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Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

RMPS REVIEW COMMITTEE MEETING

II

Rockville, Maryland

Friday, 22 September 1972

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1 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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4 RMPS REVIEW COMMITTEE MEETING

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Conference Room G-H
Parklawn Building
Rockville, Maryland

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Friday, 22 September 1972

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P R O C E E D I N G S

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a 1

1 DR. SCHMIDT: I think probably we should begin.
2 We thought that the order of the day would be to begin with
3 Mississippi, which is the last of the demonstration presentations
4 for the committee and then stop and talk a little bit about the
5 visual aids and the sources of information coming to the
6 committee. Then go on to a report of the Missouri Site Visit
7 and kind of a status report on Missouri. Them move to my state,
8 New Mexico, northern New England, Texas, Indiana and Memphis,
9 in that order, finishing before coffee break this morning.
10 So we will begin then with Mississippi. Dr. Hess.
11 DR. HESS: Thank you. I would like to begin just
12 by giving particularly for the new committee members a little
13 bit of background on Mississippi so that you understand a
14 little bit better what some of the specifics are in our discus-
15 sion today.
16 At the April 1971 Review Committee meeting, when
17 Mississippi RMP was reviewed, a number of us were very con-
18 cerned because of a program which did not seem to be functioning
19 very effectively in a region which perhaps has some of the
20 greatest needs of any region in the country by almost any
21 health or economic index you want to pick. Mississippi is at
22 the worst end of the spectrum, whether it be per capital income,
23 whether it be physician population ratio, whether it be neo-
24 natal mortality, you name it, Mississippi is at or near the
25 bottom.

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#1 1 We were very much concerned that rather than

Reba 2 2 unduly punishing a region, that this region above all else

3 needed some assistance in order to get itself reorganized to

4 qualify for funding more appropriate to the needs of the people

5 of the region. As a result of that deliberation, an assistance

6 site visit was scheduled in September of 1971. And a number of

7 staff and consultants visited the region.

8 We had two days of frank -- listening to problems and

9 discussion and feedback to the staff, the coordinator, and to

10 select the members of the RAG. And then we returned to wait and

11 see what happened. Some of us who were on that September site

12 visit returned again to see what had occurred.

13 We might just indicate for you some of the -- I

14 haven't had a chance to look at them, some of the recommendations

15 that were made at that September site visit. Concerning the

16 regional advisory group, we recommended very strongly that they

17 review their committee structure and reorganize it more

18 in keeping with the new directions in which RMP was moving.

19 At that time it was largely categorical in its

20 orientation. And we specifically recommended that they deal

21 with questions of planning and evaluation and help the RAG

22 become more intimately involved in these activities.

23 The core staff was not functioning particularly well.

24 One of the problems was they were quartered in a variety of

25 locations around the University of Mississippi Medical Center

#1 Reba 3

1 and this physical separation did lead to some fragmentation
2 and lack of coordination of activities.
3 And we also recognized that there was some need
4 for better communication and stronger leadership thrust
5 from the coordinator. We also recommended that they consider
6 setting back their time deadlines for their requesting a re-
7 vision in the time for application in order to allow them more
8 time to make the adjustments which we recommended.
9 We offered the assistance of the regional office
10 in Atlanta, RMPS staff in Washington and pointed out they had
11 a good deal of work to do. The items that we will report on
12 and discuss today then deal to a large extent with many of the
13 changes which have occurred since that September site visit, and
14 Tobert will begin the discussion of that as well as giving
15 you a little more background on the region, Bill Tobert.
16 MR. TOBERT: The Mississippi Regional Medical Program
17 covers the entire State of Mississippi, serves a population of
18 about two million two hundred thousand people. The region
19 is bordered on the east by Alabama, on the south by the
20 Gulf of Mexico and part of Louisiana. On the west by Louis-
21 iana and on the north by Tennessee.
22 So the upper counties of Mississippi are somewhat
23 shared with the Memphis Regional Medical Program in planning
24 an coordinating of activities. There are two distinct geographi-
25 cal areas of the state. The first area is the north and south

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Reba 4

Delta which starts in the Tennessee border, goes on down through, over to Vicksburg. It takes in the whole area. It takes in all that portion of the Mississippi Plain which lies within the state border and which comprises what usually is referred to simply as the Delta.

This area is one of the two geographical areas, it is by far the smaller taking up about one-fifth of the total land area of Mississippi. It is the only section of the state where agriculture still provides more personal income than manufacturing or government but this is changing due to the influx of small industries, the inability of crop producers to pay a minimum wage and the technological advances in farm machinery.

The other area is the East Gulf Coastal plain stretching in Mississippi from the Tennessee hills of Appalachia in the north to the Point Hills of the south which terminate along 359 miles of Golf Coastal shoreline. Mississippi is almost uniformly rural in terms of population distribution.

The basic urban structure is the small town, often housing one or more light industries but frequently few physicians, nurses or dentists. Poverty was and is a fact of life for too many Mississippians regardless of race.

A total of 154,000 families or 30 percent of all families in Mississippi earn less than $3,000 per year and are ranked in a poverty class. The Mississippi RMP

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#1 1 headquarters is located in Jackson which is also the capital

Reba 5 2 and is also the location of the University Medical Center who

3 serves the grantee for RMP. There were two subregional offices

4 of the RMP located in Oxford and in Gulfport. These offices

5 were just recently established, with supplemental funds awarded

6 to the region for health services, educational activities.

7 The future plans include a joint staffing of the

8 Oxford office with staff from the Memphis RMP (Slide), there

9 are ten economic development areas in the state.

10 The Mississippi Regional Medical Program recognizes

11 the fact that health care generally follows trade patterns

12 in Mississippi and the ten districts form the basis of any

13 approach to improving health delivery systems as well as the

14 care people receive in the region.

15 These ten areas are also designed to become the

16 comprehensive health planning areas of the state. CHP agencies

17 located in Jackson and there are two CHPB agencies currently

18 funded, one in the southwest and the other in the Three Rivers

19 area. Two more have applied for funding, Central and Northeast,

20 (slide) and the RMP has been actively involved in the develop-

21 ment of the agencies and they have a close working relationship

22 with this staff.

23 It should also be noted here that Memphis is also

24 assisting in the formulation or development of some of the

25 agencies in the northern part of the state (slide). This

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Reba 6

1 overlay shows some of the regionalization of some of the
2 activities they have proposed in the application of the review
3 today.
4 Part of this application, the large majority of the
5 projects and activities were centered around the university
6 medical center in Jackson. During the past year the Mississippi
7 RMP have concentrated their efforts in developing activities
8 which have outreach to all parts of the state. This simply
9 (slide) shows the geographical make up of some of the members
10 of the regional advisory group.
11 There are 37 members of RAG, with an adequate
12 balance of consumers and providers. The involvement of RAG
13 members this past year is one of the more positive steps the
14 region has taken and Dr. Hess will comment more on this a little
15 later.
16 (Slide) This chart depicts the distribution of
17 funds for the region during the three operational years and
18 it shows the comparison of what has been and what is to be during
19 the next triennium period. Clearly it illustrates the change
20 from a categorical program to emphasis on multi or non-categorical
21 activities.
22 This has increased from an average of 15 percent
23 during the first three operational years to 49 percent which is
24 proposed in this current application. It should also be noted
25 that previously a large percent of the program staff budget

#1 Reba 7

1 went into the medical school for supplementing some faculty
2 salaries.
3 This is no longer the case. All members of the
4 program staff are full time employees of the RMP, with the
5 exception of the Assistant Director of Planning and Evaluations
6 who is also a private practicing physician. During the (slide)
7 site visit of September 1971 one of the major concerns of the
8 site visit team was the organizational structure of the region
9 both in the program staff and regional advisory group.
10 This overlay illustrates the complexity of the organi-
11 zation prior to September 1971 and very clearly illustrates
12 the categorical make up of the region. There were categorical
13 coordinates, as you see here, that related directly to the coor-
14 dinates of the RMP, and program staff had very little liaison
15 with these people.
16 The regional advisory group, the categorical
17 committees were composed of non-RAG members. And RAG was no
18 more than a reactionary group. The categorical committees
19 were actually directing the program. (Slide)
20 This is certainly no longer the case and we feel that
21 the restructuring of RAG and program staff has been a major
22 accomplishment for the region.This reorganization was begun
23 during a retreat in early December of 1971.
24 The program staff are young, dedicated, very cohesive
25 hard-working group. All of the positions are filled with the

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Reba 8

1 exception of the Assistant Coordinator who they are looking for
2 now. And the part-time Assistant Director for Planning Eval-
3 uation I have already mentioned.
4 (Slide) The restructuring of the Regional Advisory
5 Group has resulted in total commitments and involvement of
6 all RAG members. No longer are there ~~commitments~~ COMMITTEES of non-RAG
7 members. Each member of RAG is requested to serve on at least
8 one of the task forces.
9 Each task force is responsible for one or more of the
10 goals of the region, and members are involved in reviewing
11 and monitoring the activities and projects that pertain to
12 these goals. And the goals of the region are shown in each
13 of the task forces, manpower, professional education, health
14 systems design, EMS and public health education.
15 DR. HESS: As you can see from your previous document
16 there were four staff visits to the Mississippi Region during
17 the late part of 1971-1972, as well as numerous telephone
18 contacts and various other forms of assistance. The site visit
19 team for this visit as you can see included Dr. Merrill of the
20 Council, Dr. Nichols, who is a black physician from Susquehanna
21 Valley, Mr. Donald Tranto from Georgia RMP who was a very
22 valuable asset to the team.
23 Mr. Van Winkle of Harvard, Mr. Ashby, Mr. Nelson,
24 Mr. Ballou and Mr. Grift from the regional office in Atlanta.
25 This application that we are to consider today includes a request

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1 for triennial status; Expansion of program staff, and funds
2 for additional regionalization, developmental components, con-
3 tinuation of three previously approved funded projects and
4 funds for 19 new projects.
5 Going over now the review criteria as outlined in
6 the site visit, as already mentioned by Mr. Torbert the
7 roles and objectives of the region have been revised and are more
8 in keeping with the new directions of RMPS. The coordination
9 between the university medical centers and the Mississippi RMP
10 appears to be extremely good, there always has been good working
11 relationships there and these continue.
12 The Mississippi RMP has moved into new categories
13 outside of the medical center. This has accomplished several
14 things. First being that the staff are all together now
15 physically, where they are able to communicate and work more
16 effectively together.
17 And it also has removed any -- some of the questions
18 that existed about undue influence and too close liaison with
19 the medical center. We found no problems of real concern in this
20 area. Some of the statistics which reflect hopefully in part
21 the impact of the Mississippi RMP are shown here in the site
22 visit report.
23 Some of them are very dramatic. In 1968, the neo-
24 natal death rate was 28 per hundred thousand live births in
25 Holmes County. This was reduced to 19.8 in 1970, and 7 in

#1 Reba 10

1 1971. This reduction is so dramatic you almost question the
2 statistics. But the people there feel that there is no question
3 but what the pediatric nurse assistance and midwife program
4 and so on has had some influence in reducing the neonatal death
5 rate.

6 The regional satellite units have been set up around
7 the state. They have a very well organized and smoothly
8 functioning renal disease program there as near as we can tell.
9 One of the important accomplishments of this program is to
10 reduce the cost of dialysis for their patients.

11 They bring families and patients into the medical
12 centers, train them in the use of dialysis and then through
13 the use of trailers which have been set up around the families,
14 a member of the family can come in with a patient and perform
15 the dialysis for the patient.

16 Heart clinics have been set up around the state which
17 have been -- have resulted in care being given to patients who
18 previously did not have access to this type of care. The
19 existence of the stroke care unit in the medical centers has
20 resulted in the treatment of a large number of patients, the
21 training of a number of physicians and nurses from various parts
22 of the state who are now better qualified and equipped to
23 provide higher quality care to patients with this type of
24 problem.

25 Pulmonary training programs and inhalation therapy

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#1 Reba 11

1 has been established in a number of inhalation therapy
2 aids trained who can now provide this type of service in hos-
3 pitals outside of the medical centers located throughout the
4 state.
5 The coronary care unit which initially was funded
6 and operative at the university medical center has trained
7 120 nurses in coronary care and they now are functioning in
8 various areas throughout the state to provide a more sophisti-
9 cated and effective type of care for patients with coronary
10 heart disease.
11 Through the efforts of the Mississippi RMP program
12 for training of dental hygienists was initiated and this has
13 had more spin-off, in that there is now discussion of the
14 possibility of initiating a dental program there. But through
15 the use of the training of these additional people, additional
16 dental services are now available.
17 They have been giving attention to the question of
18 continued support and an example of this is the Hollandale
19 midwife project in which through the fees which are being
20 collected for the services to patients, medicaid and so on,
21 these fees are being put back in to help support the cost of
22 the program.
23 There was some concern about what withdrawal of
24 some of the support to the Medical School faculty might mean
25 in terms of their availability to participate in RMP programs

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1 and continue education and so forth. And the Dean indicated
2 that there was some uncertainty as to how much of the time
3 of the medical school faculty might be -- he might be able
4 to fund and pay for out of other sources in order to continue
5 some of the thrust which they had begun in earlier times.
6 The region is giving attention to the improvement
7 of health care delivery for underserved minorities, this is
8 a major area of emphasis for the region, and all of these
9 projects that have been conducted in the past have had very
10 important impact and emphasis on the care of underserved
11 minorities.
12 The needs are tremendous in this area and what has
13 been done is only beginning then to scratch the surface, but
14 the region is certainly very conscious of these needs and
15 appears to be taking appropriate actions. As far as minorities
16 on the staff, currently they have one minority professional
17 and one minority secretary, and this is an area that we gave
18 additional emphasis to, on the site visit, and they expressed
19 their intent to employ additional minority people in unfilled
20 positions or as new positions open up.
21 One of the outstanding programs which has been
22 conducted there is one in which they are seeking to attract
23 black medical students who are going to school outside of the
24 state to come back to Mississippi and practice.
25 As I am sure most of you are aware there is suddenly

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a nationwide competition for qualified black medical stuents, and many of the best students, black students, in Mississippi are being actively recruited by medical schools from all over the country, and are going there to continue their education.

Through the black physicians in Mississippi, Mississippi RMP, these students have been, many of these students have been contacted and brought back and discussions were held in an effort to show them some of the changes that are happening and to develop in them a desire and commitment to return to Mississippi and practice when their training is completed.

I was going to take sometime now -- now it is going to take sometime to know how effective this effort will be but it certainly seems to be an appropriate one. Along with this is a much greater awareness in the University of Mississippi itself, of the need to admit black students within their own state and they seem to be making progress in this area.

Going on to the coordinator, the -- Dr. Lamton has been coordinator since January 1971, and we found evidence on this site visit that he indeed is beginning to exert a much stronger leadership role than when we were there in September of 1971.

At that time he was relatively new and feeling his way but after the site visit and the report which came back he has not hesitated to take the recommendations seriously and to move on them.

#1 Reba 14

1 There seems also to be a much better working relation-
2 ship between he and the staff. And whenwe were there in September
3 of 1971 we were getting all kinds of informal feedback in the
4 hallway and so on of some of the communications programs
5 and leadership problems which existed.
6 This time we pickedup none of that kind of thing. And
7 there were many indications that the working relationships
8 have improved. His relationship with the RAG seems to be
9 cordial and effective and we found no evidence of any discord
10 in that area.
11 The program staff has been strengthened, they have
12 hired a number of additional people who seem to be quite
13 capable. Some of them are young and not too experienced as
14 yet, but appear to have good potential. One of our concerns,
15 however, was in this area, in that the Assistant Director
16 for Planning and Evaluation is a practicing physician.
17 He is an internist, hematologist, gynecologist who
18 has a private office and exactly what this half-time means we
19 are not sure. But it was evident to us that this is an area
20 that does need strengthening, and one of our recommendations is
21 that this be made a full-time position, and that the new
22 people that they have brought onto the staff be given some
23 additional training and orientation so that this area of core
24 staff might be further strengthened.
25 They have a new person in the area of evaluation.

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1 From our discussions with him he seems to be a
2 competent person, a lot of good ideas and a good approach to
3 evaluation and we are hopeful that the evaluation might improve
4 over the next year or two. Regional advisory groups represent
5 the key health interests in the region. And as indicated by
6 Mr. Tobert's presentations now much more actively involved
7 in planning and decision-making for the region. Attendance at
8 the RAG meetings have been running over 50 percent, they have
9 requirements that if more than three meetins are missed then
10 the member is dropped from the RAG.
11 The grantee organization is performing its function
12 effectively as we could tell and we have no questions about
13 that. The major health interests are participating and there are
14 a wide variety who are involved and they always seem to be in
15 full support of the objectives, and -- of Mississippi RMP
16 and what it has accomplished to date.
17 Mr. Tobert indicated the -- how the state is divided
18 into subregional areas for health planning and RMP has been
19 instrumental in helping to facilitate this development and
20 they are working closely inthe development of these local
21 planning areas.
22 Active discussions are going on concerning organization
23 in nine of the ten areas, and five of these are in the active
24 planning stage at the present time. There is an adequate
25 mechanism for obtaining CHP review and comment.

