been planted already even in that February 10
18 letter. It has been suggested, and they have heard that.
19 And they recognize that as a product. And would this action
20 coming when it does not come off as being a little bit of
21 we are punishing you already kind of thing? And possibly the
22 suggestion that Dr. Ellis raises of having somebody work inter-
23 nally to bring about change might represent a more meaningful
24 alternative than bringing down the guns quite that firmly.

25 I just raise it as a suggestion in terms of the

1 image of RMPS with regard to the local autonomy of these
2 programs.
3 DR. SCHERLIS: I would like that to be made very clear.
4 DR. MAYER: Mac, would you care to sharpen your
5 thoughts either in consultation with Sister or how do you want
6 to arrive at a level of funding or do we suggest that you
7 might all do that tonight and plug in that blank tomorrow
8 morning?
9 DR. SCHMIDT: Either $500,000 or $600,000.33.
10 DR. HESS: To resolve that dilemma, I would like to
11 make a suggestion.
12 On page 4 of the pink sheets here, the summary sheet --
13 DR. MAYER: Page 4 of what sheet is that, Joe?
14 DR. HESS: The summary sheet, table of contents,
15 Northeastern Ohio anniversary application, page 4 that has the
16 figures on it, financial summary, if you add up out of the
17 column "Current Year's Award", one operation year, and I am
18 assuming that these are 12-month figures, if you add the
19 $481,000 for core, $55,000 for subcontracts and then add
20 approximately $70,000 for the phaseout of operational
21 activities, you end up with $600,000. And I think that falls
22 in the guidelines, shouldn't hurt them unduly in terms of staff
23 and planning activities, give them some money for phaseout, and
24 still the message should be there.
25 So I propose $600,000 as the figure.

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1 DR. MAYER: O.K.

2 DR. SCHMIDT: The mover will accept that.

3 MISS ANDERSON: I second it.

4 MR. PARKS: I would think if we are planning to
5 extend this operation, that some consideration be given to the
6 recommendations from the staff which are on this, what did
7 you call the other color -- on these pink sheets -- which
8 do contain some very valuable suggestions, both on the first
9 page under recommendations and on page 2 of the critique which
10 calls, really, for certain kinds of overall guidances and
11 certain kinds of technical assistance and support.

12 I think, for example, if we are going to allow this
13 program to continue and expect Dr. Glover to produce, it is
14 then encumbent upon RMP to provide him with all of the kinds
15 of support that would give him at least a chance to succeed.
16 I think that ought to be considered in light of the money, for
17 example, with $600,000 that has been recommended and also with
18 regard to the time period within which he is expected to
19 perform.

20 That is, to disengage him entirely, whatever has
21 transpired in the past, and try to give him some freedom of
22 movement.

23 SISTER ANN JOSEPHINE: I think, too, it would be very,
24 very important if staff can to find this assistant for him,

25 an adequate assistant, because to fill this role effectively

1 is going to require a lot of hard work. And it is going to be
2 a very tiring thing. And I think without an assistant and
3 without the ability to delegate, you can almost predict it is
4 notgoing to work.
5 DR. MAYER: Yes, Mr. Ashby.
6 MR. ASHBY: Dr. Glover, I don't think he intends to
7 stay more than two years. And he is actively looking for an
8 assistant to train. And as I said before, he has one of the
9 biggest critics of this program. And at the same time, if
10 you consider the new coordinator, they have been without a
11 coordinator for 17 months. And then you limit their funding
12 to an amount where you can't operate.
13 SISTER ANN JOSEPHINE: But he can plan.
14 MR. ASHBY: Right. But it is like saying we are going
15 to extend you for one year, Dr. Glover, although we are going
16 to place these restrictions, and here is what you are going to
17 come up with. We know you are not going to do it because you
18 don't have the facilities and --
19 SISTER ANN JOSEPHINE: I think it is just very, very
20 important you reflect the thinking of this group. And I don't
21 hear you reflecting it now.
22 DR. MAYER: I am reminded of the comment that Bob
23 Marston once made when there was a leveling off at $1.2 billion
24 in the NIH budget. And everybody was having at him. And he
25 said, "Well, you can still do a lot of research with $1.2 billion.

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1 And I would have to say that you ought to be able
2 to do a fair amount of planning with $600,000.
3 Mac.
4 DR. SCHERLIS: I was going to say that is particularly
5 true when you have $250,000 floating around that can be used
6 for feasibility studies. Most feasibility studies I have
7 seen usually have been $3,000, $4,000, $5,000 in the
8 developmental component stage. And these are in the range of
9 $26,000 and $30,000 which to me is a major project and not
10 just core function.
11 I think there is enough fat there to move.
12 DR. SCHMIDT: Concerning what Bill said, I think it
13 is important to state the action of this committee as intended
14 by me is not to be vindictive, punitive, or anything else.
15 But it is meant to be a directive and be just a little bit
16 crisper than some of the actions and some of the things that
17 have been going on, particularly in that area.
18 It is clear there has to be certain things happening.
19 And I think that there would be enough money with $600,000 to
20 reach the end point that is, I feel, necessary to set for
21 this region.
22 And the action of the committee is trying to be
23 helpful by setting an end point and giving some clear choices.
24 One of them is to make the case for the region.
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25 DR. MAYER: Yes, Phil.

1 DR. WHITE: It seems to me you are going to have
2 difficulty doing what Sister thinks should be done if we are
3 going to send this clear message you have a year to go or else.
4 How in the world are you going to recruit that kind of guy to
5 come in and help Dr. Glover under those circumstances?
6 Aren't you going to kind of have to suggest that
7 Dr. Robbins or whoever is the head of the Cleveland Clinic
8 or somebody lend some expertise, give them somebody on leave
9 of absence from one of their institutions to get this thing
10 moving? At least, he is going to have a job to go back to in
11 case it flops.
12 DR. MARGULIES: We have some thoughts about how we
13 might be able to do that on a 3- to 6-months basis with someone
14 who can really be of direct assistance. But that is the
15 dilemma.
16 We have been carrying them on all this period of
17 time saying, "Well, you know, if we just give them the chance,
18 they will get the people and they will get things going."
19 And it hasn't worked. So it is a situation in which whatever
20 decision you make, you are going to feel a little uncomfortable
21 with.
22 DR. WHITE: I think the point earlier was if Dr.
23 Robbins -- I am not picking on him particularly -- but if the
24 people in that region want to see this thing go, there is

25 probably enough talent already in that area that they ought to

1 commit some of those hours of those people to make the thing
2 go.
3 DR. MARGULIES: And if they can't find something
4 that needs to be done in Cleveland, they are having great
5 difficulties in their perceptions.
6 DR. MAYER: John, you had a comment?
7 DR. KRALEWSKI: Back to this budget, I don't want
8 to beat it to death, but I am sorry I still don't understand
9 it. If we are recommending $600,000, what do we recommend as
10 a start -- this year?
11 DR. MAYER: September 1, 1972, to August 31, midnight,
12 1973.
13 DR. KRALEWSKI: And that will be consistent with
14 the letter from Council? Are we asking them to revise?
15 DR. MAYER: Yes. It can be made to be consistent
16 with the letter from Council.
17 DR. KRALEWSKI: And the group here feels, I gather,
18 there is enough information in this document right here that
19 we can make that $600,000 decision at the moment rather than
20 having maybe a small group with staff iron out a figure here
21 later in the day?
22 I don't feel I can, but if the rest of the group
23 feels they are comfortable with it, I will go with it.
24 DR. SCHERLIS: I would submit if you go through
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25 the entire application, you will come away with the same feeling

1 of restlessness.

2 DR. MAYER: Yes, Mac.

3 DR. SCHMIDT: Two comments.

4 One, if staff or anybody has a better figure to come

5 up with and want to justify it, I think it would be fine to

6 reintroduce that later this afternoon or tomorrow. And I

7 think it would be considered.

8 The second one is in my conversations with people

9 at Case, Cleveland Clinic, Medical Society, and so on, they

10 haven't got the foggiest idea of whether they want a Regional

11 Medical Program or what one is. And I think at some point

12 everybody from delightful what's his name in the Cleveland Clinic

13 on down have to get off this business of the Feds are going

14 to keep putting money in here and we get plenty coming in

15 anyway, and we don't need it. They have got to quit ignoring.

16 And the big problem of getting a Regional Medical

17 Program going in that area from what I have been able to see

18 is that people by and large have just ignored it. And if this

19 is a way to get them to pay some attention, whether it is

20 borrowing people from the university or whatever, then, fine.

21 But people have to look at it and say, "All right, here is a

22 decision." They have never really done that.

23 DR. MAYER: Does everyone understand the motion?

24 MR. PARKS: One question.

25 DR. MAYER: Yes, Mr. Parks.

1 MR. PARKS: On the recommendations from the staff
2 anniversary review panel, there is a rating of 245. May I
3 ask what that means and on what scale?
4 DR. MAYER: That is on the one to five scale, I
5 assume. That puts it in group C which is the lowest grouping
6 which at least says something, but it is at least barely in
7 there.
8 MR. CHAMBLISS: If I may make a comment there --
9 DR. MAYER: No, I am sorry, it must be .1111.
10 DR. BESSON: It runs from zero to five hundred.
11 DR. MAYER: Yes, right.
12 Yes, Mr. Chambliss.
13 MR. CHAMBLISS: I was simply going to let the committee
14 know that the desk chief, Mr. Van Winkle, would be available
15 to answer any questions on that if you have further questions.
16 DR. MAYER: O.K.
17 Comments? Everyone understand the motion?
18 DR. SCHERLIS: Is there any feeling of staff that we
19 are misreading the signals? I am curious.
20 DR. MAYER: All I have heard is a feeling that
21 the therapy may not be appropriate. But I think the diagnosis
22 sounds pretty good with everyone. At least, that is what I am
23 hearing.
24 MR. CHAMBLISS; The comment from staff would be that
25 I feel the diagnosis is quite proper. We have some concerns,

1 great concerns, about this region.

