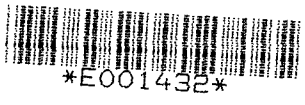
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Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

- - -

Twenty-seventh Meeting

of the

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Rockville, Maryland
Monday, 5 June 1972

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CR 6499

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PROCEEDINGS

DR. MARGULIES: If we can all have our seats, the meeting will come to order.

I would like to call your attention to the agenda book which is the basic text that we will follow during the course of the next two days and particularly ask you to note the statements on confidentiality of meetings and the conflict of interest statement which are in there so that these instructions will be preserved during the course of the meeting and thereafter.

Before beginning the main part of the discussion for the day, there are some people I would like to introduce if you have not already met them because we do have some new members of the National Advisory Council and I will list them not in order of importance but in alphabetical order.

First, Susan Curry on my right. She is a second year medical student at the University of Florida in Gainesville. Mr. Edwin C. Hirito from Los Angeles who is to her right with one chair inbetween.

Dr. Gerhard Meyer on my left over here who is a practicing physician and associate clinical professor in San Antonio. And Mrs. Mariel S. Morgan from Albequerque.

I also should announce to you that Harold Hines has resigned because he found that the pressure of business didn't allow him to be here to regular -- on a regular basis and so

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he has resigned which means that we will have a new --

I would particularly like to welcome the four new members to this council. Ordinarily we would have had a period of orientation for you but as you know the time involved is too limited.

We do have some new members of the National Review Committee also who we will talk about in a few minutes. What we will do is set up a period of orientation as soon as we can so you can get accustomed to the usual procedures of the National Advisory Council.

I think it is fair to tell you, however, that no member of the council has felt constrained by his newness. This council is in many ways the most effective -- well, I think probably the most effective of the National Advisory Councils. It has never acted in an inhibited fashion. It is made up of people who are willing to say what they think. It has been flexible and has changed with the times. It has continued to change. I think that you need feel no hesitation in entering in at any point that you think you should, say what you think, and don't be surprised if you disagree or agree with half, less, or all of the rest of the members of the council. It is that kind of a group.

I would also like to recognize the fact that Dr. Chase is here representin- Dr. Musser for the Veterans Administration. You all know John Chase. Dr. Ogden will not

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be here at all for the meeting. I understand that neither Dr. DeBakey nor Dr. Roth can be here tomorrow so we will cover as much ground today as we possibly can.

Dr. Wilson will address the meeting tomorrow morning rather than today and we had thought that Jerry Riso would be here but he will not be.

There are just a few details involving the meeting -- this meeting of the council, an explanation of why we are in this room and some things which you need to know about the course of the activities in general.

I would ask Ken Baum to acquaint you with them. Ken, I think you remember, is the person who makes the council function, prepares agenda books, gets people where they need to get and does most of our thinking for us.

Ken?

MR. BAUM: Let me take a half minute here with a couple of announcements. I think Parkinsons Third Law says the amount of discussion is inversely proportional to the subject.

First, about coffee breaks. We are going to have the usual coffee breaks at about 10:15 and 2:15 in the afternoon. On the other hand, because this room is small, it is the only one we could get this time because we moved the meeting up a month, coffee is going to be served in what is called the Charcoal Room of the cafeteria.

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I think we have provided everybody with a little map in your books. If not, we have more on the back that shows you how to get to the Charcoal Room. At coffee break time just go out the door, turn right, walk to the end of the hall, the cafeteria is on the left. And if you walk all the way through the cafeteria, it is the last bay on the left and will be set up with pots of coffee and so forth. It is the usual dime for coffee and 15 cents for doughnuts and things like that.

Could we please have a show of hands on how many people are going to require transportation to the Washingtonian for the dinner this evening, council members?

(Show of hands.)

If the people who need transportation would please see Mrs. Handal at the back of the room sometime during the meeting we will get whatever arrangements have to be made.

Incidently, Mrs. Handal was the one that sees to it that things work smoothly not me really.

(Laughter.)

For the dinner arrangements this evening, the happy hour will begin around 6:00. Anybody who doesn't know how to get to the Washingtonian, we prepared a route map so you can all get lost. Just don't take the wrong turn which gets you back to Washington. Anything else, ask Mrs. Handal and me and we will try to help you.

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The dinner tonight is going to be through the Washingtonian's buffet line. We have a private room. There will be a private room for happy hour, but everybody will go through the buffet line for dinner. I thought I would explain that first.

Dr. Wilson and Dr. Stone, as far as we know, are planning to attend the dinner tonight, too.

Because this room is so small, anybody who is going to be leaving the meeting permanently, that is particularly the guests around the room, if you are going -- if your part of the meeting that you are interested in is finished and you are leaving, if you would please advise Mrs. Handal or the secretary at the door, we can use your seat for some of our own staff. We have had to be very careful to control attendance at the meeting because there isn't enough room for everybody who would like to be here.

We will have a few seats that we are going to be rotating people through and we hope it causes as little inconvenience as possible.

When we get to certain places one group will shift in and another group will shift out so there will be a little bit of shuffling back and forth.

The only other thing is that there are a couple of unfamiliar looking folders perhaps on the desk. In addition to the council agend, books which are black and the binders

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with the rings in them which are all colors of the rainbow, you have an additional two books. One is this blue folder which contains some information about the review of emergency medical services applications and there is this brown cover folder with information about the review processes for manpower programs.

When we get to the RMP application review, there is an additional folder which we will be passing out to you in a black envelope with management information system tabulations but we didn't want to overload the desk. I thought we would mention what you have in front of you. I think that is all.

Thank you.

DR. MARGULIES: You had mailed to you the minutes for the February 8th and 9th meeting. If there are any additions, corrections, or comments to be made on them, I would appreciate hearing them at this time.

DR. DE BAKEY: I move they be approved.

MRS. MARS: Second.

DR. MARGULIES: All in favor?

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No response.)

DR. MARGULIES: There are some guests here, some of whom are going to participate actively in the council and agenda during the course of the day and I would like to

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introduce them to you.

I don't think Fred Stone is here yet but he will be. Dr. Van Hoake is on my left over here. He is the new director of the National Center for Health Services Research and Development and we are going to ask him to talk to us during the course of the morning about some of the tighter relationships which we are looking forward to having here.

Dr. Gordon MakLeod is over here on the left. He is the director of the Health Maintenance Organization Service and will be involved with our review of the HMO applications.

Dr. Margaret Edwards from the National Cancer Institute is here, I think. Here she is right over on my right.

Dr. McFinleave from the National Heart and Lung Institute, next to her over here on the right, Arthur Brourg from the National Library of Medicine. They cluster together rather effectively.

Mr. John Corn, Smoking and Health Program, way over on the left. Mr. Elmer Olexa of HEW audit agency. We have to be careful of him.

There are some special consultants who are here. I don't believe that Scherlis is here yet. He will be later on in the morning. Warren Perry a member of the RMPS review committee is here. He was chairman of the review committee for supplementary grants which we considered about ten days

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a little over, whatever the time was, about eight days ago and he will be presenting the review of those supplementary grant applications.

There are some new members of the staff also whom you will have an immediate reason to know and work with. One is Dr. Larry Rose of the Professional Technical Development staff who is right here on my right. He is in charge of the emergency medical activities here.

Bob Walkington chief of the evaluation branch over there on your right in the office of Program Planning and Evaluation.

One other bit of business to get out of the way to get confirmation therefore, is the consideration of future meeting dates which are scheduled now on the new three a year on October 16 and 17, February 7 and 8, and June 5 and 6. The last two dates in 1973.

Any problems with those, any reasons of major importance why we can't schedule them then?

All right. We will go on. If there is anything we have overlooked, I would appreciate hearing about it.

End #1

I would like to spend a few minutes with you now considering some of the major issues which includes policy questions which I am sure you are going to be interested in. I consider this an opportunity to discuss some of the subjects which we are going to bring up.

The first of these has to do with budget, and just by way of review, I think you do recall that we had last year -- some money which was held back, some $44.5 million, which was available for release during the current fiscal year. Also, a reminder that our appropriations now, one year appropriations and this makes a considerable difference in reviewing.

As a consequence, '69 funds held over from the past year and the new appropriations, when there was a release of funds we were restored to active level of about $145 million for the total RMPS program. The amount which was available for grants and contracts was actually $135 million, and there were certain funds earmarked which you will hear more about during the course of our discussion, some 16.2 million, maximum, for health maintenance organization activities.

These will require only a part of the RMPS funds so that we will have a remnant of the 16.2 million, which will probably be in the range of $7 million, which will be available for regular RMP activities. It was $8 million which was earmarked for emergency medical systems. I will describe that a little more fully in a moment.

That was set aside for a contract activity conducted out of the Office of the Administrator which is now at the point of completion of review of the contract. There was $7.5 million set aside for area health education centers. That has not been released.

It is not certain whether it will, and if released, what the character of the restrictions, if any, will be, and we will talk about that in a moment.

I think you recall that there was $5 million set aside for a Cancer Center to be constructed in the Northwestern part of the United States, and we will have an updating of that request.

That left -- and that is the basis upon which we have been functioning. Ninety-eight point three million dollars for the regualar RMP grant activities. If the -- if we have about $7 million left from the HMO activies, and if the 7.5 million is released from OMB that will mean that our level of funds available for regular grant activities would -- and that is the key figure -- is a 112.0 million. Of that, all but 7.5 million is definite, but the 112 million is the maximum we would have available between now and July 1, for use in RMP supported activities.

We are prepared to utilize that full amount with no difficulty because of the variety of activities which we have developed.

Now, there is, of course, the next fiscal year to consider, beginning July 1. This year Congress has moved quite rapidly. There has been early action in the House, early action in the Senate, and they are now at the point of reviewing the individual House and Senate recommendations and subsequently reaching some kind of a conclusion.

The figures which are under consideration range widely and I think it would be impossible to predict at this time what the final outcome will be. I think that it is of great importance that the total request to Congress by the Administration was one hundred and -- was over $131 million this year, which is in contrast with the request of a year ago, which was about 52.5, recognizing a rising interest in what the regional medical programs does.

Customarily, Congress accepts the administration's request, and adds to it. Whether it will this year, and whether that will actually survive the appropriations process is speculative, and I am not very interested in speculating with you.

There have been a series of suggested amendments. One for a life plan for dialysis and transplant for kidneys. There has been a very large suggested amendment which would deal with categorical diseases among other things so that the figures range all the way from 131 million to 229 million; meaning that my reasons for not speculating are fairly obvious.

The House and Senate Committees are scheduled to

consider the appropriations bill this week and it is possible that they will complete their action. It would not be surprising if they did this time, because there are other things which are on their minds during the course of the summer and early fall which will probably encourage them to complete their activities.

Is there any question about this? I know it is a quick runthrough but most of you are fairly familiar with it.

DR. ROTH: I would like to ask some specific questions about the earmarked HMO funds. Is this the right time?

DR. MARGULIES: Good a time as any.

DR. ROTH: Well, as this council probably knows, most of you know, some of us have been disturbed about the fact that money appropriated for the RMP has been diverted from our program, from RMP, into the promoting of the Health Maintenance Organizations, the HMOs, for which there is no existing legislation.

There has been no HMO legislation passed and no money per se has been authorized for the development of HMOs. Now, if I am correct, during 1971, the initial grants for HMO, the money was, shall we say, pirated from the CHP funds, the 314E funds in respect to 38 grants which were aggregate, about $3.3 million, and there were 15 grants which were funded under the provisions of Section 1110 of the SRS activities; and then there were, in other words, 14 contracts, amounting to about 2.2 million that came under Section 304 of the Public Health

Service Act; but since that time, there have been additional grants up to a total of 110, for planning and development of HMOs, and it has been made abundantly clear that this is planning and development only, that there is a specific restriction against operation of any of these.

I think, thus far, I am on sound grounds of statement of fact, is this approximately correct?

Now, there have been a number of concerns around this town about the way this money was achieved in the House Appropriations Committee Hearings. Some sharp questions were asked of the Secretary, and others as to where in the world, they got the authorization for this money. I believe I am correct in saying that there is still a specific investigation going on in respect to $900 thousand of the one million, ten, that was diverted from Section 110 -- 1110 of the SRS funds.

The question being raised as to whether this was -- I do not know whether the right word in this context is "illegally," but diverted in a fashion that should not have been permitted. Now, we get, in our distributional material this time, some very interesting opinions from Assistant General Counsel for Public Health. Now, one with relation to the area, Health Education Centers, which makes it relatively clear that in the absence of specific legislation, there is very, very little RMP money that could possible be devoted to the support of the AHEC.

That is not important except to view in a comparative fashion with regard to what has happened with the use of our RMP money for the support of HMO grants. I would like to quote to you -- I think you all have this in your black book before you -- I do not know -- it is under the Tab HMO, Grant Procedures, and it is the item there, if you will -- it is Office of General Counsel, under the date of May 3rd.

If you look down to the middle paragraph, "This office has previously advised in the context of proposals for HMO Planning and Development, that this is the important thing to the extent that proposed HMO activities fall within the purposes of Section 910(c), funds would be available"; and below this, below the blank line, Section 910(c) is quoted as saying, "The Secretary is authorized to support research, studies, investigations, training, and demonstrations designed to maximize the utilization of manpower in the delivery of health services.

End #2

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I don't know how many of these HMO grants you have looked at closely and seen what they were requested for and how they were being used, but my question is are any of them by any stretch of the imagination being used for any of these purposes in 19(c)? My opinion, maturely achieved, is no, they are not. HMOs, we are told by the Administration, already exist, to the extent that they service some 7.5 million people of these United States. There are 30 organizations that they call HMOs. Of these 30, I believe none were subsidized in their organization by federal funds. They operate without federal funds; there is no reserve.

"Studies" is a very vague word. I don't know. This would be the weak point in my position, I suppose. Any time you are doing planning, I suppose you are involving some kind of study, but I think in the context of maximizing the utilization of manpower, which is what all these studies and reserves are supposed to be doing, that HMO planning is far from the mark.

Such evidence as exists in respect to HMOs is that manpower productivity is a little lower in this kind of organization in terms of patient hours per physicians or number of patients per week or per month, and so on. Obviously, the planning is not being done in this area. The planning is being done in the financing, the setting up of capitation mechanisms and it is my position that this has robbed us of a number of

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millions of dollars and we on this council sit here session after session approving grant applications, only to learn later on that they have been approved, but unfunded because we haven't got enough money to fund them.

Now, dammit, ~~19(c)~~ 910 -- Title ~~9~~ 910, Section 19 money can be some of the most valuable money in RMP, because you aren't restricted to a region. We could be doing more with 910 money in the emergency medical service field, just to pick one place, than we could do with our specific grant money.

I would like to raise the question, and I think there are several ways to do it, but I think the easy way, hopefully, is in an unemotional, out on the board administrative fashion, to find out if it is not possible to stop this raiding of our treasury.

You have talked about 16.5 millions coming in with an HMO earmark on it, and we might salvage seven of it. I might be disposed to see what we could do to have 16.5 million of it. I assume it would be impossible to get back any of the millions that have already been diverted. I have no particular appetite for a useless procedure for starting a congressional investigation or getting some senators and congressmen raising the devil with the Office of the Comptroller, but can't we do something about it in our own group? That is my question.

DR. MARGULIES: Let me make a partial response to you, Russ, and Gordon MakLeod is here and can certainly add to

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it. I don't do it on the basis of administrative decisions and the fact that the funds would not really be available to us if we didn't use them for this purpose. Let's set that aside for the moment and raise the question of the appropriateness of ~~19~~ 1110(c) for the health maintenance organization activity. It really is a matter of judgment about what an HMO (notice) can be.

From our point of view, we have felt comfortable with the use of the funds for this purpose because the HMO can offer to us the only system that is useful for some of the things which we need to do and learn to do, which is a close enough universe between the provider at one end and the subscriber at the other end, so that you have an understanding of what you want to achieve and a system in which you can do it.

One of our great problems in achieving some of the progress in RMP is we deal with a system which is not bound together in such a way that you can say that these are the providers and they act in such and such a way, and these are the users of those services, et cetera.

I believe, and many of us on the staff do, that if the HMO can be put together so that you have an understanding about a contract for services to be performed, it will provide the kind of laboratory for improved uses of health manpower for improved monitoring of the quality of medical

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care, for a better understanding of what we mean by health maintenance and an opportunity to test these ideas when the opportunity is not nearly as well-defined or as controllable as it is in the HMO. I think I would have to agree with you that the beginnings of the HMO primarily have to do with the development of a reimbursement system, with actuarial data and with putting together the system itself. But thereafter, once it has occurred, we, for example, in looking at the ways in which we want to achieve a better provider management of the quality being delivered, have found the HMO gives us opportunities for better learning and for better application, which the rest of the system does not, because it is too widely scattered.

But perhaps Gordon, you would like to -- do you want to come up here and comment on this?

This is Gordon MakLeod, whom I introduced a few minutes ago.

DR. MAK LEOD: When I walked in the room, I asked if Dr. Wilson was here, no; Mr. Riso here, no. I asked should I be here, and he said sure. What I thought I would do now is respond to some of the queries, but try to address the issue at the level where I think I sit as the program director and that this has in fact had high administration. There has been departmental administration and concern for the different system. They have looked at three important aspects and one,

MAC LEOD

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of course -- the first and perhaps the foremost one is manpower and cost and quality. I am not sure how the balancing works, but the three certainly do interrelate very closely and in order to address these three problems as they have been spelled out for the -- all of you innumerable times, the HMO strategy was devised -- the HMO strategy really was built upon the development of the last 20 or 30 or 40 years, as Dr. Roth has said in terms of prepaid practice group and in the last 15 or 20 the medical care foundation movement has moved into this area.

This kind of activity has had authorities passed by Congress to do certain things with respect to the health care delivery system in the country. I have heard the secretary explain before these congressional committees that Dr. Roth has referred to that there is existing authorities for the activities that we are involved with, perhaps as a defense on his part, perhaps as an awareness in addition to the opinion from legal counsel which is in your booklets, there is another one which isn't published here, which we can get where there is an approval from the Office of General Counsel for the utilization of RMP money if the activity is maintained to the planning and developmental phases.

It is with these guidelines that we have proceeded over the past several months in addressing the planning and developmental grant activity and also in the areas of contract

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activity for supporting HMO activity at this early planning phases.

I think the -- from a substantive point of view, I would be happy to respond to questions you might wish to raise at the programmatic level. I do think it is perhaps more appropriate to address some of the decisions with respect to the issues Dr. Roth has raised at the higher administrative levels and I might say one other thing just as I conclude these very impromptu remarks, and that is that one of the issues that has been discussed over and over again in a program getting started such as HMOs is using existing authorities in order to bring to the attention of the Congress the experimental activity that we have been involved in and the results of that experimental activity, so that Congress, in fact, can react, "How do you do this? What sort of funds do you use to get this kind of activity underway? And what has happened in the past?" And this may also have happened for RMP actually, is to have used funds from programs which are interested in the same objectives to a certain extent, in order to get them underway at a preliminary phase and at the same time be going through the congressional process in order to get the support for these activities.

DR. DE BAKEY: May I ask a question in this regard? Aside from the judgments that have been made concerning the legality of the diversion of funds for these various purposes,

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may I ask to what extent is the role of the council in the funding that is approved by Congress for the regional medical programs -- to what extent is the council involved in its advisory role and -- as to the dispensation of these funds?

I realize there is a legal basis for the advisory role, but I am particularly concerned about what responsibility the council has? In other words, these funds have been diverted, to my knowledge -- I don't recall the council approving the use of funds for the specific purposes.

DR. MARGULIES: Dr. DeBakey has asked about the authority that the council has in determining utilization of funds. In actuality, the grant -- the use of grant funds from RMP sources for HMOs has not as yet occurred and there will be on the agenda for this afternoon, a consideration of that kind of use of grant funds. There can be no use of grant funds for any purpose in RMP without prior approval by the National Advisory Council.

The council has two roles, which I think you know more clearly than I do: One of them is to approve the award of grant funds for any activity ~~191(c),~~ 910(c) or anywhere else in the program. It also has the responsibility for advising on policy and, of course, in that case we have, with no exception I can recall, accepted the advice of the council and followed it.

That, however, is obviously not binding on the

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secretary because it is advisory. He can always set it aside.

The other part of the machinery, however, which is a little less obvious, is the decision which the Administration, any administration, may take, saying we would like these funds used for this purpose. Now, that cannot be done. Supposing that an administrative decision should come along saying we should put X amount of money into an activity we have not heard of. What would usually happen is that the funds would be available for that purpose only, with an agreement between the Executive Branch, HEW, and the OMB. If the council chose to support that activity, the funds would be used for that purpose. If it chose not to, then the funds in all likelihood would not be released for RMP at all. So that that administrative decision cannot give warranty that the funds will be used. It can give warranty that they will be used if they are going to be used only for that purpose.

MARGULIES

DE BAKEY

DR. DE BAKEY: The reason I asked this question, not because I didn't know the answer, but rather to bring to the -- for discussion, a matter that I think is extremely important in the role of every individual who is a member of the council and that is the responsibility involved here in relation to the program, programming. That, I think, is the most important responsibility of the council.

In an appropriation of funds released by Congress, the council -- one of the council's primary roles is to determine

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priority of the funding. This is done in determining the awarding of grants, but it is also done in terms of awarding certain funds for specific areas, specific programs.

Now if you introduce into the order of priority for the use of these funds, a matter such as HMOs consideration, then it seems to me that the council must determine whether within the limitations of the funds available, this particular program has the proper authority to refund them. This is why I really raise the question because I think it is quite important for the council to make decisions and indeed it is the responsibility of the council to make its decisions. This is its advisory role.

DE BARRY

That is why I consider this a rather important decision and not one that the Administration determines without having the advice of council, because it does involve a utilization of funds appropriated by Congress for a specific purpose, regional medical programs activities. The diversion of those funds for another purpose may or may not be legal. This is not really an important question because really it is a matter of judgment in interpreting whether or not it falls into that program. My interpretation may be different from yours.

But it is the responsibility of the council not in that sense to make judgments, but rather to make its determination within the priorities of its decision-making

mil-10

process, whether or not this really falls within a high enough priority within the limitation of funds to even be funded.

Therefore, it belongs within the consideration of the council.

End 3

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DR. MARGULIES: I certainly subscribe to that view. I would like to pose the administration's problems, and I don't mean this administration's, any administration's problems, however, in a consideration of what the council does.

One of the inherent strictures in effective policy deliberations and one which we have all objected to accepting when it applies to us is the separate status of interrelated programs.

We recognize, for example, the relations between HMO, National Center for Health Services, ~~RMD~~ R&D, Migrant Programs, and so on, and it's in the nature of the political process and one that must be preserved that many of these activities have a constituency of their own, have a method of gaining support, and are as a consequence very sharply focused on a final purpose which is to achieve what the people who backed it wanted to achieve.

Now the problem of an administrator, whether it is a secretary or the administrator of Health Services and Mental Health Administration, or anyone else, is to take that variety of activities, and many of them overlapping so you can sometimes identify anywhere from five to 45 authorities which apply to an activity, look at the funds available, the resources available, and try to integrate in that process what is on hand to develop a program which is coherent and which serves a total purpose.

ar2

In order to do that, the issue is not RMP policy alone, but also RMP plus all of the other policies which are interdependent.

Now setting aside whatever one may think about HMO as a new policy, if I remember the early days of RMP, one of the severe problems under which it operated was the availability of [illegible] authority, the availability of funds, and the [illegible] point of zero.

As a consequence, it took a long period of time to go from ground zero to something better. In that way the council felt uncomfortable, but felt they had to get the show moving and use funds.

In attempting to build another activity which becomes an administrative priority like HMO, that kind of slow start and fumbling around can be diverted only if you get something moving.

I know this is a dilemma for administration, and it is troublesome for other people, but if one can assume -- and I think it is a reasonable assumption that HMO legislation will be passed -- it is a lot better to be prepared for it by having already developed some understanding, developed the people available, have things in motion so that the results achieved will be ahead by two years or more where they otherwise would have been.

That obviously comes into conflict with isolated

policy decisions and I think at least that's part of what we are discussing today.

DR. ROTH: Harold, may I also say that I suspect most members of the council must recognize that in this we have gotten ourselves unhappily precipitated into the middle of an almost partisan political issue that has nothing to do with science or our fundamental job in sitting as an advisory council.

The HMO thing came in as a slowing began. It was espoused by administration, with a big A, and all sorts of interesting things began to happen as soon as this caught on, and the initials began to be popular. Both sides of the aisle have now taken proprietary interest in these initials and nobody really knows what an HMO is going to be until we get some definitive legislation.

We have three pieces of legislation in the current Congress, and lord knows whether anything will happen to any of them because of the diversities of sponsorship. Probably, my guess is, that nothing is going to happen in the 92nd, and you are going to get new bills in the 93rd Congress, and you may still have more new bills changing the definitions of HMO.

At the present moment, we have the Staggers bill, the Roy Bill, and the new Kennedy bill. They are quite dissimilar in their characters. There is a move to really

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liberalize the HMO concept to the point where it will embrace virtually all the foundation.

Under some concepts of HMO, there are six foundations that are already being funded to move in the HMO direction. Our funds are being used to promote something that has not been legislatively defined and I think this is a far cry from my concept of why we sit around here and why we stay home reviewing grant applications to try to work out ways in which the medical profession can extend the benefits of what we already know how to do for people who need it. We are not interested. We are not funded, and the original Congressional intent, I think Dr. DeBakey would agree, and nobody ought to know it better than he, was not to be a research and development thing. It was to use the knowledge and disseminate the knowledge that we already have in this country and in this world.