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1 The Mississippi RMP has participated in and/or has
2 available to it a rather large data base documenting the
3 health fields and resources of Mississippi. However, there
4 has been thus far an apparent lack of the expertise needed
5 to move from available data to program development. This is an
6 area we emphasized to them a number of times and we are hopeful
7 that there might be some immediate and further movement on this
8 and we have a recent letter from Dr. Landon indicating they have
9 already begun to take steps to address this issue.
10 All the current projects in the current triennial
11 application were developed concurrently with re-thinking
12 of the goals and objectives and restructuring of the RAG and
13 program staff. Consequently the projects have not evolved as
14 a result of the re-thinking which has gone on during the last
15 few months although several of the projects are compatible
16 with that expressed by the new goals and objectives.
17 Coordination program staff has improved substantially
18 and they have developed a plan for systematic monitoring of
19 individual projects both by written reports and site visits,
20 by project monitoring teams which will include program staff,
21 RAG members and other consultants. Written project progress
22 reports and financial reports are also a standard requirement.
23 We have already mentioned about the new full-time
24 evaluator for whom we have a good deal of hope. He did not have
25 an opportunity to have much influence on the evaluation aspects

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1 of the projects which are submitted in the triennium, but he
2 does hope to have some influence on their functioning. And
3 we were assured they would have an active role in reviewing
4 and participating in the development of all new projects so
5 that adequate evaluation is built in from the very beginning.
6 We identified some problems in their documents,
7 differences in evaluated criteria between the stated objectives,
8 the project development guidelines, the technical review cri-
9 teria, and developmental component priorities, the RAG rating
10 forms and the program evaluation statement.
11 We felt these all have been developed at different
12 times and with somewhat different people and we felt, we
13 recommended that they sit down with all of these now and try to
14 make them consistent and uniform with one another to avoid
15 some potential confusion and improve the baiss for carrying
16 out their evaluation.
17 The region has established priorities. This was
18 accomplished during the retreat of the Regional Advisory
19 Group in December of 1971 and they are congruent with national
20 goals and objectives.
21 They have begun a School of Allied Health at the
22 University of Mississippi Medical Center, and this is on its
23 way now. The initiation of this school has been attributed to
24 a signific at degree by the RMP, and they are actively on

25 their way now in recruiting faculty and students and hopefully

#1 Reba 18

1 this will begin to supply a gap in health manpower in the region.
2 Now getting down to the recommendations of the site
3 visit team I am going to save, wait on the financial recommen-
4 dations until last. We did feel they were ready for triennial
5 status. There was no question that they had addressed all of the
6 areas of concern raised in the September 1971 site visit.
7 And they were in a substantially better position
8 as a region to manage their own affairs and to more effectively
9 address the needs of the people although there are still a
10 number of important areas that they -- where they need further
11 improvement.
12 We recommend that there be a full time director
13 of a planning evaluation staff, and that this section should
14 engage in a good deal of training and we suggested as one part
15 of the training of the staff some RMP's which they might visit
16 to learn the methods and techniques that would help them.
17 We emphasized the need for developing consistency
18 with the statements having to do with evaluation mentioned
19 earlier. We felt that their applications, their projects, needed
20 better documentation of need and this went back to the need for
21 strengthening their planning section.
22 We also felt that they needed to improve their technical
23 review input to the RAG, that there were some projects that
24 we looked at, as examples, where we questioned some of the needs
25 as far as the equipment and budgetary items and felt that they

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1 could well benefit from some qualified experts to work with
2 them in reviewing these project requests and determining what
3 was actually necessary and the methods that would be most
4 effective in addressing the methods of the project.
5 We recommended that they should work to obtain both
6 CHP and state funding of on-going health planning data collections.
7 There was one project in this group which is directed toward
8 improved data collection, and apparently no one is in a
9 position at the moment to undertake this activity, yet it is
10 a very important and essential activity for all health planning
11 in the state.
12 And we agreed that this would be a worthwhile
13 thing for RMP to initiate but it should not be looked upon
14 as a major on-going activity. Another question which came up
15 during the course of the site visit was the staff salary scale
16 which is determined by university salary scales.
17 And we recommended that the salaries should be reviewed
18 with the medical center administration to see if the mechanism
19 can be developed for more adequate program staff compensation.
20 Our concern was that this might be a liability to the program
21 in that they may not be able to retain qualified people and,
22 therefore, continue to build a strong program. I would end
23 my comments at this point.

end 24

1 # 2 fls 25

#2

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1 DR. SCHMIDT: I would remind the committee that
2 in front of them are these blackbound books that are computer
3 printouts, and some of the questions yesterday that had to do
4 with funding levels and money going to projects and so on,
5 are very efficiently and effectively answered in the computer
6 printouts, and I personally find them of great value and would
7 recommend them to the committee for funding information.
8 Secondary reviewer is Warren.
9 DR. PERRY: I believe in a characteristic way
10 Joe has done a tremendous job in reviewing the program.
11 My greatest interest in the program, I have not been in the
12 region, it's been only through application review in the past,
13 has been this tremendous concern and development in manpower
14 potential. Educational programs have really moved in this
15 state. It is a state that has not had that level of expertise
16 and such to do this. They have been calling in in the allied
17 health area, I know three of my dean type colleagues have been
18 down there in consultation. They have been moving ahead, as
19 has been said here.
20 A member of our staff in Buffalo has been there
21 in the dental school and dental hygiene program and moving.
22 They're doing a tremendous job as they look at their needs
23 in that state. They recognize the importance of all levels
24 of health care personnel in there, and I think this is a
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25 tremendous development here.

ar2

1 My only concern is going to be in some of the
2 recommendations on the level of funding here which I would
3 like to turn right back to Joe to make. There is no question
4 but this state has made a major turn and is moving in a most
5 positive way.
6 DR. SCHMIDT: Bill, was anything left out that
7 should be -- all right, Joe, can you put a proposal on the
8 table then?
9 DR. HESS: The site visits team had some difficult
10 in arriving at a funding level recommendation. I will place
11 that before the committee at this time. There was another
12 wide variety of opinion as to what it should be. I suppose
13 that I ought to express to you some of my personal reservations
14 about this.
15 This came as a sort of compromise, the team
16 recommendation is a compromise. And I happen to personally
17 be on the lower end of the scale concerning the spectrum of
18 opinions of the team for funding recommendations, but neverthe-
19 less the recommendations which we ended up were in order to
20 leave and catch our plane.
21 DR. SCHMIDT: The suspense is killing me.
22 DR. HESS: You can see here on your page 11 of
23 the report the total figures. On the sheet over here we have
24 broken these down. We agreed that with the expansion in
25 more subregionalization, some of the additional activities

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1 that the program staff planned to get into and so on, that
2 the increase in program staff budget was justified.
3 We felt that they were ready and could effectively
4 use in the first year developmental component of $96,315. The
5 total for operational projects we felt was somewhat high.
6 There were three specific projects there totaling about
7 $200,000 that we had some serious reservations about in terms
8 of their appropriateness when one considers the total health
9 needs of Mississippi, and we reduced their -- our recommendation
10 was something about $230,000 below that requested by the
11 region for operational projects.
12 So the total ends up with 2,110,138. They had
13 already received approval for, through supplemental funding,
14 183,634 in kidney, so if you subtract that, it comes down to
15 1,926,504, which is the first year recommendation.
16 The second and third year, you can see on the
17 sheet the kidney money will be included in that, 2.2 and 2.4
18 million the second and third year.
19 So I will place this recommendation on the table
20 in the form of motion, but also say I have some reservations,
21 particularly considering the fact that the first year is a
22 10-month year for them. I have some personal reservations
23 about whether they can effectively use that 1.9 million during
24 that first year.

25 DR. SCHMIDT: All right. Dr. Hess then moves

ar4

1 with some reservations, then, the team report. Is there a
2 second?
3 Warren, do you second this or not?
4 DR. PERRY: Yes, I am going to second it, to get
5 it started here. I -- not having been there, not having a
6 chance to, you know, really be a part of looking at the new
7 projects and such, it is a -- really a, more than a promissory
8 note. It is really an accolade in this funding amount.
9 I would like to ask Bill in relationship to his
10 knowledge of the region of your feel for their ability to
11 handle this increase.
12 MR. TOBERT: I share with Dr. Hess the 10-month
13 budget at that level. I had no qualms on the second and third
14 year at all. But I think there can be some justification in
15 reducing the first year.
16 DR. SCHMIDT: Before I call on Dr. James, Mr.
17 Griffith, the regional office representative, is here, and I
18 had asked Ted if he has any comments.
19 MR. GRIFFITH: No comments at the present time.
20 I go along with the proposed activities so far.
21 DR. SCHMIDT: Obvious and maybe stupid question
22 is if you are worried about the 10-month thing, why not give
23 them ten-twelfths of that amount for the first year?
24 DR. HESS: Personally I think that would be more
25 reasonable. I figured it several different ways, and I think

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1 that would be an appropriate way to go about it.

2 DR. SCHMIDT: Well, the chair won't intrude on

3 the workings of the committee.

4 Dr. James?

5 DR. JAMES: As a new member of this committee, I

6 get a gut reaction from the report as given and as stated

7 in the site visit report. My gut reaction relates to the

8 fact that we have seen a state that has long been known to be

9 without, use its own resources to develop a kind of program

10 that seems to be evolving with the professional help that

11 came about in December of '71, demanding new direction.

12 And I think I would like to emphasize the fact

13 that they have not had the professionalism and expertise prior

14 to December of '71, apparently shows that the efforts of --

15 of funding apparently have been -- has resulted in the train-

16 ing of personnel which in the long run has affected a net

17 change in direction of what I have heard all day yesterday,

18 that is, in fact, the people have apparently been the

19 recipients of the funding of the efforts of the Mississippi

20 regional program, if this is in fact what is absolutely the

21 case, as seems to be written in this program.

22 And I, for one, would want to re-emphasize the

23 fact that sometimes when you don't have enough money to go

24 on, you don't have the expertise and professionalism which

25 in turn helps to cloud an issue and really you do not get the

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1 services to the people, maybe this is what it is all about.

2 And I would strongly suggest that the expertise

3 and professionalism be offered these people on a higher

4 scale so they can use their basics, their abilities to

5 continue their efforts to train more people in Mississippi

6 which net results in services to the people.

7 The fact that infant mortality, this is an

8 absolute fact, it does sound, you know, almost fictitious,

9 doesn't it? But if this is an absolute figure, can we

10 duplicate that same figure in any other region across the

11 country?

12 I think if the regional medical program did nothing

13 else but to reduce the infant mortality rate, it has served

14 a very useful purpose.

15 DR. SCHLERIS: I was wondering if I could see that

16 overlay to show how the direction has changed in Mississippi?

17 I confess by saying I always, in driving, have been told by

18 my family of a very poor sense of direction. And in trying

19 to review briefly, I do have some questions to ask about

20 specific projects.

21 I am trying to discern what is really the change

22 in direction. The multiple is probably where there is some

23 reason for my questioning this. I am sure heart disease is

24 probably about 13 percent. But if I look at heart disease,

25 cancer and stroke, I would think that the numbers really don't

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1 reflect some of the changes here unless these are put into
2 multiple, because as far as some of the new projects coming
3 along the line, those to be supported, some of them appear
4 to be very much what we have been looking at for a long time.
5 The ongoing projects to be supported,$122,000. They put in
6 some projects, I don't know what you did, electrical hazards,
7 that probably went under multiple, but this is a set of a
8 model electrical hazard safety program, and the hospital
9 then to put it through the community. This is about $80,000.
10 This has now been used in most communities as the responsibility
11 of the hospital itself.

12 Radiotherapy is coming in as a new project for
13 $80,000.

14 Education of radiologists, setting up of peripheral
15 centers, is coming in again at a significant level of support.

16 Pulmonary therapy as a model project is coming
17 into a 50 to 100-bed hospital to treat pulmonary disease and
18 cystic fibrosis, stroke system to be set up for $58,000.

19 My concern, as I look over these projects, is that
20 many of them are what we have been used to seeing over the
21 past several years, and my concern is that they are isolated
22 projects related heavily to heart disease, cancer, stroke
23 and related diseases, rather than being a part of a new direc-
24 tion.

25 Some of the new directions concern me a bit.

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1 $39,000 for educational program for mentally retarded
2 children is something that I am sure is necessary, but I
3 again think that this is the RMP picking up things that
4 should be done in other ways. Controlled in effect in
5 hospitals, to set up a model unit and then if other hospitals
6 are interested, help them, is $32,000.
7 I have only looked at a few of these, but those
8 that I have looked at would suggest very much a good deal of
9 what has been going on in the past. Now if the change of
10 direction is in the interest of core, that's one thing, but
11 I don't see it reflected at all in these projects, and
12 there are myriads of them and just scanning them quickly, I
13 wanted to know how you define the change in direction, admitting
14 that I have a poor sense of direction.
15 DR. HESS: Well, I had commented on that in passing,
16 in that their rethinking occurred at the same time the
17 projects were being developed and consequently, particularly
18 the first year projects do not reflect that, so that it is
19 kind of a phasing problem that we have seen in many other
20 regions.
21 And this, the very questions you are raising, are
22 some of the things that bothered me and raise questions in my
23 own mind as to how much of a favor we are doing the region to
24 get -- give them enough money to get started and obligated on
25 some of these projects that I, in my own mind, thought ought

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1 to be low priority.

2 Now some of these we -- site-visit team -- we

3 felt strongly ought to really be looked at very carefully.

4 We told them so in feedback session, that we just questioned

5 whether these were consistent with the needs and so on of the

6 region, and that they needed to go back and rethink that whole

7 business and look at those projects again.

8 Now, I think they are developing the mechanism

9 and the wherewithal to do that, but this application does not

10 reflect that kind of thinking, you see, and it is a question of

11 how much faith we collectively have in their ability to go

12 back and look again at these projects.

13 My own feeling is that there should be enough

14 restriction on funding that they can be very selective about

15 which ones they choose and which ones they choose to fund --

16 which ones they choose to fund and which ones they choose not

17 to.

18 And they are going to need some continued help and

19 supervision in order to get things organized and consistently

20 moving in the direction that we would like them to be.

21 DR. SCHERLIS: Well, my concern is that once we

22 gave them developmental component, it should be on the basis of

23 our knowing that they have indeed demonstrated a change in

24 direction, because in looking at the projects, I have a feeling

25 of deja vu as far as what we would have a few years ago of

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seriously challenged as being bits and pieces of projects coming in from all over.

I am sure they will do something, but I don't know if they really demonstrate any program, you know; our concern should really be program, we shouldn't be talking projects, and our chairman has been most kind in letting us talk projects, because I don't see it as a program, but as bits and pieces of unrelated projects.

My immediate reaction is I question whether we have had a demonstration of their change in direction, but rather what we have been shown is that they recognize there should be a change in direction, have given us a list of projects, that while they will do good, I am sure, doesn't really reflect a level of maturation to demonstrate that they are ready to go in the developmental component.

I would like to have some other points of view on this. I know this is not the view of the site-visit group.

1 DR. LUGINBUHL: I would like to summarize my
2 views on what I have heard. It seems to me this is an area
3 of desperate need. We would like to give them as much
4 funding as they could well use.
5 Also it seems if they had made real steps toward
6 developing an organization, that we are all concerned that
7 they are still pretty embryotic in their development; they
8 are still focused on projects that aren't very well
9 coordinated, and if we give them too much funding, they are
10 likely to commit themselves very deeply to projects that will
11 not readily be pulled together in a coordinated program.
12 From that basis I wonder if it wouldn't be wise
13 to take a hard look, particularly the first-year budget,
14 with the thought in mind that if indeed they do set
15 priorities, that they do move towards a coordinated program;
16 that funding could be increased more rapidly in the second
17 and third quarter.
18 Specifically it is not clear to me from the yellow
19 sheets as to whether their first-year requests, indeed for a
20 ten-month period or is it for a 12-month period; if it is
21 for a full-year period, I would think this would reinforce
22 the suggestion that that be reduced to five-sixths of the
23 amount suggested over here which would be about $1,505,000.
24 Can someone tell me, is that first-year request
25 for ten months or 12 months?

1 MR. TOBERT: It is for ten months.

2 DR. LUGINBUHL: That would seem to me to be a

3 rather large increase and I would like to move an amendment

4 if that is in order.