2 DR. MAYER: Sister Ann.

3 SISTER ANN JOSEPHINE: May I just make a comment

4 to you sitting at the end of the table after you were so nice

5 to brief us in. These are the kinds of pressures I get from

6 my board. And several years ago, I was saying this is too

7 harsh a way of doing it. You know what? I am learning it is

8 a good management tool. You will be surprised how many good

9 things can come out of it. But I do know that it is terribly

10 important that you share our feeling about it.

11 This is really a measure to make it possible for them

12 to get moving. And so you will have to be very supportive of

13 it because they will read it very quickly.

14 MR. ASHBY: I want to apologize. I was talking out

15 of school.

16 DR. MAYER: Further comments?

17 Yes, Lee.

18 MR. VAN WINKLE: I think one of the major reasons for

19 their problem out there is the fact their executive committee

20 and board of directors are one and the same. And that largely

21 reflects Dr. Charles Hudson's thinking. And I am hoping that

22 when we get this new piece of paper that tells us what the

23 RAG relationships and coordinator relationships and these

24 sorts of things are, we can put sufficient pressure on them to

25 change their by-laws.

1 But that is what is a real grievance out there. And
2 they are dictating, there is no question, the executive
3 committee and board of directors are the same, and they are
4 dictating to the coordinator or non-coordinator.
5 DR. MAYER: Other comments?
6 (No response.)
7 All those in favor of the motion say, "Aye."
8 (Chorus of ayes.)
9 Opposed?
10 (No response.)
11 We effectively have gone past coffee, but let's
12 take about a 10-minute break to mark the sheets and stretch.
13 DR. SCHERLIS: Just one sentence that I think under-
14 lines what you said. The organizational structure is apparently
15 not well understood, and it is amplified as it goes on in the
16 next few pages.
17 (Whereupon, a recess was taken.)
18 DR. MAYER: Could we start, please? Are we ready,
19 John?
20 DR. KRALEWSKI: Right on.
21 DR. MAYER: This is new. It isn't anniversary, but
22 was site visited.
23 I might comment before John begins that what we have
24 just done in terms of Northeast Ohio, there was a SARP rating

25 in which the question was appropriately raised about what that

1 meant. And then we proceeded to go on to rate it.

2 I think what we might do in those that have already

3 been rated by SARP, we need to make a first decision which is

4 do we agree with the rating. And if we say, yea, then we

5 stop there and go no further in terms of subratings. If we

6 say that we do not agree, then I think we are saying that we

7 want to also rate it, and we all rate it.

8 John, we knew you were coming up because I assume

9 that is your material on the blackboard.

10 DR. KRALEWSKI: Right on, yes, indeed.

11 DR. SCHMIDT: Were you asking a question or making a

12 comment?

13 DR. MAYER: I am making a statement unless you want

14 to approach it otherwise.

15 DR. SCHMIDT: I think we should rate the region.

16 Is that what you were stating?

17 DR. MAYER: Yes.

18 Well, maybe we need to take a minute.

19 DR. SCHMIDT: I think staff rated. I think that is

20 beautiful. I think we ought to rate it, too, as a committee.

21 My gut feeling is that staff's numerical score is a

22 little bit high, although I agree with the comments and

23 suggestions.

24 Am I out of order? Am I talking about something

25 else?

1 DR. MAYER: No, it is a question of -- Well, let
2 me go back. When we originally talked, and I don't know
3 whether I am two meetings back, one meeting back, or three
4 meetings back, when we were talking rating scales, we said
5 that those which are anniversary reviews within the triennium
6 would be handled by the staff anniversary review panel, SARP,
7 that we would also comment on those and discuss those. And
8 then the question came in terms of how much time would we spend
9 on them and would we rank them, etc.

10 And I think where we were was to say, "All right, we
11 will look and see what the staff anniversary review panel
12 which was set up to do that job does, and if we agree with the
13 figure that they are at, fine. And if we don't, then we owe
14 it to ourselves to go ahead and rate them."

15 DR. SCHMIDT: Are you talking about the 245 score
16 that was brought up before?

17 DR. MAYER: Yes, for Northeast Ohio.

18 DR. SCHMIDT: I would be uncomfortable with matching
19 my motion against that point score.

20 DR. MAYER: And we therefore rated it. So I have
21 no problems with that. All I am saying is we need to address
22 ourselves with each of the applications which on this sheet
23 have numbers. We have to address ourselves do we want to
24 accept that level or do we want to rate them ourselves? That
25 is all I am suggesting.

1 Maybe what you are saying is you want to rate them
2 all.
3 Yes, Leonard.
4 DR. SCHERLIS: I think having this sheet in front of
5 us makes us focus on individual items as they are presented.
6 And as such, it is a very good way of focusing the attention
7 of the group. In so doing, a rating is arrived at. And I
8 would think we should do this with each presentation that is
9 made here.
10 I find it difficult to accept another rating without
11 going through the mechanics myself to see if I agree. But
12 once I have done the rating, then it is there and it is written
13 and something might as well be done with it even if the
14 committee that goes over this chooses to disregard it. But at
15 least I would like to go through the mechanics of doing it.
16 DR. MAYER: O.K., does staff have any troubles with
17 that?
18 DR. SCHMIDT: If there are great discrepancies in
19 this rating and staff's rating, I think that is a nice danger
20 signal that would signify we have got a problem that ought to be
21 looked at.
22 DR. BESSON: I have viewed this as just your calling
23 the presence of this rating to our attention, no more.
24 DR. MAYER: All right.

25 DR. SCHMIDT: You got that?

1 DR. MAYER: Yes, I got that, Mac.

2 DR. SCHERLIS: Does the chair understand the message?

3 (Laughter.)

4 DR. MAYER: Fine. I am happy with it. I very

5 comfortably ranked it.

6 Herb, do you have any problems with that?

7 DR. PAHL: No. The committee is at liberty to

8 rate any application at all. The whole purpose of SARP, of

9 course, was to relieve this committee to the extent possible

10 from having to look at those applications which in general it

11 didn't have concern with. But you are at liberty to take on

12 the full job of rating each and every application if you so

13 desire.

14 The rating by SARP is to give you assistance to the

15 extent that you find it to be helpful.

16 SISTER ANN JOSEPHINE: Are these figures converted

17 into figures like this? Isn't that where these figures are

18 derived from?

19 MRS. KYTTLE: Yes, Sister.

20 DR. MAYER: O.K. I gather when we have discussed

21 them, we want to rate them. Is that it?

22 O.K. Sorry I raised the issue.

23 John, are you ready?

24 DR. KRALEWSKI: O.K. The Nassau-Suffolk RMP, most

25 of you, I guess, know that covers the two counties of Nassau

1 and Suffolk in Long Island, a long narrow, expensive piece of
2 real estate a little east and north of there.
3 The program was site visited a year ago. And at that
4 time they approved a three-year --
5 DR. MAYER: John, could you get a little closer to
6 the mike or get the mike a little closer to you?
7 DR. KRALEWSKI: The program was site visited a year
8 ago and at that time decided to approve a 3-year application
9 for them, but to site visit them again this year to determine
10 the progress they were making and determine at this point
11 in time how much money we should recommend for the next two
12 years of that three-year grant.
13 By way of history, the program is relatively new.
14 It developed initially as part of metro New York program.
15 Then it was split off some three years ago. They got a
16 planning grant to form a new region, Nassau-Suffolk Region.
17 They operated under that planning grant for two years, made
18 a fair amount of progress. They had a lot of support from a
19 lot of the different health care agencies in the region. And
20 then at the end of that time, they applied for an operational
21 grant. That is when we got into the scene in terms of a site
22 visit which I chaired at that time and was a three-year operational
23 grant that they were asking for.
24 Now, at that time on that site visit we uncovered some
25 seaknesses that we were concerned over, and they are as follows:

1 Number one, their organization was difficult to
2 understand if not to say the least in fact it was difficult
3 to explain. They had one organization that was both part of
4 RMP and CHP. They had difficulty explaining the difference
5 between their Regional Advisory Group and their grantee
6 organization. They had numerous amounts of committees and it
7 was difficult to determine exactly what those committees were
8 doing. So organizationally, a problem.
9 Secondly, within the organization, it seems as
10 though they had some weaknesses in their staff. They were
11 hiring people kind of at random the way it looked to us, and
12 they weren't fitting them together into a cohesive unit.
13 They lacked the data base and, therefore, many of the activities
14 that they were engaged in again appeared to be kind of on a
15 random basis rather than based on a rational plan. There was
16 some data to support that plan.
17 The Regional Advisory Group was large, and the
18 participation was relatively minimal. They had fairly good
19 mechanisms to involve consumer groups and underserved groups
20 in the decision-making process, but again it looked as though
21 they were probably not taking advantage of those opportunities.
22 And the attendance at the RAG meetings was low, particularly
23 among the minority groups.
24 The goals and objectives were another area of
25 concern. They were broad and difficult to operationalize.