It was not set up to be a poverty program, and the moment we become one small drop in that poverty bucket as a program or debt -- I think this council has a very real role in this thing, and although we may be overruled by what is done with the money through manipulations from above, I think it would be appropriate for the council to say strongly and clearly that we think this is an inappropriate diversion of funds, and if this isn't where they wanted the funds to go, they shouldn't have put them in RMP. They

should have put them some place -- because what our 910(c) ~~19-C~~ is being equated with now, it is being alleged that 910(c) ~~19-C~~ has the same purposes as 314-E, for example, and CHB.

We have been spending years trying to point out there isn't an identity of interest or conflict, that we aren't on a collision course. We are supposed to be doing different things.

I think we have just been caught up in a political issue which is rather distasteful to one who is trying in a nonpartisan way to do the best we can, to use the monies for the purposes that we are all enthusiastic about.

DR. MARGULIES: I think that there is some embarrassment even now in the administration over the need to use funds from other resources for HMOs. It is no secret that the administration had every reason to believe that HMO legislation would have been passed months and months ago so that this would not have occurred.

What has culminated is an arrangement in which there has been initiated enough -- pardon me -- enough HMO activity to make it possible to look at what it is and to keep it on a tentative basis until there is further definition. And whether the early offset of activities was -- what the council might have agreed with or not, there is an investment in effort which we at the present time find useful which would be set back, which would indeed be lost

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if these funds were not for that purpose.

The Secretary accepted the idea in his testimony that RMP funds should not in the future be used for this purpose, and indicated to the appropriations committees that this is the one and only time it would have been done.

In fact, it isn't really in the budgetary thinking, Rus, a use of RMP funds, and this may sound a little like sophistry, but it really went like this: Funds for RMP were frozen in fiscal '71. There was a need for funds in fiscal '72 for HMO. There was an agreement to release those funds that were frozen out of RMP for that purpose. They would be used for that purpose, but not for another one.

It was expected that the whole 16.2 million would be available for HMO, and that was the case. However, with the slowdown of activities which followed the slowdown of legislative performance, not all of those funds were to be used. So whether it is counted as a blessing or not, it means we will get $7 million for RMP activities for this fiscal year, which would otherwise not have been available to us.

I know that's not responsive to your question, but what the administration tries to do, again, is find the resources available to do something, to put itself in a better operating positiong than it otherwise would have been.

I, for one, would be very regretful if we

completely handcuffed the administration, which does from time to time have to move into different positions to move things in a new expression.

The expression "tin-cupping" has been around the federal government for a very long period of time, and if you don't provide the opportunity to pick a little from here and there to get something done that needs to be done, it restricts the mobility.

If we confined every program to a rigid definition of its purposes, we would have even more fragmentation than we now have.

You, on the other hand, feel this is overdoing it for a given purpose, and I recognize that difference.

DR. ROTH: I am glad you labeled it sophistry.

(Laughter.)

DR. MARGULIES: I said it may be.

DR. ROTH: Of course, all you have to do is go one more step. This council and RMP are presumably going to have nothing more to do with HMOs after this one fiscal, this one year.

If you needed any other testimony to the fact it isn't RMP business, I guess this would be a good piece of testimony.

DR. DE BAKEY: The point that's important here is that the funds used for any purpose that are in a sense

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assigned by Congress to RMP is the business of this council. That's the point I am making. I don't think that it's proper, whether or not the organ which is used or acceptable, is proper to use these funds without having consulting council. I am not arguing with whether or not it should be done this way. My argument is concerned with the role of responsibility of the council. That's the only point I am making.

DR. MARGULIES: They have not been used.

DR. DE BAKEY: It may well be that the council would agree to do this. My point is that the council should be consulted.

DR. MARGULIES: They will be. That is a -- on the agenda. There have been no grant funds used. However, you realize that these funds can be converted into contracts in which case the council would not be involved.

DR. ROTH: May I ask another question?

Out of the 110 extant grants for HMO funding, how many came out of this branch of HEW?

DR. MARGULIES: No RMP funds have gone into that.

DR. ROTH: No RMP funds? How about contract grants?

DR. MARGULIES: No. Nothing in contracts either. The exception to that -- that's correct, isn't it, Gordon?

DR. MAK LEOD: Yes. I think perhaps the closest

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thing to RMP involvement in HMO is myself, who was a member of the consultant staff of RMP before I became a member of HMO.

DR. MARGULIES: You shouldn't have said that.

(Laughter.)

DR. MAK LEOD: Our activity to date has been funded within HSMHA through 314 money and outside of HSMHA from the SRS authority, which you alluded to.

DR. MARGULIES: The exception to this, Russ, would be any intra-RMP activity in support of HMOs that you know about.

DR. ROTH: I know. This has been cropping up in grant applications. That doesn't worry me at all. Maybe this is better preventive medicine than I thought if nothing has been done. Maybe we can prevent something.

DR. MILLIKAN: I was going to add that I don't think there is any issue about us handcuffing the administration. This was a phrase that cropped up a few moments ago. I share the feeling that it is the responsibility of the council to make its feelings known about the fashion of the policy level at which the objectives of RMP are molded, and that we sooner or later should be called for a kind of opinion review of a situation like this, albeit contract or grant or whatever.

It seems to me if we are going to work as a

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community of folk in trying to put together over a continuum, the real issues of RMP, we ought to do it in a combined fashion.

I think at a given time there may be differences of opinion among us, but that the administration may handcuff us. We aren't going to handcuff them. We are only advisory and we recognize that.

DR. MARGULIES: Except you control the funds.

DR. DE BAKEY: Could we go off the record for a few moments.

(Discussion off the record.)

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DR. DE BAKEY: We can go back on the record, if you want.

DR. MARGULIES: Tony?

DR. KOMAROFF: Last February when our sudden riches were described to us but all of the earmarking was described, we all, I think, felt richer and somehow more supine and I know that the Review Committee has felt the same sense of frustration that we are hearing around the table.

Is there any way the specific issue of the HMO funds aside of conveying this kind of sentiment to the Administration because a devitalized advisory group is a significant below to the viability of the organization? Has that sentiment been conveyed? We all expressed it, I think, in February.

DR. MARGULIES: Yes. And of course Dr. Wilson will be here tomorrow morning and I think it is perfectly reasonable for these issues to be raised. The point which Dr. DeBakey just made is certainly a critical one in the RMP. It has been my feeling that in the development of some strong regions and most of them have become much stronger, that we are in a position to do some things with the categorical diseases, sensibly, better position now than we ever have been, that we can carry out categorical control activities which will really affect the whole delivery system rather than serve the special interests of a handful of people as many of the early

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activities did.

However, the fact that I think so or the staff thinks so doesn't satisfy the questions which Dr. DdBakey raised at all. His points are very well taken. There is also the very interesting question of how comfortable we are, the Council, the Administration, and others with the process of decentralization. This regularly comes up. There is no point in trying to escape it. If you in fact do allow the program to proceed in the direction of local judgments, local talent, local efforts being applied to local problems and get stronger and stronger peripheral programs, parallelling the movement towards stronger state government activities and so on, do you imperil the achievement of national goals? Are the two necessarily inconsisent and that is something that this Council needs to consider very carefully. It is a subject for real deliberation.

I am surprised when we are told that the problem with the individual RMPs is that they are not responsive enough to national policy when our primary problem is to keep them from all jumping in the same direction the minute that they hear that is the way we are going to go. Within a few minutes the telephone is ringing saying when do we get our application grants in. That has never been an issue but that is not generally appreciated.

You will see in the grant reviews for supplementary

award that in a period of a matter of a few weeks the idea of emergency medical services and expanded education activities was advanced from an early inquiry to the full development of applications and a number of excellent ones. This took very little time. It wasn't a question of the local determination process being indifferent to national policy but more a matter of whether they could be responsible to national policy and have it been meaningful locally. This is part and parcel to the whole question.

The issues you have raised today are the issues which the coordinators are raising, particularly the one of selecting priorities for funding and so on. I think there is nothing more legitimate than your very careful review of it and transmittal of your concern. This becomes particularly important -- let me just take advantage of the opportunity to bring up the other two issues which take relatively little time.

In considering new legislation, because there will be new legislation for the regional medical programs this year, our legislation has to be extended by July 1 of 1973. So also does the legislation of the other programs, which you have been discussing today and a number of others. It would be rather natural for those who review it in Congress and in the Administration to try to look at these legislative proposals together and get something more comprehensive than has been available in the past.

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The comment you have been making today, whether positive or negative are pertinent to the development of legislation which produces whatever specificity or whatever flexibility you think should be in our legislation and those that are apposite to it.

On the other hand, there are specific requirements which are imposed by Congress which are of an entirely different kind. One example of that wasthe expression by Congress of their insistence that pulmonary pediatric centers be funded at the level of the preceding fiscal year. We are making every effort to make sure that occurs. This was part of the appropriation language and is a specific act by Congress which expresses the will of the people. There is no reason to question it.

We will, as a consequence, be looking at some pulmonary pediatric activities, either new or extensions, which will allow us to maintain that level of $1.7 million in total for the pulmonary pediatric centers. But this again is a different kind of an issue when it is a Congressional question. What you are really looking for I think is a better way of dealing with the Administration on policy issues and I am obviously not an adequate representative of those policy considerations because I represent RMP policy considerations andam responsive to those decisions which are made elsewhere.

I think it is quite right that these questions be

raised and that you get the kinds of answers which you are pursuing. This also has something to do with the description of the role of the Council in new legislation.

The categorical issue, you are absolutely right, Mike, the -- there are a number of reasons why people have felt that RMP is not appropriate for some of the large increases in funds for categorical activities and probably the most significant of them is the brief final life history of the chronic disease control programs which is the point at which I entered regional medical programs at the first place and was under hot debate at that time. This has made a lot of people feel this is not an appropriate place for those activities to be carried out.

I did meet with the President's Advisory Council for Cardiovascular Disease and expressed to them our willingness and eagerness to engage in effective categorical disease activities.

The one thesis that I presented, which I feel strongly about, which the Council may wish to consider, is that an excellent categorical disease program inserted into a bad delivery system will end up with bad cardiovascular disease delivery and that you cannot carry out a control program by setting up a few major demonstration centers and depend upon something called education which is really exortation to get the providers and the consumers to do what they ought to

do.

At this point if RMPs and certainly where they are at their best it is true -- if RMPs play a role they can play a control role which will carry it from knowledge into the delivery system better than they could have in the past. When I first entered this program, it was the scattering of activities with a coronary unit here or there or a training program for emergency medical services with no emergency system or registry of some kind which wasn't tied into anything at either end which tended to characterize too much in the program.

But if you are going to have a well knit structure out there, and policy here, and you are going to decentralize to the best that local judgment can be utilized, it is going to require a high degree of observation and negotiation at the Council level to make sure that the central purposes are carried out effectively in the periphery.

I doubt that we have debated that as well as we should have up to the present time.

DR. MAK LEOD: May I add something on that? I would like to just add that the -- where the process is today is clearly part of the Administration's approach to handling this particular issue and the Administration has proposed to have Council act en bloc following the recommendation of the National Advisory Council some months ago.

As you will find out later on, as Harold has mentioned,

what the process has been to date.

The one other point that I think is not directly germane to that particular action but it is the development group of which the RMP, National Services Research and Development, Comprehensive Health Planning, Hill-Burton and the HMO make up the group is -- was included -- included HMO's at the outset and I was part of the dialogue that went into that. It was considered to be a developmental activity. There was some considerable debate as to whether it should go into the service group, because of the service orientation. But the decision was made to include that as part of the developmental activities and perhaps at some later date on passage of legislation to have its -- convert from this particular level of activity.

I would just want to be very responsive to what Dr. DeBakey has said and say that we have as part of this reasoning process, and you will hear the recommendation of the ad hoc group later on, looked at the -- what we consider to be important RMP considerations and they included the coordination of the sources and services and the improved manpower utilization and productivity, effective medical records, information systems, approaches to the increased accessibility of medical care. We did it to the extent that we had anticipated and had actually received something on the order of $8 million in grant requests and we have tailored that down,

prior to the presentation before the ad hoc group, to just a little bit over 4 million trying to bring it into line with the objectives of the regional medical program service as we have seen it, recognizing that they aren't specific to the heart, stroke, and cancer but perhaps in a broader area related to the general disease.

We wanted to look at the total approach at this point in time.

DR. MARGULIES: I would like to -- we can come back to the discussion and we certainly will when we go to the bloc review activities. I would like to follow up. As a symptom of the relationships between this Council and the decentralized RMPs, by pointing out to you that you have right from the time over two years ago to the present had a series of regional medical programs in which the coordinator was particularly singled out for his level of ineffectiveness, where over a period of time there were frequenty recommendations that he be given somebody to help him out in an administrative deputy role.

We have at the present time a replacement of something between 75 and 80 percent of those who I was hearing all about at the time that I entered. It can be done, you can have a separation of central direction and local function and still carry out some major alterations. I think you will also, as you look, and you have been, that the regional advisory group

will see some striking changes going on. There will be more of them. So the degree of management is significantly greater than sometimes people think that it may be. I think if you go over in your own minds the list of changes or taking a look at Rochester, North Dakota, Oklahoma, Colorado, Wyoming, Syracuse, and on down the list, with the exception of two or three, those that have been a source of real distress have been relieved significantly and were some very good replacements so that it can happen.

Let's move on in the agenda, on the assumption we can get back to this if you like.

I would like to call your attention there is a result of the multiphasic health conference with the report in the agenda books. I don't know how much opportunity you have had to look at it but it is there primarily for explanation. If there is any further action you want to take on it, it is subject to your review.

The conclusions in it are an affirmation of earlier action taken by this Council. You will recall in general we felt there had to be a much better evaluation of what is going on in these activities than there have been. I asked in turn that this be considered as a HSMHA kind of a responsibility because there are similar activities in a number of other programs. The conference supported that view and if you would like, you can take action, if you have had an opportunity

to look at it, to accept this report as consistent with the existing views of the Council or put it off until you have a chance to look at it.

DR. KOMAROFF: John, those recommendations, that certain of the projects will be changed so that a joint perspective study will be done? Okay.

DR. MARGULIES: Russ?

DR. ROTH: Harold, this maybe sort of superfluous but this has been such a fascinating thing to me to see some of the readouts and I am just singling out one, the Illinois project, multiphasic screening to detect coronary in persons and individuals with subclinical heart disease. I think RMP in this project has shown an extraordinarly important thing and that is that it tells us here that 22,929 of these examples have been evaluated and they have notified the people who showed evidence in the opinion of the examiners that they were to be regarded as precoronary or coronary prone or that they actually had subclinical heart disease and the statement comes along that 50 percent of those people went to physicians.

This is very different from saying you ought to have an annual physical examination. Here these people, presumably intelligent enough to hold jobs in industry, and with insurance protection, you can bet on that, practically 100 percent, are told you have something wrong, you have

heart disease, or you are set up for a coronary, and still 50 percent of them don't do anything about it.

Gee, if this isn't something we ought to make something of and try to find out the answers on how you get these people to do something about these findings, I am sadly mistaken. This is one of the more exciting things and at the same time depressing to come out of our studies. I just couldn't let it pass without pointing it out.

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DR. MARGULIES: The professional and technical development staff has felt very strongly about that sort of thing. So far as I am concerned it also underscores the difficulty of carrying out a meaningful control program unless you deal with that particular fact.

You can demonstrate as long as you want, but if there is no one out there to respond, it isn't going to matter.

DR. ROTH: I don't want to use this for a soap box, but I have long been using the illustration of a hospital administrator whom I knew well for 50 years who sits in her office and allows a carcinoma breast to get flungating and metastasized, surrounded by the talent to do something about this early.

It wasn't lack of money, lack of education. It was fear, basically fear or mistrust on her case of the people she worked with every day.

In the case of the 50 percent of the Illinois union members, you have to do more studies to find out exactly what these bare years are.

DR. DE BAKEY: Yes, but I think, Russ, I think one of the important things though is to look at the positive side of this.

Over 50 percent of them did respond and they picked up this group.

Now, I think this is important -- an important objective of the program. To be sure, there are 50 percent of

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them that didn't respond, but the fact remains we picked up some people in terms of the control program that needed attention which would not have been picked up without this.

DR. ROTH: I am happy to be happy about the 50 percent.

DR. DE BAKEY: I agree with what you are trying to say, but what I am trying to bring out is here is an example of one of the real objectives of the program.

You know, this is the kind of achievement that I think needs to be emphasized. There are many others. I don't want to get started on it because I would take up too much time with the council.

I have given my speeches before in this area, because of the lack of achieving control.

DR. SCHREINER: I think the point Russ is making about studying the bare years, go beyond that. I wouldn't accept the fact that 50 percent of the people are going to doctors is doing anything about it.

We ran into this basis. You can report back and get the man to go to his doctor, but the doctor doesn't know what to do about it or there is no concerted program to take it from point C to point B.

DR. ROTH: What did the 50 percent that went to their doctors do?

DR. SCHREINER: They may have ended up producing more cardiac neuroses. We don't know what happens after they are

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picked up.

DR. MARGULIES: It is precisely that failure with these activities to pursue to see what happened with both 50 percents that has made us fell we have to evaluate this thing much more before we set up any more. We don't know what that means.

All we are saying in this report to you is that we still feel that that kind of a study needs to be carried out before we put more RMP money into it.

If there is no objection to this report, we will consider it acceptable to the council at the present time.

Let me then remind you on the three cycle review process that we are well established into it, that the regions which had to change their anniversary dates have all gotten new anniversary dates.

This has given us a certain amount of finding flexibility in this interesting budgetary year and at the same time has gotten people on to a three cycle arrangement quite comfortably with actually relatively little objection to it.

A few minor bookkeeping skirmishes and that is about all.

What we are doing with the regions is negotiating new levels based upon an extended fiscal year so that a region which was moved, we will say, from July 1 begin date to four months later, has been given funds to carry it through 16 months,

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but these have been limited so they can renegotiate new levels.

In the process of renegotiating the new level, it gives us the ability of supplying the funds either in this fiscal year or next fiscal year which allows us then to consume a very wide range of potentialities in the money we have between now and June 30.

We were not surprised that we would be -- as we were on June 1 uncertain of our total funds available to a total of about $1.5 million with 30 days to decide.

In fact, we rather suspect that would be the case and we are well prepared for it. Part of it has been to put the regions on a new kind of a cycle.

We have, in the process of doing that, been able to achieve two other things. One of them is to schedule staff visits to the regions three to four times per year on a regular basis so there is no uncertainty about it in the minds of the regions or the staff with a higher level of priority to the regions which have in the review process shown up rather poorly so we can use our skills where they are most needed.

This is going to be on a scheduled basis as the needs are dictated by the status of the program as determined by the review process.

We have also been able to cut down the staff paper work.

In fact, we had to do it and it looked like a certain

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accommodation to the exigencies of life and it was.

On the other hand, I think it has improved the paper work by making it simpler. However, if you find that the simplified versionsavailable to you are not quite as adequate as they have been in the past, they don't give you as much information as you would like, we can respond in a limited way to changes which are requested, but if we are going to have a smaller size staff as we have, a larger budget, the possibility of increased demands of the kind Dr. DeBakey is describing, more staff visits, we can't do the same kind of paper work and we are going to be doing some adjusting between various levels of good so we may have a little more of one good and a little less of the others.

I hope you will be tolerant. That is a rather familiar administrative exercise.

I would also like to bring to your attention -- and this may become extremely important in the light of the discussion we just had during the first part of this morning -- that there are draft guidelines and regulations which have been prepared by the staff. They are in the agenda book under the title "proposed regulations."

What will be done with those regulations if they are left unaltered is they will be put in the Federal Register. You would be well off to review those carefully, because once in the Federal Register, and once accepted in general, they do

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become the regulations under which we operate and the deal with the very tough question of the relationships between the grantee, regional advisor group, and the coordinator and his program staff.

That in turn has very heavy implications for what this National Advisory Coucnil does, because it has been a strong feeling as an expression of the legislation, not a clear definition of the legislation, an expression, that we entertain grants which come to the regional advisory group which in turn have been subject to their scrutiny and which represent their policy of determinations.

At the same time, a number of the regional medical programs have gone thorugh varying degrees of conflict of regional advisor group and grantee.

We still have some instances in which the grantee is convinced that the final decision belongs with it and that if the regional advisor group says we should do B and they don't like it, they can cancel out that request.

If that is to be altered, and we are trying to express what appears to be the Council view, it will have to be altered in the very near future.

Those regulations are not going to be circulated to the regional medical programs now because they are not official and if they get altered we will simply have more confusion.

In the meantime, they represent a basic effort which

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has been an extremely hard labor on the part of the staff here.

DR. PAHL: I would just like to interrupt for a minute and say in my presentation, when you finish our other point on agenda, I would like to bring the Council back to this section of yourblack loose-leaf binder as well as an item which Dr. Margulies has been referring to which is actually in your folder.

If you want to proceed with that general introduction we will have a few more specifics later.

DR. MARGULIES: At the risk of no later taking advantage, but perhaps Bob, you have gotten some sense of the Council in the period of time that you have been here, we are very pleased with the fact Bob Van Hoek has taken over as director. All of us have felt that there is much more that we can do together than we have in the past because he is there and although he has only been director for a brief period of time, I am sure you know that Bob Van Hoek has been a very active part of HSMHA since it was organized or right from the very beginning, has occupied key roles as deputy administer and deputy director in a variety of circumstances; and I have asked him to come here.

If you will Bob, come up and acquaint us with what you are doing and encourage the Councilto be argumentative.

MR. VAN HOEK: Thank you Harold.

I appreciate the opportunity to visit with the

council.

I have only been in the present position two months and I am getting acquainted with many of the details of the center and its programs.

Much about what I am going to say in the next few minutes in opening really comes from the perspective of my three years experience in the office of the administrator in which I was involved in evaluation, planning, budget, operation of virtually every program in HSMHA.

And during that time one of the things that concerned Dr. Wilson and the staff of the agency was the difficulty of getting plans and programs developed in a cooperative fashion among the various programs.

It appeared to us that in general the programs and some of it, of course, based on the history of the programs themselves and the agencies' formation functioned quite independently and developed their programs with certain priorities and objectives in mind which were related to the objectives and programs of other activities in the agency.

So there would be times when looking at a particular area of activity, it appeared at least that many of the programs were doing the same kind of things, supporting the same kinds of activities, with very little interrelationship.

It was interesting to sit here this morning and hear some of the discussion about multiphasic screening and

other activities and this can be -- we can take similar areas of development in the area of manpower development and the utilization of manpower and the development of ambulatory care clinics, or developments for the poor, some of which have been jointly planned and some of which have not.

From the standpoint of the center, I see the center's role one of participating in as well as carrying out through its programs studies on how health services are delivered, the components of the related services activities, and the effectiveness of those activities and also to identify problems and to develop answers to those problems.

Let me take off, since the multiphasic activity was discussed, let me take off there as an example.

For instance, one of the basic questions I am continually asked wherever we deal with preventive care, disease control programs, multiphasic screening programs, and so forth, is what is the level of patient acceptance, patient followup, and response to whatever professional guidance may be given.

It is amazing at least from the standpoint of the national center how few studies are actually being conducted in that area, probably one of the most important areas in the health field, simply, once the individual or patient or consumer is in the system, and there is followup and the patient has direct contact with the health services

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system, what is the professional response to that -- the identification of that problem.

In other words, what is the quality of care and the quality of services rendered and in what manner is it presented?

Is the fact that the patient's acceptance or consummer's acceptance is low, is that partially due to the lack of education from the standpoint of the professional to the consumer or the types of knowledge that are available to the professional in providing that service.

That, again, is an area in which there are a number of projects in which the Center has done relatively little.

As far as I can tell, from my own experience, very little in the agency as a whole has been done.

I would say at the moment from the standpoint of the Center, I see those as two of the highest priority areas.

This is not to say that these are programs which will be done independently with the Center, but in conjunction with the 314(a) programs in both designing the studies as well as carrying them out.

I might point out that the budget of the Center is on the order of some 64 to 65 million dollars which represents only three percent of the HSMHA budget and one tenth of one

percent of the total dollars in health care expended in this country.

Therefore, it is important for us to use that fund, invest that money in conjunction with other developments in the -- trying to improve helath services.

Another area that I feel the Center should place great emphasis on and which will require the participation of any HSMHA programs as well as non-Federal programs, is in the area of resource utilization and productivity.

By this I mean a combination of studies on manpower, studies on technology -- the application of technology to health delivery and the utilization of facilities with the major emphasis on ambulatory care.

And rather than the Center supporting the training of new kinds of manpower or the construction of experimental facilities and so forth, the major emphasis will be placed on actual studies of productivity, using industrial engineering and systems engineering approaches, economics studies, and studies on proficiency of health manpower and development of testing and education -- testing techniques which can measure proficiency productivity which can then be used as a feedback into the educational or training processes and also working with professional organizations to feed back into recertification and relicensing as that develops through the various specialty boards and licensing bodies.

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I think that in in general, those are some of the thoughts that I have and I would be interested in your reaction to that.

I hope that in the future we will be -- we will continue to have joint discussions on our program activities.

Harold is going to be participating with me in a meeting of our advisory council later this month in the same way.

Thank you, Harold.

DR. MARGULIES: Thank you.

Are there some --

MRS. WYCKOFF: How do you relate to the community base manpower programs that we are working on now? Does your agency relate to those?

VAN HOEK ~~DR. SCHREINER:~~ At the moment, and I am speaking from a little information, I don't believe we have had any direct involvement in those community based programs. This is an area where I think it is extremely important that we develop a mechanism for joint planning and joint program development and implementation.