5 DR. SCHMIDT: The Chair will accept a move to

6 amend.

7 DR. LUGINBÚHL: To reduce the first year to

8 five-sixths of the amount up there. I will leave the exact

9 calculations to someone else. I did it very quickly; it is

10 about a million and a half dollars, and to omit the

11 developmental component for the first year.

12 DR. SCHMIDT: There is a move to reduce the amount

13 to five-sixths and omit the developmental component for the

14 first year, leaving the second and third years at the

15 recommended level but with obvious interaction between staff

16 and the Review Committee prior to the funding of the second

17 year.

18 Do you accept that total restatement of your

19 amendment?

20 DR. LUGINBUHL: Yes.

21 DR. SCHMIDT: All right.

22 Is there a second?

23 MISS KERR: I would second.

24 DR. THURMAN: Joe is afraid to ask you what you

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25 thought. You said you compromised upward for the plane.

1 What would you really think?

2 DR. HESS: Well, my feeling was that they could

3 effectively utilize somewhere in the neighborhood of 1.6,

4 1.7 million. This would cut out about $400,000 worth of

5 projects and if I use my priority system, the ones left in

6 would be ones that are truly helpful and directed to some

7 very urgent problems there.

8 But I share the concern which you expressed. The

9 infections in hospitals, electrical hazards and so on were

10 ones which obviously came up -- we were very surprised that

11 they got through their review process and this is one of the

12 things that gave me some concern.

13 The nurse or I should say the cancer project is

14 just a one-year; this is the final year or I should say,

15 the stroke care demonstration is a final year for that

16 project so that 122,000 only appears in the first-year

17 budget and I think they are obligated to continue that

18 previously approved -- but taking all these things into

19 account, it is my feeling that they could have quite a bit

20 of money to play with and, not to play with but to use

21 effectively, and still show them that we had confidence in

22 what was happening, give them the support which they need to

23 begin moving more strongly in directions which I am convinced

24 they will move in and not do damage to the program.

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25 DR. THURMAN: Mr. Tobert, what is your feeling

1 about staff reaction to the business of cutting them, this
2 level or lower?
3 We heard a lot yesterday about how if we did not
4 show our faith, hope and charity that we might seriously
5 hurt somebody.
6 MR. TOBERT: No, I don't think this would affect
7 the operation at all.
8 DR. THURMAN: What I am really asking is 1.5
9 or lower. Let's look at both of those, 1.5 and then also
10 the lower because I share every concern that Dr. Scherlis
11 had.
12 MR. TOBERG: If it is any lower than 1.5 without
13 a developmental proponent, I think it might have some
14 concern on the staff.
15 DR. SCHMIDT: The move to amend was so
16 inconclusive that it is a substitute motion and so really
17 the motion we are talking about right now is the lower
18 amount.
19 John, first.
20 DR. KRALEWSKI: I am in sympathy with cutting the
21 thing back. I have mixed emotion over developmental
22 components, whether we give it to them in programs and
23 help them organizationally to do this or whether we give it
24 to them as a pat on the back.
25 Organizationally speaking I had been inclined to

1 say the program would be better of if you would reduce the
2 budget in the area of projects and gave them some developmen-
3 tal money to play with. I think I would be inclined to
4 believe though that ending up with 220,000 which must be
5 one of the larger developmental components ever given to a
6 program would be fair. But I would think that developmental
7 component in terms of perhaps somewhere in the area of that
8 first year's program, going up perhaps around a hundred for
9 the second two years, with the cutbacks to bring the total
10 budget down to a million and a half, taken out of the
11 projects, might be more helpful to a program such as this
12 and give them more running room and give them a chance to
13 turn it around if they are trying to turn it around.
14 DR. LUGINBUHL: Is that an amendment to my
15 substitute motion? If it is, I will accept it as a change.
16 DR. SCHMIDT: I will accept that as an amendment
17 to the substitute motion. The seconder was Elizabeth.
18 MISS KERR: Yes, and I would accept it.
19 DR. SCHMIDT: All right, the motion now includes
20 a developmental component of 96,000, which, for the first
21 year then. How about the second and third years?
22 DR. KRALEWSKI: I suggested a hundred thousand
23 isn't much of an increase but suppose we say 90,000 the first
24 year, a hundred the second two?

25 DR. SCHMIDT: All right, 90,000 the first year and

1 a hundred then for years two and three. So that is the motion
2 that is now on the floor.
3 Further discussion? If not I will call, "Question."
4 Bill?
5 MR. TOBERT: By reducing the developmental
6 component for the second and third year does this in effect
7 reduc the total amount you are awarding for those two years?
8 DR. SCHMIDT: Yes, it would be a reduction of 1
9 110,000 year two, 120,000 in year three. Year one, it would
10 be, without calculating centrigrade and Fahrenheit, are you
11 going to take five-sixths of the amount after the subtraction
12 or before the subtraction? Oh, developmental component
13 isn't subtracted. So it is five-sixths of what?
14 DR. KRALEWSKI: What I was suggesting is a total
15 budget of one and a half.
16 DR. SCHMIDT: Including developmental component?
17 DR. KRALEWSKI: Developmental component is 90.
18 DR. SCHMIDT: That clarifies it.
19 Does the staff understand the recommendation?
20 All right. I will call for the vote then. All in
21 favor please say aye. Opposed no.
22 I hear no dissent.
23 I would like to just take a few minutes now before
24 moving on to a report on Missouri to ask the committee to
25 express themselves concerning the staff efforts at presenting

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1 information to you about regions as part of the review and
2 triennial applications, that backgrounds the regions a little
3 more.
4 You have seen the slides that have gone up. You
5 have heard two presentations by staff as part of the committee
6 review. One of them was done by John, I believe, as part of
7 his review. He used the visuals that were prepared by staff.
8 And we have talked in the past about the informa-
9 tion that comes to the committee, the amount of it, the
10 detailed nature of it and so on. I called your attention
11 purposely to these books because they do have some of the
12 budget breakdowns that are most handy.
13 You have the applications now in their new form.
14 And you have the reviews of these three regions that were
15 done by staff. So could we have some guidance from the
16 committee on what they think? Dr. Ellis?
17 DR. ELLIS: Mr. Chairman, I would certainly like
18 to express great appreciation for the work of the staff in
19 setting forth these audiovisual presentations. I think they
20 have been very, very helpful.
21 Many times in trying to describe a region it is
22 just impossible to do so so that people listen and hear
23 what it is all about when we are talking. But they get our
24 attention; we understand exactly what the region is like and

25 I am just very regretful that I wouldn't have it when I

1 present this complicated region today.

2 DR. SCHMIDT: Elizabeth?

3 MISS KERR: I would also commend the staff for this

4 and I would further make a comment and then a request.

5 As I review regions which I intended and plan to

6 visit and also which I review for reporting, I have done the

7 same thing with my own little feeble handwriting on the map

8 that is produced for me on the materials trying to identify

9 locations, centers and so forth.

10 This is very helpful I found but my request would

11 be, could this kind of material be developed and -- and

12 included in the review materials prior to the review, the

13 site visit even? I think they are that important.

14 DR. SCHMIDT: I think that would be a goal to be

15 achieved. Certainly the maps of the regions could be done

16 for all regions that were coming up for trienniel review and

17 some of the funding history and particularly things like

18 these pies that show that the whole yellow thing was the

19 medical school and now the medical school has been cut down

20 to a little piece of pie and I think that these sorts of

21 visuals are great, and could be done in advance.

22 MISS KERR: For example Texas, as large as it is,

23 I had to get some idea of locations of agencies and so

24 forth prior to having a meaningful review from the applica-

25 tion. So this would be very helpful.

1 DR. SCHMIDT: Let me -- I almost feel a consensus
2 of the group. Let me ask for criticisms; assuming that the
3 committee does favor these, let me ask for criticisms of
4 what has been done either in length of it or detail of it.
5 This doesn't include the Rochester one which was
6 a 30-minute special but I am talking about the five to ten-
7 minute quickies and particularly for other information that
8 you would like to have that might be helpful.

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End #3

9 Bill?
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1 MR. HILTON: If overused in our initial enthusiasm
2 with this kind of a "B" approach, it can probably, I think
3 envision a time it might become monotonous. I think it is
4 possible to guard against that if we are aware at the outset.
5 I would suggest restricitng the use of the particu-
6 lar approaches in the overheads to the background data. We
7 have 50 local RMPs and even though we have been to the place
8 before, individual members may have been there before, it is
9 a good idea to have that background refresher, geography-kind
10 of display of territory, perhaps consider building up a library
11 of that kind of data for each region.
12 I suggest, too, perhaps some variety, like for
13 Hawaii, we had -- in addition to the overhead we had the little
14 plastic what do you call it, topographical models. That kind
15 of variety and other approaches to variety would help minimize
16 the boredom of this kind of approach, I would think.
17 DR. SCHMIDT: I was hoping for some flowers, myself.
18 MR. HILTON: Yes, I would too, like to applaud the
19 staff for the effort and I think it is great.
20 DR. SCHMIDT: All right, Leonard?
21 DR. SCHLERIS: We had planned some really spectacular
22 events for Hawaii. I can tell you we shared every bit of the
23 Aloha spirit at our presentation yesterday, that we had in
24 Hawaii. Only those of you who were there will really appreciate

25 what that alludes to.

1 I think these are excellent. I would make one sug-
2 gestion, that is the value of putting specific numbers that we
3 are talking about on the wall chart that we have. It is really
4 a great help and I would suggest that this be done previous
5 to the meeting, perhaps, someone on staff could write down for
6 each of the regions, what has been the previous level of
7 support and what is being recommended, because we can all look
8 at the numbers together, and it furnishes a great deal of
9 value.
10 When you use a wall chart, just use a rough draft
11 on the over head, where someone can cross it out and modify
12 it.
13 DR. MARGULIES: For one thing, as you have pointed
14 out, these presentations are all on prime time, so the
15 question of durations is significant. Certainly, the kind of
16 overlay and in-depth analysis for the beginning of a triennium,
17 I would imagine is a first priority in putting this much effort
18 into it.
19 It emphasizes two things, however, and I would hope
20 that the review committee would help to guide us in one of
21 them, rally, both of them; as much as possible.
22 There is always the risk in presenting data in a
23 particular way as a preparation for a triennium review that
24 we will begin to influence your thinking by the way in which
25 we put it together.

1 It was quite obvious for example, we were making
2 a point in presenting the Rochester regional medical program
3 as a case study. You could also see we could have picked other
4 programs for that purpose. We are not going to deliberately
5 do that kind of thing, but in the selection of data and present-
6 ation, there is the risk that that will occur.
7 There also is a constant problem which will grow
8 in time in selecting data with the knowledge that no matter
9 what we present, it is rather incomplete. A case in point, I
10 think of Ted Griffith, down at the end of the table representing
11 the HEW REgional Office.
12 It would be fine if we could, in some manner, have
13 a concept of what else is going on in other kinds of health
14 activities within the region. To do that is without really
15 innundating you with materials extremely difficult. But, we
16 are going to have to do something about how that might be
17 achieved.
18 It would be very helpful if one knew that, what is
19 going on in X areas or is not related to a lot of other things
20 which are underway or are intended from other origins. What I
21 am suggesting is sort of reorganizing the whole Governmental
22 system in presentation. We cannot do that.
23 The other thing I would like to mention, we have
24 brought up and which Bob Chambliss spoke to you about, yester-

25 day, is the significance, under the circumstances, of the staff

1 Anniversary Review Panel, because if we are to continue with
2 the kind of staff review for those programs, which are not
3 undergoing intensive review, by the review committee, it will
4 give us a greater quality of differentiation for what really
5 requires full-time by the review committee; what needs to be
6 referred to, and what does not present major problems so that
7 it can be kept in some kind of balance.

8 Obviously, you are being burdened with some heavy
9 responsibilities, and you will have to accept our kind of
10 discretion in developing for you what needs to come this way,
11 and what requires that kind of time.

12 DR. SCHMIDT: I would like to comment on the Staff
13 Anniversary Review Panel reviews from my perspective and see
14 if there is the consensus of the committee. If not, we can
15 discuss the Staff Anniversary Review Panel reviews further.
16 To me, these have been very high-quality efforts by the staff
17 and the reporting of these, the information that is in the staff
18 summaries, the written word that comes to the committee that I
19 look at gives me such a good feel for what went on with staff
20 in their deliberations that I can very quickly be satisfied,
21 or dissatisfied with what went on by my review of these reports.

22 In the last number of years, I have detected no
23 dissatisfaction on the part of the Committee with this Staff
24 Anniversary Review Panel process, or the information it gets
25 to the committee.

1 I think the Committee must have the perogative of
2 asking for explanations for actions if they do not understand.
3 But, I don't think there is any need, right now, or any desire
4 on the part of the Committee, to change that process, or the
5 process of reporting the information to the Committee.
6 That was what I expressed to staff during the past
7 few weeks, and would ask if the Committee members disagrees
8 with that at this point?
9 Warren?
10 DR. PERRY: I think, although we do not need, you
11 know, no further approval, if we all agree in the importance
12 of the audio-visual, from one of the comments made yesterday
13 that indeed, the review process might be more open and less
14 involved.
15 This is another important reason to have this quality
16 and kind of material. If there, we can anticipate, you can
17 anticipate other people around. That would be most helpful
18 to have those kinds of things around, so that each person can
19 respond in relationship to it.
20 Also, I think that there can be judicious choice on
21 the part of the staff as Harold has said. Perhaps, for the
22 triennium. For the important ones. Let us not get in the
23 habit of doing it for everyone, let us do it for those that are
24 really significant and we need for the review.

25 SISTER ANN JOSEPHINE: I would join the other members

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1 of the Committee in complimenting staff on their presentation.
2 And, as I have had an opportunity to function on this committee,
3 I begun to realize that the diversity between the regions,
4 not in the area of needs. That is quantitative rather than
5 qualitative, but the diversity is rather in where individual
6 programs are at the present time, as compared with other
7 programs in an awareness of how to go about meeting the object-
8 ives of the program.
9 And I would think that this type of review, carried
10 on as part of the program should be very helpful to staff,
11 because in putting myself into the role of a member of staff,
12 and sitting there and listening to this, I might well say, You
13 know, in these two programs, that I am responsible for, these
14 efficiencies have been met very effectively and I need to
15 communicate them with those who are working with the other
16 programs.
17 And in this way we can really begin to share resources
18 that are resources of the regional medical program. And I
19 think we have not done that as effectively in the past as we
20 can do it, now. We have reached a point in time, and it is
21 really sharing facilities.
22 DR. SCHMIDT: Let me end this by asking staff if
23 they have any questions of the Review Committee about the
24 information or whatever?
25 If not --

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1 DR. CHAMBLISS: I might say on behalf of staff that
2 we do appreciate your words of approval for these efforts in
3 the visuals. Especially in the staff of the division of
4 operations and development and DPT, but I think this committee
5 should know who has spearheaded this effort in terms of the
6 visuals.
7 I would like to just say Miss Judy Flasher, over here
8 at the door, has spearheaded this, and also with equal assist-
9 ance, Mr. Frank Schniowski, who has provided the data for the
10 visuals. Frank is over here and you all know him.
11 Thank you.
12 MR. RUSSELL: I would like to say one thing. I
13 think it would be helpful to the staff when on a site-visit,
14 if the site-visitors feel, if a particular visual would be
15 helpful then this would give us direction, we would appreciate
16 it.
17 DR. MARGULIES: That picks up what I wanted to
18 comment on, Dick, and that is that in the interest of express-
19 ing the kind of diversity which you spoke and Sister Ann,
20 everyone has recognized, if I get the sense of this committee,
21 you will accept the idea that the development of the visual
22 materials and the manner of it is something which might continue
23 to be left to the style, to the interest, to the motivations of
24 the staff people connected with the program.

25 I think that would be better than to say, we have

1 one single format which we want to follow. This will give them
2 a greater sense of involvement and I think, they can probably
3 do better that way.
4 MR. SCHNIOWSKI: Dr. Schmidt, as part of the experi-
5 ment we had one presentation given by staff, another one that
6 was a joint-type, Staff Review Committee and a third one,
7 by the Review Committee members.
8 The Review Committee has commented on the audio-vis-
9 uals. I wonder if we could find out if they have any preference
10 in the future as to the type of delivery they would like to
11 see?
12 MR. HILTON: I would go for that second approach.
13 Specifically, with staff though there would be opportunities
14 as Merle has already suggested, to someway propagandize present-
15 ation to some degree, I think we will guard against it,
16 particularly the staff covering those things that are of a
17 geographical and demographic objective, reporting kind of
18 nature with regard to the region, and with committee handling,
19 the other kinds of concerns were here to address.
20 DR. SCHMIDT: I like the quality of interchange
21 with staff being part of the presentation. I see all the heads
22 are going like this.
23 DR. KRALEWSKI: I have always liked to use slides
24 in a presentation. While I agree, I think the background data
25 is well presented by the staff; I think it is useful as an

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1 introduction.