1 Well, we found at that time, however, that there was
2 a great deal of leadership being expressed by Dr. Pellegrino
3 at Stonybrook, and there was a great deal of leadership, we
4 thought, at least, in terms of the coordinator of the program,
5 Dr. Hastings. So we believed that they had the potential
6 and that they were on the right track. The kinds of projects
7 they were becoming involved in seemed to make sense. They
8 seemed to express a great concern over the health needs of
9 the underserved populations of the area. And it looked to us
10 as though they could in the long run be capable of running this
11 organization and doing a pretty good job of it.
12 On that basis, we approved that three-year grant.
13 And then this committee last year again with the stipulation
14 that we site visit them this year to see how they were doing
15 and determine how much money we could give them or if we
16 should cut them back in terms of amounts of dollars.
17 Well, this year's site team then, it is noted in the
18 book here, I chaired it, Dr. Komaroff was there from the
19 National Advisory Council; Dr. Sattler, general practitioner at
20 the Yankton Clinic in South Dakota; Charles Moore, Assistant
21 to the Dean for Financial Affairs at Eastern Virginia Medical
22 School who helped us a great deal in terms of ironing out the
23 financial problems of this organization; and then the usually
24 excellent staff here from RMP that accompanied us on the site
25 visit.

1 This application, then, that they were presenting to
2 us at that point, and they are one year now into their
3 triennium, is asking for a continuation of their core staff.
4 It is asking for developmental components. It is asking for
5 four new projects. And it is asking for funds for one project
6 that had been previously approved, but not funded.
7 We spent two days with the group and generally tried
8 to look at again their organizational structure, goals and
9 objectives and how they were formulating projects and programs
10 to meet those objectives.
11 We found that they had made a substantial amount of
12 progress. First of all, they have reorganized their top
13 echelons of the organization. They split off a group of
14 individuals from their RAG, and they formed a separate corpora-
15 tion. And they now have therefore a grantee organization --
16 it is a separate non-profit corporation -- and a Regional
17 Advisory Group.
18 Now, the membership, there is a great deal of cross-
19 membership on these two groups. And that, I gather, is the
20 concern of some. And you may note in here some letters that
21 have gone back and forth between RMPS and the program.
22 But the site team felt that they are making an
23 honest attempt to live up to the requirements of RMPS and still
24 have a functioning policy-making group here that will keep the
25 program on the right road. And we felt that although still

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1 cumbersome and still a bit artificial and still a little bit
2 difficult to explain unless you are an organizational theorist,
3 the doggone thing appears to be working. And that in the
4 final analysis is a real plus, we thought. And it seemed to
5 be doing the job for them.
6 So they have reorganized the top echelons, and
7 they keep them together, then, through a number of interrelated
8 again committees.
9 They have also reorganized their staff. They have
10 had a turnover of some of their internal staff, and this has
11 given Dr. Hastings an opportunity to bring on some new talent.
12 And he has done so in terms of one deputy manager who we felt
13 was a real strong individual. And he is in charge of program
14 development. And they have also brought on a gal who is
15 a CPA.
16 Now, in terms of the functioning of this group, they
17 have allowed the CPA to really take over most of the financial
18 management of the program and have split their organization
19 away from the Stonybrook Foundation. This foundation was
20 previously providing them with administrative support, mostly
21 financial management. So they are providing their own support
22 now with this gal who is a CPA. And as a result of that, they
23 are saving a fair amount of overhead expenses in their program.
24 We felt she was really a strong gal. And we felt
25 that the reorganization of this staff has been a real plus.

1 People now know who they are reporting to. They know what they
2 are supposed to do. They have still got a few people in the
3 wrong boxes, but he knows that. And we felt that in the long
4 run, he is going to iron this out probably within the next
5 12 months in terms of shifting some people and adding some
6 people.

7 He wants to add someone with a little more quantitative
8 methods background, and we supported that. And he wants to
9 add someone with a continuing education background. We felt
10 that that was perhaps a move in the right direction.

11 They have developed a fairly tight review system.
12 And that was reviewed separately by RMPS staff. And the
13 report that they gave us was that it was a good system both in
14 terms of the review process and monitoring of the projects
15 after they are on board.

16 In terms of questions regarding the central thrust
17 of the program, we were fairly satisfied that they were now
18 able to take their projects that they have ongoing and the
19 new projects and the core activities of which they have many,
20 and put those together into thrusts that are meeting needs in
21 the area.

22 Now, the data base that they are attempting to use
23 for this is still very weak, although they are making some
24 progress in it, and they are making some progress in getting
25 Stonybrook to pick up a part of it. So there may be a data

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1 base form at Stonybrook in the next couple of years. Still,
2 at the present time, the data base I would say is relatively
3 weak.
4 But we were impressed with their informal communica-
5 tion system with the community. They are working very closely
6 with the planning agencies. They have subregional groups
7 organized under their planning activities to bring minority
8 groups and other consumer groups into the decision-making.
9 So they stay pretty close to what is going on.
10 As a matter of fact, when we question them about the
11 activities in the area, they really show a high degree of
12 knowledge of the activities and where the needs are and how
13 they might put together some programs to meet those needs.
14 And we were impressed with that even though they weren't able
15 to demonstrate it again with hard data.
16 Cooperation with the medical profession and the
17 hospitals and health departments again was good. I talked
18 with a number of docs from the medical societies and while they
19 disagree with some of the things that RMP is doing in that
20 area, they nonetheless to the man said that Hastings is a good
21 guy, he is honest with them, he is doing a few things that
22 may be a little too much for them to handle at the present
23 time, but they have no big fight with his overall mission.
24 And he is doing some things in terms of trying to
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25 change the pharmacist role, for example, where the pharmacist

1 will be acting as a consultant to the physician. And I asked
2 the docs whether anyone is going to accept this. And they
3 said they thought it was the greatest thing that ever happened.
4 They want to get that pharmacist out of his pouring from one
5 bottle to another. And they sure agree that this was going
6 to be a real asset.

7 I don't know if they will ever pull it off or not,
8 but nonetheless, to hear a fair amount of docs say that they
9 supported it and understand what he was trying to do, it was
10 impressive to me. He had got onto these guys and convinced
11 them it was a reasonable approach.

12 He has also provided assistance to a couple of groups
13 to develop HMO planning grants. One of them is funded, two
14 more are in review cycles. They may not be funded now because
15 those funds were cut back. But nonetheless they provided
16 assistance to providers in that capacity. And he has provided
17 assistance to some of the larger corporations in the area so
18 that what they are doing is attempting to develop some kind
19 of a rational plan of health care for their employees. And,
20 of course, these groups are looking toward HMO kinds of
21 organizations to provide that care.

22 And then, the medical society in turn is saying,
23 Maybe we better get into this act if industry is going to
24 start buying care from organized groups so that we can be
25 one of the providers of that care.

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1 Again, he has been able to do this without blasting
2 it out of the water. We were fairly impressed with it.
3 Well, a number of other activities underway that
4 we felt were useful. Two projects that he has here for approval.
5 One of them deals with manpower problems in terms of providing
6 pediatric nurse practitioner training, and one of them
7 deals with both manpower and distribution of care by forming
8 a department of community medicine in one of the community
9 general hospitals, again a task that took some doing with the
10 medical staff of that hospital.
11 We felt that these were on the right direction.
12 They were making a contribution.
13 Maybe I will stop there for some comments from the
14 secondary reviewer before I go on to some recommendations and
15 the funding requirements.
16 DR. MAYER: O.K., Gladys.
17 DR. ANCRUM: By and large, I agree with the report
18 that Dr. Kralewski just gave. I think they have acted and made
19 satisfactory progress on most of the recommendations of the
20 year before.
21 A few of the things that he talked about, I did have
22 some questions on. I think he has cleared up a little bit.
23 I was concerned about how much input they were getting from
24 the target groups, especially the poor and the near poor and
25 the elderly and disabled that they talked about increasing

1 accessibility of primary health care.

2 They had had one conference, but it didn't say exactly
3 what the representation or composition of the group who was
4 there or any plans of following through with having any
5 more community input or getting what the felt needs or
6 expressed needs were for the groups they were trying to plan
7 programs.

8 The other thing that was in the report and I think
9 you just mentioned it was the representation of the RAG of
10 minority groups. They do have nine minority members out of
11 a group of 84. And of these nine, only approximately half are
12 any of the committees. And I would presume they could probably
13 get more involvement by assigning.

14 They have currently four out of nine people on
15 committees. And there are five that are not serving on any
16 of the committees.

17 The other questions I had or comments were two about
18 the new program. And one was cleared up just now when he
19 talked about that new pharmacist assistant. I didn't see how
20 this would fit in, but the doctors think that they can get a
21 lot of help from this. Then I guess that isn't as much of a
22 question as I thought.