One of the areas I found a major problem in, again from my experience of several years in the agency, is that we have a tendency to start programs with certain assumptions or initiate new programs with certain objectives which could be stated in quantitative terms or output terms, and then we

could measure what we have achieved at some point subsequently.

The tendency to take many of the things as an acknowledged fact or impression, a fact unsubstantiated by some very limited information or studies seems to me that what we need to do in health services,research and health services delivery, is model some of our programs on the clinical research collaborative models that have been carried out and that is to develop some uniform protocols for large scale programs, either for demonstration or developmental activity which then a number of groups in the country can participate in with you with very well defined objectives, well defined procedures and stages for evaluation so that at some point, three years or five years from then, we can determine what we felt was a way to go,in fact, proved to be the case.

There are many examples of this that I could cite in programs, concepts such as Outreach in ambulatory care programs.

If you look at what we support in Outreach activities, they range all the way across the board in the characteristics of the Outreach, what kind of services it provided, and there is no way of comparing the different programs other than by very intuitive subjective judgment.

DR. MARGULIES: We have felt when Bob and I have talked that there is a continuum between RMP and RMD which has not been adequately developed.

This is emphasized by the kinds of discussions we have had today but also by the fact that we do not regard RMP as a source of innovative new reserach into delivery systems but rather as a mechanism for making sure what is worthwhile becomes a part of the system.

Too frequently the problem of the transfer of new understanding is not addressed and it really doesn't matter whether you are talking about new scientific knowledge, which was the original focal point for RMP or the transfer of new delivery knowledge.

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We have all heard the coordinator complain something was happening in his backyard he didn't even know it was there.

I doubt -- if there aren't more questions, the room is getting very hot and it is time for coffee.

Fifteen minutes, please.

(Recess.)

DR. MARGULIES: Could we reassemble, please?

I think if we get started again on the council agenda we can move along. There are several people who have to leave early and we want to get as much business out of the way as possible before we go. I am going to shorten some of the things which I had planned to tell you because they are going to come up again in relationship with the review processes and so we will skip over them. We will be talking about the emergency medical system applications and the distinction between what we are reviewing and the contract activities. We can do that when we get to those reviews so you are clear about it. I can at that time also let you know who the subcommittee members were for the various special supplementary grant review processes which were carried out.

I would only like to make one special point about the educational activities which are going to be under review for supplementary award. We are not empowered to support something called an area health education center but that is around a very clear cut difinition of what the area health center is

and that definition is tied closely to the original Carnegie Commission record which describes the AHEC as the satellite of the university health science center with the understanding that the recipient is the health science center which develops a collateral activity in a community and has the general managership of it on the training of undergraduate medical students, residents, and other graduate physicians in primary medical care.

We have invited as a consequence, applications which are really carried under no particular title and believe me we are better off without a title for a number of reasons but which are community based, which are an extension of RMP activities of the past several years and which deal with certain educational goals that are appropriate to RMP.

We will get to them in the very near future. These primarily came out of the St. Louis conference and -- with the coordinators and the number of discussions we have had.

There is, however, one action which the council is being asked to take. The last time which the council met it agreed to -- I would like to have you look at tab No. 8 on this one. Congress agreed to delegate to the director of RMPS the authority to provide funds for the planning of area health education centers with certain limitations, $50,000 for each one, a maximum of five such activities in any one regional medical program.

MR. BAUM: It is community based education criteria.

DR. MARGULIES: Sorry. I was thrown a curve. Community based education activities which is not their title. That is just a way of locating them.

DR. PAHL: The document being referred to is behind the tab delegation of authority which is about half way through the black binder.

DR. MARGULIES: At the time you met, you did delegate the authority to provide for some planning activities for what were called area health education centers and since we are not doing them, we are asking you to change that delegation to one which refers to community based education activities for the same purpose. It is really a matter of new language and conforming to our new position.

MRS. WYCKOFF: I move we change the language and -- area health education centers to community based indication programs.

DR. MARGULIES: Mrs. Wyckoff has moved that this delegation be altered as indicated in the tab in your book.

DR. OCHSNER: Second the motion.

DR. MARGULIES: It has been seconded. Any further discussion?

MRS. MARS: I don't quite understand the reason for this.

DR. MARGULIES: The reason is to allow us to respond

to early planning activities, Mrs. Mars, during the cycle when the program might be ready to plan something, nine or ten months ahead of the time when it would be coming in for its regular review processes and since it is a relatively new activity in some regions, it would be delayed up to a year in what is an early planning or feasibility activity unless we can provide them with the funds to do that earlier. Sometimes it would also run into conflict with the -- when their award level is at the level of the council approval and they say you have to wait until it is time for their review to come in which would slow them up too much.

MRS. MARS: Thank you.

DR. MARGULIES: Any further discussion? All in favor say "aye."

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No answer.)

DR. MARGULIES: I would like to recognize the fact Dr. Scherlis has come in. He is on the review committee and will be here for the discussion of the applications for supplementary awards for emergency medical care.

I wonder if this would not be a good time to ask Mr. Champliss to bring you up to date.

DR. CHAMPLISS: As a matter of special interest, the council staff felt that the council would like to be

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apprised of the new review committee memberships. As of June 30th, there will be four members of the committee retiring, Dr. Michael Spellman, Dr. Gerald Besson, Dr. Philip White and the past chairman of the committee, Dr. William Mayer. All will be leaving the service of the review committee. That will leave four vacancies on the committee and the need for the appointment of a new chairman. That new chairman will be Dr. Max Schmidt who has served with a great amount of distinction already on the review committee. Dr. Max Schmidt.

Also there has been one appointment to the committee that has been formally accepted. That person is Mrs. Maria Flood from El Paso, Texas. There are two other names that have already been approved but it would be injudicious at the moment to give them until that process has been fully completed. Those two appointment will be made, hopefully, soon.

Another matter that it was felt the council would be especially interested in has to do with a question that arose from the Washington-Alaska regional medical program having to do with the use of the proceeds of a grant activity covered by or supported by regional medical programs. They raised a question as to whether that could be granted to them for the benefit of a private company, the Video Record Corporation, which we understand is a subsidiary of RCA. They asked a question as to whether that corporation could be given a non-exclusive right to duplicate and then sell the proceeds of some films

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that were made under a RMPS grant. We felt this was a policy issue and it was submitted to the office of the general council for determination.

We took the position in RMPS that whatever was most favorable to the regional medical program, we would support that position and in our inquiry made to the general council, a decision has come forth which is, in fact, favorable to the RMP. They asked the -- the question was raised and they answered it with three answers.

First, they said that the grantees of RMPS funds may produce and distribute video tapes or the proceeds of those tapes which were -- which were the -- which were funded through RMPS without prior review by RMPS. In other words, they can make a distribution of the proceeds of grants, tapes, films, and so on without our approval.

However, they did say that these items were items of property and that the distribution -- the use of property was a matter for the grantee institution to decide and not for RMPS to decide.

The second question they raised -- they dealt with, that since the proceeds of video tapes are copyrightable materials, that this -- these copyrights to be subject to the right of RMPS to a royalty-free non-exclusive irrevocable license for the use of the video tapes. This means that RMPS would have a property interest in the tapes and that this

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property interest would come to RMPS royalty-free and at no cost.

The third point that they dealt with had to do with royalties or the proceeds, the monies coming from the use of these tapes. The general council office finally said that all royalties or other fees received by the grantees from the use or distribution of video tapes produced with grant funds up to the amount they charged to the grant for the production of video tape, that is to say there would have to be a recoupment by the RMP of the exact amount of money that was put in it supported by a grant and after that amount was recouped, then that amount would have to be refunded to RMPS but it went on to say that RMP should look favorably upon the use of those funds that were recouped for the continuation of other grant activities.

So, here we have a policy determination by the general council office on the use of the proceeds of grant funds in the area of video tapes and films.

We think that this is something of an advancement of the RMPS mission because now after the recoupment, the proceeds of activities supported by grants can be used further for the supporting of other grant activities, assuming, of course, this has been cleared by RMPS.

Thank you.

DR. DE BAKEY: You say that the money can be used,

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the proceeds could be used for the advancement of the RMP program. Do you mean that once the amount of money that the RMP puts into the program has been returned, that total amount, then what happens beyond that point?

DR. CHAMPLISS: It means that the grantee can use that amount, can use the further proceeds to further its activities.

DR. DE BAKEY: Can or will?

DR. CHAMPLISS: Can or should.

(Laughter.)

MRS. MARS: For the same purpose, in other words, to make further films?

DR. CHAMPLISS: Or for whatever purpose --

MRS. MARS: Any purpose? It doesn't necessarily have to go back and make further films?

DR. CHAMPLISS: That is right.

DR. SCHREINER: What happens to the recouped money?

DR. MARGULIES: That becomes RMPS money which you can leave there or bring back in.

MRS. MARS: Doesn't have to be used apparently to make further films, for any program activity.

DR. MARGULIES: At this point, the amount involved is not going to represent a windfall but the issue is of broader importance when you think of the potentialities in various programs for bringing fundsin, particularly, demonstration

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activities involved in patient care, for example.

DR. DE BAKEY: It seems to me that this sort of is not really a very clear policy.

DR. CHAMPLISS: I would agree there. We understand that further clarification of this policy is already in the making.

DR. MARGULIES: Mike, it is a legal opinion.

DR. DE BAKEY: That is why it is not clear.

(Laughter.)

MRS. WYCKOFF: Sounds like we are going into the grocery business.

DR. MARGULIES: If there are no further questions on this, I do want to return to that important document and regulations which I think is of very high interest to the council.

begin Rep

DR. PAHL: In recognizing that a number of people will not be here tomorrow, I feel it important to take up a number of documents that we have either sent to you or have in your folders and I will try to highlight the aspects for you which I believe we want to call to your attention and leave the rest of it for your more leisurely perusal later on.

DR. DE BAKEY: Could we get some clarification before we start on where these proposals stand? None of them have been published?

DR. PAHL: No. Let me say for the benefit of you and

particularly the new members of the council, we have a tab in the middle of the black binder called proposed regulations and it is titled first draft regulations and it means just that. These have not been issued. They are in draft form and the thing which I was going to end up on, I will say now we earnestly request that you look at these today, tomorrow, and take this section back with you if you will, look them over, and sometime within the next two to three ~~years~~ weeks, we would appreciate any constructive comments, additions, deletions, and so forth in writing from you and the letter can be addressed to Dr. Margulies or to me.

We will then take whatever comments you have and begin work with the general council office in developing the final regulations which will then have to be published in the Federal Register subject to, again, a time period for comment to come in from anyone in the country.

Again, any modifications made on that basis have to be published. So we are at the stage where these are truly draft and nothing will be done, I would say, until the latter part of June in working again with the general council office. We would like to have your comments.

DR. DE BAKEY: One question, that is how do these differ from what has been published so far in the Federal Register?

DR. PAHL: This is really an updating of the

earlier regulations, taking into account our mission statement which was endorsed by the adminstrator and his council a year ago and also putting into effect --

DR. DE BAKEY: The reason I want to know is I think in evaluating these regulations, we would like to know, you know, what has been published in the Federal Register, or at least, be able to bring it up to date. What are the changes?

MRS. MARS: Yes. What are the changes?

DR. PAHL: Let us ask Ken.

DR. MARGULIES: One point that should be made, however, is that back of this lies the decision to move away from the excessive use of what are called guidelines, to the use of regulations which are published and which allow public access and comment, so much of what we are entertaining here has been carried under guidelines which are not really regulations.

DR. DE BAKEY: We went through a lot -- in the early days, went into the Federal Register, and I just wanted to be sure we are brought up to date on the relationship of these to what exists now in the Federal Register.

MR. BAUM: Let me explain what has been done.

The regulations that we have now are the regulations that were originally promulgated from the program and have not been changed since 1965, or whenever they were pushed through. There was a need to do really two things with these regulations.

One was to bring them up to date so that the regulations are consonant with the new law that we are currently operating under. That made a number of changes, broadened some of the statements of purposes, widened the representation

required on regional advisory groups, completely changed Section 910, added construction, and those are not reflected in the currently applicable regulations that were passed back in 1965. So, these regulations are designed to close some of those gaps.

The second thing is that within the last year, the Secretary has issued a directive that instead of promulgating policy, you make the rules for your program in a formal and official manner, by putting things into regulations as opposed to having policy statements, which can be changed by staff, day-after-day.

And, in order to go through the rule-making procedures we have required first of all, by law, to consult with the Counsel. Secondly, the departments' rule-making procedures require that anything you are going to make a regulation be published in the Federal Register and there be an opportunity for people to comment on those for 30 days.

That they then be finalized and possibly changed substantially, republished for comment for another 30 days. But they are finalized 30 days afterwards. Now, these regulations take into account the changes that were made in the law and in addition to that, they try to incorporate some of the materials that reflect the way the program is currently being operated.

For example, the mission statement that was developed,

what was it, Herb, about a year ago; the review process requirements and standards which we have put out saying what the local regional medical program must do in order to meet the standards for reviewing their own projects, and things like this have been built in.

The document you have in front of you was drafted up in the presumably proper legal language, by the General Counsel Office, after they have taken a look at these program documents and then built them into this.

Since they gave us their first draft, we have developed some additional papers and some additional things and they are kind of reflected on some language on the back page of the draft, which we wrote up and they have to be put into appropriate legal language.

That, essentially, is what we have been doing with these.

DR. MARGULIES: I think it is also fair to say, that at least some of the detailed relationships were never spelled out in prior guidelines with the specificity that is in here. They have been left to sort of definition, as we went along. We have had a variety of understandings. The effort here is to put them in very specific language with the understanding they may, or may not be acceptable.

MRS. MARS: Excuse me. This will provide, then, all the mission's statements, the guidelines? These will be

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torn up as bits of paper and it will all be in here?

DR. PAHL: No. No. These represent the published regulations and the more detailed statements such as the mission -- the mission statement per se is not incorporated in here.

The concepts of the mission statement are. The mission statement itself, will still be utilized as a program document but it would not have the force of a regulation.

Now, in returning --

MRS. MARS: What about the guidelines?

DR. PAHL: Our guidelines will return to being guidelines and those things which are requirements will be put in the form of regulations. So, anything which ends up as a regulation will be a requirement placed upon a regional medical program, and an additional implication and understanding, policy matters, will come out as guidelines if there is some degree of interpretation and flexibility possible.

These will be firm program requirements.

MRS. MARS: This is really a finalized situation, so to speak?

DR. PAHL: And they represent the firm program requirements, organizational structure, priorities, things of that nature. We will still be issuing guidelines, and policy statements, but they would not have the force of a regulation in terms of placing a strict requirement on a RMP. You need

You need both.

DR. MARGULIES: There are two practical advantages to this, aside from the content.

One of them is that it now allows the guidelines to be guidelines instead of being both guidelines and regulations which has confused regional medical programs regularly.

Secondly, it will allow us to have the force of real validity when we deal with aberrations in the internal management of a regional medical program, such as a Grantee Regional Advisory Group relationship which does not fit our understanding.

At the present time, all we can refer to is the broad language of the legislation, which is too nonspecific, or guidelines when there is authority. When there is violation, the regulations will give us a firmer basis for carrying out the will of the council as expressed through those regulations.

MRS. WYCKOFF: On the other hand, these are frozen?

DR. PAHL: They will be frozen.

DR. MARGULIES: They are not readily changed.

DR. PAHL: This is why they are written by the General Counsel Office, in appropriate legal language, as well as the fact that they are broadly written, so they would not have to be changed from day-to-day. they are not frozen in the sense they cannot be changed.

It is just that one has to go through the Federal Register procedure for any modification, and this is some months

of work and so it would not be advisable to include in this language of such a specificity that it would be out of date three weeks from now.

MR. MILLIKEN: Are these more appropriate than a sight-visit?

DR. PAHL: If questions come up, these represent program requirements and so serve as a reference point for the program. They are the force of law. An RMP must. But there will be additional guidelines and so forth for sight visits, etc.

DR. MARGULIES: It is -- as a way of illustration, some amplification, all that the law says is that the Council will consider an application which has been submitted by regional advisory group. It does not say, in our legislation, what the role of the grantee is in determining the responsibility of that regional advisory group, what the extent of its responsibility is, or what the limitations are.

That is why you have regulations to identify the intent of broadly-stated legislation. Then, the way in which you make that -- make sure that functions is the way.

You have three levels. Basic legislation and regulations, and guidelines, which are much more a matter of the management.

DR. PAHL: I can illustrate that. I had not planned to do it in this order, but if you look at the last page of

these suggested regulations, it is not numbered, it is after page ten in the document, Section A is titled "Grantee Coordinator Relationships." Please do not read it at the moment.

What I want to do is point out it is a brief paragraph in rather broad language. I will call to your attention in a moment, that in your folder there is a four-page document which spells out in much greater detail than we would want in regulations, the actual roles and responsibilities of the RAG.

The coordinator and the grantee. This would be a good example of how the regulations give a firm requirement of a conceptual nature, and the subsequent guidelines interpret and give much more specificity and give a basis for actual program operation.

Now, I would like to call to your attention, for consideration now or at your pleasure, at this meeting and certainly subsequently to this meeting, in terms of writing us comments; Section 51(b) on the bottom of page three and most of page four.

This is the section entitled, "Priority of Regional Medical Programs," and consists of a listing of items which you may wish to consider. Again before you read this, I would like to go through the whole little presentation. Then we can come back; otherwise you would not get the whole perspective.

This section is of specific interest to the Council

evidenced by this morning's discussion. It has to do with priorities, which would be published and of some force of requirement on regional medical programs. That section is particularly important.

Most of the sections have to do with the mechanics of the program, and I do not think we will do violence to anything that we are accustomed to. And the last page, the suggested additions to the proposed regulations, has a section on the Grantee--RAG coordinator relationship.

It has a -- this is the last page of the document, page eleven. It has a section on ~~19~~ 910 and a section on construction. These would be new parts of the regulations which have been added as a result of the authority under our present law, and program decisions made subsequent to the enactment of the legislation.

I would like to indicate the following: It is difficult to know how these relate to what has already been [illegible] and, Ken, we can get copies of what are now the present regulations, and give them to you at this meeting, or get them to you immediately in the mail; so that you will see what are our present regulations, published regulations, and then send you also, a copy of this so you will be able to compare.

This is what the General Counsel Office did. They took our present regulations, our present legislation, and the important policy documents that have been developed by us, and

developed this revised set of regulations, proposed regulations, from a consideration of all of those. We would be most happy to have you review, whether you think the present regulations and what you know to be the direction of the program and the documents, whether these are accurately reflected.

We do earnestly solicit your comments here or written comments upon your return.

Now, having said that, I would like to ask whether it would be your pleasure to go over that section on page three, and foru, now or whether perhaps, you would like to have an opportunity to review this over lunch hour, or something and take some time this afternoon, after you have given it some thought?

Clark, you raised the issue with me?

DR. SCHREINER: Bear in on it.

DR. PAHL: Okay.

Open for discussion.

DR. DE BAKEY: The first question I want to ask, is in relation to the priority. Are these listed in any order? Because that is not clear the way it is stated here. In other words, you have given some indication of what constitute priorities, but what is not clear is whether these represent priorities themselves. In other words, does, for example, under 51(b)106, Paragraph A, and then Section One, does that have priority over Two?

MR. BAUM: As I recall, and I do not have the document in front of me, these priorities were taken out of the mission statement of a year ago. I do not know if they used exactly the language of the mission statement or rearranged it.

I would have to compare it. But essentially, what we did was to furnish the General Counsel Office with some documents like the applications statement, some others that I mentioned, and they took those documents, extracted from them, and put them into what they feel is the correct legal form, and I think that is where you get this set of priorities.

I would have to look at the mission's statement. It was done by the Legal Department, not by us.

DR. DE BAKEY: If I recall, the mission's statement was just a listing with no intent to give priorities to the mission.

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DR. MARGULIES: I do not think there is an intent.

MR. BAUM: No.

DR. PAHL: There is not an intent but this is not clear.

DR. DE BAKEY: You are dealing here with priorities not with mission.

DR. PAHL: That is correct. It is not clear here and we would clarify it.

DR. MILLIKAN: Looking at A, there are eight items, and in five of the eight, the word "care" is a key word.

Could we have a definition of the word "care"?

Items 1, 3, 6 and 7, the word "care" appears. I think that is important enough that it might even want to be included under 51-B-102.

DR. PAHL: Section on Definitions.

DR. MILLIKAN: I would like to hear some discussion on it.

DR. DE BAKEY: I think this is important because I don't think there was any -- that there was ever originally or in the new law that carried on the regional medical program, certainly, a concept of providing any care that would, say, be the type of medical care we usually speak of as reimbursed care.

So it becomes rather important, I think, to distinguish this type of care.

DR. MARGULIES: You need to describe -- I think what it is and what it is not.

What it is not is payment for services and what it is needs to be defined in some aspect of health services delivery.

DR. ROTH: It also makes reference to primary and secondary care and this has been subject to various definitions, depending on what you are talking about.

I think primary and secondary care should be defined.

DR. DE BAKEY: Now, in paragraph 4, that same area, this is a question which I am asking because I think it is important.

In the Mission statement, under Paragraph 4, where it says "need to increase utlization," and then it says especially.

Now, I think the reason I bring this up is because that adds in a sense to the priority.

I want to know if that is in the original Mission. If not, we have added something to it.

MR. PETERSON: I am pretty certain and I can get some copies of the Mission statement.

DR. PAHL: We will get copies of the Mission statement.

I don't know. Even if it is in the Mission statement,

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it doesn't have to be in the regulations, if it is council's opinion or the opinion of the public at large that this should not be in the regulations.

So we are not bound by that, whether it exists or not.

DR. DE BAKEY: The only reason I am concerned about it is because it, in a sense, provides a form of priority.

DR. PAHL: Yes, it does.

DR. DE BAKEY: I am not at all sure that that ought to go into regulations.

Priorities from the standpoint of the council's role can vary from time to time. They can vary in terms of the funds that are available, they can vary in terms of what is timely and effective.

It may well, for example, prove that -- let's say allied health personnel, certain types of allied health personnel, does not increase the capability of achieving the goals of the program.

I am just using that as an illustration.

Well, you would be tied down to your form of priority in the regulations that would, in a sense, frustrate council's priorities at that particular time.

So I think it is important to -- in terms of priorities, because these become sort of rigid, once they

are published in the Register -- to be very careful about the wording of priorities.

You see, this comes -- this is really the whole sort of heart and core of a council's role. This is -- you are almost saying, well, you know, you are almost -- you almost don't need a council if you set up a set of priorities that is so rigid that you can have a bookkeeper take care of it for you.

I think -- I personally think it extremely important to word this in such a way that there is great flexibility provided the council in exercising judgment for priorities.

DR. PAHL: Yes.

MR. HIROTO: Would it be necessary to list the priorities at all? Couldn't it just be listed as areas of concern?

DR. MARGULIES: Actually, if you read it, they are not priorities but they are the basis for determining priorities.

I think the point that Mike has made on this one is one that we would like an expression of council opinion on.

You can leave it as it is, you can alter it, you can delete it.

I think this is as good a time as any to consider which way you would like to go because you are quite right.

It does single this out particularly with the word "especially," which raises it to a higher level.

DR. DE BAKEY: Well, Harold, I wish you had had more of an illustration. I am very much concerned about establishing in regulations a set of priorities.

I think once you have these established in the Register, they assume all the authority of law and you don't really have any more capability of modifying that law which you have now so long as you are exercising judgment within the framework of the law, you see.

Now, you establish these which, as you say, are Missions and bases for determining priority.

Well, if they are bases for determining priority, then they constitute the Mission.

Therefore, it is up to the Council to make decisions regarding the priority of achieving those missions in terms of the applications that it has before it, in terms of programmatic discussions, policy, and so on.

So I am really raising the important question here as to whether or not it is desirable to put into regulations, really, or into the Federal Register, which, as I say, has all the authority of law, a set of priority values or criteria that obviously can vary from time to time, but if you write them down in the form of law, they no longer vary, they no longer vary. This it seems to me ties the hands of

the Council and I am not really certain that it isn't a violation, so to speak, of the responsibility assigned to the Council.

That is the real point I am raising here.

DR. SCHREINER: What would you think of saying, in determining priority of considerations, the Council shall take into consideration and then have a paragraph rather than a list of one, two, three, four, five, six, seven, eight, nine, ten, so you don't get this rank order, and include some of these items that the Council will take into consideration.

In other words, instead of saying the secretary, say the council. That puts it back where you want to put it.

MRS. MARS: You have to have some criteria, whether you call it priorities.

DR. ROTH: I was just going to make a tongue-in-cheek observation that the moment you put down specifically these things as priority items, it seems to me that you virtually cast in concrete the shape of every grant application because every good grant man is going to go down one, two, three, four, five, six, seven, eight, and cover them in his application.

This is what has been happening to us in the past.

DR. PAHL: We are somewhat caught because what the secretary has said some moments ago is that we can't continue to issue "guidelines" and operate on those guidelines as if

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they had the force of law without actually giving the public at large an opportunity to see that they are being applied as univorm requirements across the RMPs, so we would be back in the same position where our regulations didn't really reflect what our true program requirements are.

Now, I think there is a very good point here that we don't necessarily have to have lists and one, two, three, four, but if we are going to use these as the basic requirements for considering grant applications, then in honoring the spirit of the secretary's mandate, we should have something in our regulations pointing out to applicants what we really are looking at in terms of their programs which, of course, will be reflected in funding decisions.

MRS. WYCKOFF: I would like to see a definition of "allied health."

DR. MARGULIES: Come on, now.

(Laughter.)

DR. KOMAROFF: What about, as George suggested, that paragraph saying very broadly that RMPs are designed to link facilities and to disseminate information from a central source in both the category 5 diseases and in various improvements in the health care delivery system and let it go just that vaguely.