2 I think it is useful during the presentation to have

3 the use of slides, also, though, so really, what we are saying

4 is part of what I am suggesting is part of each of these

5 approaches we have previously outlined.

6 And I think that the site-visit is the time to out-

7 line the kind of, kinds of slides, that you will need for that

8 presentation, because then, you can highlight some of the parts

9 of the program you feel are necessary.

10 I think this gets away from the fact then, that the

11 staff may be worrying about their slanting it in a certain

12 direction.

13 DR. SCHMIDT: We will want to bring this to a close,

14 quickly, then.

15 DR. JAMES: Yes, I have a very, very quick comment

16 to make.

17 Again, being new, I certainly enjoyed the audio-

18 visuals yesterday, and I would concur that the joint presenta-

19 tion by Staff and site-visitors of the committee, make it a

20 presentation; I also would like to comment that this kind of

21 presentation with the broader presentation of actual figures

22 on the board, helps one to determine where the level of funding

23 would be, because sometimes I see coming about, ceiling figures

24 that may apply to a funding, and I believe this would help to

25 deter the use of ceiling figures.

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1 A figure out of the ceiling.

2 MISS KERR: One other quick request, is if it were
3 so that we could have these graphs prior to a site-visit, and
4 then if there were such changes as were dramatic enough to show,
5 could this suggestion be made by the visiting team to the
6 staff member, and the staff member, at his discretion, then
7 develop the second audio-visual for comparative purposes?

8 DR. SCHMIDT: We will accept that as a suggestion.

9 Sister Ann?

10 SISTER ANN JOSEPHINE: Some of the regions are begin-
11 ning to develop their own visual material, and it may well
12 be that some of the visual material they have developed could
13 be used for this type of presentation, without a duplication
14 of effort.

15 DR. SCHMIDT: I think Staff will be sensitive to
16 that.

17 MR. TOOMEY: I would like to comment on the fact
18 that seems to me that we are, -- we have been asked to look
19 rather specifically, precisely, and indepth, at the program
20 problems of the organizations that we visit and with which we
21 are concerned.

22 Then, in the course of our discussions, we begin
23 to focus on projects that are part of that. Yet, it is very
24 incidental. I cannot help but feel that the projects are
25 extremely important in terms of ananlyzing the congruence of

1 the project to the program. And, I am going back to Staff
2 Anniversary Review Panel, because I think those reviews are
3 great.
4 I think, perhaps, the most effective presentation
5 on your charts have been the changes from the categorical to
6 the multiples-kind of projects. And, I think if one further
7 facet of Staff Anniversary Review Panel could be, because we
8 are not taking the time to review the projects in any depth;
9 that they probably know them better than anybody else, and if
10 they could spend just a little bit of time on, or at least
11 a comment in relationship to the project, itself, to the pro-
12 gram that we are most specifically concerned with.
13 Do I make myself clear?
14 DR. SCHMIDT: Yes, everybody says, yes, and it is
15 captured and while you have your microphone on, let us turn
16 then to Missouri and a brief status report from the site-visit.
-4/s-5 17 MISS KERR: I am assuming we need not do anything with
18 that on our evaluation sheet, right?
19 DR. SCHMIDT: That is correct.
20 This is for information.
21
22
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MR. TOOMEY: I visited Columbia a month, in company with Dr. Thurman, Dr. Pellegrino, Dr. McPhedran, Donna Howseal, Dr. Farrell, and Judy Silsbee. There has been a kind of major problem in the Missouri RMP. Frankly, it has been a program and organizational kind of structure problem.

For instance, at the top level there is a problem with the regional advisory group. It was initially established under Dr. Wilson in three parts. It was a tri-part RAG.

One part was an advisory council, the second part was project review committee, and third part was a liaison committee which was project oriented. When these three groups met, they in a sense, represented the regional advisory group.

However, they met separately as well, and with the advisory council being only 12 people and with the project review committee and liaison committee being made up predominantly of the prior groups and most specifically, of the University of Missouri people, it was a very closed kind of corporation, rather than an open advisory group with input from much other than the University.

When this problem was called to their attention, they made the decision that the advisory council with 12 people was in fact their RAG. In fact, it does not meet the requirements, the legal requirements of a regional advisory group because it does not have all of the representation, even the legal representation, Veterans Administration group, and I think some other

kar 21 Bill, what was the other? CHP Agency? In addition to which
2 it had only one minority or consumer involvement. It was one,
3 one lead who was black and who was a housewife, and she repre-
4 sented the female, the black and the consumer, all by herself.
5 Their focus in the past had beeon on, naturally, the
6 extremely categorical nature of the projects. They had been --
7 they had been very equipment-hardware oriented. They didn't
8 have adequate goals, subgoals or priorities and within the past
9 year, they have had a group headed by, I think it is Dr. Mare
10 who has worked, I guess, with great vitality and enthusiasm
11 in developing a set of goals and subgoals and priorities.
12 However, they felt that the objectives that should
13 be established in order to achieve these goals should not be
14 established by their goals committee and it should not be
15 established by RAG, but in order to allow the local regions
16 covered by the Missouri RMP to give to the establishment of their
17 projects and their objectives, the local flavor that was necessary
18 they left the objectives out. They felt very strongly and
19 organizationally they have six or seven subregions and they have
20 a part-time coordinator in each of these subregions and they
21 felt that each of the subregions was geographically so different
22 and the needs were so varied that for a central group to establish
23 the objectives for these regions was undesirable. So they did
24 not -- they did nothing other than establish the major goals,
25 the purpose, the major goals and some of the subgoals.

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kar 31 Their major goals are the enhancement of the availability and accessibility of health resources, enhancement of quality care and the moderation of costs. And they have under each of these major goals, they have subgoals to the total of 13. Frankly, they have done an excellent job. Their goals and subgoals are great. And if you can accept the fact that the regional area should be able, through its own input, to establish the objectives for that area to determine what its major objective would be, then it is not an inadequate or it is not an undesirable approach.

The program staff was -- had not had its organizational structure changed from the time that it was categorical in nature. And I think I would put it in another framework. They have an organization which is inadequately structured to carry out the goals and subgoals that they have established. They did not have an evaluative mechanism.

A committee was established, but it is a little bit hard when you have no objectives to evaluate whether or not what you are doing is being accomplished as it should be. So the evaluation committee really exists in the same kind of a void as the specific objectives exist.

We were concerned with the part-time regional coordinators, and really it wasn't until we had an opportunity to meet with these gentlemen, four or five of them being physicians, and retired or semi-retired kind of situation. And

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1 when we did meet with them, we found that they were, in my
2 opinion, a very dedicated group of people. The problems that
3 have existed really are the fact that they were part-time and
4 there it did take them a considerable amount of time to travel
5 through the region for which they were responsible to relate to
6 the priors and other people in that region and to begin to draw
7 out of the region the things that the region might do.
8 They felt that they would be better if they had some
9 part-time help themselves in terms of secretarial help or data
10 gathering or kind of people who were -- these with all physicians
11 and they felt they needed some nonphysician help in the -- in
12 their work. As part of the organizational structure, I think
13 that we looked ver hard at the coordinator, and I don't -- I
14 think I would feel more comfortable when I would say that they,
15 and I quote from a review of their fifth year application, site
16 visit report in '71, "The site visitors find the organizational
17 effectiveness of the coordinator weak. The doctor is not as
18 forceful an administrator as he could be." And in '72 the remark
19 is, "Other leadership is still considered weak. Not only does
20 he exhibit through the lack of organization within the program
21 staff itself, but in addition to which he is director of health
22 program for the University extension division and he is director
23 of a HSMHA contract in consumer education, and to compound the
24 weakness which seems quite apparent, he is now devoting only
25 54 percent of his time to the direction of the Missouri RMP."

kar 5 1 Now, the explanation for this is that the consumer
2 project is operated through the University and the University
3 has said this is congruent with the RMP program which is operated
4 through the University and therefore, we will put it in RMP and
5 make Dr. Rickley the director.
6 These, I think, with the organization problems, the
7 structural programs of the organization, the lack of specific
8 objectives even though the goals were considered to be -- in my
9 opinion they have done an excellent job. I think each of these
10 items was reported directly to their group.
11 I would like to ask Bill if he would like to contribute
12 anything to this, Bill Thurman?
13 DR. THURMAN: I think that I would just add a couple
14 comments. Bob has outlined most of the concerns. One of the
15 members with us from council indicated, said this was nothing
16 more than a day-long feedback session which is really the feel
17 you got for what we did because it was at times very sticky,
18 uncomfortable and at times they kept coming back to us with
19 questions like, what is the difference in definition between the
20 advice you send and the recommendations that you send.
21 And we tried to respond to each of these and it was a
22 long, drawn out type of feedback session. I think that one
23 thing that concerned them the most was whether or not review
24 committee and council's handling of the VAS situation should

25 have been clearer to them than it was, and Dr. Pellegrino's

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1 statement about that, and one of the reasons I have been con-
2 cerned today and yesterday about out patting people on the back
3 who haven't turned the corner is the Pellegrino statement that
4 they have had hit in the head with a 2x4 and still haven't
5 changed.

6 So I think this was a very worthwhile visit. I
7 wonder if we could have one word about council's feelings about
8 not concurring with our recommendation last time around about
9 triennial status for this group and I think the only other point
10 that I would add to what Bob has said is that the coordinator
11 problem represents a significant problem and lead to our ultimate
12 recommendation.

13 MR. TOOMEY: I don't know if the council is familiar
14 with the fact that after the VAS project, which is a computer
15 project, and Dr. Billy Jack's office related to the medical
16 school, council of the advisory committee had recommended it be
17 funded no longer; then a separate contract was signed with
18 HSMHA in order to continue.

19 DR. SCHMIDT: Bill, what did you mean by your ultimate
20 recommendation?

21 DR. THURMAN: Bob is going to present our recommend-
22 ation in just a minute, I am sure.

23 MS. HOUSEAL: In response to your council about why
24 council decided that, they felt withdrawal of funds in the amount
25 of a hundred thousand and the site visit would be strong enough,

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1 and they though it would be too harsh to withdraw triennial
2 status.
3 DR. SCHLERIS: What will be the result of this site
4 visit, I gather it is information only, or are there specific
5 recommendations?
6 DR. SCHMIDT: I was a little puzzled, obviously,
7 again I am hanging on tender hooks because there was some
8 recommendation made.
9 MS. HOUSEAL: The site visit team was to go out and
10 carry the message from last time. The recommendation had already
11 been met or set by review committee council at their last
12 meetings. The program recommendation, those Mr. Toomey gave
13 regarding settling the RAG issue, making the coordinator full-
14 time, making objectives more specific, evaluation section on
15 core staff, the site visit made no funding recommendations.
16 With regard to the computer contract, there was
17 another site visit held by HSMHA officials this summer and con-
18 tract funds of contract will not be forthcoming from RMPS for
19 this activity, but will be supplied by national centers for
20 research and development.
21 DR. THURMAN: I didn't mean to leave the Chairman
22 hanging in mid-air. I think Donna has outlined our recommend-
23 ations.
24 A very specific request was made by the site visit
25 team which Bob outlined to have a letter forthcoming from RMPS

kar 8

1 outlining these specific forms. My apologies to the Chairman.

2 DR. SCHMIDT: No. Any other comments then before

3 moving on?

4 DR. SCHLERIS: Does this go to council with a re-

5 affirmation of our recommendation from before, or is it just

6 where it was before, because I don't see where this is really

7 more than, you know, it might be well if you did this. Funds

8 have been our means for having some impact, however transiently,

9 on a region.

10 MRS. SILSBEE: I think Dr. Pellegrino, who used to be

11 on the review committee originally and council, descrived it

12 best as a therapeutic site visit. There were indications, not

13 only beforehand, but at the time of the site visit, that letters

14 that had come and advice that had come from the review committee

15 and the council, again, the site visitors looking over the

16 material could not understand how the region could have failed

17 to have gotten the message, but when we got there, we realized

18 there was a filtering process and they had failed to get the

19 message.

20 So this was an opportunity to have a face-to-face

21 discussion, to make sure that what the committee and council

22 had been saying was understood by the regional medical program.

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23 DR. SCHMIDT: All right. We will move on.

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1 DR. SCHMIDT: We will go onto Bi-State before
2 coffee.
3 I guess we are still with Mr. Toomey.
4 MR. TOOMEY: The visit to Bi-State was in regard
5 to an application for triennium status.
6 A review of the problems that existed with the
7 Bi-State, Bi-State RMP, indicated first of all that the
8 Regional Advisory Group had been relatively inactive;
9 That there was a Scientific Educational Review
10 Council, and an administrative liaison council made up of
11 representatives from three medical schools, Washington
12 University, St. Louis University, and Southern Illinois
13 University.
14 And the indications were that these two
15 committees which review all of the projects made the basic
16 decision and made their recommendations then to the Regional
17 Advisory Group.
18 And the record would indicate that the Regional
19 Advisory Group met seldom or perhaps three, perhaps four
20 times a year, and never for more than two hours at a time, and
21 with only approximately one third of the RAG members present.
22 This led into the problem of the grantee
23 organization, which was a joint organization, a so-called
24 consortium, made up of these three universities, who, as a
25 consortium, handle the grant funds for the Bi-State RMP.

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1 Another problem apparently was the internal
2 organization of the program staff, which was structured
3 in such a way that all of the members of the staff reported
4 to Dr. Stoneman, the coordinator of the Regional Medical
5 Program.
6 Additionally, because it was a Bi-State area and
7 covered the area around St. Louis, Missouri, and, in
8 addition, covered the southern part of Illinois, which
9 included the state capital in Illinois, Springfield, where
10 there was a concern because the Illinois RMP, which was a
11 growing organization and more aggressive, increasingly
12 aggressive organization, was concerned because the state
13 capital of Illinois was being covered by a Bi-State RMP,
14 rather than the Illinois RMP, as an expression of the --
15 either of the agressiveness of the Illinois RMP.
16 They had just recently funded a project in
17 Southern Illinois which theoretically was in territory
18 covered by Bi-State RMP.
19 Finally there was a concern about the relevance
20 of goals and objectives tothe region's health care needs.
21 The specific issues were -- with which we were
22 concerned were the organizational structure, the role and
23 influence of the consortium, the internal organizational
24 problems of the program staff, the dispute over the Southern
25 Illinois area with the Illinois RMP, the role of the program

committees and the adequacy of proposal development and review process and relevance of goals and objectives to the Region's health care needs.

In the establishment of the goals and objectives which came about March 1971, their objectives and priorities were groupd around six major areas.

Their first was manpower;

The second, the health care delivery systems, rural and urban;

Third, continuing education;

Fourth, medical care, primary, secondary and tertiary, and the cardiovascular, cancer, stroke, and other diseases;

Fifth, demography and statistics; and,

Six, medical information.

And their priorities followed this ranking.

We were concerned about the categorial orientation of the objectives, recommended that there be deemphasis of the traditional categorical interests.

The objectives tended to reflect highly pre-determined assessment of regional needs.

During the categorical period, let me say this: One of the problems that had previously existed before the Bi-State RMP came into being was the inability of the two medical schools in St. Louis to relate to each other in

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1 carrying on programs in an effective manner.

2 The RMP during this categorical period brought

3 these two medical schools together and their cancer and

4 cardiovascular program seemed to be particularly successful.

5 Their other projects that they had accomplished

6 were in the training of coronary nurses, and in a library

7 network which utilized the services of both Washington

8 University and St. Louis University and spread through great,

9 I think, in terms of about a hundred hospitals throughout

10 the region.

11 During the past year the Bi-State RMP became

12 involved in developing a major medical service emergency

13 project which was funded this past spring.

14 In the area of continued support, the radiation

15 therapy program has become self-supporting. However, it is

16 being continued and the nurse coronary care unit is continuing.

17 One of the projects that had been established

18 under the old RMP was a -- under the categorical phase of the

19 RMP, was a project, Pruitt Sago, which is a housing section in

20 St. Louis. There they had made an effort to establish a

21 program and project which would provide health care services

22 through the utilization of medical students and training home

23 health aides at that center to provide care to six thousand

24 residents of the Pruitt Sago area.

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25 With the exception of thatproject, and beginning

1 to look at the problems in East St. Louis, there had been no
2 indication of minority concern or minority interest on the
3 part of the Bi-State RMP. They are now concerned with it,
4 not only the urban health care, but the rural health care, and
5 they have -- part of their consortium is Southern Illinois
6 University, which, in its new medical program has adopted
7 the -- its prime interest, that of developing delivery of
8 health care services to the people in the rural areas in
9 Southern Illinois.