23 The other was in line with the nurse pediatric
24 practituiner training. Here again in the original proposal,
25 they mentioned having a program which would train both LPNs,

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1 licensed practical nurses, and RNs simultaneously in the same
2 program, I should say. And both the American Nurses Association
3 and the Academy of Pediatricians had recommended the program
4 be for registered nurses who have been prepared on a
5 baccalaureate level.
6 And I was wondering what rationale they were using
7 in order to institute a program that two professional groups
8 make a different recommendation. And apparently this has
9 been changed. They are going to use the registered nurse
10 now. Is that correct?
11 MISS FAATZ: From what I understand, their proposal
12 is for training baccaluareate degree nurses. The CHP comments
13 and particularly the CHP group, is we think you ought to
14 train half. Half the group trained should be LPNs. There is
15 no indication they acted on that suggestion.
16 I don't know where it stands, but the project
17 proposal as submitted in here is for baccalaureate degree.
18 DR. ANCRUM: I know on the original grant, it
19 said both, and I felt it should be. I agreed with the ANA
20 and the Academy of Pediatricians that it probably would need
21 to be someone prepared on a baccalaureate level in order to go
22 out and then further function as an independent practitioner.
23 DR. MAYER: Any other comments, John?
24 DR. KRALEWSKI: We were concerned over the involvement
25 of minority groups and the RAG decisions also and brought

1 that to their attention again. And it is a bit of a dilemma
2 for two reasons.
3 Number one, they are aware that their participation
4 of the RAG members is not good. And they have been holding
5 RAG meetings at different times of the day, evenings, instead
6 of during the day, and different locations, and it still hasn't
7 improved. And we suggested probably they are going to have to
8 develop more working committees to get RAG involved.
9 The second thing is that with the minority groups
10 they rely pretty heavily on one of their CHP men -- I have
11 forgotten his name -- Jim Mura, to make those contacts through
12 his subregional areas that he has set up. And he is a good
13 guy. I thought he was a good guy.
14 And I checked him out with a couple of other people
15 who I thought would rule on his qualifications fairly in terms
16 of his ability to rap with the groups. And they said, yes,
17 he is a good guy. And they thought he was doing an honest job.
18 I think that their input is probably more than looks
19 like on paper is what the feeling I think that our site team
20 got out of the business. But still they needed attention to it,
21 and I think that they are going to have to do that in the next
22 year or so.
23 DR. MAYER: Leonard.
24 DR. SCHERLIS: I note in the site visit of June 1971
25 a comment was made that although none of the projects are

1 specifically disapproved, disenchantment was expressed with
2 the project which was computer assisted EKG diagnosis.
3 I noted that it was funded for about $98,000 a year and they
4 requested another $58,000 the coming year. And I was wondering
5 if either you or Dr. Hinman had further details as far as
6 what is the exact contributory nature of that program to the
7 overall RMP assessment of needs in computer assisted EKG in
8 the area.

9 DR. HINMAN: I am not familiar with that specific
10 program. From a policy standpoint, the position that was
11 taken was that on currently funded activities would not
12 be affected by that decision.

13 DR. KRALEWSKI: Questioning that project with the
14 group, they justified it on the basis that it is creating a
15 system of hospitals, and I don't know. I suspect that in the
16 long run it probably isn't to the degree they think. In other
17 words, they think it is persuading some hospitals to start
18 sharing some ideas and start sharing some data. And therefore
19 they are going to start falling into more of the system than
20 they have in the past.

21 Now, many of the hospitals in this area, by the way,
22 are proprietary hospitals. And this makes some of these things
23 very difficult.

24 I can't defend that project. I really can't.

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25 DR. SCHERLIS: I bring it up only because there has

1 been RMP statement on this, and I was interested in exactly
2 what the yield of this was.
3 I would suggest that this like all of the programs
4 be collated and looked at to see what yield there has been.
5 Because I think there would be some valuable information on
6 planned programs.
7 MR. STOLOV: Dr. Komaroff was extremely interested
8 in this, and he pursued this in the discussion with the project
9 directors, in fact to the point of mentioning that there is
10 something up in Boston that is self-supporting. And you are
11 probably more familiar with it.
12 And I believe in their rationale for budget which we
13 will go into later, we took this into consideration. The region
14 does plan to look at this closely and look at the next projected
15 funds and hope to cut them sharply or eventually make it self-
16 supporting.
17 So I believe this was focused on in the executive
18 session and in the discussion we had of the project.
19 DR. SCHERLIS: The financing of this could be, as was
20 pointed out in the site visit report, rather sticky.
21 DR. KRALEWSKI: Again, they hope those hospitals,
22 apparently, will come up with that kind of funding and this
23 will build the bridges between them. It is kind of shaky.
24 DR. MAYER: Sister Ann.
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25 SISTER ANN JOSEPHINE: I noticed here on page 5 of

1 the yellow sheets that it said one of the other issues requiring
2 attention of the reviewers is the mechanics of the project
3 evaluation strategy. And if this is not too clear, then the
4 accomplishment of this objective we are just talking about
5 isn't too likely to happen effectively.
6 DR. MAYER: John.
7 DR. KRALEWSKI: I think our site team felt that
8 they had tightened up their review process considerably since
9 last year and that, as a matter of fact, we are in a position
10 now where they could and probably are going to phase projects
11 out before the project comes to its normal termination.
12 If anything, the process they have developed is so
13 elaborate it is going to take up a lot of their time to do it.
14 But they have got it well ironed out. And it is, I think, one
15 that will work.
16 SISTER ANN JOSEPHINE: Is it accomplished by setting
17 criteria at the same time for evaluation?
18 DR. KRALEWSKI: Yes. What they do is on a project,
19 they outline the things the guy says he is going to do. They
20 get six-months reports on whether he has accomplished what he
21 said he was going to do. If he doesn't, they go out and
22 visit hin, see if they can help him. If he hasn't made
23 corrections in X amount of time they give him after that, they
24 say they are going to phase it out. They haven't yet, but they
25 are getting those reports. We did see the reports they are

1 getting.

2 DR. MAYER: Additional comments?

3 (No response.)

4 John, do you want to lay out --

5 DR. KRALEWSKI: The budget I put over here so we

6 see it perhaps a little better.

7 What they are requesting, then, is staff, core

8 staff, here $446,000 which is the same as last year. But in

9 addition, then, a developmental component, new projects at

10 $235,000 and then their ongoing projects that have been

11 approved before, $475,000, which would come up to $1.3 million.

12 And in reviewing thatwhole thing, we came up with

13 these figures over here. They have some unexpended funds from

14 their core staff. And it looked to us as though they are

15 probably going to continue to have that and that they are

16 not going to fill all the spots they have vacant, but will

17 probably fill a couple, but not all of them. Therefore, we

18 could probably deal with a sum along about $381,000.

19 We thought we should give them the developmental

20 component, so we did vote that.

21 And then looking at these new projects, a couple of

22 them, again, the kidney projects, one of them has been visited

23 by a separate committee and disapproved, and the other one,

24 the regional organ procurement program, which was recommended

25 for approval, so that is in this. And that total was $235,000.

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1 And going through those projects, we thought they could
2 probably do as well at about the $200,000 level. It may mean
3 that they are going to cut back a little bit on them.
4 Then, with their ongoing projects again taking into
5 consideration the things that were just mentioned here and some
6 of this project that is a little bit shaky and what it is getting
7 accomplished and the fact we feel somebody else should probably
8 be picking this up, we thought we could reduce that from the
9 $475 level to the $360,000. And so therefore, our recommenda-
10 tion would be to give them $1,099,000 which would be about
11 a $230,000 increase over what the Council has now approved
12 them for which is $868,000 for this coming year. We would
13 give them then roughly $230,000 increase for the program at
14 the present time and recommend that both for the 02 and 03
15 years.
16 We felt that their quality of their leadership at
17 this time and the progress of the program would warrant that
18 kind of increase. And yet, as you can see, it is less of an
19 increase than what they had asked for and one that I think
20 they can realistically handle to do the job.
21 DR. MAYER: Comment on the kidney proposal.
22 DR.HINMAN: This was the one I had started on this
23 morning when the sequence was rearranged.
24 The one that was recommended for approval was the

25 renal organ donor program which is a prototype or prelude, if

1 you will, to a New York metropolitan area, the New York Metro,
2 New Jersey, and Nassau-Suffolk 910 application for a coordinated
3 organ procurement for that region. It was our feeling that
4 the part that was being submitted by Nassau-Suffolk was
5 appropriate, and we recommended funding at $27,060 which I
6 understand is in your figures here. Is that correct?
7 DR. KRALEWSKI: That's correct.
8 DR. HINMAN: The second was the home dialysis training
9 program, and that is the one over a year ago staff had
10 recommended that they seek advice from a mature program that
11 was doing home dialysis training and had developed appropriate
12 curriculum.
13 They ignored that advice and came in with a rediscovery
14 of the wheel type of application for $31,200. And we recommended
15 disapproval of that one.
16 DR. MAYER: Additional comments?
17 DR. BESSON: Will our letter of advice indicate the
18 Council opinion about that home dialysis project?
19 DR. HINMAN: Yes, sir.
20 DR. SCHERLIS: Is there a developmental component?
21 DR. KRALEWSKI: Yes.
22 DR. SCHERLIS: That is included?
23 DR. KRALEWSKI: That's right.
24 DR. BESSON: Are there any aspects of the developmental

25 components, John, you felt were not meritorious?