You don't get locked into those things that look

sexy to us today and you fulfill kind of cheaply the mandate of the secretary.

DR. MARGULIES: We have no objections to that, but we also continue to receive considerable criticism which has been extended this morning on the failure of the RMPs to more carefully define what it is they are setting out to do so that whether we do it in regulations or somewhere else, I think we have to make sure that it is understandable and probably the part that needs to be underscored and Herb has already said it, but it needs to be said again, is that this does provide for public review.

That doesn't necessarily mean grantees, but any part of the public that wants to know what it is the RMP proposes to do and want a comment on whether they think they ought to do it.

It will probably be followed at sometime in the future with greater disclosure of this kind of meeting.

It will be very difficult for someone to look at the minutes of this meeting and judge whether some action has been taken without some understanding on the basis of regulations of what it should be.

It is somewhere between those kinds of demands that I think we have to find our course.

DR. DE BAKEY: But Harold, it is one thing to set up a definition of Mission in the program and it is still

another thing to set up in terms of priorities of how you achieve that Mission, regulations, really, that are factors in making the assessment of judgment.

DR. MARGULIES: I am not disagreeing with you.

DR. DE BAKEY: That is the distinction I am trying to make.

I have no objection, of course, to amplifying in some form the Mission in the form of regulations. I think that is quite desirable, but I am raising a very serious question as to whether you allow those then to become the rigid criteria of judgment.

DR. MARGULIES: I think we could function without the priority statement. I am not deeply concerned about that because that is a temporal kind of thing, a formative one.

DR. PAHL: I think that is an excellent point and if the Council wishes, because of the major impact that that would have on this statement, rather than have you respond to this statement more fully when you return, if you would permit us to revise this section and resubmit it to you for your further comments and if a definition of "care" is required, under the revision, to have that included also, we would then ask you to look at the revised statement at your leisure at home and write us comments rather than trying to pick each point.

We would also go through the statement very carefully in the sense of not alluding to priorities.

I do not mean to terminate discussion on any part of the document. I thought perhaps I should say we should do that.

MRS. WYCKOFF: If we were going to do the things that are listed here, it would mean an appropriation of at least a billion dollars.

DR. DE BAKEY: Perhaps we should.

DR. MARGULIES: That would be one way of getting to it.

DR. SCHREINER: This gives the procedures for approving which are essentially what the secretary is doing. The only value it seems to me in giving priorities is to get the potential grantees who are reading this, have a feel for what kinds of things are in mind of the council and I think -- that is why I think that the secretary is going to assign priorities in 15-B-06 after first saying that he is going to approve -- that these are the ways in which he approves the action of the council and the next thing says the priorities of the council. That negates the whole purpose of the council. It seems to me, you should have a paragraph saying -- even as a historical statement -- saying the council has given emphasis to these kinds of things and then the kinds of things mentioned without 1-A, 1-B, 1-C. It gets specific enough to give people hints about what it is they should apply for but it doesn't say that one is going to be ahead of two or four is going to be ahead of eight. That is going to be something the council determines. It is sort of a preamble.

I think it is fine to put down your philisophy even if it is a historical statement.

DR. PAHL: We will do away with the priority sense and recast this whole section in a different way.

DR. ROTH: I would just like to speak strongly to

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to this and emphasize one thing that those of us who have been going through this presentation of grants have had drummed into us but it hasn't been mentioned here today: A program which would be totally inadequate and be worth nothing for funding in sophisticated Boston area may be extremely important in--

DR. DE BAKEY: Houston.

(Laughter.)

DR. ROTH: We have been hung up on this business of equating excellence and facilities and so on and so forth to needs. I think we always have to remember what is going to come up.

Many times in our emergency medical services we are told if need is a qualification one program may rate a four or a five plus whereas if resources and ability to effectuate a program, they are down at the zero level. We don't want to get hung up on these priorities.

DR. MARGULIES: I think as Herb indicated we can and I think these points have been extremely helpful. There is one aspect of the regulations that probably has a -- questionably has a higher priority in time than anyone else because we have so many programs hanging fire waiting to know what we are going to finally do and that has to do with the coordinator RAG grantee relationships.

Maybe you want to comment on it?

DR. MILLIKAN: Are we leaving this?

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DR. MARGULIES: No. Not if you want to continue with it.

DR. MILLIKAN: Even if you change it to goals missions, et cetera, I think there needs to be a great deal of attention paid to each of the items mentioned in the eight under A. For instance, look at Item 1. This is a complete change. I think you need to go over these things very carefully. Item 3 mentions metaphores. For improved knowledg and treatment. There is a real mix for you. On the one hand, you have an educational function, on the other hand you are right out there treating patients for funding. That is a real dandy.

DR. ROTH: Back up to 2, which says, prior early increases in reliability or accessibility and moderation of the costs. I am not sure but what an RMP function is not to moderate the cost but to determine what the costs may be and to find out what the problems in funding are.

To say that the RMP project has got to be directed at moderating costs is a perversion of the kind of research and development that RMP may be appropriately doing.

DR. MILLIKAN: In Item 5, this is where we came in this morning. Take a look at Item 5.

Here is the authority in our regulations for HMO.

DR. MARGULIES: That would disappear in any case.

DR. SCHREINER: It is interesting that Title 9,

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Diseases are mentioned.

DR. PAHL: Without belaboring the point, I think I am going to reiterate what Mr. Millikan has said and this is not to throw off responsibility but has been drafted by general counsel on the basis of their interpretation of what our documents and existing regulations policy guidelines criteria and so forth either say or imply.

To the extent that these words keep in either our documents are not sufficiently clear or the interpretation is too broad for our purposes but I do want to indicate again whatever revised language we come up with must go through the General Counsels Office because it winds up to be a legal document and these words mean more things to us also as staff than -- we don't have to do everything because it is stated in the regulations, but these are the interpretations which General Counsels Office has gotten out of our officially publicized program documents.

To that extent we have to work back and forth and eventually come to an agreement, but we take all of our statements very seriously.

DR. DE BAKEY: Where it gets important is when you get down to the money.

DR. PAHL: Of course.

DR. DE BAKEY: I hate to bring up this, but that is how things get done. The regulations can affect both the

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expenditure of the money and how the money is to be used. That is why this becomes completely important.

You see, if you go back to the Mission statement, you see, that was a kind of a policy guideline and indicating some changes. That doesn't have the kind of authority for spending money that the regulations would have. That is why this becomes so important and that is the point I was making about the rigidity which regulations once they are published in the Federal Register become the rigid guide they become on how you spend the money.

DR. PAHL: Well, I think speaking on behalf of the staff and all those who participated in this, we not only recognize but understand the statements, will recast this and will be again very appreciative of additional comments after we send you a revised version.

It is important and we are truly seeking council participation before we get to this point. Of course, even after council has approved and general counsel has approved to whatever the final wording is and it gets published in the Federal Register, there is still time for the public at large and yourself to take exceptions to statements.

We will have time after publication for time to review and come in.

DR. MARGULIES: Clark, you have more on that section?

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DR. MILLIKAN: Not at the moment.

MR. MILLIKEN: I have a question on this priority concept. The discussion here it seems to me we may be saying two different things. Some of the council may be saying let's wipe out the priority concept, you know, let's not go it. I hear staff saying, perhaps, council along with everyone else is stuck with a priority responsibility, but how this is worded is the fine difference.

DR. MARGULIES: If I get the sense of the council, what they are saying is that the establishment of priorities is something which must be determined by the council with recommendation to the secretary, obviously you cant leave him out, he is the person who has the authority to spend the money but this is something which we should feed in the language which indicates it is the responsibility of council to address priorities and to make those priorities well known to the the public and regional medical programs in conformity with the law.

That is a much more comfortable position to be in. So you may find if you go back over this Mission statement, I think you will find if you reread it that you would like to amend it now. It is a year old and it is subject to revision.

DR. PAHL: If we are finished with the discussion on the regulations, I would like to turn your attention to two

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documents in the manila folders at your desk because this should follow closely upon the present discussion. There should be a manila folder at your desk.

A separate manila folder and behind the --

The first statement is beyond two maybes of how to get to coffee and supper, is a statement called Governing Principles and Requirements Discretionary RMP Funding dated May 26. This is for information purposes for you and at this point has not be distributed beyond some of our own staff and to you. It is a statement which tries to set forth generally applicable principles and gives those specific conditions under which RMPs must obtain approval from headquarters staff for certain specific kinds of rebudgeting in their programs.

This is not the development of new policy. It is trying to put into written form the principles which we have been following and I would call your attention primarily to the fact that we have made a separation between those RMPs which are within the three year triennial period and those which have not yet been approved for a triennial period, but that governing both of those kinds of RMPs are a set of four general principles given at the top of the page.

What we propose to do is have you look this over at your leisure and unless there are some severe changes which should be made, we propose to send this out and have this as an administrative policy. We would appreciate your

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comments now or in the next few days but it doesn't represent anything which has not been our operating guideline, I believe.

Dr. Roth?

DR. ROTH: May I ask a question?

The requirements -- prior RMPS approval is required in the following instances. Now, would you tell me what prior RMPS approval, what is the methodology of accomplishing this? What is that?

DR. PAHL: What really happens is that depending upon the nature of the inquiry it would be the correctors approval alone or would come to the council for example renovation in excess of 25,000 or any new construction. We would tend to use administrative judgment and if a request came in for $33,000 and was appropriated to what the council had intended and had approved through its discussion of the application, perhaps six months ago, then we might feel quite free to grant that authority in that specific instance or even though it were a small sum, if we had questions, then we would bring it back to council for consideration if it were of a policy nature.

We didn't know exactly how to spell out in detail just what the dividing line would be because most of these things you would not wish to have come to your attention.

In fact, they have not been large volumes of requests.

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Some of these are items, for example, B-1-D on the end stage treatment of kidney disease, as you know, is a matter which comes to review committee and council. What we are merely saying here in print is that the region may not embark upon such an activity without first going through the regular processes which you have participated in and will participate in again today. But in general it is a matter of -- the way it is written it is a matter for administrative discretion by the director.

DR. MARGULIES: This is sort of a mild level, Russ, which you may want to question. I don't think there should be any confusion about it. In deciding at what point of RMP can take action on its own, at what point it should be referred to RMPS and at what point RMPS, meaning the director, should bring it to the council.

In earlier discussions you felt there should be some discretion exercised by us in bringing subjects of concern to you and we have tried to spell it out. You may have some questions or some misgivings about it which I would feel very comfortable hearing expressed.

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Take 11

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DR. ROTH: I just get hung up when I take my first fast look at it and see you need prior RMPS approval for anything involving, 1B, human subjects.

To me that is people.

MRS. WYCKOFF: Yes. What is "human subjects"?

DR. PAHL: This is an impossibly difficult area, as you know.

There is a whole departmental operation and regulation for those kinds of federally supported projects which really involve human subjects for experimentation.

What we have basically done here is recognize in print that there is a departmental policy and NIH, of course, has the most elaborate review mechanism for this kind of activity and we are merely putting in print for the first time that there is this departmental regulation, and if the request came in, which in the opinion of our staff required departmental approval, then we would invoke the necessary and established mechanisms for providing that review, namely, through the NIH, and an official letter of approval back.

If the nature of the activity being requested was such that it did not have to invoke such an activity, we would merely say over the phone,and send a confirming letter, no approval is required, proceed.

This is really providing a guarantee to the applicant

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that he won't get in trouble later with a departmental regulation.

As you know, it is very difficult in the area of human experimentation to draw the line. It involves such things as questionnaires and the social and behaviorial sicences.

It is not just a medical experimentation.

DR. SCHREINER: The word "experimentation" is not mentioned.

MRS. WYCKOFF: What is this immunization?

MRS. MARS: Why not spell it out more clearly?

DR. PAHL: That is the problem.

It is not that easy to spell it out clearly.

DR. MARGULIES: It may not be experimentation. It may be an invasion of privacy.

DR. PAHL: Sending a questionnaire under certain circumstances is an invasion of privacy.

To spell out "invasion of privacy" would require a tome.

What we are doing is alerting. This is not a regulation. It is an administrative guideline and we are alerting applicants, if they are involving human subjects, they have the responsibility to bring that to our attention and we can decide whether it is within the scope of the departmental requirements or not.

DR. DE BAKEY: I think things like that are best treated vaguely.

DR. PAHL: It is an extremely complex area.

DR. MARGULIES: If you were to set up two activities and compare the results on health outcome over a period of three years withone group getting what you think is good treatment and the other group getting the control, you run into some problems. You can't just pass that off.

Maybe it is an experiment, maybe you should say leave that group the way it is,that is not an experiment. This is the time we need to bring it back in for Federal review.

There have been rules written to cover that.

DR. PAHL: There is a body of regulations covering that area.

We don't propose to duplicate it.

This is for your information only, but if there are comments in the next few days, we would appreciate having them

Otherwise, we will have this as an issued document.

The second document is one I do wish to call to your attention very seriously.

It is the RMPS policy concerning grantee and regional advisory group responsibilities and relationship, also dated May 26.

There is a covering memorandum of May 26 on that

document.

Mr. Margulies referred to this earlier and the reason we want to call to your attention this document is that again this would not be a regulation, it would be an elaboration of what that paragraph in the proposed regulations intends to say and what it proposes to do is spell out for the first time in the history of the program what headquarters and council, because we seek your endorsement of this, what headquarters and council feel to be the proper relationship between the grantee and the regional advisory group.

As you know and as will become more clear in the course of the meeting, this time there are serious problems which arise because of lack of clear guidelines as to what the roles and relationship of the grantee, the coordinator and the regional advisory group are or are intended to be.

We have a number of problems now because of lack of understanding or lack of agreement as to what those applied understandings are.

This document makes it very clear that there are two legislativly established units in a regional medical program, namely, the regional medical group and the grantee.

Tradition, custom, history and practicality have established the coordinator or the director of the regional medical program as the third important unit in this local

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organizational framework but he is not mentioned in the legislation and in this document we have placed the responsibilities and role of the director or the coordinator under the title Chief Executive Officer and have that as a major subsection of the grantee because the coordinator is an employer of the grantee.

What this document therefore intends to do is to try to set forth as clearly and unambiguously as possible, and has gone through numerous drafts and has been approved at this stage by the HSMHA branch management policy office, so that unless otherwise changed, it has the approval of HSMHA and would be a HSMHA policy as well as an RMPS policy.

I want to call to your attention three things in this document.

The first is -- on the first page, under Section B, Grantee, the key statement.

The grantee organization is charged with the responsibility as follows:

The grantee organization shall manage the grant of the regional medical program in a manner which will implement the program established by the regional advisory group and in accordance with Federal regulations and policies.

This statement, together with supporting statements under the section titled "Regional Advisory Group" later in the document clearly sets forth the regional

advisory group as having the responsibility for establishing the program.

It is not the grantee, it is the regional advisory group.

That is a very important point which, took some degree of discussing as the document was being formulated and redone.

The second -- well, let me follow that up by saying on page three, under the regional advisory group, to make sure there is no misunderstanding, the overall responsibility of the regional advisory group is stated to be "The regional advisory group or RAG has the responsibility for setting the direction of the RMP and formulating program policies, objectives, and priorities."

Now, the second point which I wish to direct your attention to again is on page 1 under grantee and that is Item 3, first of all.

That is Section B3. The grantee shall select the chief executive officer, that is the coordinator, on the basis of regional advisory group nomination.

So even though the chief executive officer, the coordinator or director of the RMP, is the employee of the grantee organization, he can only be selected, he or she can only be selected by the grantee on the basis of nomination by the regional advisory group.

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DR. OCHSNER: Is that the way it is now?

DR. MARGULIES: It is and it isn't.

DR. PAHL: Nothing is uniform across 56 regional medical programs.

Any statement we write here is going to have three unhappy medical programs.

It is impossible to develop understandings after a program has been in operation five years and not affect somebody adversely.

It doesn't matter what words are written, there can't be happiness throughout 56 or 57 RMPs.

MRS. WYCKOFF: It isn't retroactive, is it?

DR. PAHL: No. And there will be implementation in a logical and phased way.

But what it is saying is that this is what we perceive to be the proper role and relationship of the coordinator to the grantee.

DR. MARGULIES: I think in further response to your question, in practice, certainly in the last two years, the grantee has not selected a coordinator without fairly heavy involvement with the regional advisory group.

That part, I don't think, is going to cause any particular difficulty.

I think the last point will come to haunt this council. It should be made clear here.

In all honesty, I think we better face up to it now.

I would like to call to your attention Section B2.

This has to do with the election of the chairman of the regional advisory group and if there is to be trouble in any of the regional medical programs as a result of this document, we believe it will be as a result of this particular section.

What this says is that the grantee will confirm -- and says subsequent selection of RAG chairman and the word "subsequent" refers to the fact when an RMP is first being established, then the applicant,who is usually the grantee, has to select the usual chairman.

After the RAG bylaws are developed and approved by RMPS, up until now it has been the practice, I believe, of the majority of the regional medical programs to have the selection made by the regional advisory group without any need for confirmation by the grantee.

It is our position, the few of us who have been instrumental in developing this statement, it is our position that the appropriate relationship, not what exists, but the appropriate relationship, and one which must exist for a truly effective and viable RMP, is one in which the regional advisory group chairman is confirmed by the grantee.

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We believe, as we conceptualize it, that in the region there is a grantee organization, a coordinator, and a regional advisory group.

Unless the relationships of all three are good working relstionships, then, in fact, there is a serious problem and over the last year and a quarter a number of these problems have come to your attention and to Dr. Margulies' continuing attention necessitating sometimes changes of grantee, but more often than not, changes of coordinator or RAG chairman.

What this document proposes to do is say what should be a functioning relationship in a triangular relation.

This means the coordinator is nominated by RAG but selected by the grantee, since it is the grantee's employee.

The RAG chairman is again selected by the regional advisory group, but confirmed by -- confirmed by the grantee organization, which means that at least there is an acceptable individual in a position of importance on the RAG, acceptable to the grantee.

We feel this is imporant and if this document, which has not been submitted to the regional medical programs as policy, if this does have your endorsement, there will be a few regional medical programs that will find it very uncomforatble.

We know that already.

If we don't have this, the regional medical programs will find it more satisfying and comfortable as a document but it won't lead to an improvement in the relationships which do exist.

We will continue to have, in our opinion, in my opinion, the same kinds of problems which have been coming to this council as a result of difficulties in this triangular arrangement we have, which we call a regional medical program.

With that, Dr. Cannon, if everyone is comfortable with it, and we hope they would be, we can have this endorsed.

We are trying to say to you there has been some problem from some RMPs, particularly with regard to this point.

DR. CANNON: I think there would be less problems than we had in the past.

DR. MARGULIES: Having a set of rules is more important than full pleasure in them.

I don't see any great problems in what we have said.

DR. CANNON: I move that we accept this.

MR. MILLIKEN: Second.

DR. MARGULIES: We have a motion and second that this be accepted.

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All in favor say aye.

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No answer.)

DR. PAHL: In recognition we are fast approaching lunch hour, let me say a few items are for your information only.

I don't think they require any particular discussion except that you may well be interested in the regional evaluation survey which was completed a while back and has to do with the present state of evaluation and of resources and activities in the regions, together with a document which points out how we plan to use our evaluation funds in fiscal '73 in very specific ways as well as a listing of contracts which are funded by us both in the kidney program and otherwise.

These documents -- we will be pleased to answer questions should you have one.

There is one last point of business which I think is important and that has to do with the kidney guidelines and I would ask Dr. Hinman to please present this point of business.

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DR. MARGULIES: We will ask Dr. Hinman to go over these kidney guidelines. We will adjourn for lunch. After lunch, we will proceed to some updating on the Cancer Construction Facility, and move from there to a review of the block actions on the supplementary awards for emergency medical systems, health maintenance systems, and for the education activities.

So you can sort of set your timing accordingly.

DR. HINMAN: Thank you.

On May 3rd, this document was mailed to all of you, the coordinators of the Review Committee. It incorporated the discussions which had been held with this discussion over the past two meetings, and discussions in the field over the last eight to ten months.

The prime emphasis had been to try to begin to move the kidney supported activities into the regional medical program activities at a local level, and yet still maintain a certain amount of program direction so there would not be overlapping and under-utilization of expensive facilities.

The emphasis here is upon the development of a regional plan for the treatment of resources for ~~in~~end stage, kidney patients, which must be approved by the RAG. And, then applications from individual RMPs or investigators must meet this regional plan. We have emphasized there would be a local technical review that would be performed by three experts in the

field who do not reside or work within the region submitting the application, and that they must be approved either from our list of consultants maintained here, or a curriculum vitae, sent to us for approval by the RMP; the written comments of these reviewers would be presented to the regional advisory group who would disapprove or approve the project and sent it into headquarters.

There would not be an additional review at the Washington level. It would be presented to the Review Committee for priorities concerning funding.

This was discussed after the last Review Committee Session. There was a question on one part of it which I will bring up in a moment. I am wondering if you all have any questions concerning any element in the document so far?

DR. MARGULIES: For the benefit of those who are now on the Council, let me say very quickly, that the dialysis and transplant program for kidney disease in RMP, has been operated on a different basis from the other activities.

Our intent, over the long period of time, is to establish on a kind of national network basis, a method of investing RMP funds that will lead to an orderly development of centers for dialysis and transplant, so that we do not scatter activities according to individual perceptions, but rather move toward location and development of competent centers, located in a geographically strategically way so that at the end of a

period of time, we get as close as possible to total access to a very predictable number of individuals who will require dialysis and transplant.

As a consequence, we need a separate set of guidelines which has been up for discussion from time to time. This is the final phase of that discussion. These were distributed. We have had no negative comment that I know of from the regional medical program, and there was, as will be indicated in a moment, some question raised by the Review Committee.

DR. DE BAKEY: One question I wnated to raise about it. I think it has confusion. In paragraph Six (b), it says, "Assure maximum utilization of full-time transplantation surgery." I think there is some confusion about what they mean by full-time.

DR. HINMAN: The intent was that this would not be a general surgeon doing it as a ten percent activity, but an actual surgeon devoting the full percent of his time to transplantation, not trans -- kidney transplantation, alone.

DR. DE BAKEY: it has been interpreted differently in different places. In our region, it has been interpreted two ways; Full-time in the sense of financial full-time, and in the second sense that he would not do nothing else. That, to me, you know, important to clarify because it has created a lot of difficulty within our own program for this reason.

I think, you know, you have no idea what words like

this will do when you get out in the periphery of where they can be interpreted differently and sometimes, they are interpreted differently because the people who are involved in the interpretations want to interpret them their way, you see?

DR. MARGULIES: This also -- you picked up a very critical point.

DR. DE BAKEY: I am always doing that.

(Laughter.)

DR. MARGULIES: It was very extensively deliberated because the question was centered around whether you can get an effective transplant activity going without a true basis of commitment for the surgeon and the surgical team involved and in some of the proposals we had, the attitude was, "Well, of course, you know some one can come along and do it," which we find highly unsatisfactory.

We are trying to make a clear-cut commitment and support to that commitment.

DR. DE BAKEY: I think that is desirable. I agree with you completely that there be in a sense a commitment to the program. But, this can be done in a number of different ways and different places. I am not at all sure -- I had been entirely happy myself with a patient -- as a patient with a man who is a full-time transplant surgeon.

DR. HINMAN: Dr. De Bakey, a question was raised as to whether a person spending 75 percent of his time, whether

this represented full-time. We interpreted this representing full-time.

DR. DE BAKEY: Yes. But you see, it is being interpreted differently. Thatis what I am saying. For example, we have in our own group, all of us are full-time, you know. We are regarded as full-time. That does not mean we give kidneys full-time or curettage full-time. We have had a team that is well integrated.

DR. MARGULIES: I think we can do better with it by referring it more to a full commitment, rather than full-time, which is really what we are after.

MRS. MARS: Could one say, fully-qualified?

DR. DE BAKEY: No. I think the intent is not the qualification because you can get that established. The intent is -- important, but it is not being interpreted that way. It is desirable to make this intent a commitment.

DR. HINMAN: Absolutely. We have one region that has a number of places calling themselves transplant centers in which the transplant is less than ten a year. We do not feel this is adequate to warrant our RMP support.

DR. DE BAKEY: I think it is important to encourage the expansion of the program. The need is greater than is being met so to speak.

DR. MARGULIES: I think we can send out a clarifying statement without changing the document which has already been

circulated.

I can do that and make the point that what we are after is some method of assuring there will be some one there who will devote enough time to it, to develop the team, the confidence, without depending upon the appearance of enough patients to make it possible which is another kind of approach. We can follow that.

MRS. WYCKOFF: Is Section 910 something we are using for any of these, yet?

DR. MARGULIES: We will be, yes. And we will be using 910 in this review cycle.

DR. HINMAN: If there are no other questions, I will share with you the concern of the Review Committee. During the discussions at the last Review Committee Meeting, the question was raised concerning our statement on page three, Item Two, the Second Paragraph in which we stated that should the RMP desire to choose its own Review Panel, the names and curriculum vita must be clear to the Division of Professional and Technical Development.

After considerable discussion, they made a motion that recommended to you all, that the wording be changed, and require that the local RMP only utilize consultants whose names are furnished by us, without them having an opportunity for input.

This, from my personal standpoint, the document has

only been out for one month and we have not had an opportunity to see if any problems will arise from this. So far, any of the RMPs that have been reviewing kidney proposals have called and asked for suggestions of names; we have given them at least one or two more than they have wanted, and they have been very comfortable with this arrangement.