10 And they now have five new projects of the
11 Bi-State RMP directed toward the underserved.

12 Dr. Stoneman is the coordinator of the Bi-State
13 RMP, and I think we agreed that Dr. Stoneman was a very,
14 very dedicated and very, very fine, dedicated, intelligent
15 person.

16 However, it was our feeling that he was over-
17 stretched in terms of attempting to relate to not only all of
18 the areas in the two states, but he was on the faculty of the
19 St. Louis University.

20 He carried, continues to carry on a practice in
21 surgery to a minor degree, several hours a day, two or three
22 hours a day, is what he has stated.

23 And in light of this -- and he also is president
24 elect of the St. Louis Medical Society.

25 Consequently, he is in a position where in light

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of his desires to relate individually to every person who works on the program staff and the outside activities, we felt that, as much as anything, that Dr. Stoneman deserved a deputy coordinator, somebody to work with him in the internal organizational matters of the program staff.

The program staff, individually, as we met with them, and talked with them and listened to them, seems to be quite an excellent group of people.

They had one organizational structural problem which related to the use of part-time associate coordinators at each of the universities in each of the categories and in Southern Illinois, in their rural health care delivery system.

And it was our feeling that these part-time categorical coordinators should be phased out and that full-time associate coordinators, who would have an interest in the organization rather than in the category of medical care, should be added to the staff, or should be substituted for the part-time people.

As mentioned earlier, the RAG met just three or four times a year, and then for only approximately two hours. Their attendance was minimal, only averaged about a third.

As businessmen, which is where it seemed their greatest strength lay, they felt that they were in a position where they should delegate to the universities, to the SERC and the administrative liaison committee the work of developing

dor 7

1 program policies for that particular organization.

2 And they did not feel that it was their

3 responsibility to take as active a part as we felt they

4 should. Consequently, as we looked at both the RAG and the

5 grantee organization, it was our feeling that the influence

6 of the universities should be phased out of that program and

7 one of our recommendations was that the SERC would be phased

8 out entirely and that the Regional Advisory Group would be

9 made more representative with more consumer interests and

10 minority involvement at the core level.

11 And as part of our looking at the mechanism by

12 which our projects came through the various committees to

13 the Regional Advisory Group, Dr. Mitchell awnd Maria Flood

14 reviewed, they did an audit trail, if you will, of two of the

15 projects, and I might interrupt and ask Maria Elena if she

16 would like to comment on the trailing of the projects?

17 MS. FLOOD: There was some concern by the site

18 visit team that the university had exerted some tremendous

19 pressures to be assured the projects were named only at the

20 medical school emphais but, indeed, as we went through the

21 review process, we didn't find this to be true and rather

22 found that perhaps the medical schools, the universities, had

23 lacked support in helping them develop mechanisms for proper

24 review, but there were some glaring deficits in the review

25 process we encountered.

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1 We were not provided with the cover sheet that
2 the regional Advisory Group meeting, page one of the Regional
3 Advisory Group meetings that we reviewed, which carried the
4 names and attendance records.
5 We were -- all three meetings, the review
6 started with page two. It could have been an oversight.
7 The review process reflected some deficits in the
8 fact that if the reviewer felt that there were conditions
9 to be met by project proposals, there was no documentation
10 that this information ever got back to the project proposer
11 or that, indeed, funding was not approved until these
12 conditions were met.
13 We thought of two studies, one being a medical
14 school oriented,three-pronged nurse-physician assistant type of
15 concept, which was originally rejected and then subsequently
16 resubmitted with a little different approach and was approved
17 on the second review.
18 The other project was a very poorly documented
19 project from a minority impact area, had to do with the
20 educational facilities for allied health training, and it was
21 one of the problems we encountered in this, that there was
22 no formal development of a format for submission to projects.
23 Our opinion reflected some deficits in the
24 management capabilities of the staff in developing a format
25 for proposers to follow and formal structure for the review

dor 9

1 process.

2 MR. TOOMEY: Thank you.

3 Certainly, the prior groups were involved,

4 including the comprehensive health planning agencies.

5 As a matter of fact, the relationship was be-

6 ginning to be so close and RMP was sufficiently interested

7 in continuing this and working closely with the Comprehensive

8 Health Planning Agency that they recommended to us at the

9 time that we arrived there that, or they didn't recommend,

10 they requested that we give consideration to a funding to

11 strengthen and to allow the Comprehensive Health Planning

12 Agency to continue to become more and more involved in the --

13 in helping in the assessment of needs and in the planning

14 for the area.

15 They used the Comprehensive Health Planning Agencies

16 to the extent that it is possible to use them now. They see

17 that it is possible for further developments to take effect

18 with the Comprehensive Health Planning Agency and they would

19 like to make them an active ally and provide them with some

20 funds to enhance that whole record.

21 As a matter of fact, as they assess the needs

22 and resources, they felt that this continued active

23 cooperation between RMP and CHP should be encouraged.

24 Their program staff monitors all projects. They

25 control the financing. They monitor the fiscal affairs.

dor 10

1 Another problem that they had was the planning
2 and evaluation was in the hands of one person, a one-person
3 department, and they felt that even though this person was
4 a well-qualified Ph.D, that this perhpas should be split.
5 Bi-State RMP has developed an action plan and from
6 the application and presentation of the visit, appears sound
7 and includes several excellent components.
8 The RAG has assigned priorities to the objectives
9 and they rank health manpower and health care systems highest.
10 Continued education and catogorical disease strategies were
11 lowest.
12 Their immediate priorities include data base
13 improvement, primary care strategies and medical information
14 systems.
15 We believe that the REgional Advisory Group needs
16 strengthening and they need to direct, need to direct themselves
17 to do a more adequate job of meeting the needs of the
18 region.
19 Now, much of this sounds, in a sense, it sounds
20 negative and I think, I suppose it is easier to pick the
21 program apart than it is to promote its strengths, but they
22 have done an excellent job with the development of their
23 goals and their objectives.
24 They have disseminated these goals, they have a
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25 mailing of 8000 organizations, and institutions and individuals.

1 In addition to the dissemination of this
2 information they used an interesting mechanism of requesting
3 back from the people to whom they mailed this information
4 requests for projects and programs and specific areas. They
5 felt they coudl establish a program of providing, if you will,
6 it was mentioned yesterday as "mini-proposal," but these
7 are a little larger than the five thousand dollar proposals,
8 these would be $25,000 proposals, and at the end of the year,
9 they would have, through their evaluative mechamism, they
10 would be able then to focus in other ones which were most
11 promising and most desirable.
12 The staff, as I mentioned before, was excellent.
13 They have one member of the staff, a Black professional, who is
14 extremely interested in the problems of the innercity and is
15 working with groups in East St. Louis and in the Pruitt Sago,
16 and in the whole Bi-State area, to develop projects which
17 would be of assistance to the minority groups, their health
18 service education activities, the non-AHEC, if you will.
19 The AHEC which is non-AHEC, is in the hands of
20 a new person, who is a Ph.D. in education and has begun some
21 programs in this area.
22 Their work in the emergency medical services was
23 excellent. They received, I believe, about a quarter of a
24 million dollars to carry on this, or to initiate more planning
25 in this and the development of a larger program in this area

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1 then.

2 Their review of projects has certainly

3 improved, also.

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1 In brief, it was our feeling that the organization,
2 while it does exhibit some weaknesses, that with the addition
3 of a coordinator, deputy coordinator -- let me go over it
4 this way. We feel that Dr. Stoneman and his staff have the
5 capability, professional qualifications and interest to build
6 a first rate RMP. The goals, objectives and plans were rele-
7 vant and sound. It has some organizational problems which
8 presently hamper its growth but with a deputy coordinator,
9 the reorganization of RAG and broadening of the involvement of
10 people in the area, we think it has a great potential. We also
11 felt triennial status should not be withheld because of the
12 weaknesses but rather it should be approved on a tentative
13 one-year basis -- if it is triennial status, but with the
14 recommendation that it be reviewed at the end of the year.
15 The recommendation for the request for funding was for a
16 million four, the first year, a million 463 the second year,
17 a million five the third year.
18 Our recommendation was a $1,150,000 be approved
19 for the first year, $1,230,000 the second year, $1,316,000
20 the third year.
21 This includes funds for a deputy coordinator
22 and a $50,000 discretionary fund for Dr. Stoneman. Dr.
23 Stoneman's concern as far as the developmental component as
24 opposed to having his desire for developmental component
25 was in order to contend with the problems that existed in

1 the fact that Illinois RMP had developmental funds and he had
2 none and he wanted to be in a position to handle new projects
3 as they came up when they came up.
4 DR. SCHMIDT: Thank you. Secondary reviewer,
5 Dr. Thurman.
6 DR. THURMAN: I will have very little to add to
7 what Bob has said. I think just because of the fact that the
8 Missouri site visit came on at the same time the turf question
9 will become a major question and we heard some question of
10 concern when we visited Missouri because of their interrelation-
11 ship with Bi-State. I think the question of the coordinator
12 probably needs discussion by the whole Review Committee because
13 of the points that Bob has raised. And I don't think any of us
14 would disagree that if he is to continue in his present
15 action, that a very strong deputy director is needed. Lastly,
16 my concern, as already reflected by Bob, is the continuing
17 project-type orientation.
18 It would appear that this tripartite of RAG
19 basically and their appointment of associate coordinators,
20 if this is not constantly monitored by staff, will perpetuate
21 this type of categorical approach.
22 MR. TOOMEY: I might ask Maria Elena if she wants
23 to add anything to this?
24 MS. FLOOD: Well the only comment I might add is
25 that we got the feeling the first day that there was a strong

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1 staff capability and this was definitely reenforced as the
2 visit progressed. But the management problems are acute, and
3 there has been comment here at this committee that you can't
4 correct a weak coordinator with a strong deputy but in this case
5 Dr. Stoneman is not really weak. It has just been his insecurity
6 without someone under him to allow the staff to develop
7 the mechanism of interrelationships. They come to him, they
8 answer to him, they report to him. If he were given a strong
9 deputy that could pull together the management trends necessary,
10 I feel strongly personally that this particular staff,
11 under the leadership of Dr. Stoneman, could indeed develop the
12 program and follow the recommendation that we made to begin
13 a trend towards an improved RAG commitment and RAG participation
14 in policy planning and in goals,objectives, and also broaden
15 the scope of the program to really become a program and
16 deemphasize this mini-project advertising that they have used.
17 DR. LUGINBUHL: It is, of course, difficult to
18 judge a program without having visited it and just from
19 hearing discussion and reading the documents. I hope my remarks
20 are not overly critical but I can't help but raise a number of
21 questions from the comments that I have heard and from the
22 review of the material that we have.
23 First of all, it appears to me that there is some
24 problem with this consortium, and I wonder who is minding the
25 store. You have got three different medical schools involved

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1 in this. I asked yesterday specifically who has the authority
2 to replace a coordinator that is inadequate and I was told
3 that it is the grantee. I am not quite clear, who is the
4 grantee in this case, and who has the authority? Who makes
5 the decision? You have got two vice-presidents of health
6 affairs at large medical schools, another developing medical
7 school involved, but who actually makes the decision, who moni-
8 tors this program, that is question number one.
9 Secondly, I can't help but have some question about
10 the coordinator. After a day and a half, I am beginning to
11 think that the terms hard working and dedicated are euphemisms
12 for incompetence and I can't help but think that the suggestion
13 that a deputy coordinator be appointed is simply a way of
14 patching a very worn tire. I may be wrong in this but
15 I can't help but raise this question. From my point of view,
16 a strong coordinator, a good coordinator is not necessarily a
17 person who is a strong individual or who has a great deal of
18 personal dedication. I think one of the most important
19 qualifications of a coordinator is the ability to delegate,
20 is the ability to organize and motivate staff and when I hear
21 the coordinator has not developed staff, that he does reserve
22 judgments for himself, then that to me raises very serious
23 questions and I think that is a very serious deficit to try to
24 correct with a deputy.
25 If he hasn't seen this need himself and developed

1 the ability to delegate, I think that it is difficult to
2 force this by the appointment of a deputy. Finally, I would like
3 to raise a question about the budget.
4 I see that the coordinator is listed as 93 percent
5 effort but I read in the narrative that he is a practicing
6 plastic surgeon. I can't help but ask, what is the control that
7 we have over this man's total income? I don't know what the
8 relationship between this program and the consortium is, but if
9 there is simply no limitation on his outside income and the 93
10 percent figure means very, very little, then I can't help but
11 be worried about the amount of effort he puts into the program
12 and the amount of time he puts into his private practice.
13 In summary, I would like to know who runs the
14 consortium; I would like to hear a little more conversation
15 about the real ability of this individual to run this
16 program. And I would like to have some further insite into the
17 financing.
18 MR. TOOMEY: The consortium has agreed that
19 Washington University will be the grantee agency. And they have
20 an arrangement through which Washington University is the,
21 really, grantee agent, although the three do work together,
22 but it is Washington University. Dr. Guzzi, I believe, was
23 the name of the man from the medical school who is responsible
24 as far as Dr. Stoneman is concerned. You know, as a fellow
25 in management, I think I would agree with you under most

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1 circumstances.

2 However, there are some circumstances and this I

3 have seen, that people have varying degress or varying kinds

4 of abilities. Dr. Stoneman's ability is one in which he became

5 a participant in the program as a volunteer member of the

6 faculty when he was a member of the faculty of St. Louis

7 University. He is thoroughly dedicated to its goals, even its

8 present goals. He is, I would say, an extremely capable person,

9 although to be honest with you, he would be better off if he

10 were trained in management rather than in surgery.

11 But he has been trained in surgery and within, if

12 you will excuse me, those limitations, he does a rather

13 fabulous kind of job. He does need somebody who is trained

14 in administration who understands the kinds of things that you

15 are talking about to work with him. He relates well to all of

16 the universities. He relates well to all of the other

17 physicians. He relates well to his own staff. They are

18 extremely loyal to him, I think in every way, by every

19 indication. He relates extremely well to the, if you will,

20 the power, the financial and economic power structure in

21 the community. They have a great deal of faith in him. Perhaps

22 too much.

23 I think this is one of the cases unlike the

24 neighbor that he has in Columbia, Missouri, where I think the

25 administration does not have these abilities. As far as the time

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1 is concerned, we did ask him about this and he, his work
2 is done basically at night and on weekends as far as his home
3 surgery is concerned. I know it is a problemand I don't
4 know any way around it but he says that in order to supplement
5 the income that he receives from the RMP, that he continues
6 a small private practice. He also does continue with his
7 teaching at the St. Louis University.
8 DR. PAHL: Doctor, I would like to comment on
9 Point 3. You raised the question about what the control is
10 over the total income of coordinators. At the present time,
11 there is no policy within RMPS, HSMHA, or department that I
12 know of that provides any control over total income, other
13 than the usual ones of not being reimbursed twice for presumably
14 the same time expended.
15 However, there is increasing concern being expressed
16 and much more so in recent weeks from both RMP and also the
17 department andwe have been interested in this matter for quite
18 a while ourselves. Not so much the total salary as the matter
19 of part-time direction of RMPS programs and whether programs
20 which are running at $2 million a year can, in fact, be
21 effectively conducted without the full-time direction of
22 the chief executive officer. It is almost impossible for
23 any single program in HSMHA to write a grant management
24 policy about salaries because you are very familiar with all
25 the problems involved with time and effort and we just get into

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1 a tremendously complicated activity. But I should say that
2 there is very serious concern on the part of people within
3 RMPS and at higher levels about the costs of managing a program
4 and the results for the monies being expended, and what consti-
5 tutes good management. And I think there are continuing
6 efforts that are partially underway now. We have some
7 analyses going on now and I think we will be trying to develop
8 some reasonable kind of statement so that we can improve
9 the management of these programs without at the same time
10 trying to impose nonworkable definitions of time and effort that
11 NIH and others have found so impossible to implement.
12 DR. SCHMIDT: We have two or three issues on the
13 floor. One other one that has been brought up is whether this
14 region really is ready for triennial status given the stated
15 efficiencies in the review process particularly in the area of
16 discretionary funds and whether they have the adequate
17 review and decision mechanism that even meets the minimal
18 standards set by RMPS for the use of discretionary funds.
19 MR. TOOMEY: Let me comment on that a moment,
20 because there was difference of opinion as to its readiness
21 to assume the responsibility for a triennial status. And I
22 guess what we did was to compromise the situation which was
23 to say, triennial status but review at the end of the year.
24 DR. SCHMIDT: Sister, were you going to comment?
25 SISTER ANN JOSEPHINE: Yes, I would just like --

1 Mr. Toomey, has this program done anything to provide services
2 in Cairo, Illinois? I know this was requested.
3 DR. SCHMIDT: The answer is no.
4 John?
5 DR. KRALEWSKI: Just a couple of questions and
6 comment here that might go along some of the lines you were just
7 outlining but on the budgets it wasn't clear to me whether we
8 were giving them money to add staff. You were recommending
9 $750,000. They were running 517 or something such as that, the
10 way it looks. Could you clarify that for me quickly, what will
11 they be able to do with the 750? Along with that are you
12 recommending developmental component?
13 MR. TOOMEY: We were recommending full-time people
14 rather than part-time people as associate coordinators to
15 replace the part-time coordinators that were at Southern Illinois
16 and at the other universities.
17 Rather than having them as linkages to the
18 universities, having them in the area of rural health, urban
19 health and taking a segment of the responsibility for the
20 structure, itself, we were recommending in addition to that
21 only the deputy coordinator.
22 DR. KRALEWSKI: Do you recall how many FTEs that
23 would add?
24 MR. TOOMEY: Four.
25 DR. KRALEWSKI: Four? And were you recommending

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1 developmental component?