1 DR. KRALEWSKI: Well, they list a relatively large
2 amount of activity that they thought they could get into with
3 the developmental component. And our question was whether or
4 not the value of them because it seemed as though they made
5 sense, or most of it. But our question was how they were going
6 to decide which ones and how they were going to carry them out.
7 Because they have a certain amount of capability on their own
8 staff, and obviously they are going to have to buy some other
9 talent on this.

10 And I think they convinced us again the review
11 technique they are going to use would sort that out and that
12 it would be a negotiation process where a number of interest
13 groups would have a chance to shoot at it. And so we were
14 fairly satisfied with that.

15 Then, their ability to carry it out, they have a
16 fair amount of contacts now with, of course, Stonybrook and
17 can draw on a lot of the talent out of those programs.

18 There is, for example, a health administration program
19 forming at Stonybrook. And they have graduate students on hand
20 now. And they have plans to use some of those graduate students
21 with relatively small funds to collect specific pieces of data
22 for them in different areas. It seemed as though it made sense
23 to do it.

24 Maybe some of the staff would like to comment.

25 DR. ANCRUM: May I just ask a question in that area?

1 I am not terribly familiar with the Harvard study,
2 but I know some of their proposed programs. And they are
3 also tied in with the Harvard information system. Would there
4 be some duplication in what they have been getting from the
5 Harvard study and what they would redo themselves?

6 DR. KRALEWSKI: That Harvard study was, in my
7 estimation, a very unfortunate investment. I don't think they
8 got any information out of it. I think they put some bucks in
9 somebody's pocket. And I think that they made a real mistake.

10 DR. BESSON: What Harvard study?

11 DR. KRALEWSKI: They had a group from Harvard come
12 in and do a study last year --

13 DR. MAYER: John, we can't hear you.

14 DR. KRALEWSKI: They had a group come in last year
15 and do a small study for something like $45,000 worth, something
16 of that nature. And what they were supposed to study is the
17 degree to which the community had really understood what RMP
18 is all about, to get an idea of how well they are doing in terms
19 of their publics.

20 Well, the people that they interviewed, we discovered
21 after we asked them if we could look at the study, were unfor-
22 tunately the people who were on RMP's board. That seemed to be
23 a strange group to look at from my point of view. But they
24 pointed out this is a group they really could get ahold of.

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25 DR. SCHERLIS: It is a well-controlled study.

1 (Laughter.)

2 DR. KRALEWSKI: Strangely enough, they found this
3 group had heard about RMP and made everyone extremely happy.
4 and made everybody extremely unhappy as soon as we raised the
5 issue of who they had interviewed.

6 MR. STOLOV: A footnote to that, in defense of the
7 region, this is a headquarters contract, and the RMP graciously
8 accepted to participate in a headquarters contract that was
9 not initiated by RMP. They are one of the regions cooperating.

10 DR. KRALEWSKI: They paid for it, though, didn't they?

11 DR. MAYER: When you are saying headquarters, you
12 are saying RMPS?

13 MR. STOLOV: Yes.

14 DR. MAYER: Very interesting.

15 DR. ANCRUM: I didn't hear all of the details, but
16 I heard a little bit about the Harvard study when I was at home.

17 DR. MAYER: You understand, Gladys, what the Harvard
18 study was, not a study at Harvard, but a poorly done study by
19 Harvard, I gather.

20 DR. KRALEWSKI: Maybe I am being too tough on them
21 since we reviewed the study so rapidly. Maybe we didn't get
22 the full impact.

23 DR. BESSON: As I look over their development
24 component, they have had 15 projects they are talking about.
25 And they add up to $230,000. How did they come to a figure of

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1 $79,000?

2 MR. STOLOV: This is RMP policy, 10 percent of their

3 last year's funding if they made requests up to that. That

4 is policy here.

5 DR. KRALEWSKI: The question we have is how are they

6 going to take those and decide which ones to do? It is a

7 real test of their ingenuity.

8 DR. SCHERLIS: Of their maturity.

9 MR. STOLOV: There is a footnote they are thinking

10 of some contract mechanism and are interested in exploring

11 that of Harvard.

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

13 Sister Ann.

14 SISTER ANN JOSEPHINE: This 13 percent overlap in

15 their organization between CHP and RAG and with the need now

16 by law, I think it is spelled out somewhere here, for CHP

17 comment and review, I would think you have a little difficulty

18 here.

19 DR. KRALEWSKI: Well, because their projects are

20 going to be reviewed by their own staff?

21 SISTER ANN JOSEPHINE: Possibly.

22 DR. KRALEWSKI: Their projects are also reviewed

23 by some other planning groups in the area which may give them

24 some checks and balance. But there is no question about the

25 fact they will have that staff melded into one at the present

1 time.

2 And you know, we in looking at it and looking at

3 things they are doing felt there was a strength. I don't know.

4 I suppose you could deal it either way. But it seems as though

5 they are making a lot of use of that interchange of talent.

6 Certainly in terms of administrative services, it

7 saves them a lot of problems. Because they have got this one

8 gal, the CPA, who is really handling all of the financial

9 affairs for both organizations. And that is a real plus.

10 They are doing that at a very low rate.

11 SISTER ANN JOSEPHINE: Who is funding it?

12 DR. KRALEWSKI: We are funding it. We raised that

13 issue, too, by the way. And they probably are going to switch

14 her half over to another one. But they have other people who

15 are funded the other way.

16 DR. SPELLMAN: Is Dr. Pellegrino still as strong?

17 DR. KRALEWSKI: Yes, he is still actively involved

18 and was very much in support. And he was there at the site

19 visit.

20 DR. MAYER: Yes, Dr. Schmidt.

21 DR. SCHMIDT: The coordinator is a very well-trained

22 person.

23 (Laughter.)

24 DR. MAYER: One of my finest, is that what you are

25 saying?

1 DR. SCHMIDT: The pharmacist -- now, I am blocked
2 what we call him -- the clinical pharmacist has been functioning
3 on the wards of our hospital for years. And one of the most
4 beautiful things is I asked for them to start rounding. They
5 have been dispensing all medications on patients floors for
6 years, but I asked them to start making rounds with the physicians.
7 And every time the physician writes a prescription, an order
8 for drugs, the pharmacist has one of these little battery
9 computers, and he just within seconds tells the resident how
10 much that cost. And that one single thing, as far as I am
11 concerned, has made the program very worthwhile.
12 He has come back and checked with people in George
13 Miller's operation and so on, some of the theory of the review
14 system. And we reviewed the procedures there from time to
15 time. We have a lot of consultation on them.
16 If anything, they are a little overly elaborate.
17 And he needs seasoning and experience. But we have great
18 confidence in him that he will be able to knock the corners off
19 and get the complexities out and come up with some very sound
20 and perhaps some of the soundest procedures in RMP as a whole.
21 DR. KRALEWSKI: We were impressed with him. The
22 question that came up with our team was whether he was going
23 to stay there or not because he was developing so well, whether
24 he would stay or not. And I had a chance to chat with him a
25 little about that one evening, and he assured me that he has

1 at least a 2-year commitment to the program. And then he may
2 consider some other things, but he will be there for two
3 years.
4 DR. SCHMIDT: He will duck back into academic
5 medicine someplace in two or three years.
6 DR. MAYER: Any further comments?
7 DR. KRALEWSKI: Should I put that funding in the form
8 of a motion?
9 DR. MAYER: Yes.
10 MR. GARDELL: Before you go any further, I wondered
11 whether you had given any thought to the possibility of funding
12 that activity jointly with CHP.
13 The reason why we are considering it is that there is
14 quite a thrust coming from the administration to jointly fund
15 activities that are closely related and interrelated as far as
16 expenditures of funds are concerned. This would seem to be a
17 natural. This is probably the closest this program has come
18 to any such possibility. And it is being discussed at the
19 moment.
20 Now, did this come up at all in your survey time?
21 DR. KRALEWSKI: It did not. We never talked about
22 CHP funding at all.
23 MR. GARDELL: I don't know whether it is appropriate
24 to raise it now or not, but I might just ask what your thoughts
25 would be to the possibility of this should we be able to come

1 up with one grantee, one award funding two different programs.

2 DR. KRALEWSKI: Well, from an organizational point
3 of view, I think it would be a good move. From a theoretical
4 point of view, I think it would be a good move. Because I
5 think they could identify to you the kinds of things each
6 organization is doing and lay out a budget for each. And there
7 is no question about that they can do that very well.

8 Whether you can get things together at the next level
9 to do that through the State and region, etc., I really couldn't
10 answer.

11 MR. GARDELL: It would in effect mean we would get
12 a single application from a single agency and make a joint
13 award coming from one of the two programs, possibly the RMP.
14 So in effect, we would be coordinating our efforts with CHP
15 in a review of the application, the expenditures, visits, etc.
16 We could work together very closely.

17 DR. BESSON: Could we have more of a discussion
18 about joint funding? That has been talked about for a long
19 time. This is the first time, Jerry, that I have heard there
20 is a mechanism established for doing that.

21 MR. GARDELL: There are several mechanisms for
22 jointly funding grants that are coming into being. There are
23 programs presently staffed in the Office of the Secretary,
24 one for jointly funding grants between Federal agencies, and
25 the other for funding grants jointly within the Department.