DR. MARGULIES: The Review Committee felt very strongly about this. Their argument was if you are going to use outside consultants, and try to obtain objectivity, you have a much higher level of security by doing it by a national panel with the assignment or at least, the request for professional assignment coming from RMPs rather than from a panel from which the RMPs made their selections; and felt there was in the later sources, the source of some bias.

I do not think it would do any harm -- Len, do you have any further comment you would like to make?

DR. SCHERLIS: I think what you have stated fairly reflects the review. We felt there is no reason for having a kidney project than there is to allow a region to select its on-site visitors.

I think you should have some national standards and the best way to have them is by having a national panel and that automatically, when they stated that they had a real project, this should be looked at by a national panel.

I do not believe in having a panel selecting those

groups they wish to select.

DR. MARGULIES: That was really the axis on which the argument went on, George?

DR. SCHREINER: I think you should give them that flexibility. There are two problems with having a closed national panel. One is that it is true that it does guarantee a certain amount of standard quality, but it also is true that generally speaking, people who go in such panels, activities are -- have other attributes besides their competence.

One is they have the time available, and two, is that they are often selected on the basis of a certain kind of breadth that you might not find in all technical consultants. Whereas when you are putting together a program from scratch, you might want a technical competence that you are not going to find in the older, more established panelists, who are on the registry.

It seems to me that the RMP can utilze that. If they are going to have three regional renal authorities -- if the trouble is with the AV fistulas, that are breaking down, you might not want a renal guy. You might want a very good peripheral vascular surgeon. As long as they are subejct to some kind of a veto power, it seems to me that the document as it exists, gives this added flexibility.

I also think it would be bad to change things. We change them too often.

DR. MC PHEDRAN: Could you have the best of both worlds by adding a member that would be on everyone of the site-visit items?

Have a national group always represented in the site-visit team, plus special technical advice which was suggested by the particular program that was being sight-visited?

DR. SCHREINER: These really are not site-visits. These are site-visits. (indicating.)

DR. MC PHEDRAN: I am sorry.

DR. SCHREINER: The region is putting together a program and obviously, it is to its best interests to get the most expert people.

DR. MARGULIES: It is partly that, but it is also partly to see what they have put together.

DR. SCHERLIS: It is my interpretation the work will be done by the individuals selected. From there, as I listen to what you said, as I recall our discussion, the rest of the Review Committee would not be related to the technical aspect. This is not just relative.

It is when it comes in, it would have the stamp of approval on it, saying the technical review is excellent, but the people who did the technical review will have been selected by that group of individuals putting together their own program. This is a technical review?

DR. SCHREINER: When the region is visited, the site-

visitors will look at who did the technical review.

DR. MARGULIES: I think -- the thing is that it is a question of degree. We would restrict them to a group of consultants whom we have selected for that purpose. The real discussion is whether it is adequate to have them select from that restricted group, or whether we should assign from that restricted group.

The paper which has gone out already, has made that that they could select from that group.

MRS. MORGAN: This is a group you have selected prior to this.

DR. MARGULIES: Yes. That we have selected or that have been suggested to us. We have agreed they should be a part thereof.

Now, if you wish to change it in deference to the Review Committee's objectivities, we can do that. Or we can leave it as it stands, and see how it functions, and review it in the future to see if it needs to be altered. Either way.

DR. DE BAKEY: In the document here, you make it quite specific that the RMP's Review Committee will not review on a technical basis, the merit.

DR. MARGULIES: That is right. It is to be done by the consultants.

DR. DE BAKEY: So in a sense, you are putting the responsibility for the technical aspects on the consultants?

DR. MARGULIES: Yes.

DR. HINMAN: We do not do technical review of the RMP applications on a project by project basis anymore, except in the EMS round.

(Laughter.)

DR. MARGULIES: This is the one in which we wish explicitly build in technical review.

DR. DE BAKEY: Wait a minute, you do on your project visits. You have technical review on project site visits. I think there is a lot to be said for keeping it the way it is. I would be inclined to leave it the way it is in spite of the strong feeling of the Review Committee.

I think there are some good reasons for leaving it this way.

DR. MARGULIES: Any further discussion?

DR. DE BAKEY: Secondly, I do not see why there is such a big point made by the Review Committee.

DR. MARGULIES: Well, like with any other discussion, you sort of have to be there to get the feeling of it.

Would anyone like to make a motion on this?

Want to ponder it further?

DR. SCHREINER: You want a motion for approval of the guidelines? I would so move.

MRS. MORGAN: Second it.

DR. DE BAKEY: With clarification of the full-time

time business.

DR. SCHREINER: Right.

DR. MARGULIES: Moved and seconded, the guidelines be approved as they have been distributed with a letter of the clarification of the meaning of full-time surgeon.

All in favor, say "Aye."

(Chorus of Ayes.)

DR. MARGULIES: Opposed.

(No answer.)

DR. MARGULIES: We will reconvene at 1:16.

(Whereupon, at 12:35 p.m., the hearing was recessed, to reconvene at 1:16 p.m., this same day.)

nd #12

AFTERNOON SESSION

(1:35 p.m.)

DR. MARGULIES: You will recall that part of the unfinished business of the last meeting had to do with the action of the Council regarding the application for a construction grant for a cancer center in Seattle.

There was a motion by the Council which was passed to provide the grant award if certain conditions were met. As you know, this was a specific action which had been made by the Appropriations Committee in the preceding fiscal year, identifying $5 million for this purpose.

There were very careful reviews of the applications including the primary one which came from Seattle. There has been a series of events following that which Mr. Russell, who is the head of the western group of programs will summarize for you.

We have not awarded the grant and if it is to be awarded it must be awarded within this fiscal year because we had to make sure that all of the requirements were met and give the Council the opportunity to see whether or not they would accept the application in the modified form.

So, if you will bring us up to date?

I should add that the amount of work which has gone into this on the part of the staff has been extraordinary and it's been very carefully correlated.

We won't detail all of that. You can assume that's been the case and Dick will take over from there.

MR. RUSSELL: As most of you will remember, the award was contingent upon the applicant's meeting a number of specific conditions. There were four major conditions.

The first one was that all relevant federal, state and local requirements concerning expenditure of federal funds for the construction of the proposed type of facility -- this includes all needed licenses, permits, approval, et cetera -- be met.

The applicant has satisfied this condition.

The second condition was that the University of Washington and Swedish Hospital formalize their relationships with the Fred Hutchinson Cancer Research Center through written agreements.

There now exist formal affiliation agreements between the Fred Hutchinson Cancer Research Center, Incorporated and the Board of Trustees of the University of Washington and between the Center and the Swedish Hospital Medical Center.

The third condition was that all conditions contained in the Council's November 10, 1971 statement on cancer center to serve HEW 10 are satisfied.

In February, you remember Council received the report of the January site visit to the Fred Hutchinson Cancer Research Center and found that most of the conditions set forth in the

November statement of Council had been satisfied.

Those conditions which were not satisfied at that time were covered by the conditions placed on the awards.

The fourth condition was that the provision of space to accommodate 20 beds which would be isolated from the Swedish Hospital Medical Center be reconsidered with further justification for review and approval by the National Advisory Council, RMPS.

This condition stemmed from Council's concern that research patients in isolated units often receive inadequate general care. The placement of the beds in the Fred Hutchinson Cancer Research Center it seemed would separate the research patients from the general medical services that they would require.

Further it appeared that adequate emergency services might not be available to the research unit since there was no indication that the professional attention and facilities required for emergencies would be available immediately.

Now, you have before you the applicant's response to Council's concerns. This is the letter dated April 22nd, signed by Dr. Hutchinson, President and Director of the Fred Hutchinson Cancer Research Center, Dr. Lobe, Medical Director, Swedish Hospital Medical Center and Dr. Donald Thomas, Head of Medical Encology at the University of Washington.

This states the consideration of the bed has been

reconsidered and the plan to place the beds in the center was reaffirmed, the primary reason being if the beds were not placed in the center, the regional concept in the Northwest area would be seriously jeopardized.

What the letter does not say, but is a fact, is that if the beds were placed in any other facility except the center, one of the major institutions in Seattle which is heavily involved in cancer programming will not participate in the center.

Therefore, the entire regionalization concept will go down the drain.

The letter as you know states that the center will have complete medical staff ranging from house officers to fellows to a senior staff of 24-hour coverage seven days a week.

The beds in the center will not interfere with the excellence of treatment and care given to the patients. Since the center will be connected to Swedish Hospital by a short tunnel and elevator, the patients will be in immediate proximity to all hospital services.

The applicant believes that any emergency measures could be promptly instituted and the treatment facilities available will be closer than in many large hospitals.

In summary, then, the Fred Hutchinson Cancer Research Center has responded to all of the conditions placed on the award. Through administrative and previous Council review, it

has been determined that to date all forms of these conditions, the issue of the bed locations, have been satisfied.

Since this requires Council consideration, this is what we are placing before you now.

MRS. MARS: First of all, I would like to make a motion that the money be awarded with the condition that the fourth condition be taken out of the motion that was previously made. I think that the -- it's very necessary that the beds be in the research center. I think we would be doing them a great deal of harm and defeat the purpose of the entire center, for what it stands for, not only in regionalization, but it is going to stop teaching; it is going to stop research.

It becomes part of Swedish Hospital; the patients become under the supervision of Swedish Hospital and having met the people involved, the caliber of the type of individuals involved in the Fred Hutchinson Center, I just cannot see that there would be any question whatsoever as to the treatment and the type of care that would be rendered patients under their supervision.

So, therefore, I think that we are doing them a great injustice by insisting that these beds go into Swedish Hospital. I think the whole purpose would be defeated entirely and, as I say, a great injustice created.

I met these people; I talked to them. I think this letter explains - I think everything that is said in this letter

would be carried out and they could be completely trusted.

DR. MARGULIES: There is a motion to approve the grant award and accept the placement of the hospital beds as proposed by the applicant. Is there a second?

DR. DE BAKEY: I second.

DR. MARGULIES: Be moved and seconded. Further discussion?

DR. OCHSNER: I presume -- they say the Swedish Hospital will supply recovery room. Will that mean that the patient will remain in the recovery room in the Swedish Hospital?

MR. RUSSELL: I do not know, sir.

DR. OCHSNER: The supplying of the recovery room doesn't mean anything unless the patient remains there.

MRS. MARS: I think this is a fact. This would be carried forward.

DR. DE BAKEY: I don't see how they can possibly duplicate in the center a recovery room and intensive care unit.

MRS. MARS: I don't think there is any attempt made to do so.

MR. RUSSELL: Dr. Ochsner, I believe Mrs. Mars' observation is correct. Having looked at the schematic plans and not being an engineer, I can't say for sure, but I don't see plans for a patient recovery room.

DR. OCHSNER: I wondered whether they were going

to leave the patient there because they were so adamant about not leaving the patient there.

DR. SCHREINER: On this scheme where are the elevators?

MRS. MARS: There's a tunnel, you see, which goes underneath and this tunnel is very short. Actually, we walked the ground distance above and it's not very far.

DR. OCHSNER: Ninety feet.

DR. SCHREINER: I presume the building is somewhere inside.

MRS. MARS: I can't remember where the elevators would be.

DR. SCHREINER: It would make a difference if the elevator were at the other end of the building. Not that I would predict that hospital architects could be that stupid, except I haven't worked in one yet in which they haven't been.

MRS. MARS: I presume there will be some such errors made.

DR. MARGULIES: They have had extensive architectural consultation. They have not had legal consultation to the extent you heard this morning, George.

Any further discussion?

DR. DE BAKEY: How many beds in the center?

MRS. MARS: Twenty. And there is space, adequate space to increase that number at some future date.

The one thing that we fought them particularly on was the fact that so much space was relegated to parking areas. This in the end obviously was not necessary and that space can be utilized and at some point can be utilized for more beds if necessary as well as laboratories.

So that all this, every inch of ground will be utilized for the research center. As I said before, the caliber of people involved, there's just no question in my mind that care, proper care would not be instituted and carried out to the nth degree.

DR. DE BAKEY: To what extent will the University of Washington participate?

MRS. MARS: They will participate as far as teaching and their students coming over, supportive faculty. I believe part of their faculty will be involved in it. They would use it for their own teaching purpose.

DR. MARGULIES: I think all of the affiliation agreements, they are not only signed but I think there has been a real effort to work out the usual kinds of sticky details when you have research grants in one activity going on in another.

I think they are probably as far along as one can get before the building is completed.

DR. SCHREINER: I can see where we are under a lot of pressure here. I don't think we should gloss over it, no

matter how competent anybody is in the cancer field. That is a long way from a complete medical staff.

It's fine if you are not dealing with very sick patients, but if you need a pulmonary machine in a hurry and there are a couple of them across the street, it's going to pose real problems in the thought that you could have a totally competent emergency service serving 20 patients.

It means one of two things: Either they are not going to be complete or its going to be very expensive. You can't get around the logistics. You can't provide a complete medical staff for 20 people.

MRS. MARS: No. But the facilities are completely available within 90 feet so to speak.

DR. MARGULIES: If there is no further discussion, the motion is to approve the grant award with the conditions which you have established and which have been met, dropping out the requirement that the beds be moved out of the center.

All those in favor say aye.

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No answer.)

CR 6499
End #13

DR. MARGULIES: Thank you, Dick.

BEGIN EMS

CR-6499
#14
nb-1

We will now move to the consideration of the special actions which are going to be presented as bloc actions, one on emergency medical services, the other on health maintenance actions.

Len, do you want to come up to the front?

By way of introduction, these are carried out as supplementary reviews because we were, at the time of setting up the review processes, unsure of the total amount of funds which would be available to us in June. This is June and we remain unsure of the total funds which will be available to us. At least that part of it was correct. What we therefore decided to do was to provide regions the opportunity to respond to a special supplementary award concept.

We had in the course of doing it to set up some very specialized procedures. Obviously, the best thing to do would be to combine review committee and council membership to carry out these review processes and that we have done.

With the emergency medical systems, we asked Dr. Scherlis to act as chairman of a group which included Dr. Bessen and Mr. Toomey and Drs. Roth and McPhedran from the council. They did participate in that review. We also had some consultants in emergency medical systems to come in; Dimmick from Alabama, Kenrick from Ohio.

The subcommittee activity was headed by Dr. Rose whom you met earlier.

nb-2

The only other thing I want to say before Dr. Scherlis makes the presentation is that there are two activities in the emergency medical field which are undertaken at the present time. One of them is a contract activity which is managed out of the office of the administrator and which provides with a total of $8 million for five demonstration contracts to be carred out by those applicants who within the contract award in a national competition. That competition is under way at the present time.

The contracts submitted, the responses to proposal have all been in. They have been through review. Site visits have been conducted. We do not at this time know which of the applicants will receive the contract.

Now, because these contract requests came in at the same time as our emergency activities and this was deliberately planned, we have set up a mechanism for keeping a day by day information flow between the contract activity and RMPs activity so there is no possibility that we would be awarding to RMP funds which are also being awarded through contract. There won't be any duplication.

Back of this effort lies the desire which I feel rather strongly about to make sure that anything which is done in the emergency field through major demonstrations does not simply remain five interesting demonstrations as is so often the case.

nb-3

We hope that we can follow the earlier thrust of RMPs towards emergency medical services by setting the stage for a much better integration of emergency medical care than has been present in the past and by establishing an environment by anything which comes out of the major contract demonstrations will have meaning for fuller utilization across the country.

We have generally followed the same principles as the contract has followed in its review processes.

Len, if you would like to introduce what you have done.

DR. SCHERLIS: First I want to thank you for the opportunity of presenting the findings of our subcommittee. I particularly want to thank Dr. Roth who was here,because I had been impressed until I read the review in the American Medical Association Bulletin.

The committee was faced with what to me is one of most formidable tasks that a review committee can have and it would have been impossible without the help of staff.

I will allude to that in a moment. We had some 35 projects submitted from the various regions and some of these projects really existed have not just one but six individual projects. This itself said something to us as far as the review was concerned. Each region had received some very well detailed guidelines as far as what was hoped there actual application would include and it is interesting to note that

nb-4

some of them went right down the line and almost rephrased the grants, exactly what the application planning had indicated. Others indicating a high degree of independence paid no attention to what the guidelines were. Some were inbetween. Some of the applications really addressed themselves to the total system of care which is what the committee was basically interested in. Unlike the contract funds which in some instances look at specific aspects of emergency care, the applications we were most interested in really related to a total system which involves not an excellent project on trauma or one on coronary disease, but one which put all of these together.

This had to be part of our consideration because they are talking about a total system. One couldn't begin at this stage to front part of the system which was so highly categorical that it could not come to terms with what could be a total system of care. At the same time there had to be some realistic limitations in our consideration, not just because of the function constraint, which we don't know about because we are operating in a vacuum here as far as knowing what funds are available, but because of the constraint too that any system being proposed now might begin with a small bite of what can be done but yet it had to pay attention to the fact that whatever bite was now supported would be part of an overall planning process.

nb-5

The staff work that I have alluded to briefly, was an excellent one because what had been done was to go through all of these projects in some detail looking for actual page references in terms of the guidelines set out. The reviewers had six or seven programs for primary review and another six or seven for secondary review.

You know the thickness of these grants, particularly when there was a time limitation on the applicants, what was done was to give us three or four pages of material which were relevant and then everything else which was of background material.

The background material, as you know, becomes more and more extensive as the program becomes more and more limited. I for one ended up with many dry figures. The volume of the material was unbelievable.

The review meeting was an all day affair. We did not adjourn for lunch, we did not adjourn for coffee, just to give you an idea of the problems we had.

We reviewed the 35 projects in some detail trying to, as I indicated, trying to look at a total system of care to make sure that all of the community components were involved with plans, looking for demonstrations of needs.

It is simple to come up with a project that says finance 50 ambulances each one of which is a coronary care vehicle and to list all the hardware for -- telemetry and to

nb-6

go into a system of communication. But what we tried to find out was if this related to a system of care which got involved with existing emergency rooms, hospital facilities. In great measure the work of the Interagency Society -- ICHD -- these reports helped us particularly the one on the stratified system of care.

A lot of the emergency care in the area of heart disease relates to it. As I said that is not the categorical support.

The type of evaluation we had from the staff is a highly detailed report which we paid great attention to. At least it gave us a sense of what was included and what the rating was.

Dr. Rose is to be congratulated for the work his group did on this.

In total we reviewed 35 projects. The amount requested came to a total of $14 million for a grand total of three years of $33 million.

Five of them we gave recommendation of disapproval to: the remaining 30, the first year where 14 million had been requested, we recommended a funding for the amount of $5,788,000. For the second year, 3 1/ 302,000.

Some of the recommendations are in terms of taking what had been a large request, sometimes totally several million dollars and grading it down to what we requested that

nb-7

they were funded for planning. In some instances the plans were excellent. In terms of the involvement of community groups which would have to be Z part of the program, we felt this was a glaring enough omission that we would recommend no funding or minimal amount for planning.

There was a wide variation as far as the content of these proposals. In one or two instances, indeed a total system of care was set up involving training of the necessary medical and allied health groups, transportation which was on a broad base not just dedicated vehicles, emergency medical services, lay education, professional education, and a whole gamut of care involving trauma, heart disease, psychiatric care, and so on.

The others which were packaged for hardware, out of the blue, without there being any indication or support whatsoever. The levels of support vary markedly. We graded them as best we could, giving a priority grading, five being the highest. In natural fact only, a few fours were present. Some you will note were zeroes. In some instances the applications we received really weren't sent to us. I say that because it was apparent from dates and from letters of approval that they had been prepared in the past for other sources of funding and because some were duplicates of what had been sent for the contract funding and as such really didn't address themselves to systems of care, only looked at

nb-8

very small parts of the package.

The members of the committee here, Dr. Roth, Dr. McPhedran will vouch for the fact that if we had difficulties it was in terms of wading through what looked like systems of care until you got down to the fact that these had really a lack of wide community support, a lack of evidence of acceptability in the total community.

Some states which submitted two or four or six different applications weren't related. Thus a variation as far as levels of support which were suggested.

My own feeling is that emergency medical services is one of the very few opportunities which the regional medical program has of setting up cooperative ventures in systems of care and actually addressing RMP to the problem of stratification of care, reference centers for types of care, and putting the various individuals involved with emergency care into committee or planning group, probably involving what I think is a very important aspect of regional medical activity.

Thank you.

Dr. Roth, Dr. McPhedran?

End of #14

CR 6499
15
dh 1

DR. ROTH: I think that he has given an excellent summary of the dilemma or the problem that we had before us. It was perfectly obvious as I had occasion to say earlier this morning, that presented a problem that we have run into many times in RMP:

If need qualifies you, certain areas automatically get a top priority, and if resources meet those needs, you're in trouble. So we did the very best we could.

I think the council should be aware that when you look on this summary page, you almost don't have to look over the last two columns to see what happened. The programs that got rated five and four made out reasonably well in the financial dealings, recommendations.

The people with the threes and the two and a half and so on, have made out less well. But this is merely a reflection of the concensus of the resources those extremely poor in many of these places where the need is so tremendous to at least give them money to go on with further planning and try to get a show on the road.

It may be far more important than just its reflection in emergency medical services, because this may be the very first bit of honest to goodness impact of RMP in any respect in these areas.

DR. MC PHEDRAN: The only thing I have to add is that Dr. Scherlis prepared his own material and made intelligent

dh 2

comments. I move to accept his recommendations.

DR. ROTH: I second.

DR. MARGULIES: It has been moved and seconded that the recommendations of this special review committee be approved.

Let me say again that in this, as in other kinds of applications, we -- whether we know exactly the amount of money available or not is incidental. We do try to look at the quality of the proposal rather than the funds available and try to match the two together.

There are practical reasons for doing that, and quality reasons for doing that. They worked hard. It was an extraordinary exercise, and the comments have appreciation, I'm sure the staff endorsed totally.

Is there further discussion of this recommendation?

DR. ROTH: Only to give an order of magnitude to Dr. Scherlis' comment about the bulk of the material, since it arrived one day before I left on a 10 day trip around the country. I weighed it. Sixty pounds of it.

DR. MARGULIES: We had planned on your cancelling that trip.

(Laughter.)

DR. MARGULIES: Any further discussion?

DR. DE BAKEY: I would like to ask one question in regard to this program. It seems that as Dr. Roth said, this may have potentially great impact and I'm wondering if the

dh 3

council wouldn't do well to give some thought to assessing this in terms of its total priority of funding in this area?

DR. MARGULIES: I don't know if you all heard Dr. DeBakey. He was commenting and agreeing that the emergency medical area is one that is particularly appropriate for RMP, and rather than merely taking action on the motion, he wonders if it might not be appropriate for the council to comment on the kinds of priority it would give for funding on the assumption there may be competition for funds.

DR. ROTH: Well, it probably is important for the council to recognize, maybe everybody does, but for example, you will nothing that Florida which typifies, one problem was turned down completely, zero, disqualified. Not because it wasn't one of the best programs in the whole bunch, but because it had been previously fully funded through a formal RMP grant.

I just bring this up as evidence of the fact that this is not an exclusive program. This is using some money. We don't even know how much, really.

DR. MARGULIES: There are two complications for any kind of action you might take on the priority. One has to do with whatever we do between now and the end of the year, and the other has to do with the level of encouragement we give to programs either that meet our needs and could not be funded, or programs that need further development and refinement during the coming year.

dh 4

I received a note just now that the house has -- the committee actually of the -- subcommittee on appropriations has reported out a recommendation of $150 million in grants contracts, etc., for RMP's. At least we have one stage of the discussion under way.

I don't bring that in because it means anything specifically, but it calls to mind the fact we have another year coming up and priority considerations which the council is concerned with.

DR. DE BAKEY: I think it has appeal, too, in addition, so that I think it deserves considerable and serious consideration. Possibly encouragement of the whole as expected of the program.

I don't think this is being done well in most of the programs.

DR. KOMAROFF: How does our action effect the council approved level for a region and is there any flexibility for a region that gets this awarded to take any of that money and redirect it into other activities.

DR. MARGULIES: No. What we will have to do, when we are through with those special actions, is request of the council a motion to adjust the level of the RMP to acommodate whatever has been approved by supplementary grant.

But the exacty way in which these awards are going to be handled is -- we still have to negotiate because it

dh 5

depends in part on the language attached with any release of the 7.5 million and any language with the release of the remnant of the ~~MHD~~ HMD money.

If they say we can spend it but not raise the level of commitment, we may have to release funds for more than one year. If not, then we can work it out over a period of time. So if you take the action to allow the region to adjust its level, it can do any internal manipulation which it needs.

It does imply a raised level of commitment on paper.

Any further discussion? Does anyone want to take further action, or did you want to amend the motion?

DR. DE BAKEY: No. I really didn't mean it that way. I thought it was just wise that we take cognizance of the importance of this program, for one thing, and secondly, to -- as an -- express some kind of sense of power on it. I didn't want to get into the establishment, but rather than to express a sense -- in the sense that council wishes to express that, then if that is all I was intending to do.

DR. MARGULIES: Well, without going through the motion process, may I feel free in stating or in taking this as a sense of the council, this emergency medical activity is of high priority and should be given full consideration in any executive funding?

I see nods. All right.

If there is no further discussion, all in favor of

dh 6

the motion say aye.

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No answer.)

DR. MARGULIES: Thank you.

DR. MILLIKAN: I have a question. Somebody like Tristate now, two and a half million, what will the phasing be?

DR. MARGULIES: That's part of the problem. If OMB says you can use it, the money, but you can't raise the commitment level in the second and third year, we may have to devise a method of either scaling it down or doing what is effective forward funding of it to make sure it is made available.

That kind of acting process has not been selected yet. We are still trying to get it clear. We have a few days left.