2 MR. TOOMEY: No, no. I guess it is semantics but

3 it is called discretionary funds.

4 MR. KRALEWSKI: One other comment I don't know if

5 I am reading this data, you know, from our book here

6 right or not. But it seems to me that last year in terms

7 of the award that we gave them which essentially was supposed

8 to be used for, you know, for the, to carry on their

9 program, develop some other projects then develop a three-year

10 program for us. It appears that they implemented some 22 pro-

11 jects with it at very low level funding and now we are coming

12 back this year and asking to increase that low level funding

13 for all but two of the 22, up to, you know, much more substantial

14 funding. And I raise the question over whether,you know, that

15 indicates any real, you know, ability to really handle

16 the question over what projects should we implement and how

17 should we best handle some funds.

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1 MS. HOWSEAL: This region had its budget stated
2 for three months in order to phase into our three-cycle review
3 process, and they operated with the funds to discontinue some
4 of their old process and initiate some of the new ones with
5 this last three months funding, and they did it only with the
6 three months period knowing the projects could be turned off
7 if the reviewers felt they didn't have merit, but it's not
8 any -- they aren't projects started a year ago, they are brand
9 new projects being started the last three months of this present
10 year, and it is because of our need to bring the region into a
11 different review cycle that that this was done, not because
12 of the --
13 DR. KRALEWSKI: 22 projects?
14 MS. HOWSEAL: Not only 22. Some of those were
15 held over from the last year.
16 DR. KRALEWSKI: They don't show that unless --
17 well, I may be reading this wrong.
18 MS. HOWSEAL: The printout probably doesn't show
19 when these projects were initiated. If they were initiated
20 during the last three months, the printout would probably show
21 they started at the beginning of the year, when in reality
22 they would only get funding starting October.
23 DR. SCHMIDT: Dr. Luginbuhl?
24 DR. LUGINBUHL: I would like to ask a question,
25 point of information. I am looking at the budget in the actual

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1 grant. I note that the budget in the actual grant lists a
2 number of associate coordinators, but they are categorical.
3 They are not the kind of associate coordinator that you are
4 recommending.
5 If this award is made under the terms that have
6 been outlined, what assurance do we have that they will hire
7 the kind of associate coordinator that we are recommending
8 as opposed to going ahead with the budget?
9 I am trying to get some feeling for what authority
10 this recommendation has, and I am asking this particularly
11 because I got the impression that this program had been given
12 some guidance in the previous year about the need for re-
13 structuring the organization, and apparently did not follow it.
14 MR. TOOMEY: I don't know that it had the instruc-
15 tions of the previous year, and I really can't answer honestly
16 the fact that they will do what we say.
17 I would assume if you tell them that this is the
18 basis on which the funding has been made that they will
19 consider it directly enough. I don't think they have much
20 alternative.
21 DR. SCHMIDT: Seems to me at this point to
22 enlarge a little bit on your question, that what has been
23 recommended as one-year funding level was site visit, and so
24 in theory, staff, et cetera, would carry back to the region

25 the strong concerns of the committee and the assurance that

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1 the committee would be looking at what they have done, during
2 the coming year. And the stick that one has is the
3 funding level or the second and third years of the triennium,
4 if you wanted to use a bigger stick, what the committee
5 could do would be to recommend withholding the triennial
6 status and give them one more year, and have them revise
7 the triennial application and come in in one year with the
8 triennial request. That would be a bigger stick yet.
9 Let me just ask a very simple question that hasn't
10 been asked for a year or so around this table, but is this
11 a viable region?
12 MR. TOOMEY: Yes.
13 That's a simple answer. But you have got interest
14 in the community, you have got interest on the part of the
15 medical profession, you have got a great thrust coming out of
16 southern Illinois, as I see it, in the future. You have,
17 you really have. A personality of the man. He is a good man
18 running that RMP. You have got capable, qualified staff.
19 You have got an interest in education. You have -- you really
20 have the backing of those three universities.
21 One of our concerns had been that the university
22 was exercising too great influence. In actual fact what
23 they were doing was evidencing great interest. Now at the
24 time that it was categorical, I am sure there was great
25 influence coming from the university in terms of their

1 projects. Right now what you have is great interest on the
2 part of the university in extending its own services and its
3 own concerns through RMP.
4 So I think there is no question, as I look at the
5 total picture that this is a very viable organization. This
6 was one of the reasons why despite our discussion as to
7 triennial status that we felt with all of these pluses,
8 despite the fact that you can focus on the minuses very
9 easily, in light of all of the intangibles, that this has
10 potentially a great future.
11 DR. SCHMIDT: Do you feel that the turf problem
12 with Illinois is a minor one or moderately serious one or
13 very serious one?
14 MR. TOOMEY: Well, I don't know how to evaluate it.
15 We talked to Dr. Snoke who was out of the governor's office.
16 He is not ready to make the decision himself.
17 DR. SCHMIDT: Dr. Snoke is totally confused by the
18 whole thing. You wouldn't be able to get anything but confu-
19 sion out of Dr. Snoke.
20 MR. TOOMEY: Certainly the recommendation that
21 the two groups get together and there is some indication
22 that can declare areas of primary concern which would be
23 southern Illinois for the bi-state RMP, and perhaps what we
24 might call a DMZ in the Springfield area in which there would
25 be some concern on the part of both Illinois and bi-state.

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1 But, you see, southern Illinois is up in the
2 Springfield area and relates to bi-state as far as its school
3 is concerned so that there are some problems, and this perhaps
4 would be one of those areas in which there is an acceptable
5 overlap.
6 DR. SCHMIDT: Dr. Thurman?
7 DR. THURMAN: I would just agree with Mr. Toomey's
8 analysis. I think in answer to your question, it is a
9 viable region.
10 My second question there, is there a motion on the
11 floor?
12 DR. SCHMIDT: Yes, there is a motion on the floor
13 made by the principal reviewer. I am not sure it was seconded.
14 I will ask at this time if the motion which was to-wit,
15 "approval of the triennial status without approval of the
16 developmental component, but with discretionary funds to the
17 tune of 1.15, year one; 1.230, year 2; 1.316, year three" --
18 is that the motion?
19 MR. TOOMEY: With review at the end of the first
20 year.
21 DR. SCHMIDT: That's correct, with review, with
22 a site visit? In one year prior to the making of the second
23 year award.
24 Is the motion seconded?
25 It is.

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1 Dr. Thurman?

2 DR. THURMAN: I would like to offer a substitute

3 motion going along with the funding, but withholding triennial

4 status with preparation of a triennial application for next

5 year.

6 DR. SCHMIDT: All right, is there a second?

7 DR. LUGINBUHL: I will second.

8 DR. SCHMIDT: Substitute motion is seconded.

9 Let me ask someone whether or not this would cause

10 some breakage or to what extent would this be thought

11 detrimental?

12 MR. TOOMEY: I think I'd defer this to somebody

13 who knows the area better than me.

14 MS. HOWSEAL: Well, there are two sides of the

15 story. One is the tougher problem and how this will be

16 settled in the next year. That obviously is a consideration.

17 The second is that this region last year came in

18 with a triennial application and staff said that at that time,

19 is that correct, that they weren't ready for triennial status

20 at that time, and held them off an additional year?

21 Their program plan seems pretty well in order.

22 But it is the organizational problems that need to be worked on.

23 I think it --

24 DR. SCHMIDT: The question is, breakage, damage

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25 and so on.

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1 DR. LUGINBUHL: I have heard discussed several
2 times in the last day and a half this question of breakage,
3 or injury to a program by the use of too severe measures
4 to try to bring about remedial action. It appears to me the
5 two measures that are available are, one, some form of budget
6 reduction; and, two, withholding triennial status. I would
7 gather that both of these have been employed on a number of
8 occasions in the past. It would be very helpful to me in
9 voting on this kind of a question to get some indication of
10 what kinds of damage have actually been observed from these
11 classes of action in the past.
12 In other words, has this really resulted in
13 significant injury to some programs, or is this a concern that
14 possibly has been weighed too heavily? If that is the case,
15 it would obviously indicate to me that we should use these
16 measures more freely rather than less freely.
17 I just don't have any feeling for what effects
18 these actions have been on programs and just how real a threat
19 it is.
20 DR. SCHMIDT: I will try to answer that. I think
21 that as you hinted at yesterday, the committee during the
22 five or six years that I have watched it, has chosen the
23 route of not stressing region, if there was a question of too
24 much breakage, it opted not to stress the region in that
25 way. Usually other routes for effective action have been

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1 taken. Either the chairman of the site-visit committee,
2 such as Sister Ann, or the director of the program, or
3 somebody went out and got to the people who had to listen
4 who were in a position to do something.

5 Then either the coordinator was removed or the RAG
6 chairman was removed or the RAG structure was altered. But
7 I don't think that a club has been used with enough force
8 in the past, to answer your question.

9 The committee, if it's erred, has erred on the side
10 of being conservative, using these other routes to get the
11 messages back. And I -- actually the committee has talked,
12 and staff knows the talk about stopping funding completely
13 of a region, for example, withdrawing regional status, let
14 alone, you know, something else.

15 And these methods have not been used for really,
16 if you look back the regions, Indiana will be coming up,
17 which has more or less a cataclysmic year that was achieved
18 really through two site visits in a row, and we will be talking
19 about that.

20 So that I ask the question quite deliberately from
21 my experience, that sometimes you will run the danger of
22 the RAG or some of the critical people just throwing up their
23 hands and saying the hell with it, and going away. And we
24 haven't taken that risk deliberately in the past.

25 Mrs. Flood?

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1 MRS. FLOOD: I would like to comment. My point
2 of view as to the potential breakage, I think the member
3 universities of the consortium expressed to the site visitors
4 a concern to fulfill their participation in the guidance of
5 the regional medical program in the new light of RMP de-
6 emphasizing the medical school-oriented projects and
7 emphasizing more trends toward a programmatic approach.
8 Seemed to be no qualms on Dr. Posta's part.
9 I think that this is true, Dr. Schmidt's point,
10 that perhaps the problem of withholding triennium status
11 to this particular region, which I think is viable and has
12 potential, would in a way give these consortium people
13 that feeling to heck with the whole thing, we have tried, but
14 may be going the wrong way, and now we are getting no backing,
15 and because of the tougher problems, not giving them potential
16 with some secure funding for the future of these years, I
17 would put in a word for the triennium.
18 DR. SCHMIDT: The issue should be clear for the
19 committee then. The substitute motion would withhold the
20 triennial status, but do everything else that the original
21 motion did so that you will be voting really in effect on the
22 triennial status with the substitute motion. Are you ready
23 for the question?
24 All right, all in favor -- do you understand that
25 if you vote yes, you will be voting to withhold triennial

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1 status?

2 All in favor of the substitute motion, please say

3 aye.

4 Opposed, no?

5 The motion is defeated. The original motion then

6 is for triennial status, et cetera, et cetera, as I recited it

7 before. Are you ready for that question?

8 DR. SCHLERIS: Like to have a little discussion

9 about the discretionary funds which sound like a developmental

10 component to me.

11 DR. SCHMIDT: I will try to speed this up by comment-

12 ing. I think probably the reason they want them is to be

13 able to compete with the Illinois regional medical program

14 that does have these funds it can sprinkle around and stimulate

15 this in their back yard, and they have got to be able to

16 stimulate this in their back yard in order to be able to

17 develop the sorts of things that will change their direction

18 that we are telling them they have got to do, and we have

19 discussed before that sometimes the regions that deserve the

20 developmental component least need the funds the most in order

21 to have flexibility, et cetera, and I would assume that this

22 is the situation there. Is that accurate?

23 MR. TOOMEY: That's accurate.

24 MR. HILTON: Are we endorsing the concept of

25 discretionary funds for other regions? As -- seems to me we

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1 had some discussion about the developmental component versus
2 discretionary funds at some earlier region some months back,
3 this came up then, too.
4 Are we saying that this is a viable option for
5 folks who don't qualify for the developmental component?
6 DR. SCHMIDT: I think that each region almost has
7 to be looked at individually. Obviously the answer to your
8 question is yes. But we aren't making any general pronounce-
9 ments or anything else.
10 DR. PAHL: Dr. Margulies indicated to me that
11 he will be presenting this general topic of discretionary
12 funding and developmental components and other names by which
13 these funds go before the forthcoming October council, not
14 trying to make a policy at that time, but to clarify the issues
15 and perhaps come out with a definitive statement, because we
16 do not have a general pronouncement and obviously we are
17 getting into this area.
18 At the moment you are free to act as you choose
19 on individual case-by-case basis.
20 DR SCHMIDT: I think we will kind of restrict this
21 to a couple more comments.
22 Dr. Luginbuhl?
23 DR. LUGINBUHL: Two quick questions. If we are
24 indeed giving the developmental component, why don't we
25 call it that? Why do we use some other name?

1 And number two, is the letter that goes to this
2 program, or is the advice that goes to this program going
3 to include some expression of concern about having a part-
4 time director with a -- with another outside activity?
5 DR. SCHMIDT: The answer is yes.
6 All right, I am going to call the question, unless
7 there is some -- something new. Because we are just simply
8 not going to get through our day's work unless we shorten this
9 up.
10 DR. JAMES: The question comes then to my mind,
11 in this kind of situation, if, in fact, there needs to be
12 some restructuring of organization and which eventually
13 results in restructuring of program, then monies that are
14 already allocated, if in fact they could not be redirected,
15 I am at a loss to understand why there should be -- why
16 that the RMP should be awarded additional funds for --
17 whether it is called developmental or discretionary, when in
18 fact it would appear that the base monies that are available
19 need restructuring and when that is done, and used to
20 restructure, organize restructure program, then it, to me,
21 would show that the whole program then can very well use new
22 funds for development, once it gets its base straightened out.
23 DR. SCHMIDT: I think the way I will answer that
24 is to say that the committee just voted not to deny triennial
25 status. That means that in the committee's opinion, the region

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1 has the ability to make the necessary decisions to expend the
2 funds they have wisely. One category of which is loose and
3 not earmarked for projects now, but is, quote, discretionary,
4 unquote.

5 All right, I will put the question. All in
6 favor of the motion, please say aye.

7 And opposed, no.

8 There are "nos," but the "ayes" have it, and the
9 motion is carried.

10 I think that we will at this point take a no more
11 than 15-minute break and start again promptly in 15 minutes.

12 (Recess.)

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1 DR. SCHMIDT: We are going out to the great state
2 of New Mexico which has the largest regional advisory group
3 in the history of the program.
4 During your comments I hope you will discuss why
5 they have a regional advisory group that seems to include the
6 whole population of the State of New Mexico.
7 MR. HILTON: For the record I can't be heard. For
8 the record, okay.
9 Just a few preliminary comments and I will make
10 them very brief in view of the pressure of time.
11 My talk deals with specific sources, very general
12 items, before we go into specifics to kind of sensitize you
13 to some special problems of the New Mexico area.
14 I should mention that since the submission of the
15 printed documentation on New Mexico we have received much
16 new data, as recently as the day before yesterday a phone
17 call giving us additional information which I will bring up
18 at the appropriate points throughout the report.
19 We were under, during our site visit, some time
20 pressures. The New Mexico Program staff had taken the
21 liberty of preparing quite a fairly well stated -- using
22 overheads, other kinds of materials which pretty much blocked
23 in our time. We were forced to subdivide ourselves and
24 fractionate their well-organized plan in order to get a lot
25 of ground covered we wanted to cover.