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1 We have a third one now that I am working with off
2 and on in the Office of the Administrator which has to do with
3 jointly funding programs within HSMHA. And I think what is
4 going to happen ultimately is if we don't get on board and see
5 some of these occasions where we can move in this direction,
6 we are going to be instructed to do so. That is already coming
7 from the Department. The Department didn't even have an
8 option. It was told that was what was going to happen.
9 So we are trying to look for avenues where we can
10 do this where it would be the easiest way possible.
11 Now, there are a lot of administrative problems that
12 can arise. With this program, however, we are probably the
13 closest to any of them where it could be worked out. We have
14 had some preliminary discussions with the Regional Office
15 staff. And, again, here is another problem because that
16 program is decentralized to the Department's regional office
17 whereas we are a headquarters operated program as far as the
18 funding is concerned for review.
19 DR. MAYER: Leonard.
20 DR. SCHLERLIS: I find myself unable to participate
21 in this discussion since I have no concept of what the
22 organizational structure is in that area, what the funding
23 problems are, what portion of the budget is involved, how
24 this would affect total RMP package and so on. And I would
25 take this as an informational item which I find very interesting,

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1 but I would find it impossible as a member of the committee
2 to support this or to deny it.
3 I would think if it is thought to be something we
4 should be involved with, we should have time enough to be
5 briefed in it. I would hate to see a preliminary expression
6 come from this group.
7 I find it fascinating, but I have no idea how to
8 react to it.
9 DR. BESSON: I find it fascinating, too, Ed, but I
10 have an idea as to how to react to it. And that is for us to
11 use it as a model. As I have been looking over in line with
12 Sister's comments about whether the relationship between
13 Comp Planning and RMP here was cooperative or incestuous, I am
14 very much impressed with how well they do those things.
15 DR. SCHERLIS: Sister did not use those terms.
16 (Laughter.)
17 DR. BESSON: No, I am sorry.
18 DR. KRALEWSKI: Let the record reflect.
19 DR. BESSON: We can expunge that.
20 This was an opportunity for us to do something like
21 that. There seems to be a great deal of joint staff, joint
22 interest and programs, programs which I see in their development
23 component could very easily be funded through Comp Planning
24 rather than Regional Medical Program. And if there is a
25 mechanism now through even the Office of the Development and

1 out of the administrative office in HSMHA, Secretary's
2 office, for us to try it, maybe we will like it.
3 DR. SCHERLIS: You end up eating the whole thing.
4 (Laughter.)
5 DR. MAYER: Mac.
6 DR. SCHMIDT: My problems with this would be sort
7 of the confidence limits of getting through such a mechanism.
8 If somebody would tell me it is a point 9 type of thing,
9 I would be comfortable. I suspect it right now about a point 1
10 or 2. And I would hate to have this committee action in some
11 way tie things up which is what I would be afraid would happen.
12 It takes longer to do things, to work things out,
13 to get things clear, to get HSMHA to agree, to get the OMB to
14 agree, to get so and so on. And whatever you are trying to do
15 is what we have been hearing earlier this morning.
16 So if there is money that can come, fine. It is a
17 beautiful thing to do. But if it puts something at risk , then
18 I would say no.
19 DR. BESSON: Could we try it, let's say, for one
20 project just to let the Council know we are thinking about
21 it and to enable the Council to run with the ball if they like.
22 MR. STOLOV: May I comment on that? Dr. Komaroff
23 is on Council, and I think he shares your concern. He may
24 bring it up then.
25 I just wanted to let you know he has similar interests

1 as expressed here.

2 DR. BESSON: I don't think we have to do anything

3 else except approve of John's recommendation with the added

4 paragraph that the fact that the review committee is aware of

5 joint funding possibilities and would encourage the Council

6 to choose one or another program.

7 MR. GARDELL: That is all we need. That would be fine.

8 DR. MAYER: With the caution that we would not like

9 to see such efforts through the administrative entanglements

10 inhibit the development of the RMPs we are voting to support.

11 DR. BESSON: That is your proviso, but it wouldn't be

12 mine. I would like to think that somewhere along the line

13 RMP is going to shed its parochialism and think of the problem

14 in a systems fashion rather than what RMP's territory is and

15 be sure our territory is protected at all costs. Because we

16 will never approach the problem inherent in health systems

17 if we only think in terms of our dollars and protecting what our

18 dollars buy.

19 DR. MAYER: That is not what was implied in what I

20 was saying here. All I was saying was I was hearing concern

21 being expressed by Leonard that it is difficult with the data

22 base that we now have about this particular region to know what

23 the implications of that are. That is the concern I have got

24 which is a very simple one.

25 DR. SCHERLIS: I support completely Jerry's

1 philosophy, but I would not suggest any action relevant on the
2 basis of the information we have.
3 I agree with the systems approach. I agree these
4 two programs have to be brought closer together. I don't think
5 I know enough to make any judgment relative to the specificities
6 of what you come out with.
7 DR. MAYER: Further comments.
8 John.
9 DR. KRALEWSKI: Should I put this in a motion, then?
10 DR. MAYER: Yes, please do.
11 DR. KRALEWSKI: I move that we approve the funding
12 level of $1,099,000 for the 02 year with then an equal increase
13 for the 03 of $230,000 and along with that we indicate our
14 support for joint funding of programs such as this if it can be
15 worked out at some future date or something such as that.
16 DR. MAYER: O.K.
17 DR. SPELLMAN: Second.
18 DR.MAYER: And I assume that figure if in fact the
19 kidney dollars come out separately that that figure would be
20 reduced by the $27,060 if that is how it happens.
21 DR. KRALEWSKI: Right.
22 DR. SPELLMAN: I was going to ask a question. You
23 said the CPA, a woman, that actually provides the financial
24 management system, yet the grantee is a separate corporate

25 entity with a kind of mixed membership. The grantee then is

1 not providing management. What is it doing?

2 DR. KRALEWSKI: What they do is provide -- they are

3 fiscally responsible. In other words, when they spend dollars,

4 they review large expenditures, and they audit the firm and

5 things such as that. But they are providing their own internal

6 support.

7 DR. SPELLMAN: So they are buying a very small

8 grantee service package.

9 DR. KRALEWSKI: As a matter of fact, as a result of

10 that, and it doesn't alter our figures, they take away all

11 of their overhead so they probably save I don't know how many

12 hundreds of thousands of dollars.

13 MR. CHAMBLISS: Very low indirect costs there, Doctor.

14 DR. SPELLMAN: I was interested how they do it.

15 DR. MAYER: It reduces their indirect costs.

16 DR. SPELLMAN: I don't know that we want to encourage

17 that.

18 (Laughter.)

19 DR. MAYER: If my leg were long enough, I would have

20 kicked you under the table, Mitch, but I couldn't do it.

21 DR. SPELLMAN: There is such a thing as taking merit

22 too far.

23 DR. MAYER: John, I assume you are including in the

24 recommendation the 03 suggested level of $1,000,138 because

25 that is above the currently Council approved level and will

1 take action by this group.

2 DR. KRALEWSKI: Right.

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

4 (No response.)

5 All those in favor say, "Aye."

6 (Chorus of ayes.)

7 Opposed?

8 (No response.)

9 All right, shall we try one more prior to departing?

10 Nebraska?

11 Joe, are you ready? Have you got an estimate

12 before we turn you loose of the time sequence we are talking

13 about here?

14 DR. HESS: Well, more depends on the committee than

15 on me. I can do my part in about 15 minutes.

16 DR. MAYER: That's all I can ask.

17 DR. HESS: A little over a year ago, Sister Ann and

18 I were out there as a member of the site visit team to visit

19 Nebraska. And we had to bring back a rather gloomy report

20 and some recommendations for rather difficult actions which were

21 conveyed rather clearly and explicitly in the advice letter

22 that went from the main Council under the signature of Dr.

23 Margulies. And the purpose of this site visit then was to

24 determine among other things what actions had been taken in

25 line with those recommendations.

1 And those eight recommendations are outlined on
2 the secondpage of the site visit report that you have.
3 The region at the time of our earlier visit had just
4 come through the process of separating from the South Dakota
5 component, just reformed as a separate Nebraska region. And
6 there are some problems relating to that.
7 We found that there were some very fundamental
8 problems in terms of program management and direction. And
9 these eight points which you see outlined on the site visit
10 report addressed those issues.
11 I could say that in summary all of these issues,
12 that this advice letter had been taken very seriously, that
13 shortly after the receipt of the letter, the program coordinator
14 resigned, and very shortly thereafter a new coordinator was
15 appointed. He had been with the RMP previously. And by
16 September of last year, the RAG had sort of reformed itself,
17 and they were down to brass tacks and working.
18 And most of this past year has been devoted to
19 reorganization, reforming the region and trying to address
20 those questions and suggestions which were raised in this advice
21 letter.
22 The newly appointed coordinator is proving to be a
23 good coordinator. He has shown the ability to provide
24 directions to RAG. Many of the actions of the RAG have been
25 upon his advice, and they have acted on it and not hesitated to

1 react to his leadership.

2 He has made a number of rather difficult decisions,

3 one of them being that some negotiation with the medical

4 school and the core funds now were under his direction instead

5 of under the medical school's control. And I think that kind

6 of action is indicative of the strength of leadership that he

7 is providing.

8 The RAG is playing a much more active role now than

9 they used to.