DR. MILLIKAN: I'm also looking at it from their end of the line. If they get 2.5, what kind of continuity is going to be established at the other end? This is quite a change? How much will they need to continue, what's the second year level, third year level?

DR. MARGULIES: If we find that the potential level at stake is higher than they can reasonably expect to reach by rejuggling , we will not get them involved in that kind of spiral because there is that danger.

DR. SCHERLIS: That has to be a very carefully

dh 7

monitored program.

DR. MARGULIES: This is what we can determine when we know our total funds available and make some kind of guess, with luck, this month on what the level will be in the subsequent year. We are really walking a tight rope on this. The recommendations we need, the final action will be very complicated.

DR. DE BAKEY: Chances are it won't be less than one fifty?

DR. MARGULIES: I wouldn't think so.

DR. KOMAROFF: Could there also be a sense of council that any requests come through the formal process?

DR. MARGULIES: There is no question about that. They will. This number of us like, and there was no choice we had.

HMO APPLIC.

The next item for discussion will be the applications for health maintenance organizations which will be -- Dr. Mak Leod here?

Jerry, would you like to join us up at the front table? Mr. Riso is now with us.

We will go through the HMO applications, through the education applications, and then we will do our very best to get to those requests for action which depend upon the presence of individuals who are here only for this afternoon. We will try to keep things moving as effectively as possible.

For this portion of the presentation, in just a

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moment, I will turn it over to Dr. MakLeod. There are three members of the council who participated in the final review process of HMO applications. They are present here today.

Dr. Komaroff, Mr. Watkins, and Dr. Cannon.

DR. MAK LEOD: I want to thank you for the opportunity to present this part of the application process of the HMO service. As I indicated this morning, this was my intent for the day, and I'm glad to have the opportunity to go over it with you.

I thought it might helpful just to briefly review the -- where the HMOS is today and some of it has been mentioned earlier today. I think it would be helpful to summarize just for the record.

We have in reserve here a copy of the pink sheets that were prepared for the interprocess and they can be brought in if you wish. Rather than clutter up the process, we have them outside on a table. If you wish to have them brought forward, we would be happy to do so.

The ad hoc group does have copies of the pink sheets in front of them. They are the yellow colored books with the green binders.

Mr. Carfin, do you want to bring those books forward?

DR. ROTH: Would it be possible to have this deferred to the next council meeting? I'm not prepared for the stuff in books?

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DR. MAK LEOD: Let me just say what has happened to date is that the review process was intended, at the session last week, was to really -- actually review the review processes itself. Instead of having the ad hoc group and the other members of the financing project review group go over in detail all the applications. Let me explain briefly where the process starts, and where it is at the present moment within this particular sequel.

A request for applications for continuation support, no new support, of existing grant applicants to the HMO service were sent out during mid April and at that time, it was announced that the review process would be essentially decentralized to the regional health directors offices throughout the country.

The processes involves a review at the regional level involving the Social Security Administration, the Social Rehabilitation Service, and various programs within HSMHA. In some of the regions, there are special advisory counsels to the regional health director as in California, which is composed of the California Medical Hospital Association, the regional medical program in that area, the organized labor sits in on that committee, and other members of council summer groups are represented on that particular advisory committee.

It was our feeling that nod to have cross contact between the central office and the regional office that the -- that their should be a representative from the central group

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sitting in the regional review process. At the regional reviiew processes each of the applicants were asked to make a presentation approximately two hours in length before this composit group. We then turned it around and asked the -- for a central review that involved different programs within HSMHA, including the regional medical program, comprehensive health plan, plus regional representatives to come in and to provide continuity now from the regional level back to the central level.

The central review is more highly technical. I think it's fair to say the regional review reflects many of the local programs that exist and a regional action with respect to a deferral or a disapproval, would be considered by our standards as a mandatory action.

At the central level of actions, we would review those actions which have been approved regionally, and to the extent that we approved them, which was usually with conditions, the action would then be generated one further level. That level was to a -- what we have used in the past which was an outgrowth of a policy coordinating committee that was made up of the Social Security Administration, NIH, OEO, and to this group, we asked the ad hoc group from the regional medical program national advisory council to join in the discussion.

At that time we presented the -- generally the service to date with a -- the grant activity during the first sequel, the second sequel, and at the present time, and showed

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the trends that had taken place and the proposed -- the past expenditures and past all locations of money. The dialogue was active and vigorous and several proposals which made and incorporated into the award proposals which we are not presenting before this particular council for an even block action.

I would at this point in time perhaps turn it over to a representative of the ad hoc group to ask for their reactions and responses.

DR. CANNON: I would say that the review process was certainly adequate --

end 15

DR. MARGULIES: Could you use the microphone?

DR. CANNON: So far as the review process, as Dr. MakLeod has described to you, we thought the review process was certainly adequate, in some places too much, perhaps, being confusing.

There were several points which we discussed that council would be interested in.

We did rehash again the absence of any reference to an ongoing educational process which the council previously had stated in its minutes as being necessary if we were going to be charged with any responsibility of quality -- for assessment of quality.

Likewise, on some occasions, we found that there was inaccurate information on whether or not certain groups were officially signed up for HMOs.

But if you will turn to -- you don't have this --

(Laughter.)

DR. CANNON: If you have it, you would see that there is a diversity of groups applying in quite -- I can't find it myself.

(Laughter.)

DR. CANNON: In which the medical schools, about 9 percent, and the physicians groups and foundations, total about 30 to 42 percent and the hospitals about 10 percent and the consumer public, 20 percent, and insurance

companies and private, about 20 percent.

Now, if you put the physicians groups, medical schools, and hospitals into one category, you would see that they do have the potential of developing an educational component.

The last two, which consisted of about 40 percent of the consumer public, insurance company, and private, we did not see the evidence of it.

Now, I have no further comment.

I will pass it on.

I think Dr. MakLeod and the group did an excellent review.

Where the council stands in its involvement in HMO is the question and that will probably be discussed later.

DR. KOMAROFF: I think with regard to assuring quality of care standards, the one provision that we spoke about being sure to incorporate if it wasn't possible to have a formal linkage with a medical center was some evidence of a functioning peer review system within the HMO, union based HMO, so that there would be some device for assessing quality of peer.

Otherwise, any RMP involvement would be very difficult for this council to support.

Basically, I supported the council's awarding the

bloc support of the review procedure as it has been defined by HMOS and will support that later.

DR. MARGULIES: Dr. Watkins?

DR. WATKINS: We all agreed on the review process and I support this also, but Dr. MakLeod detailed the quality care especially based on the fact there will be internal and external audit and surveillance.

One of his staff explained the educational component in our opinion fairly satisfactorily.

We think this procedure should be approved.

DR. ROTH: I hate to be so ignorant about this thing, but I am still totally at sea in respect to statements made this morning that there was as yet no single RMP dollar involved in HMO funding and I believe that was a statement this morning.

We are now considering RMP involvement in what I now see is a second group -- third cycle, but, at any rate, the present cycle is to consider 37 of those whose fundings had run its course.

Now, are we talking about RMP money or aren't we?

I can't seem to find anybody that will give me that answer.

DR. MARGULIES: This is the first request for RMP grant money to go into the support of HMOs. There is at present no RMP money which is going into contracts.

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There is under consideration as a part of the $16.2 million some funding which will be used by the contract mechanism, not to support HMOs but to support collateral acitvities which will enhance the HMO development.

This will still leave a residual of approximately $7 million.

So what we are talking about is a first request to this council for grant support for HMOs for a total of $4.3 million, whatever the sum may be.

We are going to have approximately $5 million of RMP money for collateral contract activities in HMO and approximately $7 million remaining for general RMP activities of the 16.2 that we have been discussing.

DR. ROTH: And this is the first time this entire subject has been on this table before this council, is that correct?

DR. MARGULIES: That is right.

And the first time HMO funds have been requested of the council.

DR. ROTH: I rest my case.

DR. MARGULIES: We have talked about HMOs in previous meetings but not in such terms.

Jerry, would you like to comment?

MR. RISO: The HMO has three sources of funds. It is true that to date there has been no use of RMP money.

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That is not the first time the issue has been addressed because we identified earlier at the beginning of the year the three sources of funds for HMO funding and we have reached the point where involvement of the RMP funds and the RMP council, the RMP staff, is necessary.

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Our intentions have been clearly indicated, three kinds of ways, I might add.

It has been clearly enunciated from the start, all during the fiscal year, that our intentions were to fund the RHMO activity from three sources, RMP being one of them.

We identified our intentions in front of Congressman Rogers and his committee as to use of RMP funds for continued HMO activity, to continue further the work we had started with the -- some 110, not all of which would qualify, but the 110 grants made about a year ago.

We repeated our intentions on this subject before Senator Kennedy.

So there has never been in our minds, at least, any question as to the use of RMP money, never a question in our mind we would go the grant route and never any question in our mind we would follow the conventional council procedures in doing this and that is what brings us here today.

DR. DE BAKEY: Why didn't you?

As far as I am concerned, you haven't followed the Congressional procedures.

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This is the first chance I have received to hear anything about the grant applications, yet you ask me to come up and participate in a decision about the applications.

MR.RISO: We did have a subcommittee acting hopefully on behalf of this council to review the materials. That is the way we have always done.

We believe we were following a process we would follow in other kinds of activities previously.

DR. DE BAKEY: I want to challenge your statement about that. In the first place, you are taking for granted the same kind of procedure we have used on all others.

You made the decision that this was a part, that RMP could be interpreted as a means of supporting HMOs.

Congress didn't make it and this council didn't make it.

The council did go along with the idea of supporting one aspect of it, the educational aspect.

This is administrative decision, not a council decision.

You are now telling me you followed the same procedure when you haven't. This is the point I am trying to make.

This is a new subject matter for this council to consider completely in terms of its responsibility to advise regarding the disbursement of funds of regional medical

dw 7

programs.

That is the point I am trying to make and tried to make earlier today.

DR. MARGULIES: ... the council met, it was apprised of the fact that we intended to use the funds this way. It agreed that it would appoint -- would allow me to appoint a subcommittee which could act in your absence and the fact we did not do that was based upon the lack of need and the lack of timing for it.

But the council fully discussed it.

DR. DE BAKEY: I wasn't here when it did.

DR. MARGULIES: But it did. It met and acted and agreed to do that and appoint a subcommittee to do that.

DR. DE BAKEY: Maybe so. I didn't agree to do it. This is an interpretation.

DR. CANNON: I would like to say as a member of the subcommittee, when we were asked to come up here on short notice and speedy action, we were asked to approve the review process. That was our request and that is what we were told.

DR. MARGULIES: What we had expected would occur. As I indicated to you earlier this morning is that there would have been action in the spring, early spring, on HMO applications. There would not have been time for the council to meet again prior to that action, so in fact, what the council

did was to delegate final authority to a subcommittee.

It was not necessary for us to exercise that action because the review process for HMOs that we are considering now was delayed allowing us therefore the freedom to bring it back into full council.

If we taken literally the action of the council last time, we could have used that subcommittee to complete action.

We thought we shouldn't.

DR. CANNON: I think you are right about it.

I remember your delegating it, except the authority of the review committee is to review and comment on the review process, which we did, not on the question of whether or not funds from RMP should be used to establish HMO.

DR. MARGULIES: Quite right.

DR. CANNON: That wasn't the question put before the subcommittee.

I think that is -- now, this thing has been discussed in council for many, many months.

Vern Wilson discussed it with the council a long time ago. I think the final decision as to whether RMP funds would be put into HMOs -- I don't recall the minutes of the action.

DR. MARGULIES: You are absolutely right.

What we wanted was to bring to this council, council members' judgment on the validity of the review process.

DR. CANNON: You have got that.

DR. MARGULIES: Yes.

The question before the house now is whether this -- that this review is an appropriate basis for any action you can take and the collateral question then is does this council wish to utilize a portion of the funds set aside for the HMO activity with the understanding that it is a one-time grant award to continue the planning and development of HMOs.

There is no time excepting now to do it because this is the end of the fiscal year and that is the issue.

DR. CANNON: In other words, find nothing wrong with the review process.

The question before the council, the subcommittee having acted in their behalf, that there is nothing wrong with the review process.

The question now before the council is do you wish to devote the funds to this project or not.

MRS. WYCKOFF: Is RMP being used as a kind of pass-through for funds to HMO?

DR. DE BAKEY: This is one of the sources of funds, that is all.

MRS. WYCKOFF: It isn't RMP money, is it?

DR. DE BAKEY: It is partly RMP money.

MR. RISO: It was in fact earmarked at one point in time for use. When some 16.2 was released, it was released

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with the thought -- the report of the Senate indicates using 16.2 to "try out" the HMO concept. The issue, to be perfectly candid, you have two things:

One, you have it as a source of funds.

I think you have to face that as a fact.

Secondly, we feel it is a legitimate source of funds.

It is a necessary and important involvement for RMP in the HMO program.

MRS. WYCKOFF: Even though it is a one-time kind of thing?

end 16

MR. RISO: It is a one-time for '72.

DR. DE BAKEY: I challenge your statement about that too. You may think it is necessary for us to get involved in it, but that does not mean that we have --

DR. SCHREINER: Would you speak into the mike?

DR. DE BAKEY: He says he regards it as a -- what did you say?

MR. RISO: If you want to take issue with the term "appropriate"?

DR. DE BAKEY: I take issue with it because I do not think we have had a chance to discuss it in relation to the appropriateness of using it for this purpose.

One thing, I think it is important to define what you mean by HMOs and what they are going to do and ot what extent they are able to do something for the regional medical program which the regional medical program cannot do.

I do not think we have had a discussion of that at all. I am not convinced this advances the regional medical program. I made statements earlier that I had to admit we have not advanced the regional medical programs, particularly with the intent of Congress, and I have to say so, officially in a public record.

I think there is good reason and good evidence for it. You are now coming along with another program that you think does. What is the basis for your thinking of it? You

have not convinced me of that.

Your word is not enough for me.

MR. RISO: You raise two issues, Doctor. You raise the issue of lack of discussion. I find that difficult to accept, that there has not been discussion about our intent or --

DR. DE BAKEY: No. I raised the issue of lack of discussion in terms of the substance of the program, not in relation to whether or not we should be involved in it. That is the point I am making.

MR. RISO: I can only tell you about my involvement with this council. I suggest it has been minimal. I do not know what conferences you have had, to date, among yourselves.

DR. DE BAKEY: As far as I am concerned we have had no discussion of the substance of HMO programs in advancing -- As a matter of fact, we were supposed to have -- this is what I understood was the role of this delegation in determining the review processes.

Now, you are coming back to us now, and wanting us to approved funding. That is the point I am making. You can do it by contract, or you can do it with -- with or without my vote, but I am expressing my own feelings about that. That is what I am trying to make in terms of my responsibility.

DR. ROTH: I would like to say for Mr. Riso's benefit, because he was not here when it was said earlier this morning, that some of the important, extremely important

material in this whole issue has just come to us in the distributions that we got at home, and that we have here before us in the black book.

I would point out for example, the General Counsel Opinion, dated May 3rd,, which raises a very significant question, as far as I as a member of this advisory committee is concerned; that is the question was, do we have the legal authority to use RMP money and the legal counsel answer is to the extent that proposed HMO activities fall within the purposes of Section 910(c), we do.

Then, reading 910(c), the connection between HMOs and what is actually being done with the monies that have been given for HMO development and any of the words in 910(c) seems to me to be unrelated.

I think we ought to have a chance to discuss this in this council. That is all I am saying, is that it seems to me perfectly clear that the members of this council have not been sought, and that we sit here approving grants, having them unfunded because some of our monies, particularly because 910 money, are being diverted.

If this is the way it is to go, I think we should at least have a chance to express our opinion about it. It may prevail. Maybe that is the way the council wants to go. But, I think the council should have a chance to say so.

DR. MARGULIES: Russ, in fairness to the other

members of the council, this was discussed at the last meeting. I brought it to the attention of the council that the funds were going to be used for that purpose, that it would be done in such a way that it would direct those funds to HMO. I made the point that the council which it understood that the review would be by the HMO service, and that this was a method of getting activated, a program of health maintenance organizations which was considered of significance.

During that discussion, there were potentialities, particularly in the development of methods for monitoring the value of care for RMP growth, which were identified which were considered worthwhile.

It is always true in any council action, that some members are present and some are not. It is also true that any council action is subject to reconsideration. But the council then made -- passed an action in which they said, if it is necessary for these funds to be used for grant purposes prior to the next meeting of the council, we will delegate full authority to a subcommittee of the council to act in our behalf.

This was done with full understanding. It does not mean you have to stick with it but it did occur, and there was discussion.

DR. ROTH: I was present when a substantially different statement than that was adopted, and reprinted as an

Attachment F to the minutes. This was not the original statement and we had a lot of discussion about it in the council and we did not like the way the thing was originally proposed, and we came out with something that I think none of us really saw in writing.

My impression of what we did is almost reflected by this Attachment F, to the minutes where it says, the council shall discharge its -- by delegating to a subcommittee of the council actual authority to work with the Director of RMPs.

It was not my understanding they were authorized to approved grant applications and this was the first time that this was brought up before the council, which is what has led me to do a little bit of homework on where RMP grant money, I mean where HMO grant money has come from, which I reported to you this morning.

I think the council has been beautifully railroaded on this one.

DR. MARGULIES: I am sorry you think so, but in any case, the council is here to consider it. The grants have not been approved, they have not been awarded. We have come as closely as possible to what we thought you should do. In fact, there was so much attention to the wording at that time, that there was a group which met separately, reworked the wording of that action, brought it back into the council, and it was passed by the council after it was reworked.

But you are not bound by that. You are here to consider what action you want to take on this particular HMO Grant award.

DR. PAHL: Before we proceed, Tony, let me say, the conditions under which that Attachment F were developed, you may recall, were somewhat time-limited because individuals were leaving the council.

Staff developed that statement and as I recall, got two or three of you to look at it, most momentarily, before leaving the council room. So the fact that it appears in the cold light of day not to be what you thought you had read it to be, is quite possible and I think that if that is the case, and if it is not the sense of what you formerly thought you had approved, it would be most appropriate not to approve the minutes, but to make an amendment to that.

This is part of the problem of trying to get the business down with leaving, but also staff should have gotten this Attachment out to you, prior to your coming to the council meeting this morning. So. I think that should be a consideration of the council if the minutes are to be changed from what the action taken this morning was.

Tony?

DR. KOMARØFF: I did not put the period after RMPs, but to approve applications for HMO Grants. When you are called down to look at the review process, I have ambulant

feelings.

We were looking at the grants and we had to take secondhand, any assurances about the adequacy of the review process. I was assured and I would like to move that we have expressed our feeling about the way this was handled and the way council has been treated, but I would like to move block approval action in support of the HMO Grants as approved by other level review processes.

DR. MARGULIES: Moved.

Is there a second?

MR. WATKINS: Second.

DR. MARGULIES: Moved and seconded.

Further discussion?

DR. SCHREINER: Did you say something about forty percent of these not coming under the umbrella of quality control? I thought I heard something like that.

DR. CANNON: What I said, was that council in its minutes, not once, but several times, even to preparing a statement saying that if the -- if it became involved in HMOs, especially the quality of any health care program; that it would insist on an educational component in an effort to maintain quality, and that educational component should be funded not out of the costs of the medical care program.

I do not know where the minutes are, Harold, but I am sure somewhere we went through that, because they wanted to

assess quality in the program. When we met, we were not asked -- I did not understand we were asked to go any further then approving the review process, what it was, and making suggestions about the adequacy or inadequacy, and the review process was certainly adequate, but there were things that wer e left out; and one was the educational component.

This was discussed, and I have here, a report that I wrote -- that John wrote for me, as an addendum to what should have been the charge of any organization that wishes to start a HMO. Of those organizations which had applied for grnats already funded, there were those with a hospital, medical school, the foundation, the physicians' groups.

They easily could incorporate an educational component, continuing education or the process of training manpower. There were 40 percent or rather 38 percent, 18 and 20 of either insurance company or consumer-base sponsorship - which we did not see that that was assurance that there would be an educational component for -- to initiate at least on the front end, some quality control.

DR. DE BAKEY: I think it is one thing to approve a review process, but I think it is another thing to ask for the approval of funds to support a program, the nature of which in terms of its relation to the advancement or let us say, the achievement, accomplishment, of the regional medical programs' intent and goals, and objectives, is yet to be determined and

certainly it -- as far as I am concerned, there has been no convincing evidence to provide us with the conviction that this will further the regional national medical program, and yet, we are asked to approve monies on that basis, and on the basis, that the review process has been satisfactory.

Well, now, there is a lot of difference between a review process that is satisfactory or adequate, and a program that needs to be funded to advance the cause of the regional medical program.

I think in terms of the responsibility of this council for the approval of funds for these purposes, it should be provided with that evidence, not just with the evidence that the review proces is satisfactory, or that we should participate in the program.

That is the point I have been making all along that each one of us as a member of this council, has a definite responsibility, authorized by the law, to provide advice on funding of programs, that will advance the cause and intent of the law.

Now, here you come with a HMO organization, the exact nature of which is still not clear, and how it is to be operated or anything else, these are funds you want to support the development of. Now, just how that is going to advance the cause of this, and therefore, the monies by which we determine the approval of funds is not presented.

I know we have talked about it. I know all that you have said since early January. I know all of that. But, we are coming now down to voting on the funds. This is where I am, and this is why I cannot really, in a sense, participate in voting on a motion of this kind.

That is the only point I am making.

MR. WATKINS: Six months ago, I had the opinion that the council had held jealously, the educational component. When I was asked to come down for the review process, I assumed the input had been assumed already. This is the method by which we were going to allow the funds to be involved.

So we have six months of this discussion. Perhaps, I made a mistake and misunderstood the intent. I thought the intent of council was to have this input educationally, and funded so when we are asked to come down for the review procedure, we are coming down to let down now, how the review procedure was set up to fund. This was the final task.

End #17

I got this over the last six months.

DR. ROTH: I would like to second what Dr. DeBakey has said and make it clear if there is any misunderstanding, that I think it would be a disaster, I think it would really be flushing money down the drain if we carried 114 developmental experimental projects up to this point and then refused to fund them, somehow or other, to see how they work, how they fly, what they show, and what we should learn from them.

My point is that to involve this council I think has not been well done, at least, as I interpret the reactions of the council members.

There seems to be a substantial difference of opinion between council and staff on how well they were clued in on these things.

I hope there will be ways and means. There must be ways of continuing the funding of these 114 demonstration projects until they are able to demonstrate something.

I don't want anybody to think we are against that.

I do think there is a very serious question of the appropriateness of the RMP money and certainly no question if it is divorced from the evaluative factors Dr. Cannon has talked about.

DR.MAK LEOD: I would like to address the issue, Dr. Cannon raised and Dr. Watkins, too, that is health education and continuing education, that it should be a part

of HMO activity.

One of the problems that we face to date is that we have not funded ongoing service organizations.

The criteria for that phase of HMO development have not been developed todate.

What we have funded has been the planning and the developmental aspects and out of this we have found any numbers of different ways that different organizations have proposed these kinds of activities.

We have used the coordinating committee concept with a project review work group and now added to this particular session with the groups from the national advisory group to develop the policy for HMOs and to incorporate those suggestions into funds that would be used for HMOs activities.

It would be our action and our recommendation that the proposal made by Dr. Cannon and drafted here would be included as part of the policy development within the HMO service for those applications that are -- those fugure applications which will be considered for obligational support.

DR. SCHREINER: This isn't the form of a motion. We have a motion on the floor.

DR. MARGULIES: No, no.

DR. SCHREINER: There are a variety of reasons why I might vote against the motion but I will single out only

one for discussion.

Regardless of confusion about prior comments at this council meeting and transmission of information and bits of news, et cetera, there has been one core item that I personally recall as having run through all our discussions and that core item was that if the RMP was going to be related distantly or closely to HMOs, it was going to be in the area of potentially furnishing and helping out with quality control.

I see a few nods.

There may be a little bit of memory about some of this having gone on around you.

Continuing that thesis, the idea of quality control got exemplified by the business of "educational component."

Quality control might be put in a number of different fashions, I presume. However, I just heard from our own review committee, regardless of what they thought they were reviewing, I have just heard that 38 percent of the items recommended for bloc action did not have that component in them.

I am going to have to vote against the motion.

DR. MARGULIES: Clark, the responsibility for developing effective methods for monitoring the quality of medical care in HMOs does remain in the regional medical program and there is little question in my mind that the RMP

is going to be the most vigorous arm in the monitoring of HMOs in the Federal service.

Regardless of the other features of the HMO activity,that represents an opportunity to develop techniques and to measure them and evaluate them for which we have no alternative.

Our thinking has been along those lines.

I would like to add one thing to this discussion, for whatever it is worth.

As you might infer from the conclusions, the development of the HMO activity has not been one of the most brilliant in bureaucratic history.

It began with the assumption of legislation which would have been passed about a year ago, with repeated assurances and, as I indicated to you this morning, if everybody had sat around waiting for the HMO to develop, suddenly had a bill passed and an appropriation at about this time of the year and nobody had done anything, the criticism would have been the same.

You have a group of people running the risk of mounting an activity to prepare for something which will take place, doing what they can, acting in what they consider the best interests of all, to develop momentum, staff, doing whatever is required to squeeze money here and there to get the job done, and this always does carry with it the likelihood

dw 5

of being caught with your drawers down.

Well, that is where we are. The fact is that we needed money from any source which was available to get this job done.

It was not the last time this will occur.

There are possibilities in the future that somebody else's money will be used for RMP.

If that occurs, I will bring it to your attention.

Where we are now, as I laid out to you fairly nakedly is in the need for money to get something done which has got to be done.

You are in a position of saying "aye" or "nay" to that idea here.