1 Some points pertinent to the consideration of this
2 region: The state is large geographically with a population
3 of slightly over a million. The geographical expansion of
4 the state creates special problems that the region has
5 attempted to address itself to.
6 The state is multicultural, emphatically so, with
7 the major cultures being Mexican-American, Anglo and Indian
8 and the feeling generally being that efforts to improve
9 health care have to take that fact into account and try to
10 work with the facts rather than try to change it and smooth
11 everything out and work with some kind of easy glossy kind of
12 program.
13 The state is poor, I have been told. I haven't
14 been able to verify this. The military installations are a
15 major source of employment in the state. Continued support
16 therefore for any of the projects being conducted by the
17 program staff has been exceedingly difficult and if you look
18 at some of the projects listed there, RMP has a largely
19 young staff, CHP agencies not awfully prominent in the state.
20 Then RMP in the absence of very forceful
21 representation on the part of these other kinds of health
22 concerns in the state has really become very prominent.
23 That prominence has been greatly helped by the large RAG,
24 that is a relatively new development there.
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25 But we had some concern, still speaking

1 generally, that RMP has become the center for so many things
2 in New Mexico that we may in fact be supporting activities
3 that in other states would be supported by other resources.
4 Going item by item, at a fair clip, too, through
5 our evaluations, our site visit report, I should mention
6 that the primary purpose of the visit was to review their
7 '73-'75 application, triennial application, and to assess
8 their progress since June, 1971 site visit.
9 In conducting that meeting for that purpose, we
10 observed the following things: That the goals of RMP as
11 stated in materials certainly seem to be in keeping with the
12 RMPs' mission, the increase in availability, improving
13 quality care, moderating the costs of care, et cetera.
14 We had some problem with the goals and objectives
15 in that there seemed to be an absence of measurable short-
16 term objectives in the context of what the program was
17 attempting to do.
18 General priorities have been identified and
19 there is a listed rank order which aids the program in
20 making decisions about what we found that if resources are
21 reduced, et cetera.
22 Under the area of accomplishments and
23 implementations, program staff has stimulated several
24 worthwhile activities throughout the state. They do of
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25 course now have a pretty substantial EMS activity going on:

1 Registries, involvement in the hatch area of New Mexico,
2 programs internally to aid staff, things involving processing
3 centers, and a computer budget monitoring system so they
4 can determine on a moment's notice how much they have got to
5 spend in each item, a cultural training laboratory which has
6 already done some things and plans other things that will
7 help with that multicultural nature of the state I referred
8 to earlier.

9 They are developing a statewide system for
10 statewide hospitals to centrally purchase items. The hope is
11 they will be able to reduce costs of certain aspects at least.

12 Other health agencies within the New Mexico
13 region, as I pointed out earlier, do rely pretty heavily
14 upon the NRMP. They have become the primary agency for
15 data analysis in the state.

16 Physicians do look upon the program for
17 professional and technical assistance, consultation,
18 information, et cetera.

19 Under the area of continued support because of the
20 problem of the general impoverishment of the state, they have
21 not been able to do as well as we would have liked to have
22 seen them do. There have been some accomplishments. We
23 have encouraged other kinds of things be done to get
24 additional help.

25 Dr. Stone of the medical school in his

1 discussion of his grantees, stressed I think very clearly
2 that the medical school is unable to pick up many of these
3 kinds of efforts that they would like to. He was kind of
4 emphatic about that.
5 On the matter of minority interests, the majority
6 of the state's population percentagewise is one minority
7 or another. Representation on the program staff of
8 particularly the Spanish-speaking group was in my opinion
9 quite poor; not my opinion, the team agrees on this, that
10 representation was quite poor. Very few professionals, very
11 few clerical.
12 Now, it should be pointed out one of the new
13 developments that I referred to earlier that we did receive
14 in our phone call information that the RAG for RMP has
15 met as of September 16 and that at that meeting they
16 declared their intention to initiate an affirmative action
17 plan which would remedy some of our concerns in this area.
18 Even since our meeting with the NMRMP staff there were
19 improvements in that additional persons were hired between
20 the time of our site visit and the time of the September 16
21 meeting. So there was visible evidence of intention to
22 improve an affirmative plan and it seems to suggest there will
23 be greater pickup in this area.
24 I had the opportunity to get into the New Mexico
25 area a few hours earlier than I had expected I would so

1 during that period Dr. Gay, the coordinator there, arranged
2 that one of his staff would show me around. I did get a
3 chance to visit a couple of the clinics and some of the local
4 reservations to get a kind of firsthand feel for what the
5 staff's relations were on the community level.
6 The staff, especially in the community health
7 service section of the NRMP staff, is pretty community-
8 minded, generally young, have not been as aggressive, at least
9 not as yet, as I would have liked to have seen but potential
10 is still there. Talking to a number of staff, even in the
11 setting of the clinics, and talking to the people in the
12 clinics, we were very well received.
13 The manager of one of the clinics I talked to
14 had great hopes for a continuing relationship and a
15 developed relationship.
16 We did something in this particular area in this
17 region that I don't know how frequently it is done; it has
18 not been done on anything that I have had yet. We invited
19 from the general audience comments, criticisms really, any
20 kind of thing anybody wanted to say about RMP, pro or con.
21 We did that somewhat expecting that we would be blasted,
22 especially from the Spanish-speaking section of the audience
23 but found that on the contrary, while there were things that
24 people had to say and they felt very strongly about them,
25 there was a consensus even among those who were opposed or

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1 seemed to be opposed to NRMP activities that it was doing
2 better than before and doing well.
3 Concern seemed to center around its not doing
4 enough or what it is doing isn't fast enough to please. The
5 general feeling was even from the opposition that the program
6 is having an impact.
7 Again I relate this to a large degree to the fact
8 of expanded RAG which was expanded by the way to intensify
9 representation from throughout the state. So our
10 recommendation with regard to the minority area is that
11 there should in fact be increased representation. More
12 needs to be done certainly.
13 Dr. Gay has provided, who is the coordinator,
14 James Gay, has provided pretty strong leadership in the
15 NMRNM. It should be pointed out it is another one of those
16 programs which has undergone some pretty cataclysmic change
17 in the past 12 months or so. In fact, there is evidence
18 of how change was, had been undergone and was still
19 undergoing at the very time we were meeting with the NMRNM
20 staff; the changes being some of the literature we have had
21 up to the moment of our going there to review and discuss was
22 updated in the process of their presenting their visuals.
23 One area for example, prominent instance of this
24 was the complete change in management operations right in
25 the middle of our visit, you might say, moving from a

1 matrix kind of setup in which staff operated on a task force
2 kind of basis, issue-oriented basis back to a more
3 conventional organizational staff.
4 We kind of got the feeling when this was cast on
5 the screen that it was not only new to us but probably to
6 much of the staff, as an indication of how this is
7 developing.
8 Throughout that, however, Dr. Gay I think
9 impressed us all with his ready willingness to learn, his
10 enthusiastic willingness to learn. He seemed to be
11 listening and took notes throughout the session of the things
12 that were in fact being said.
13 We began to feel a change both in the site visit
14 and of course with these recent phone calls. We have seen
15 things happen since the site visit that go well I think
16 generally.
17 Dr. Gay has established excellent relationships
18 with health providers and health-related agencies in New
19 Mexico and I guess that is best testified to by the fact
20 that a great deal of them, if not all of them are on the RAG
21 in addition to considerable consumer representation.
22 With regard to program or core staff, the
23 decision to decategorize the program staff structure,
24 moving away from the traditional emphases appears to have
25 been sound and effective and carried out, though you will

1 notice in the projects themselves that there is still a kind
2 of mix of traditional emphases, plus some of the newer things
3 that are coming out.

4 Now, traditional programs, or I should say the
5 projects, old projects listed in your printouts have been
6 supplemented by a variety of what they call developmental
7 projects, which we can go into some discussion on a little
8 later on, but these developmental projects then are to be
9 run directly by the project staff.

10 And there more than in the old projects we see
11 a real emphasis on new directions. The community health
12 services section of the NRMP staff represents the truest
13 form of what I would call a thrust, one of the truest forms
14 that I have seen in NRMP. In fact, if you look at the
15 projects, one gets the feeling as mentioned in another
16 program, it said it was being a program, it is a collection
17 of projects. However, in their reorganization and in going
18 back to more traditional organization of staff, they have
19 gotten at least some of the idea of thrust.

20 Community health services represents a compilation
21 of kinds of projects in an area that relates to working with
22 clinics, working in Indian health rehabilitation, working with
23 consumers; that thrust also has become what they call their
24 community response system.

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25 It is attempting to organize itself on a

1 statewide basis and the exact dimensions of how that shall
2 be accomplished, by the way, I am not entirely clear, from the
3 site visit and not satisfied from the material received
4 subsequently that it is really all worked out yet, but their
5 hope is that through a number of mechanisms available to them
6 the community health services component will be felt through-
7 out the state and will be the primary source, nerve center,
8 for receiving suggestions for things RMP should do in that
9 region.
10 They have got a number of approaches, number of
11 ways they can go about doing this. They have attempted I
12 think unsuccessfully to use their RAG as a basis for picking
13 up suggestions of projects and their RAG is quite extensive
14 covering the entire state.
15 The problem there is that when they try to hold
16 RAG meetings in Northern New Mexico to cut down the travel
17 they get the Northern New Mexico side of the RAG. If they
18 go to Southern New Mexico, they get the Southern New Mexico
19 side of the RAG so if they hold two meetings in the course of
20 a year they really get only one side of the state covered in
21 each meeting.
22 So we suggested to them there might be other
23 methods they use; they might go to the community health
24 education services which have already devided the state into
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25 four quarters, and to use RAGs or local advisory groups, one

1 for each of the four; that might be another way in which the
2 community health services group might be able to pick up in an
3 orderly fashion real grass roots kinds of input.
4 There is an interest there in any event in really
5 relating more closely to consumerism as it was pointed out
6 in part their success or failure would depend on bringing in
7 minority staff because as matters stand now there are only
8 three Spanish-speaking staff on the NRMP and this does create
9 difficulties in relating language and culturalwise the people
10 they are attempting to reach.
11 It is very confusing to look at now on graphs and
12 charts but has additional problems beyond that in that it is
13 a response system first and foremost.
14 Many of the accomplishments of the region have
15 really been in response to inquiries from people outside of
16 NRMP who say, "You know, we need this, that or the other,"and
17 then of course the staff has been geared up to just take that
18 suggestion and run with it as a response.
19 We did have some criticism that there ought to be
20 more initiation on the part of RMP but we think in that
21 regard that people know about the RMP, certainly not the
22 case of many regions, so they do feel free to come to it
23 despite the fact that it is not itself initiating to the
24 degree we would like to see it.
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25 The RAG seems almost too large but as I say, it

1 does reflect combining of a broad representation and I think
2 more importantly, reflects a combining of two kinds of life
3 of the program.
4 When Dr. Gay took over, he inherited some of that
5 and felt in his judgment rather than trying to erace what had
6 come before, to integrate it in a newer and bigger scheme.
7 We had less problems with the RAG than the internal
8 organization,numbers of committees, task force kinds of
9 committee structures using RAG and staff personnel to carry
10 out the programs' objectives.
11 Again new information in response to our criticism
12 of the number of committees of which there were some 14 in
13 number, the September 16 meeting had at least, there was some
14 indication in the September 16 meeting that these would be
15 reduced to nine.
16 Consumers are more than adequately represented, by
17 the way, on the present RAG and I think this is certainly
18 necessary in view of the fact of the limited impact of CHP
19 in the area.
20 One of last year's concerns, in response to the
21 Executive Board, as authorized it increased from eight to 11
22 members.
23 We also have some concern relating again back to
24 the coordinator that the structures that had been
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25 developed did not allow enough coverage of central

administration; I guess, to put it another way, if Dr. Gay got sick that the whole thing seemed it would fall apart. He didn't have enough direct help at the top.

They responded to that too. The nine-sixteen meeting did endorse the recommendation that there be two deputies, one for support services and one for operation in the programs that would assist Dr. Gay and in that way further unite or bring together the organization.

The grantee agency, you know, of New Mexico has provided excellent administrative support to the RMP. The medical school no longer has as it once did excessive dependency upon RMP, and grantee and RAG relationships are quite good.

7149
End #8

CR 7149

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Reba 1

1 One evidence of the relationship between grantee
2 and staff, we were able to determine what appeared to be in-
3 credulous, but delightful situation where the grantees is
4 apparently providing virutally rent-free facilities for the
5 NRMP as they move into additional space. I say virtually because
6 I don't know if that ever was investigated to everybody's
7 satisfaction but it looks that it might in fact be the case.
8 On the matter of participation, key health interests,
9 institutions and groups are participating in the program, this
10 accounts again for the size of the RAG. We did hear from the
11 Red Cross representative, the president of the New Mexico
12 Nurses, the CHB representative, the Medical Association, Dean
13 of the Pharmacy School, even testimony from a dissenting
14 student from the medical school locally, on some of the activi-
15 ties, but at least everyone was there and the general feeling
16 was that the problems remained with problems of the rate
17 of change.
18 We did have two recommendations under the area of
19 local planning, site visitors were made aware of some problems
20 arisen in regard to providing RMP proposal to CHP in advance
21 and for CHP comment and there was feeling that this should be
22 done so that CHP would have the opportunity to respond well
23 in advance of a proposal going to us.
24 The site vitors recommend that the Chest projects,

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25 community health education services projects should in fact

9

Reba 2

1 create four local advisory groups in the next year to provide as
2 they are willing to undertake the appropriate responsibilities
3 and resources, their share. We did have concern about the
4 actual representation on such a broad scale of the state and
5 we think if representations focussed locally, as was proposed
6 through the use of the community health education services,
7 that they will have more meaningful participation on the part
8 of each representative.
9 Feeling was that no one in the Norhteastern New
10 Mexico would be motivated to be concerned about Southwestern
11 New Mexico and to look really carefully into that but if the
12 northeastern end of it has its own LAG, Local Advisory Group,
13 relating to the program that you would get a lot more particip-
14 ation and there would be a focal concern with the local needs
15 there, other matters of assessment of needs and resources you
16 may have seen some of the very nice little brochures, the
17 informational services office of this outfit is great.
18 Publications that they made available, some studies
19 they have done on various aspects of NRMP activities, maybe a
20 set of these booklets, some 14 or 15 in number on the table
21 over there. The program has done a good job of compiling
22 community health profiles but again, I think that is the
23 last program we reviewed, there is a problem in utilizing this
24 information in carrying out the projects and programs. They have
25 done a good research job on this, at least the material looks

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#9 Reba 3

1 good, it is well written material, easily readable and I have
2 got about 20 pounds of it in the mail in advance of the site
3 visit.
4 The program does need to include assessment of need
5 and resources as criteria for review for determining program
6 staff activities; programs should make better use of the data
7 base for the fund priorities. Under the area of management the
8 site team was impressed with the innovative management pro-
9 cedures and rated this as quite excellent, included among those
10 a processing pool, means by which speedier and neater pro-
11 duction of information materials could be produced and also
12 their monitoring, computer monitoring system.
13 Budget: Other matters of evaluation, the full-time
14 evaluation director complements the agency and works well with
15 RAGS evaluation committee. Members of the evaluation committee
16 staff and RAG participate in the programs activities where new
17 programs are developed and technical review committee sessions
18 where the proposed programs are technically reviewed.
19 The team endorsed review quarterly progress reports
20 by the evaluations committee and these are required by all
21 project directors. Other matters of program proposals NRMP
22 describes developmental projects as those considered as line
23 items under program staff.
24 This matter of terminology was brought up. We had
25 a sketch in which it was the effort of the coordinator, the

#9

Reba 4

1 entire staff to characterize RMP's and to define within that
2 broad characterization exactly where NRMP came to rest.
3 Three models described to us were the traditional
4 RMP, the transitional RMP and the developmental RMP. NRMP
5 classified itself as the last type that had the flexibility
6 within program staff to function quite well in a variety of
7 areas and to really bring about change without depending on
8 branch occies, some really object to that. Some aspects of
9 their overall program in fact do look transitional.
10 I already commented on the character of the projects
11 they wished to support. They ranged from the old categorical
12 through the AHEC right now to their developmental programs, they
13 described what seemed to be pretty relevant kinds of thrusts.
14 They want developmental component funds which will be used
15 to study feasibility of identified program opportunities.
16 The establishment procedures for reviewing new
17 program proposals will be utilized for developmental component
18 requests. Under dissemination of information a program has
19 efficiently disseminated information to key groups, other health
20 related institutions. The team did suggest that the program
21 could more advantageously utilize one of the most important
22 health resources that they apparently are not using, the Lovelace
23 Foundation for Medical Education and Research located in New
24 Mexico.