10 DR. MAYER: Joe, can you use the microphone?

11 DR. HESS: The RAG is playing a much more active

12 role than they formerly had in setting program policies. They

13 have reorganized themselves into five working committees,

14 an executive committee, nominating, the budget and finance

15 and the resource and development and operations review

16 committee. And each of these appear to be performing their

17 functions.

18 The program has developed documents which spell out

19 the procedures whereby projects are to be reviewed. And the

20 relationship between the gtantee and the RAG and all of these

21 kinds of things, all of those issues were appropriately

22 addressed.

23 They have had a management consultant from the

24 University working with them, and they developed a new

25 organizational structure and developed job descriptions of each

1 of the positions. And in terms of program management, there
2 has also been much strengthening.
3 I would also indicate that the morale of the staff
4 which is one indicator is much different than it was a year
5 ago. A year ago, we had indications in talking with members
6 of the staff informally there just was no communication, that
7 they were not working together, that the coordinator wasn't
8 listening to them and so on. But you get an entirely
9 different feel this time. They were working together. They
10 felt they were part of the team and that everyone seemed to be
11 unanimous in the feeling they had made a rather major change
12 in direction and function.
13 As far as identification of regional needs is
14 concerned, there was one survey which we learned about a year
15 ago which still is the major systematic survey that they are
16 using. This is supplemented, however, by the information which
17 was picked up by the RMP staff in the visit throughout the
18 Nebraska region. And you can perhaps see from the little map
19 they have in the yellow pages, they have project activities
20 that pretty well blanket Nebraska. So they do get out and do
21 spend a lot of time out in the community. And that supplements
22 and is one of their sources of gathering information.
23 But another important thing which at least has the
24 potential of having made their impacts in terms of needed
25 identification is the study which has been carried out under

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1 the CHP agency which will be in its completed form in June.
2 And in talking with the AAUC director who is a very intelligent,
3 dynamic woman, already there are things coming to the surface
4 in that study that are going to have an impact on what RMP
5 does. And they seem to be open, their communication is good,
6 their relationships appear to be quite good between those two.
7 So I feel quite confident that that study will result in some
8 change in their objectives and priorities in the months ahead.
9 The question of phasing out of the programs, this
10 has begun. And they are aware of it, and they intend to do
11 more. There has been some joint funding now through other
12 RMPs around them. The university is beginning to pick up
13 certain projects which can be justified and so on. So that
14 they are making movement in this direction.
15 The final issue in that letter has to do with the
16 mobile cancer project. The core staff has been actively
17 involved, and the RAG also, indirecting the course of the
18 cancer project. And it seemed to us that they seem to have
19 these fairly well in hand.
20 Going on with the report, they have redefined their
21 goals and priorities. They look quite different than they did
22 a year ago. And they are consistent with national goals.
23 Most of the projects which have come through the
24 review process now tend to be ones which conform more with the
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25 older mission of RMP than the newer. And as near as we can

1 determine, one of the reasons for this is that much of the
2 core staff activities and so on, the RAGs, have been in this
3 reorientation process. They haven't had time to get out and
4 stimulate development of new projects. But they seem to be
5 aware of the need to do that. I think the chances are
6 reasonably good they will do so.
7 We mentioned continuing support.
8 Minority interests, these are not very well reflected,
9 but they have told us they have tried to get more minority
10 representation and will continue to try. As we talked with
11 the lady who is the CHP director, it seemed she had some
12 ideas and techniques for doing this that perhaps they
13 could learn from. And we suggested they might talk with her
14 and get some assistance from her in doing so. But at least
15 there was a willingness, and we indicated that we hope there
16 would be improved performance as well.
17 I mentioned already the coordinator in relation to
18 the RAG. The core staff seems to be quite strong, In working
19 with the management consultant, they have identified the need
20 for some additional staff positions -- one in the area of
21 bolstering their program evaluation segment and others in
22 area consultants. And after hearing the rationale and so on,
23 we concurred with that assessment and agreed they should further
24 strengthen the core staff.

25 The Regional Advisory Group still tends to be

1 provider dominated, but there has been some change in the
2 balance since we were there a year ago. They seem to be
3 aware and were receptive to our suggestion that they need to
4 give further attention to a broader representation on the RAG.
5 The grantee organization is the State Medical Society.
6 I think there has been significant movement in the relationship
7 between grantee and RAG, the RMPs, since we were there a
8 year ago. I think there is still some further delineation
9 refinement that needs to be carried on there, but certainly
10 they are moving in the right direction.
11 We pointed out some of the areas which we thought
12 they needed to give further attention to. And I would hope
13 that these further additional details will be attended to.
14 Their participation, we mentioned, in terms of RAG
15 participation and so on. The State Medical Society, physicians,
16 seem to be the majority, but there is good participation in the
17 State Health Department, appears to be good working relation-
18 ships there.
19 The CHP seemed to be reaching out in the communities
20 to a considerable extent, and their record is reasonably good
21 in that area.
22 Hopeful planning, they are working with CHP B agencies
23 that exist, but that program was just beginning to get geared
24 up. They have some of their own local mechanisms for doing it,
25 but I think again their performance is satisfactory.

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1 We have talked, I think, enough about management.
2 The evaluation has improved substantially since we
3 were there a year ago. We agreed there is a need for more
4 staff in this area. And this function in this area has been
5 hampered somewhat by the ill health of their evaluation
6 person. But I was filled in this morning they have already
7 taken steps to bolster this area, and they recognize the need
8 for further improvement.
9 The action plan, again, is more in the formative
10 stages because of this reorganization they have gone through.
11 They have their goals and their priorities developed now, and
12 I would anticipate in the next few months, we would see an
13 action plan based on those goals and priorities begin to appear
14 in terms of projects more related to that.
15 They have been successful in the area of dissemination
16 of knowledge. They have had coronary care training programs
17 and other educational type projects which have apparently been
18 well received and have served a real need and have been the
19 means of bringing inactive nurses and other people back into
20 the health care system. And there have been a lot of spinoff
21 benefits from the projects that were built as dissemination
22 of knowledge.
23 Manpower and facilities, there have been some, as I
24 mentioned, spinoff benefits from the coronary care and other
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25 type education activities which have had an impact on this.

1 But we really were unable to get a very good handle on just
2 how much impact the RMP is having on use of those facilities.
3 They have stimulated cooperative arrangements among hospitals.
4 There is sharing going on as a result of these RMP projects.
5 So we got the feeling that they have had some impact.
6 The improvement of care, I think what I have already
7 said more or less summarizes what I want to say in this area.
8 Short-term payoff, I think there has been some with
9 the coronary care learning resource center. They have plans
10 for more regionalization in the sense they are developing area
11 coordinators who are going to work in specific areas within
12 the region to stimulate more cooperative arrangements and more
13 joint activities in that area.
14 In summary, then, we felt that the region had
15 seriously addressed all of the issues which have been raised
16 as a result of the site visit of last year and has made very
17 substantial progress in making the necessary changes in
18 reorganization and changing the direction of the RMP.
19 As a result of this, we came up with a funding
20 recommendation of $725,000.
21 Now, that is based in part on the recommendation of
22 the Kidney Review Panel that neither of the kidney projects
23 ought to be funded. And one of the important reasons is they
24 had not developed a well-thought-out regional plan for kidney
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25 disease. So that accounts for one of the major reductions

1 below their request.

2 And we felt that there were some savings that they

3 could make in terms of the mobile cancer unit and one or two

4 of the other projects without hurting them and also that

5 some cutbacks should be made in the funding of current

6 projects to give them some seed money for feasibility studies

7 and so on to start off and do some planning at least in the

8 new directions which they want to go.

9 So that this was the rather simplistic rationale

10 for arriving at the recommendation for $725,000. We recommend

11 that they find within that budget about $25,000 for initiating

12 some small planning feasibility studies, mentioned the two

13 kidney disease activities, and we felt that they should be

14 given the option to submit a triennial application next year,

15 feeling that with another year to work and develop that they

16 may be in a position to merit that.

17 DR. MAYER: Dorothy, comments?

18 MISS ANDERSON: I was amazed, just reading the material

19 I wasn't on the site visit -- at the progress they have made

20 in just six months with this new coordinator. And I think

21 this is a real good example where rather than getting the

22 person to change their thinking in coordinators and changing

23 their action that maybe we do need to look seriously and

24 encourage some areas, regions, to get new coordinators.

25 Now, I was impressed by the involvement of the RAG

1 group. They really got involved in committee meetings. They
2 were involved in site reviews and made recommendations for
3 changes of budget and relocation and reallocation of money,
4 as I understand.
5 They have also changed their by-laws and realigned
6 budgets and did other things that really showed involvement
7 of the group.
8 I was interested that the staff kept relating to
9 a 1968 survey that was done. And I had a feeling that maybe if
10 the staff had been out in the community more, they wouldn't
11 have to wait for this new survey for some direction.
12 DR. HESS: I think maybe that is an unfair reflection
13 of the report because the staff is out in the community. They
14 get very high marks for being out and visiting around. They
15 really ride the circuit.
16 MISS ANDERSON: It seems like they have quite a few
17 things they are holding off until they get this new survey.
18 DR. HESS: That may be more a reflection of our
19 report than it is in reality. I am not sure that is really
20 fair.
21 MISS ANDERSON: Thank you.
22 Another area I thought was interesting was the
23 development of the new goals in regard to the new direction
24 that RMP is going in regard to health manpower, health care

25 delivery and management and administration.