MRS. WYCKOFF: We said at the last minute that many of the RMOs are already involved. I assume we were funding it.

Secondly, it is quite clear that RMPs will have a role in development of HMOs as quality of care monitoring and health manpower.

This looks as though we were already in right up to our necks.

How were those funded?

DR. MARGULIES: These are RMP encouragement.

MRS. WHCKOFF: They were not being funded?

DR. MARGULIES: Not through a central source, no.

DR. MERRILL: I was looking at the same paragraph Mrs. Wyckoff was but I was thinking of some of the remarks of the previous sentences. There is a clear understanding that review would not follow the normal RMP pattern.

I gathered there was some question about that?

(Laughter.)

DR. MERRILL: I would also like to know how firm or how much substance we can attribute to the remarks of Dr. Wilson on page 2.

I ask this because if it is true that there has been considerable misunderstanding about whether or not HMO should be funded through the normal RMP mechanism, and this is indeed a one-year activity, then we have made a five million dollar misunderstanding which hopefully will not be repeated.

I think as Tony has suggested, it might be more damaging having set these things up and reviewed them not to fund them at this point if we can be assured that the problem will be very well clarified.

DR. DE BAKEY: As I understand it, that one year activity is based upon legislation that has not come about and certainly, from what I see in the Congress taking place right now -- may I get off the record?

(Discussion off the record.)

DR. ROTH: Is it fair to ask -- so far, no RMP money has gone into this in the '71-72 appropriations. Are

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we now being asked to take it all? Is it all going to come out or will there still be Section 1110 money from SRS?

If so, what is the breakdown?

DR. MARGULIES: We are asked to contribute at this round 4.3 for continuing planning and development.

Whether there is additional money which is going to be used during the rest of this fiscal year from other sources, I don't know.

Gordon, can you answer?

DR. MAK LEOD: This grant activity is with respect to the HMO service, is the only one that is going on at the present time. SRS is involved in extending some of the activity in their evaluative projects that are going on.

Part of the hundred and ten, but it is a limited program, limited funds.

MR. RISO: The HEW policy, I think I have to restate it again, because -- I think we are talking to one another, the policy is to fund -- the ones that have been funded, that we would undertake, until legislation is passed, whenever that would be, we would, one, fund no additional grantees and, two, we would not provide funds for direct service, and we would confine our activities to assisting those among the hundred and ten who were determined by an appropriate review that they had made significant progress and deserved to be carried further into the program development

stage.

This is what was intended to be done with the RMP monies right now.

Our plans for next year will be to work with those that have been funded.

We have not identified 1973 in the absence of legislation, anything like the earmarks that were established in '72.

In addition to which, even if we had intentions of additional funding, we have gone on record as estimating about the level of planning and development funds needed to carry forward a mature and appropriate applicant to the point when he should begin to open his doors and forget about the planning and development work.

We will have reached with many of these that point in levels of funding early in '73.

So we have two kinds of constraints on us:

One, the fact we don't have funds, that is a very real one.

The second constraint is that at some point in time, we will have exceeded what we think is a normal amount of money to spend for planning and development and it would be just a waste of time to continue funding planning and development activities of an organization that should have reached the point of either being viable or forgetting about it.

That is the two constraints I think we have.

MRS. MARS: What exact figure are we talking about?

MR. RISO: 4.3.

MRS. MARS: 4.3 is how much money in figures?

DR. MAK LEOD: It would be 29 of the 37 applications that were submitted and approved for funding. Eight of them were disapproved at this point in time.

So it would be among the 29 that the 4.3 million would be distributed.

DR. MARGULIES: We would probably illuminate the situation considerably by more discussion, but we do have some constraints on Warren Perry, who has to leave and he has a bloc group on the education activities.

If you feel you are ready to take a vote on the motion, we can do so but we can continue the discussion.

DR. SCHREINER: There is one philosophical thing and that is whether more is to be lost from leading somebody down the primrose path to nothingness or more is to be gained of sponsoring somebody to a salvage point.

I haven't heard anything from the review subcommittee or from anybody to indicate how they feel about these.

If you will look at these critically as a triage problem, what do you have to lose?

DR. KOMAROFF: A significant triage was done at the lower level. It was reduced by 40 percent. Only the most

viable made the grade.

Is that fair, Gordon?

DR. MAK LEOD: I think it certainly is fair.

The other thing that might be said in that regard is that some of the activities going on in parallel would be to assist these applicants to address themselves to the obtaining of money from private sources so there will be activity supplementing Federal support money.

MRS. MARS: Did we include a one-year limitation in the motion?

Could we hear the motion again that was made?

Did we include a one-year limitation of funding in the motion?

[redacted] I would be willing to do that and I ought to make that formal, that some assurance of quality of care plans, whether that means medical school linkage or not must be built into all of these.

I had assumed it would be since the guidlines the subcommittee was given -- it says on page 5, that the proposed quality care assurance must be a part of each of these applications.

We had assumed it was.

DR. DE BAKEY: I am going to say I find it a little difficult to understand the basis for our approval of the money.

We have a committee that is delegated the authority to participate in the review process, to determine the adequacy of the review and to be assured that there is going to be aquality control.

Now, I haven't yet heard whether or not in their opinion these grants will advance the course of the medical program.

This has been given to us ex cathedra, as far as I can tell.

I have yet to be convinced it can do that.

You should be able to say the plans include evidence that the objectives and the intent of the legislation for regional medical programs, for which this money was given, is going to be furthered by these plans and by the HMOs.

Up to there, I haven't been convinced of that.

This is the whole point I am making. You know, I expect ex cathedra, but not to the extent of voting these millions for this purpose. I haven't been given that evidence.

DR. CANNON: Let me say that you can't pass that over to the subcommittee because we weren't asked whether or not this would advance the goals of the regional medical programs.

Our charge was the adequacy of the review process. I was told by Harold a few minutes ago that the RMP staff,

RMPS, was the ones that were doing the review.

That is exactly what they did. We came here and started about 9:30 or 10:00 and left at 1:00. During that period of time, our first two hours were taken up in describing the review process and what they have been through, where they are from.

At the last, there was a spot check of certain grant applications and these spot checks, with a discussion of certain points, such as the educational component in which we disapproved grants that didn't have the educational component clearly set forth as an example.

My understanding, when I was called, rushed to come up here, and I did so at considerable inconvenience because apparently no one else on the council would come, they told me I was about the last one.

(Laughter.)

I am just kidding. You can't pass that responsibility on to a subcommittee, the decision you are asking.

The question is whether or not they made it in the past or whether they never made it and should make it today.

I personally feel -- and I think we are down to being personal -- my personal feeling is that I think the council should fund anything that has to do with the educational component that will maintain quality in any program that we are charged to be involved in but I don't think our funds should

be used for other than that charge.

I feel that that is our responsibility. We are -- concil is supposed to look from the viewpoint and maintain quality and transfer knowledge and all those things.

DR. DE BAKEY: Are you ready to say to the tune of, what is it, four million or so, you are doing that in this program and should fund the program for that purpose?

DR. CANNON: Would you say it in the michrophone so I might hear it?

(Laughter.)

DR. DE BAKEY: I thought you were a lip reader.

I said are you prepared to say on the basis of what you have seen so far that it is achieving that objective to the tune of four million dollars?

DR. CANNON: No, but that is not what I was asked to do.

DR. OCHSNER: The thing concerning me most about this is the fact Clark has already spoken about it.

Apparently there are 38 percent of these people and we have no assurance that they are going to have quality control. There might be every reason to believe they might not.

DR. MARGULIES: Y ou might compare that with the rest of the health care system. At least in the HMO you have the opportunity to try to do something about it. It is a little

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more difficult elsewhere.

I am more attracted to the idea of doing it in an HMO.

Mike?

DR. BRENNAN: My problem with this is that an invalid process has been generated and there is only one problem. Whereas we are now sure we have a process, but we don't have it aimed at a target.

The problem for me in spending -- seeing that we should spend RMP funds here is that I don't yet to this day have any clear notion of what the content of that term HMO is.

We had a council member who drew a cartoon for me of an HMO greeting the dawn, which I would be happy to disseminate at some future time.

He was a humorist. He had a sort of fantastic bird that looked like an extinct rock or something of that sort and I think that is what our real problem is.

If somebody were talking about a clinic, detection program, an educational scheme, we would all have a pretty good idea in our minds of what the terminoloty meant, but we don't have,with respect to HMO, have that content.

end 18

DR. MARGULIES: Russ?

DR. ROTH: One other thing I would like to get straight in my own mind, this committee has reviewed and I gathered from what Dr. Cannon has said, you have disapproved some grant applications, among those 114 that were approved -- you haven't approved them all automatically?

DR. CANNON: We didn't go through it like that. I tried to describe it. The review process had already gone through and written approval or disapproval, but we spot-checked certain ones for certain features to see how the review process went about getting the information to make such a decision.

In doing that we came up with a decisional change on a couple of the applications. That's in essence the service that this committee rendered.

DR. MAC LEOD: At the present time the -- we have funded during the first funding cycle which was in fiscal year '71, 39 grant applications.

Again, the second funding cycle in December of '71, involved another 46 applications. In addition to that there were 15 from SRS, six from SD's and four or five from generator type contracts, such things as the American Association of Medical Colleges, American Association of Medical Clinicians.

These were all part of the 110 that were used for the funding cycle up until the present time. When this particular cycle was announced, invitations -- these 110 were asked if they

wished to come in for continuation support. Of this group, 37 asked for continuation support and 29 -- all 37 were reviewed and 29 were approved in the process that was put before this composite group which I mentioned.

DR. BRENNAN: I would like to call for the question and then we can make another motion if we have to. I think we have discussed this until we are blue in the face.

DR. MARGULIES: As I understand it, the motion is to provide the grant funds for those HMO's for planning and development which have survived the review process with the understanding this is for one year only and there will be adequate input to maintain a good level of quality of care in the HMO's.

All those in favor, please raise your hands.

(Show of hands.)

DR. MARGULIES: Opposed?

(Show of hands.)

DR. MARGULIES: It carries.

I age greatly during these discussions.

If there is no further reason to discuss that motion, I would like to get on --

DR. PERRY: I think everyone needs a break. I'll take a later plane.

DR. MARGULIES: That's kind of you. I think a ten-minute break would be fine.

(Recess.)

DR. MARGULIES: Could we reconvene, please?

We had a request after the last vote, which I think is highly desirable, for a recording of the -- of those who voted for, those who abstained and those who voted against. I do think we need that for the record.

If I -- if we may, let's go around the table beginning with Mrs. Wyckoff.

MRS. WYCKOFF: I voted for. ✓

DR. MARGULIES: Sewell Milliken, for. ✓

MRS. MORGAN: For. ✓

DR. MARGULIES: For the recorder, give your name if you will and your vote.

MRS. MORGAN: For. ✓

MR. WATKINS: For. ✓

MR. MEYER: Against.

DR. ROTH: Against.

DR. BRENNAN: Against.

DR. MC PHEDRAN: For.

DR. MERRILL: For.

DR. CHASE: For.

DR. KOMAROFF: For.

DR. MILLIKAN: Against.

MR. HIROTO: For. ✓

DR. SCHREINER: Against.

10 for
4 against
1 abstention ✓

MRS. CURRY: I abstained but I would like to say against if I can change.

DR. MARGULIES: You can't.

MRS. CURRY: I abstained.

MRS. MARS: Against.

DR. DE BAKEY: Against.

DR. MARGULIES: Cannon's vote was against. The vote was nine to seven.

DR. MC PHEDRAN: Where are the abstentions?

DR. MARGULIES: One and seven shown.

DR. BRENNAN: Mr. Chairman, I think it's inappropriate for a Council member to abstain on a vote to spend $4 million.

DR. MARGULIES: It may be but that's what the vote was.

DR. BRENNAN: Then I would like to ask for another vote.

DR. DE BAKEY: I think you can move parliamentarily; you can make a motion about the vote.

DR. MARGULIES: I think you may do it if you want, Mike, but two of the people who voted are no longer here.

DR. BRENNAN: My opinion is on large expenditures like this everyone ougnt to be comfortable.

DR. MARGULIES: Do you want to make a motion?

DR. BRENNAN: I make a motion to the effect that the

Council vote without abstentions on this question.

DR. MARGULIES: Is there a second?

MRS. MARS: Second.

DR. DE BAKEY: Could we discuss that.

DR. MARGULIES: I am a little lost parliamentarily.

DR. DE BAKEY: I am not sure that ought to make the final decision about what we should do. I think what is much more important is a decision that the Council feels secure with, for one thing, and certainly is -- feels that in the sense of making the right decision.

I think it's important for us to recognize that this is a precedent-setting type of procedure we are engaged in here and I really think that it really required more deliberation and consideration than we have given it.

There was a great deal of discussion in terms of the appropriateness and so on but, take, for example, you see I feel very strongly personally that I am not really able to vote on this issue in a truly honest way in discharging my responsibility because I have never had presented to me the evidence that I think is needed. It may be available; it may be available.

Secondly, I -- we have used the procedure delegating authority or delegating in a sense our responsibility and I am perfectly willing to do that and I know this is the proper procedure and we have done it effectively on numerous

occasions.

Now, here, instead of really delegating our responsibility, we have delegated in a sense another type of responsibility which was not related to the expenditure of the funds. I am not really sure that the committee that -- let's say participated in this on the basis of our request was able in itself to determine whether the Council could be advised as to the appropriateness of spending this money for this program. They have provided no evidence to this extent at all.

This is why I think it was quite inappropriate for us in a sense to vote at this point. I voted against it not because I am against the program, because I don't know what the program is, and I am asked to vote on -- to provide money for a program that -- I really don't know the nature of in terms of responsibilities, let's say, we have for the regional program.

As I said before, it's all very well and good for the administration, let's say, to determine ex cathedra it does belong in this, but then in terms of the Council, the appropriateness of the Council's decision-making, this is not enough. It is certainly not enough for me to accept that and this is the reason I had to vote against it.

If I had the evidence before me or it was sent to me in some way so I can be persuaded that it is, I would vote for it. This is why I think that it's a mistake.

DR. MARGULIES: I certainly think the points you have made in the sense of discomfort which the Council has in taking action on something which has not been properly deliberated should be a prominent part of the record. There is no question about that and I think everyone is assenting to that.

There was no sense of comfort on anybody's part in voting aye or nay on this.

MRS. WYCKOFF: This is the price you pay for accepting earmarked funds.

DR. DE BAKEY: They weren't earmarked.

MRS. WYCKOFF: I thought they were. I thought the 16 million was earmarked.

DR. DE BAKEY: That's a very important point.

Congress earmarks money from time to time for specific purposes. This money has never been earmarked except by the administration. This is the point I am trying to make.

MRS. WYCKOFF: I thought it was earmarked and we were given the responsibility.

DR. MARGULIES: This is an administration decision on funds, not a congressional decision.

We have a motion which is to make the vote on this subject one in which abstentions are not allowed. We can vote on that if you would like.

DR. DE BAKEY: I would like to amend the motion. And

hat is I would like to amend the motion to move that we set side the vote that we have just passed in terms of the ecision and -- in order that we may have some evidence provided ach one of us to deliberate further this matter and then bring t to a vote.

If you want, set another meeting, quite all right. r make it a mail vote.

DR. BRENNAN: I am afraid, Mike, that is another otion. That's hardly an amendment. If you can defeat mine, ou can make yours if you want.

DR. DE BAKEY: It's a substitute motion.

DR. BRENNAN: That's a substitute motion.

DR. ROTH: I'll second that.

DR. DE BAKEY: The substitute motion?

DR. MARGULIES: It's been moved and seconded the ote be set aside and some other process be found for reaching conclusion.

DR. MILLIKAN: No.

DR. MARGULIES: There will either be another meeting or a mail vote.

DR. DE BAKEY: The motion includes the need to provide some material to each one of us relating to the HMO's and the program and how in a sense this does provide, let's say, an advancement of the program giving us the opportunity to make the interpretation as well because it is our

responsibility to vote the money. I want to be in a position to make this interpretation.

I am really asking that this vote be set aside and delayed until we have this opportunity to do this, whether it be done by mail or whether you want to call a special meeting for this purpose is all right with me.

DR. MC PHEDRAN: Not a special meeting.

DR. MARGULIES: I see no alternative to a special meeting.

DR. MC PHEDRAN: I just think when so many people have views that coincide on so many features about this that we split almost evenly on voting on this question, it must be because we don't have good grasp. The only way we can get at that is by going over the material, I would guess. I think that -- I just never have seen the Council get split like this before. It means that there is some real misunderstanding, real difficulty, and you probably ought to get at it by reviewing material.

So, that's why I would support it although I voted the other side of the question.

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End #19

(Discussion off the record.)

DR. BRENNAN: I would like to point out that it is my understanding that Social Security funding of this program is currently under Congressional investigation.

Secondly, that I believe that if we have had a motion or if it were possible for us to have voted to support the educational, the quality control, the interinstitutional and the prior relationship planning components which are our responsibility that I would have felt better. But I simply cannot understand the present circumstances which the Congress is clearly in doubt about the program, where previous funding for it is currently under investigation, I should hate to see our program put in any jeopardy by attachment to the spending of another four million something about which there is no Congressional unanimity particularly in view of the fact that one of the sections of our act calls upon us to be very chary about moving to radical changes in the health care system in this community.

DR. MARGULIES: If we are to change the motion which you presented, it will require the approval of the seconder of the motion which was -- Mrs. Mars.

MRS. MARS: Yes. For the first motion.

DR. MARGULIES: That has your approval?

MRS. MARS: Yes.

DR. MARGULIES: The motion is changed to one which sets aside the previous vote and which asks for further

motion withdrawn

information to demonstrate the way in which the grant funds would contribute to the purposes of RMP and which calls for a subsequent ballot on the same question either by mail or another meeting of the Council.

Any further discussion?

MR. HIROTO: What kind of timing is required for the continuity of the HMO program?

DR. MARGULIES: We would have to take action on this before the last ten days of this month.

MR. HIROTO: Could I say something off the record?

(Discussion off the record.)

DR. MARGULIES: Fred, do you have any comments to make?

MR. STONE: To tell you frankly, I don't know whether anything I would have to say would help or not. You obviously have a council here that is very disturbed on the basis of certain information they feel they should have, that they do not have.

This being true, it's inappropriate to expect the Council -- if this is true and I must accept it as true, it's inappropriate for the Council to take action under those conditions.

On the other hand, the Council it seems to me in its obvious effort to help the staff must upon the receipt of this information be prepared rapidly to accept a mail vote.

I think that the -- I know the staff has done all that the staff could be expected to do. These are matters which have been discussed and actions have been taken at a very high level for which the staff is not responsible; neither is the Council.

On the other hand, it's perfectly obvious that under the law that Council has certain responsibilities which the Council is attempting to discharge.

I think the Council, feeling as it does, has a right -- a responsibility to request the information it needs to come to a decision. It seems clear to me in listening to this as an outsider, because as you all know, I haven't been here very long, the Council is trying to find the basis on which to help the staff get out of this impasse.

I accept this as -- I myself accept this without any mental reservations as an attempt on the part of the Council to find a legitimate way to be as helpful as possible in this matter.

Now, is this a reasonable explanation of what the Council is trying to do? As you know, I came in in the middle of the discussion. Does this seem right?

DR. SCHREINER: I think that's a very, very concise and accurate summary. People are bothered and none wants to pull corks and watch them for the sake of seeing the water -- we are trying to get --

MR. STONE: I hope I didn't add to your problems.

DR. MARGULIES: I don't believe there is any room.

(Laughter.)

DR. DE BAKEY: Would it be better to try to have a meeting of the Council by the end of next week?

DR. MARGULIES: Dr. De Bakey raised the question of whether it would be more practical to have a special meeting by the end of next week. It's awfully difficult to get this many people together.

MRS. MARS: How quickly can you get material out to us?

DR. MARGULIES: Very quickly, but the risk of having a low attendance on such a critical issue frightens me.

DR. BRENNAN: Mr. Chairman, is there any administrative method open to the Director of HSMHA whereby he may within the allocations to HSMHA rebudget some of the funding on his authority? In other words -- one of my problems were this is not wanting to identify at this point because the thing seems to me to be so vague in outline and so loaded with many complications that I can't clearly foresee at the present time.

I'd rather not attach the Council to what is essentially a rebudgeting authority. If the administration were to do this, and explain itself to the Congress, in that regard, it wouldn't seem to me to be quite as harmful as it

would be if we were asked to do it.

DR. MARGULIES: I think that's an interesting suggestion. We should move on.

I think probably we should take a vote on the motion which I think you all understand now. I think we will have a show of hands.

All those in favor of the motion, please raise your hand.

(Show of hands.)

DR. MARGULIES: Opposed?

(No show of hands.)

DR. MARGULIES: The vote on this is unanimous.

MR. WATKINS: No.

DR. MARGULIES: Oh, I am sorry. One negative. The rest for.

This means we will get to you material which will attempt to relate the HMO activity to RMP purposes so that you can take a vote on the material which was presented to you by ballot and we will ask for a very quick response.

Keep us informed of your movements so that we can get in touch with you.

DR. MERRILL: Will you include specifically the working of that?

DR. MARGULIES: I doubt that we can get that. Are there specifics beyond the RMP purposes which you feel need to

be addressed?

DR. BRENNAN: In principle I would like to suggest that the funding taken from RMP should be funding in part of activities which plan for the necessary educational and quality control components for inter-institutional arrangements on the part of the HMO's and for the definition of relationships between a -- the providers and the HMO's and the means by which those providers might negotiate with the HMO's for the level of their orientation.

DR. DE BAKEY: I think that's fine except for one thing. That is that we then would have to have an assessment so to speak of the amount of the HMO that would go into that.

In other words, we would have to have -- we are asked in a sense to expend $4 million or something of the total. As I understand it, it is the total amount for these HMO grants.

DR. MARGULIES: I think it's impossible for us to deal with anything other than the substance of the motion which is presented which is that following this review process the grant will or will not be made for the support of the HMO's.

Your question is what does this have to do with our RMP. That's the question we will try to respond to.

DR. DE BAKEY: I would like to do a little of the interpreting myself, Harold. I don't want the interpretation given to me, handed to me. I feel that I have enough knowledge about, you know, the HMO criteria, having at least participated

in authority to know something about the framework structurally of regional medical programs.

I think I know the criteria of the characteristics of the regional medical program. What I don't know and that's what I want to interpret, are the criteria and characteristics of HMO in relation to what I will interpret are the regional medical programs. I don't want you to give me another ex cathedra opinion. That's the point I am trying to make.

DR. ROTH: That's sort of an impossible request. Lord knows which one of the laws if any of the present bills are going to be passed.

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End #20

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DR. MARGULIES: I think we can do it on the basis of what is being funded by the HMO service. That we can do and lay it out for you so you know what the money is going to go for. That's what we will do.

May we move on to the next agenda item?

As a part of our other activities for supplementary grant awards, we did address the potentiality which began earlier with the subject of area health education centers which as I told you this morning were ruled out for RMPS and moved from there to community-based educational activities which are of a different character.

In doing this, we have worked very closely with the Veterans Administration which has been interested in the same activity and have identified with them in the review process

those hospitals which have been site-visited by the VA and which they feel are an appropriate point for their support.

These have been identified in the review process for these educational activities which were carried out in a manner very similar to what we have described for the emergency medical systems.

What we did, in order to make sure that there would be an appropriate review process, is feed back to the regional medical programs a description of an activity which is more than anything else an enhancement and embellishment of what PMP's have been doing in general to bring together community resources to improve education of health professionals and the relationship of that education to the delivery of services.

Because again we were uncertain of our funding, the amount of that or the restrictions placed on it, we have carefully separated this out from anything which appeared to be the area health education center as currently defined and as originally defined and we are talking about something else which is a program that will be apparent as Dr. Perry reviews what has been done.

In order to carry out this activity, then, we did set up a special review committee which met a week ago Sunday; again we had to act more hurriedly than we like. It was not as difficult in this case as in many others because RMP's have been involved in this kind of activity almost from the very

beginning.

Nevertheless, it did rush events and in the future this will be part of the RMP process unless we get into a strange and bewildering committee.

Dr. Perry was the Chairman and he will summarize it for you Miss Kerr from the same group; Dr. Hess from the same group and Miss Anderson and Mr. Hilton both from the Review Committee; Mrs. Wyckoff attended representing the Council; Mr. Ogden had intended to but was unable to and we had also Dr. Popna, formerly coordinator of the RMP and formerly a member of this council.

The Review Committee was headed by Veronica Cronley on the part of the -- to prepare the materials and make them reviewable by this group.

It is that review process and the results that Dr. Perry will report to you.

DR. PERRY: My flight isn't until 7:45. I made the change. I hope we will be done in a very short time.

Certainly the review process as those of us experienced at Sun Valley felt -- that it was indeed probably the best review in the three or four years that we have been a part of RMP that we have seen.

As had been mentioned when looking at the emergency projects, the review from the staff and the assistance from the staff was really exemplary as this assistance was given to us.

We in turn made them a most integral part of our process. As Harold has said, our projects and our program was not something entirely new. Many of the programs indeed are involved -- many of the projects indeed are not new and have been the kinds of projects that RMP has known in the past.

As Harold said, we were looking at supplements in programs, looking at those projects that had responded in the past in many ways to these kinds of educational programs.

All of us know that much of this had been stimulated by the Carnegie Commission Report and certainly the acceptance by the RMP's at Saint Louis of the coordinators of their great interest in moving and looking at the manpower development and utilization in various ways.

Through a consortium that many of us know is in operation in our own regions and those of us who have been looking at grants are familiar with, the providers, educational institutions, clinical institutions, and indeed in this case quite a community input in relation to these is looking at the goals to be achieved.