1 I think everything else we have touched as far as
2 I can see.
3 DR. HESS: Just to elaborate on one point that you
4 picked up and I forgot to mention is that the RAG is involved
5 in the site visits to projects. I think this is a very
6 tremendous thing. At least some member of the RAG has some
7 detailed knowledge of nearly every project. And that is, I
8 think, rather unique. I don't know. There may be some other
9 regions, but offhand I can't recall others that have that
10 degree of involvement of the RAG.
11 MISS ANDERSON: And I think another point I would
12 like to support you in is in regard to representation on the
13 RAG. They do need more minority people. There are many
14 Indians as an example in this area. And blacks also.
15 And, also, they need more allied health people on
16 their RAG from what they have had in the past to make it,
17 if you are thinking of comprehensive health care.
18 DR. MAYER: Dr. Hinman, comments?
19 DR. HINMAN: Yes. This region had two applications
20 in for support of kidney activities. They both had technical
21 review in the region by people from within the region who
22 made strong recommendations against the appropriateness of the
23 proposals. And on that basis, it is the staff recommendation
24 it not be approved even though the RAG sent them in.
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25 One of them was to produce six films of teaching

1 tapes of undetermined type for an undetermined audience. And
2 the other was to train some people for we didn't know exactly
3 what in the application. So it was our recommendation that
4 the region be given advice that there were existing guidelines
5 that could have assisted them, staff could have assisted them,
6 there were new guidelines coming out, and we recommended
7 disapproval.

8 It was $48,838 requested.

9 DR. MAYER: Further comments?

10 DR. KRALEWSKI: I have a question about the core
11 staff. How many people do they have and how was this affected
12 when they split apart and all that? Are they saving any money
13 or what is happening to the core?

14 DR. HESS: Well, you mean when South Dakota-Nebraska --

15 DR. KRALEWSKI: Yes.

16 DR. HESS: They decided there was a division of funds
17 and so on that was negotiated with RMPS.

18 DR. SCHMIDT: I think the answer is in light of the
19 activity, the core type of activity, was really Nebraska and
20 South Dakota's problem is really to build up. The flow was
21 into -- at least, I was representing South Dakota at that time --
22 the flow was kind of into Nebraska. We had a core staff. I
23 don't think they are cutting back any. The loss of South Dakota,
24 there wasn't much in South Dakota there.

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25 DR. KRALEWSKI: This budget expands that core now,

1 does it?

2 DR. HESS: I would have to go back and look at the

3 figures a year ago versus now.

4 DR. MAYER: Yes, by about $140,000.

5 DR. HINMAN: $232,000 to $376,000.

6 MR. POSTA: I might make the statement here I

7 think the core budget as outlined here for this upcoming year

8 really indicates the inclusion of four new members to the

9 staff. But in view of the fact that the drug information

10 center and resource learning center that was appointed a

11 project last year would be included under the core, I think

12 would be increased for the next year total within core is about

13 $115,000 rounded off. And that would take care of assuming

14 those two new programs or the two old programs and a couple of

15 new additions to the core staff.

16 DR. KRALEWSKI: How many vacancies do they have?

17 MR. POSTA: Frank.

18 MR. ZIZLAVSKY: They are requesting four full-time

19 positions -- deputy coordinator, associate coordinator for

20 evaluation, and two additional area consultants. And this

21 totals about $70,000. $20,000 increases for fringe benefits.

22 Previously under the previous coordinator, fringe benefits were

23 non-existent. This is something they have been fighting for

24 three years. They have finally established it.

25 That speaks to about $100,000. They have a couple of

1 pharmacy students on part time answering the phones 24 hours
2 a day which speaks to about $10,000. That accounts for about
3 $110,000.

4 We have got a little bit more money in travel, a
5 little additional money in equipment.

6 DR. HESS: I think you are asking how many existing
7 vacancies.

8 DR. KRALEWSKI: Right.

9 DR. HESS: And I don't believe there are any. They
10 are all new ones that they are asking money for.

11 DR. MAYER: Four new professional positions, is
12 that what you are saying?

13 MR. ZIZLAVSKY: Right.

14 DR. MAYER: Further comments?

15 DR. HESS: I would move formally, then, they be
16 approved at $725,000, and we also felt we ought to make a
17 tentative recommendation for $700,000 for the second year so
18 they have something to plan on, but with the understanding --

19 DR. MAYER: They will probably be coming in with a
20 triennium.

21 DR. HESS: That's right.

22 DR. MAYER: But in case they don't, we are recommending
23 $700,000.

24 DR. HESS: Yes, some sort of assurance for them.

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25 DR. MAYER: O.K., is there a second to that?

1 MISS ANDERSON: I second it.

2 DR. MAYER: Further comments?

3 Yes, John.

4 DR. KRALEWSKI: A point of clarification. That

5 $25,000 is included?

6 DR. HESS: In the $725,000.

7 DR. SCHMIDT: I am curious about this renal business,

8 Dr. Hinman. You said that the RAG approved it, but that people

9 within Nebraska recommended disapproval?

10 DR. HINMAN: There was a technical review by three

11 physicians from within the State who had adverse comments the

12 program was not adequately documented, adequately structured,

13 and they still sent it.

14 DR. SCHMIDT: From the university or Creighton or --

15 DR. HESS: One was Dr. Holmes from Colorado. They

16 were experts, kidney experts, that were called in. But they

17 were not all from without Nebraska.

18 DR. HINMAN: Two of them were, weren't they? You

19 are right about Dr. Holmes, but I thought the majority were

20 from within Nebraska. But either way.

21 DR. SCHMIDT: It was on technical grounds that it was

22 turned down, then?

23 DR. HINMAN: Yes.

24 DR. MAYER: Technical plus regionalization, I was

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25 hearing, Mac.

1 DR. SCHMIDT: I know, but you see the RAG approved
2 it.
3 DR. HINMAN: That is correct.
4 DR. MAYER: In spite of the negative comments.
5 DR. HINMAN: Yes, sir.
6 DR. MAYER: Which makes the point we were trying
7 to make earlier.
8 O.K., further comments.
9 (No response.)
10 All those in favor of the motion?
11 (Chorus of ayes.)
12 Opposed?
13 (No response.)
14 Before we break, I have got a couple of issues I
15 want to comment about. The first relates to this evening's
16 activities, to make sure we all understand where we are going
17 and how we are going to get there.
18 (Announcements were made.)
19 DR. MAYER: One of the individuals who has been
20 participating in RMP applications as long as anyone, including
21 maybe myself, Lorraine Kyttle, who is on my right, who has been
22 serving us very effectively for the last three years, four
23 sessions of this committee, this is also her last review
24 committee session. She is going to be assuming responsibility
25 for South Central Operations Areas which will include Memphis,

1 Illinois and South Carolina as her activities, but will not
2 be serving in the capacity she has. So I just wanted to
3 indicate to you this evening while we are there that it is
4 also her last go with the committee.
5 On the agenda for time, I will not be with you
6 tomorrow. My chancellor has called a budget session which I
7 have to be at if I hope to survive for tomorrow. And I will
8 have to go back tomorrow. But there were two items or three
9 items that were on the suggested items for the agenda that I
10 wanted to remind you all about so that you didn't forget them.
11 One was the, if I may call it that, emasculation
12 issue which Jerry had raised and others had raised that we
13 needed to talk about a little further.
14 The second was Mr. Parks raised the question
15 appropriately about several of the questions that we sent
16 up to the Council at the last meeting, and we need to discuss
17 a feedback of those. And I assume, Mr. Parks, you will raise
18 those tomorrow.
19 And then thirdly, there was some discussion of at
20 least some of the people at lunchtime about new members of the
21 committee and new chairmen, vice chairmen, etc. And I think
22 that issue needs to be raised.
23 And with that, I would like to say it has been my
24 very real pleasure having an opportunity of participating in
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25 this committee over the many years and chairing it the last

1 two years almost in toto. I appreciate all the efforts that
2 have gone on in terms of helping us get through and the job
3 done. It has been done very well.
4 DR. SCHERLIS: I think somebody should recognize
5 the fact that you are not being here tomorrow, this is our
6 last opportunity to formally thank you for, I think, what has
7 been not just superb direction, but maintaining our good
8 humor and I think giving us a sense of at least thinking we
9 know where we are going. And I want to on behalf certainly
10 of the committee extend to you our thanks for having been
11 such an excellent chairman over the years.
12 DR. MAYER: Thank you very much.
13 DR. KRALEWSKI: I would like to formally move that
14 into the minutes.
15 DR. BRINDLEY: Second.
16 DR. BESSON: I move it up to the Council.
17 (Laughter.)
18 DR. MAYER: That is really a policy issue.
19 Well, I hope to see most of you this evening at
20 6:30.
21 I would also like to remind you do not forget those
22 of you because I didn't remind you in Nassau-Suffolk as well
23 as Nebraska in terms of your rating sheets. And I would
24 assume that if you held onto those, fold it up neatly at your

25 place so people aren't seeing them. I think you are probably

1 in good shape. We can leave the materials here.

2 What time, 8:30 in the morning? I think we can

3 probably appropriately move it along.

4 (Whereupon, at 5:10 o'clock p.m., the meeting

5 recessed, to reconvene at 8:30 p.m. on Friday, May 5, 1972.)

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