Thus from the Saint Louis meeting in January to a point where in a short span of five or six months we did have before us a large number of grants from 17 -- I am sorry, 19 regions and over 75 projects had come in immediately on this area of community-based programs.

I think many of them, if we look at what did happen,

were greatly stimulated and indeed helped by the key concepts paper that is in your material. That final paper that came out of the Saint Louis meeting became a very important principle kind of thing. That was immediately built into many, many of the projects.

How was it possible to review such a number in one day? We started Saturday night with Harold and Dr. Paul and all the Review people that were there. Many of us were not out at Sun Valley just for the trip. It was RMP's third allied health conference and thus there were many coordinators and many people from the staff at that meeting at that time.

The integrity of the review process in that period of time I feel is a most important kind of thing to respond to here. If you look in your folder, the -- I think RMP has learned a great deal in the past few years --- the review criteria, the ways in which this was put together for this project, with three or four pages of review criteria, with recommendations from staff on these pages.

We had something to go at and look at together in relation to this. Plus people from the regions and such that were there with us.

For every project, every program we were reviewing we had people who had indeed been in that region and could respond to direct questions that we had.

So, these guides and criteria for review certainly

Dr. Hinman, Dr. Conley, the staff did a fantastic job. We all profited from it.

As an active part of the processes, I mentioned we did indeed include the staff up at the table with us, to get the totals here, and I want to refer to you four brief summaries to give you an idea of some of the kinds of projects we did look at here. From your totals you can note a total requested amount of $10,229,811, was requested in this total amount.

The recommended figure for this amount by the Review Committee, and we do have a change here that Mrs. Wyckoff who is quite an accountant found in relation to this. Intermountain is a 42,080 amount which changes the totals at the bottom to 882,060 and a grand total then of 6,800 -- $6,874,996.

In relation to this program, what about the disapprovals and the large number we did look at? What was missing? What were those areas that we considered were not at this period of time effective for funding?

Certainly many and some of the programs -- I should not say many but some of the programs we were still looking at a very traditional pattern of continuing education and trying to fit it in still in a continuing plan.

Although continuing education was an integral part of many of the programs, it was the only kind of program in

some of them that had been put together.

The community input, we looked at very carefully as we looked at the various groups that were a part of the consortium of the program that was involved here. We were looking at the needs of all of the health professionals involved in this program and particularly the leadership role of medicine as it related to some of the other health professions in these areas.

There were individual parts of a consortium missing. If there was community need in some cases, not the hospital input or the educational institution input. We looked very carefully at those pieces and parts of the total process.

We were very encouraged however at the excellent applications that were among the review processes at the same time.

Some of the consortia have already been in operation, have already developed their bylaws beyond the planning phases ready to implement.

These are the programs that were out there that have been a part of this kind of development during the past few years.

Let me read then just briefly, and I did ask the staff to give me a few summaries of some of the projects that have been approved so you can get a feel for the kinds of consortia and since you do not have available to you the large

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stack that we had.

Project number 110 from Los Angeles East. Their community-based manpower project proceeds from intensive work by the RMP in that area in the medically deprived areas of East Los Angeles. The LA East consortia which has just been incorporated has a 25 member body representing a consortia of 13 citizen consumers, three students, and three representatives each from the health professions involved in it with representatives from health care facilities, health training and educational institutions in that area.

The CBMP there would serve as an information clearinghouse, will coordinate and look at all existing training programs and will serve as a catalyst for the recruitment and training relative to that community and its health service needs.

It also hopes to act as a fund raiser for future activities of this kind.

Also in California, number 107, which impressed -- certainly some of these I am reading are indeed the kinds of projects many of us have been looking for, at times as we look at those programs that "why discover the wheel."

Some of these indeed have some very important kinds of things that have selected demonstration potential for other areas. This is great variety in the different

kinds of projects we have, but some are so well put together we can profit by looking at these.

San Fernando Valley, an already existing consortia in the San Fernando Valley will be expanded to a CBMP extending to several surrounding counties. The first year will be devoted primarily to the refinement of the administrative structure of the nonprofit coordinating governing body. High level of interest and commitment of all relevant educational health care institutions as well as the health practitioners and consumers will enable this new corporate body to serve as the primary vehicle for planning all health manpower training activities in their service area.

Long-range plans call for the development of long-range curricula in the California system. The plans, RMP community manpower project, is considered a most important model and certainly geared to that area.

A careful data base aimed at ascertaining needs and establishing priorities has already been accumulated for this project. The program is conceived as a truly cooperative effort of the health care resources and represents an integral arm of the RMP.

The range of cooperation extends from the RMP to consumers, health planning groups, to the university and community colleges, professional societies, public

schools, health care provider institutes, health care agencies, and the Veterans Administration, which is indeed a part of that project.

The ultimate goal of that program and the program projects is that of meeting the demands and need for health care needs of the region, a range of operational activity such as university-community coordination of health care programs, pediatric and nurse associate programs, evaluating home health team training programs, cooperative inter-institutional in service educational program and so forth.

Again, in this case, financial support of the program will come not only from the RMP, it will come from the VA, from participating institutions, the state, TB and Heart associations.

Unlike some of the programs, a unique effort here is that they are at this very moment identifying sources of continued financial support following the period of both the RMP and VA federal funding.

I could go on with South Dakota, with some of the other projects we did review. There were really some very strong programs that have come out in this review process. One area that you do not have on your listing there is a priority listing that has been done in addition to what you have. You have the total requested and you have a total amount. We were informed that in all likelihood, as Harold

mentioned this morning, the necessity of being unable to fund everything, that it would be extremely important to do a priority listing here.

Evolved from that listing are nine regions, and I will be very happy to read these off to you as priorities in this listing, if you wish to take your own page here under number five and check these off, I can list for you those that have been given priority attention by staff and by the committee.

Alabama project number 45; California project 104, 107, 110, Lake Erie's project 28 through G and J through N, Maine projects 27 through 37, New Jersey project 30, Northeast Ohio, project 15, Northlands project 68 through 74, South Dakota number 2 and Tristate number 19.

This amount and figure at this point is $5,218,795 at this point.

I think you know for the future as we look at this kind of programming, as we look at this kind of planning, as we look at the community-based projects here, there is certainly great future as one looks at RMP, as a part of looking in a shared way at some of the new systems developed by the relationship of many of the health professions working together, of the accessibility of health care that is showing up in quite a few of the projects from the standpoint of rural projects, projects in inner city and so forth. These

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are all, I believe, very indicative of some strong, strong input for the future.

end 21

If there is one area that we watched carefully, and one area that I believe RMP must indeed strengthen in every way in relation to those projects and look at cautiously, and that is the evaluation of out put of these projects for, indeed, if there are models here that are important, we must evaluate them and have this to share with others because the projects, as we saw them are indeed some of the strongest we have seen in this area. For the accessability of health care, some of the projects in some of the more rural states as they are looking in these areas, let's evaluate them, let's be certain that we have a good record of evaluation on whether or not it is coming out of these.

The subcommittee was delighted to have Harold and Dr. Pahl with us throughout the entire meeting, and he is especially happy to have Mrs. Wyckoff sponsored on behalf of the council. We were very pleased to have her with us.

MRS. WYCKOFF: Thank you.

DR. MARGULIES: Mrs. Wyckoff?

MRS. WYCKOFF: This was a very thrilling meeting in many ways. I had been on this council for some time. I never -- I want to compliment the staff on the wonderful preparation work they did in digging out the data that we needed. I feel it is very important for us to get off the ground with this new community-based program with projects that are good models so we will have something to point to with pride here and be an

inspiration to the rest of the program.

I would like to move approval of the report of Chairman of the Review Committee and also to recommend the priority list that he gave in case we have to use it.

DR. DE BAKEY: I would second the motion, but in some way I think it is important that we express our sentiments --

DR. COMAROFF: Can't hear you.

DR. DE BAKEY: I think it is important to express our sentiments. I think this is a very important program, and it is true that it may take a while to assess the full impact, but I have the feeling that as the -- as a programmatic activity, it can be extremely important in furthering the goals of the regional medical program, and so I would urge, insofar as it is possible to do so, that we avoid having to lean on the priority listing, and that we give this total program a very high priority.

DR. MARGULIES: Okay. Dr. Chase, would you like to comment any from the V.A. point of view?

DR. CHASE: Yes. This has been a very useful experience for us. On the many applications submitted on this first go around, there were four from the hospitals we identified to provide initial support. We -- from the applications, we identified again some difficulties which we will have to address ourselves to. Specifically, that in spite of the guide lines which have been provided and meetings held in the field in

Washington with these coordinators and the V.A. Hospital directors, we had some difficulty identifying the components within the application which were reletive to the V.A., so among those four, three of them we were able to provide on this first go around on the basis of only a small amount of money. That largely was in the realm of continuation of planning activity; in other words, an annualization of funds which we had already provided.

On the other hand, the main application got the message pretty clearly, and we were able, on an eighteen-month basis, to permit $317,000 of V.A. money to that application; the point being that now we will have to be back and work closely with these sites to help them, if you will, in terms of grantsmanship, so we have the documentation to use our legislative authority.

Counsel may be interested in knowing that we, too, are enthusiastic about this approach for the future, and we are again committing for the '74 budget year another three million dollars for our contribution.

DR. MARGULIES: I think this has been a very rewarding working relationship between two usually quite separate agencies, and it is getting stronger as we go along.

Any further comments?

MR. HIROTO: Yes. I am a member of this East L.A. task consortium. Should I excuse myself?

DR. MARGULIES: No. By taking block action we are avoiding the embarrassment of everyone but two leaving the room. We had to use those use those for illustration, but to get around that difficulty, we are asking for a block acceptance of a review process.

For the record, anyone who was involved with a region did leave the room during the review process. Mrs. Wyckoff was out during California, et cetera, et cetera. That part was kept unsullied

MRS. WYCKOFF: Can I make a motion?

DR. MARGULIES: You have made it, and it has been seconded.

Further discussion?

All in favor say aye.

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No answer.)

DR. MARGULIES: Thank you.

We have to take one other collateral action. Because of the action taken on the emergency medical systems which we feel is of high priority, we do need to get a motion from the council allowing us to readjust the level of commitment of the various regions so that they are appropriate to these actions. I would like to do that separate from another action on RMP levels which raises a slightly different issue.

DR. DE BAKEY: So move.

DR. MARGULIES: Is there a second?

MR. HIROTO: Second.

DR. MARGULIES: All in favor say aye.

(Chorus of ayes.)

DR. MARGULIES: Opposed?

(No answer.)

DR. MARGULIES: We also have another action on changing counsil action of approved medical programs, a list of which we have available somewhere. Partially, this is based upon the obligation we have by Congressional action in this case to maintain pulmonary pediatric centers at a level of the previous year. In order to do this, there are some regions which will need to have their commitment level evaded above where it is at the present time.

There are also so many regions which are so close or right at the level of the coucil approval that they do not really have any turning-around room and cannot develop any new activities. I will hand this list out to you, and while I am doing it I will read the --

DR. DE BAKEY: Would you clarify that just a bit?

DR. MARGULIES: I will go back over that. First, let me identify those in which there is a pediatric pulmonary issue, and then we will look at the two in which other action has to be

taken.

In Colorado, Wyoming, in metro D.C., in New Mexico region, and in South Carolina, if we are to support pulmonary pediatric centers and maintain our oevels of commitment at 1.7, there will have to be, as you see listed before you, a new annualized national advisory council level. Now, the other two have different justifications, and I would like either -- Bob do you want to speak to this or Judy, the actions on Florida or Tennessee, mid-south, which propose an elevated level?

DR. DE BAKEY: Let me ask one question in this regard. Congressional action was taken upon this. Was it within the current budgetary --

DR. MARGULIES: Yes, it was the action of the Appropriations Committee of the past year. We are getting to it later than I would have liked, Mike, because again we could not feel free to commit 1.7 without knowing we were going to get all the funds available. Now it appears we are close to it, and we think we should.

DR. CHAMPLISS: Specifically in the case of Florida a request is being made of council to increase their level in the amount of $321,000 to take care of the fact that in their previous application there was the amount of -- for $321,000 to cover emergency medical service activities so this is an effort to provide -- they were ahead of the whole movement here. This is an effort to provide them with a restoration of the amount that

they had already committed for that activity.

In the case of Tennessee/Mid-South, you will note that that they are right at the analyzed approved council level, and the additional funds in the amount of $263,000 would permit them to have expansion of their ongoing activities, and, therefore, request is being made to have that council -- that level approved by this council.

DR. DE BAKEY: Does that include pediatric pulmonary?

DR. MARGULIES: No, it does not.

DR. DE BAKEY: So they are really talking about two actions?

DR. MARGULIES: Yes. Well, if you want to take them together or if you want to separate them, you can.

DR. DE BAKEY: I just want to be clear.

DR. MARGULIES: There are one, two, three, four that involve pulmonary pediatric, and the others involve levels of RMP development which we feel is reasonable for the progress of the region.

DR. CHAMPLISS: The 321,000 -- specifically that is to cover additional program activities that they wanted to get underway. I am not specifically aware -- Judy?

MRS. SILSBY: This is a request to raise the level. It is not a request to give them the funds. All of these funds are allocated, and it is a matter of going in before their next application comes in. We would expect a full request to come in

to delineate what it is they want to do. Some of the regions got extended 15-16 months.

DR. MARGULIES: You see, when we extended the programs by several months, some of them were in a very uncomfortable position of wanting to initiate something new in the extended period, but not knowing what kind of continuing support they could plan on. So we had to give a reasonable level of assurance to keep things moving. All this does is give us the opportunity to respond to what is legitimate. It is not necessarily going to be assiciated with further plant support.

DR. SCHREINER: My credibility is strained by being able to predict wiggle room to the closeness of 13 dollars.

DR. MARGULIES: That's the left small toe.

This is obviously based on what they think they can develop over a period of time and gives us an opportunity to respond or not depending upon the availability of funds. You see what will happen, if the action of the House holds up or is higher than that, and we want to develop programs within an anticipated level of funding and they can't do anything for nine months to a year, we are strapped again into the mobility of a program.

DR. DE BAKEY: That's why I was going on creditability, really.

DR. MARGULIES: They have not applied for it but they are anticipating doing so.

DR. MILLIKAN: How do you decide who isn't going to have this.

DR. MARGULIES: We have gone through a process of renegotiation of budget with all of the programs that have had their fiscal year extended.

This is a by-product thereof.

DR. DE BAKEY: I would like to move block approval of this.

MRS. WYCKOFF: Second.

DR. MARGULIES: Moved and seconded. Any further discussion?

All in favor say aye.

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(Chorus of Ayes.)

DR. MARGULIES: Opposed.

(No answer.)

DR. PAHL: Mr. Komaroff?

DR. KOMAROFF: I guess I don't understand.

It seems to me we are approving a supplement without a request for supplementary funds.

Were these just prorated on the basis of the approved level?

DR. MARGULIES: No, they were not. All of the regions which were extended were given 12 months funding only and they had to renegotiate their funding for the 15 or 16 months, whatever is necessary and provide justification for that.

In the process some of them were able to justify higher levels, same levels, or lower levels. This is what finally came out of it.

DR. KOMAROFF: So in approving this supplement, they are not operating at a month three higher level?

DR. MARGULIES: They are still in the same range but this gives them a chance to do more.

DR. PAHL: Recognizing that it's somewhat late and we don't have too much time to delve into specific applications, we will have to take up at least two today because the principal reviewers will not be here tomorrow.

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So with your indulgence at the end of a somewhat lengthy afternoon of discussion, I would appreciate it if we could discuss the Northeast Ohio application.

That is in the red covered ring binder and we have Dr. Millikan as the principal reviewer. Dr. Schreiner is the back up reviewer and Mr. Ashbee, staff and Mr. Milliken -- the record will show Mr. Milliken has absented himself from the room.

Before we have a discussion of the application, I should like to say that you will notice, those of you who have been looking at staff materials and council books for some time will notice new color sheets and new formats and as Dr. Margulies indicated this is an attempt to have somewhat greater uniformity and reduction in paper work.

The important thing for the council to know is that the blue sheets in each of these sections are the summaries of the review committee's consideration relative to that application.

MRS. MARS: You said we were going to take up two. You just said Ohio. Who was the second?

DR. PAHL: Ohio itself. Northeast is first, and then Ohio will be the second application this afternoon.

Mr. Baum has also asked me to indicate that we will be passing out for your consideration if you need them, the computer print-outs, a compilation of all of these.

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Those of you who were principal or back up reviewers did already receive the print-outs he will be distributing. These are just for reference sake at the table.

While I am on that topic, Mr. ~~Lekniasco(?)~~ Schmiewski, who is chief of our office would appreciate any kind of -- Frank, you should indicate they are not compelled to read these at this point in time or you will have a rebellion.

He would appreciate receiving comments from you as was indicated by his letter relative to how these print-outs may be made more helpful in your consideration.

We will be ready in a moment. I am afraid taking up the applications out of order. We have caught Dr. Millikan somewhat unaware here and he has to get his materials in order.

DR. PAHL: Is Dr. Millikan not here? We got too far along. We are not going to have him.

I thought he was looking for his material.

Dr. Schreiner, I think the ball has fallen into your court. Would you please discuss Northeast Ohio application?

DR. SCHREINER: Is he not coming back?

DR. PAHL: It appears Dr. Millikan will not be returning. It's just that our HMO discussion lasted longer than the plane departure time.

We will turn to Dr. Schreiner comments for Northeast Ohio.

DR. SCHREINER: I am afraid I can't give as much

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detail as I would do if I were primary reviewer.

The Northeast Ohio region embraces about 12 counties in, as you might imagine from the name, the northeast portion of the state of Ohio and represents what is left over after the council's coalition efforts of the past year and centers primarily around Cleveland and the university contained therein: Case Western University which has a medical and dental school and there are a number of nursing schools and allied health schools in the area.

Principally rather heavy in medical technology and in radiation and so forth. There are, for example, 60 schools of medical technology -- I thought in reviewing the materials that the review --

DR. PAHL: Would you use the microphone, please, so our recorder can hear you?

DR. SCHREINER: I thought that the site visit data gave a pretty reasonable insight into the operation in the area and that one is really faced philosophically with two kinds of judgment and that is one could put a great deal of pressure on the group to join the Ohio area which I think most of the site visitors felt eventually should be the evolution of this particular RMP and that there are various ways of accomplishing that.

One would be to disapprove it totally and wipe them out.

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The other would be to continue them for a year of support and that attention be given to a new deputy coordinator.

I am at a disadvantage not having been on a site visit. Is anyone here who was on a site visit?

MR. ASHBEE: I was on the site visit.

The report that Dr. Millikan gave at the last council -- was a copy of that in with the materials that you had --

DR. SCHREINER: No.

MR. ASHBEE: Let me read. First is recommendation on Northeast Ohio.

He said it appears the impact of Dr. Hudson's leadership or intimidation of some personnel in Northeast Ohio changing the position of the Northeast Ohio Regional Medical Program will be one of simply refusing to cooperate or relate to or combat any of the regional programs since the Northeast Ohio Regional Medical Program has a full time coordinator. It would appear wise to fund this program at its current level on a year to year basis, possibly having an in depth project site visit during the next few months.

Under the present circumstances, it is recommended that a triangular review is not appropriate at this time.

He went on to say that activities to combine the northeast with Ohio State should be carried forward.

DR. SCHREINER: My own superficial view was that

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$600,000 is quite a bit for continuation of something that we are a little bit uncertain about, but I expect the site visitors who were on the scene and I think about all you can say is that you have a new program director, you have a RMP that hasn't moved in the direction that the council would like to have it move in, and essentially you are treading water and what's the price for treading water. If everyone thinks that's a reasonable price for treading water, I would be in favor of it.

DR. PAHL: Mrs. Silsbee informed me that Dr. Millikan prior to his departure accepted and was in accord with the recommendations of the review committee which would support then your statement, Dr. Schreiner. Would you care to make a motion or further comments?

DR. MARGULIES: Bob, do you want to comment?

DR. CHAMPLISS: I think the council should know that this is a region on very high priority for assistance. We realize the inherent problems there from a staff point of view and we have rescheduled our technical assistance and management assessment visits to that region so as to take them out of phase. We anticipate that the management assessment team and the site visit will be made next month.

We think this is a region that needs a great amount of help and that is already being put on our schedule.

DR. PAHL: Dr. Schreiner, would you care to make a motion?

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DR. SCHREINER: I move approval at the recommended level.

MRS. MORGAN: Second.

DR. MARGULIES: Motion made and seconded to accept the recommendations of the review committee.

Further discussion?

MRS. MARS: What is the hope of merging it in the very near future with the rest of Ohio? What prospects are there?

DR. MARGULIES: I think they are very vague at the present time, Mrs. Mars.

The -- part of it depends upon the strength that emerges from the Ohio merger which appears guardedly promising but they are at the point now of trying to decide what they really should be.

I think the existence of some outside people in Ohio like Dr. Cashman, who is the State Director of Health there, is going to be a very useful force.

They are talking with one another in much more regular terms than they were in the past and we in turn are going to encourage them to talk together more in the future.

I could not hold out any promise for anything more than an effort to move in this direction. It's still very uncertain. It's too bad, really, because the resources in Cleveland are tremendous for developing a good program.

If they can get over some of the personality blocks, I think they may find that coming together will be good for them in the long run. It's still very, very uncertain so far as the total merger is concerned.

DR. BRENNAN: I think in that regard our experience over the years has been that these programs are really grass roots programs if they have any health to them at all, and we --

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every time we try to doctor them too much, bring them around to what we think they ought to be before they have an idea of themselves, that we generally end up with a long period of disruption and discouragement and no activity.

If it's valid to have programs that are founded on those issues, I think you have to leave room for a great deal of patience with respect to how they are going to come along.

It just seems that this thing has been going on so long in Ohio that we might have to say to ourselves, "Well, Ohio is peculiar and let it find its own way to the water fountain because we have been trying to hold it up and make it drink and haven't been able to do so for a long time."

DR. PAHL: Further discussion.

MRS. WYCKOFF: Maybe the community based education program there will have an effect.

DR. PAHL: The motion has been made to accept the review committee's findings.

All in favor of the motion, please say aye.

(Chorus of Ayes.)

DR. PAHL: Opposed. (No answer.)

DR. PAHL: Motion carried.

DR. PAHL: Dr. Schreiner, we are going to have to call on you to start the discussion on Ohio. Mr. Jewell will be here as our staff representative.

DR. SCHREINER: I think those of you who have not

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read the report will be interested in the sentence a site visit was not performed. A great many of us had difficulty in considering this application.

That does not make my task easier. This has to do with support for the remainder of Ohio which depending whether you live in Cleveland or not is the merged or the unmerged portion. It contains a number of proposals.

First, let me address the areas in which I do have some insight and that is the two renal transplant programs which were rejected and I think quite rightly so.

The organ procurement effort does not have anything in the way of very specific -- for example, it says that a patient is placed in a waiting pool and tied up with various registries.

You don't just do that with a piece of string. There is a specific way and it's very, very difficult actually to get plugged into the registry.

There is no functional or national registry that actually needs the exchange of kidneys and some of the regional programs, the most formal one is in the mid-Atlantic area and there are a few others that are informal arrangements.

I think we have to have specifics so we know where is the terminal and who runs the computer and how do the matches get made. Who calls up whom after you make the match and so forth.

jr 4

This isn't something you do by committee or get a letter in the mail three days later that they had a kidney last week.

It has to be something operative on an emergency basis. I think that the technical reviewers did a very appropriate job in that.

The same thing is true of the proposal of organs recruited by paramedical personnel. The experts in this field are debating whether doctors should do it.

A successful recruitment of organs has been in the areas where there is a committed transplant surgeon and where the surgeon himself is out harvesting kidneys.

Dr. Koontz set the pace on this in San Francisco where he harvests all the kidneys he transplants and he has the -- he is the only person in the country with an adequate supply.

Right now it seems to be funding technicians who will go around to hospitals and explain to people that their relatives' kidneys are going to be taken out, is shooting at the wrong level. I don't think it's going to be acceptable.

I think that it has some very serious problems associated with it, and I think for this reason the review group turned it down.

So essentially what they are recommending is that the merger be consumated in the real world and that about ten

jr 5

percent more than the previous combined funds be given and that a site visit.

I don't have any other basis for -- any other recommendation than that so I would move approval of the review committee's recommendations.

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

MRS. MARS: Second it.

DR. MARGULIES: Motion made and seconded.

DR. HINMAN: I would like to make a comment about the third kidney project he recommended for disapproval.

There were three kidney projects and the local reviews did not support them because of the fact that -- Mr. Schreiner commented on the first one. The third one had to -- had to do with a pediatric necrology setup -- it had local turnout and was supported by --

DR. SCHREINER: I was lumping the two with the general Ohio program.

DR. PAHL: Could you speak up a little bit?

DR. HINMAN: This will change the funding level you were recommending. There was a $900,000 recommendation for program staff which is unchanged and a $500,000 recommendation for operational activities if the kidney was approved.

Since the kidney was disapproved this reduces it, rounding it off to $300,000 for the 01 year, $315,000 for the 02 year.

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DR. PAHL: Further discussion on the Ohio application?

All in favor of the motion, say aye.

(Chorus of Ayes.)

DR. PAHL: Opposed.

(No answers.)

DR. PAHL: Motion carried.

DR. MARGULIES: This seems to be enough to have accomplished for the day.

We will adjourn until tomorrow morning, although Ken Baum has an announcement to make regarding the activities in between.

(Discussion off the record.)

End 24

(Whereupon, at 5 p.m., the meeting was adjourned.)

End 24
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