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25 I think we should be strong on this, we would want

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Reba 5

1 it to be collected in the advice letter to this region.
2 Utilization of manpower and facilities, the site team was
3 interested in and enthusiastically supported most of the new
4 directions, the new types of manpower that were described.
5 However, they were somewhat frustrated by the
6 fact that they still are basically intentions and are not well
7 developed programs of activity. This relates somewhat to
8 the response concept, responding but not initiating. Again,
9 in talking with some of the staff in certainly the areas, they
10 have very good ideas there among this young staff.
11 There seemed to be some uncertainty, however, and
12 I had here the opportunity to speak very personally with a number
13 of the staff, seemed to be uncertainty as to whether or not
14 these good ideas could in fact be implemented. There was some
15 uneasiness and I am not certain whether the uneasiness is what
16 it was or whether it was when the administration of the local
17 RMP would endorse them, perhaps both, I think the site visit
18 in that regard would have been helpful.
19 I think the leadership, we were liberal, encouraging,
20 patted on the back where appropriate and withhold support where
21 appropriate. There are some technical legalities on some of
22 the projects. Several of them in fact appear to be designed
23 to assist established health professions, training programs of
24 one kind or another, specifically dental assistants, medical
25 technicians, inhalation technicians.

#9 Reba 6

1 This is a matter to be looked at very closely. The
2 programs intentions to emphasize new kinds of paramedical
3 manpower are laudatory but plans in this area are not yet well
4 defined perhaps because of the uncertainties that I have
5 identified. Through a variety of their programs they have
6 in fact contributed significantly to the improvement of health
7 care in the area.
8 There are four New Mexico communities who applied
9 for a national health service core assistance with the help
10 of the NRMP staff and there are several other projects, at the
11 Tierra Maria Community Clinics where there have been some
12 marked good apparently. Short term pay-off, reasonable to
13 expect, the operational activity is proposed will increase
14 the availability and the accessability to service groups and
15 enhance the quality of care in the next two or three years, it
16 was the general judgment of the site visit team.
17 We did at the time of our site visit on this matter
18 of regionalization encounter some discomfort on this matter
19 of where shall the control lie. Dr. Gay had inherited real
20 problems because of the apparent emphasis on decentralization
21 of NMRP resources prior to his assuming that role.
22 In response to that condition which was very
23 limited, created a lot of problems for him, he moved rapidly
24 toward centralizing, putting everything pretty much under the
25 central Albuquerque office control and there appeared to be
in the language and the -- the language of the application and

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#9 Reba 7

1 the thinking of the staff some uncertainty as to this issue
2 of, decentralization versus centralization of effort.
3 I think as we talked about the need for represent-
4 tation, the plan of using the local Chest LAGS, et cetera,
5 that there began to be a feeling on the part of the staff and
6 part of the coordinator, that there is a middle road between
7 these two extremes.
8 It remains to be seen whether or not this will in
9 fact come out in the wash. But I have a strong feeling it
10 will because we approached the topic from several different
11 directions from the point of view of projects and point of view
12 of local representation, point of view of staff recruitment,
13 even.
14 Not for example be able to recruit people from one
15 community that is -- to which they are indigenous to one end
16 of the state to travel to the other. You are necessarily
17 talking about some kind of decentralization in that area as well.
18 DR. SCHMIDT: Bill, I will ask if you can try to
19 wrap it up in about five more minutes at the most.
20 MR. HILTON: I think I can do it in two. The region
21 has provided evidence that they are trying to attract other
22 support. They have not been successful largely because other
23 support really has not been available in many respects but we
24 urged them to try it out on that and they said they would but
25 you really don't know what the direction is going to be.

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Reba 8

1 The state apparently is poor and local industry is
2 limited, too, in what it can contribute. All in all this is
3 a general I guess kind of summary of this before we go into
4 matters of budget, it was the site visits' feeling that on the
5 basis of what has happened since Dr. Bay assumed office that
6 this is basically a strong program in need of some guidance and
7 counsel.
8 They are willing to learn. It is not a program which we
9 are going to be having to tape record the same message each
10 year, at least we did not leave with the feeling it was. It is
11 ripe for counsel on some of its directions and goals and so
12 forth. And it is basically a pretty strong program. I think
13 with that I would normally defer now to our second reviewer
14 who happens to be Sister Ann Josephine. Since she had to leave
15 she did leave me some notes, summarizing any questions or
16 comments she had.
17 I have not had the chance to look over the notes but
18 I could do that you know, or while we are awaiting questions.
19 DR. SCHMIDT: If these notes are legible why don't
20 you pass them down to the end of the table and let staff
21 look at them, and we will ask him to summarize what she has
22 to say very briefly, and why don't you go ahead with recommen-
23 dations?
24 MR. HILTON: All right. Site visit team recommended
25 that NMRMP be approved for triennial status for 05, 06 and 07

#9 Reab 9

1 years and that developmental component be approved with the
2 condition that a mini-site visit be made within the next year
3 to review the region's progress.
4 On the matter of budget, briefly, the request was
5 in the area of program staff, $1 million 319,000. Site visit
6 recommendation was $830,000 on that figure. Developmental
7 component request was for $138,000. Our recommendation was
8 $120,000. Operational projects request was for $223,000, we
9 recommended $350,000 which does in fact include $118,000 for
10 the tumor registry which in the past was reflected in their
11 program staff, moving into their operational projects.
12 DR. SCHMIDT: This is the first year or for all three
13 years?
14 MR. HILTON: First year and carryover, I think carry-
15 over, -- let's see. Yes, for all three years.
16 DR. SCHMIDT: Level funding for three years?
17 MR. HILTON: Right.
18 DR. SCHMIDT: Frank, have you had time to glance
19 through Sister Ann's comments? Could you cover anything there
20 that might be in addition to what Mr. Hilton has covered?
21 MR. SCHNIOWSKI: Basically, Sister Ann has six
22 statements here, I will rapidly mention these. One, Sister
23 Ann comments that support from other resources must be developed
24 and this is, further supports the site visits team recommendation
25 underneath the criterion number 3, continued support, and second

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9

Reba 10

1 comment deals with her concern that maybe the developmental
2 component should be reduced.
3 There is no questionmark or there is no exclamation
4 point so I don't know how to interpret this. I am surprised.
5 The third comment deals with the question of whether RMPS should
6 provide consultation and this deals with the statement, if the
7 program is interested and seriously intends to facilitate state
8 HMO planning, it should bring people with appropriate experience
9 in managerial and financial aspects of HMO planning.
10 We tried to iron this out before the site visit
11 report was written. This is one point that was not clarified
12 and was asked to be included in this. The fourth point deals
13 with underutilization of information due to lack of knowledge
14 of the resources availability. Again, Sister asked for guidance
15 by RMP staff to insure adequate use of available data in planning.
16 The fifth deals with evaluation process. And suggests
17 that evaluation process needs to be implemented. Then the
18 final point, final point concerns the tumor registry project
19 which is -- it is a question what plans are there to phase this
20 out between the local Cancer Society.
21 These are the major concerns.
22 DR. SCHMIDT: Is there an answer to that last question?
23 MR. HILTON:We spoke with the tumor registry people
24 concerning this. We were impressed with the importance of the
25 activity, apparently beyond those who are directly involved with

#9 Reba 11

1 it. There is also a feeling of its worth. But again apparently
2 they have run into something of a brick wall in terms of
3 attempting to get support for it. The feeling seemed to be
4 that the resources simply were not there. Everyone agreed
5 it was a good thing to have.
6 Of course those who were closest to the project felt
7 more strongly about it. We did suggest that more aggressive
8 efforts should be made to seek continued support for the effort.
9 They assured us they would continue to try but there
10 was this feeling of a real frustration, that the effort really
11 wouldn't pay off so why bother in the first place kind of
12 thing. That in fact efforts in the past despite the amount of
13 work that had been put into this by one of the physicians
14 closely involved with it in attempts to recruit assistance
15 have been so futile that there did not seem to be any real drive
16 on the part of the people who were supporting the tumor registry
17 to go out and as one guy said you know spend days, weeks and
18 months at trying to do something that simply was not there.
19 DR. SCHMIDT: We do have a motion on the floor.
20 Is there a second for the motion?
21 DR. ELLIS: Second.
22 DR. SCHMIDT: All right, it is seconded, so we are
23 ready for discussion. I believe first, well, let's see, John,
24 you have got the microphone. When you are through you can
25 hand it to Dr. Schleris.

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end # 9

1 DR. KRALEWSKI: A couple of questions and comment.
2 One, I am in agreement that the state is a poor state and pro-
3 bably has some Limited ability to share in the funding of RMP
4 Programs.
5 On the other hand there is a lot of Federal money
6 going into that state, OEO Programs in the state, HMO, a
7 couple HMO planning grants, I believe there is a National
8 Center Health Services Demonstration Grant, and I was wondering
9 how much effort is being devoted by the RMP Group to, you know,
10 intermix their programs with these programs, and make, you
11 know, these funds useful to some of their activities.
12 Number two, one of the questions in the past was
13 just how much of this budget is going to support that medical
14 school, I wonder if you would comment to that to see if they
15 are really breaking away from it, and number three, the comment
16 on the question of whether they should add staff with HMO
17 capabilities.
18 I am not so sure they should, perhaps, if these
19 other agencies of HMO Grants, like the Loveless Clinic, et
20 cetera. If they are developing that kind of talent, maybe RMP
21 should stay out of it.
22 MR. HILTON: Taking your questions backwards, I
23 agree with you, our feeling was, our general feeling was, and
24 we do have a minority report on that by the way, that they
25 probably should, in fact , use the resources that are existent

1 in their HMO planning.

2 Medical school support, one of the things that was
3 shocking to us or surprising, where we could not see they were
4 getting that much out of it. They were giving away grant.
5 There was involved staff -- staff involvement, more specifically
6 on that. The Dean, at the time we talked to him was on his
7 way to, I believe it was Harvard for a course in fiscal
8 management, and when we questioned him about this, he said,
9 perhaps that is why they have, in fact not benefited or
10 exploited the situation as much as they probably could, and,
11 in fact, may, in years to come.

12 But on the matter of other Federal help, perhaps,
13 Frank can give us something on that.

14 MR. SCHNIOWSKI: In terms of coordinating with the
15 two HMO Grants in Albuquerque. Dr. Gay is on the board of
16 one of the HMO planning groups and he is actively involved
17 with the other one. I had rather not comment on why there is
18 two grants in one area.

19 DR. SCHMIDT: Miss Kerr?

20 MISS KERR: Speaking of other Federal funds available,
21 I, too, was concerned when Bill was talking about the educational
22 programs and as a point of information, the week of October 8th
23 to 13th, there will be 75 hand-picked people, 25 each from the
24 regional medical program, the New Mexico Medical Society and
25 from the Department of Education, and they are bringing in two

1 consultants; one of them is myself, to talk about health
2 care education programs, and what might be available in the
3 State of New Mexico, maybe this is one reason they are turning
4 to this kind of conference, I hope.
5 DR. SCHMIDT: Dr. Scherlis?
6 DR. SCHERLIS: Do I read the application correctly,
7 that they are asking for 35 new staff positions, is that
8 correct?
9 MR. HILTON: You are a little under. They are, in
10 fact, asking for, let us see, no, they were asking for 25 new
11 positions.
12 DR. SCHERLIS: I added it up and got 35, I guess
13 from the pages 59 up to 62, or three, but they are asking for
14 something within that range?
15 MR. HILTON: Yes.
16 DR. SCHERLIS: Looks like it is closer to 30. The
17 other question I have is in terms of page 30 of your site-visit
18 report.
19 Do I gather that you all looked at their individual
20 projects, and suggested a level of funding for each development,
21 of their developmental programs?
22 MR. HILTON: What we specifically did, was to look
23 at their developmental programs. We did this in a couple of
24 sub-group meetings. There was such a lump of some involved
25 there, in that area that we thought we better look and see what

1 it really was going into, so we did invite discussion from
2 those closely involved with the projects to get a clear under-
3 standing in our own minds, rally, what they had in mind; what
4 they were planning to do.

5 Yes?

6 DR. SCHERLIS: I don't mean to suggest that this
7 was not the way to do it, but you assumed they had good
8 judgment and evaluation mechanism, and priority system that
9 they are able to set up their own developmental program.

10 What you have done is X out most of it, then turn
11 around and give them a developmental component and say, "Do
12 with it what you like."

13 I know the hour is late but this is a rather
14 interesting approach.

15 MR. HILTON: If I can recall again, Frank, I will
16 ask your assistance on this, too. There were clues which
17 preceded our taking this action with regard to the new programs.
18 And, by the way, the team visit was chaired by Dr. Tamiroff,(?)
19 of a hospital in New York who was on vacation, so he was not
20 present at this particular meeting.

21 As I recall, one of our reasons for taking this
22 particular approach was some indication we got from earlier
23 testimony that some of the program, referring, particularly
24 about the health education for public, there had been some
25 intervention in the program thing, on the part of the

1 Assistant or Lieutenant Governor of the state, which had
2 bloated that figure from something closer to $50 thousand to
3 $250 thousand.
4 That may have prompted us to look closely at some
5 of the other new projects. There is no plan for that expansion
6 between what we recommend and what they ask for in health
7 education but that was not entirely a staff decision, either.
8 That was, in a large measure, a result of -- I am not sure,
9 is the Lieutenant Governor a member of the RAG?
10 Yes. That was largely the result of the represent-
11 ation on the RAG. And, I guess what we found ourselves doing
12 then, was sort of going through these projects with the staff
13 to kind of weed out or give them an excuse for weeding out
14 some things that had developed, problems they had inherited with
15 their RAG.
16 DR. SCHERLIS: Point of information -- the AHECs,
17 was that a one-year shot of funds?
18 Was that planning or what?
19 MR. SCHNIOWSKI: There is four, National Advisory
20 Council recommended approval for four geographically dispersed
21 community health education systems throughout the state. These
22 are four separate projects, twenty, twenty-two thousand dollars
23 apiece.
24 DR. SCHERLIS: Was that just one year? What is going
25 to happen after that year?

1 MR. SCHNIOWSKI: That is right.

2 DR. SCHMIDT: This is one year planning.

3 DR. SCHERLIS: Was that just planning?

4 DR. SCHMIDT: Planning, yes. Other comments,

5 other issues to raise?

6 MR. SCHNIOWSKI: I would like to mention one factor.

7 I am not disagreeing with Mr. Hilton when he stated in concern

8 of the area of minorities but I think it is good to point out

9 that the Program's Regional Advisory Group contains 44 minority

10 group representatives.

11 This has tremendously increased under Dr. Gay,

12 from previous years. The executive committee has increased

13 from eight to eleven members. Five of the eleven members are

14 minority group representatives. At the time of the site-visit,

15 the Program staff had three minority group representatives,

16 just on the program staff.

17 After we left and made our recommendations, our

18 suggestions, I might say, to the total site-visit, Dr. Gay has

19 increased this from three to six program-staff members. All

20 minority members on his RAG are actively involved in all of

21 the committees and the one weekness we did point out was we

22 certainly recommended an increase, we thought he was maybe doing

23 not as good a job as he could, in terms of hiring program staff.

24 And, this is the main weakness in terms of minority members.

25 I don't want to --

1 DR. SCHERLIS: How large is RAG?

2 MR. SCHNIOWSKI: One hundred sixteen members.

3 DR. SCHERLIS: That can be representative of a lot

4 of the population.

5 DR. KRALEWSKI: The whole population. May I make

6 a comment?

7 DR. SCHMIDT: Right.

8 DR. KRALEWSKI: This budget again, if I understand

9 this correctly, we are recommending more money than they are

10 asking for on operational projects?

11 MR. HILTON: Only because of the tumor --

12 DR. SCHMIDT: There is a switch of funds from up

13 on top to down in there, actually.

14 MR. HILTON: Yes, what we have done is taken out the

15 tumor registry which was listed in their request, their initial

16 request for program staff. The distinction that has to be kept

17 in mind here, is what they have done, they have got two sets

18 of projects.

19 One, under program staff; and one operational pro-

20 ject which is separated out. And we simply removed from program

21 staff their tumor registry project, and reduced that whole

22 figure substantially in terms of the other projects under that.

23 DR. SCHMIDT: Other questions?

24 Or issues?

25 DR. LUGINBUHL: I would like to question the tumor

1 registry. Seems to me that a very good test of the work of a
2 program is the ability to find other funding and the fact that
3 this program has not been able to find other funding suggests
4 to me that possibly it is not quite as valuable as it might
5 appear at first look.
6 And I may be speaking from a general bias, because
7 I have not been impressed with the value of tumor registries,
8 generally, and I have yet to see any very hard data that suggests
9 that these have had a major impact on even the care of cancer
10 patients, or advancement of our knowledge in this area.
11 So, just as a general principle, I would favor funding
12 these programs from local resources, and if these are not
13 forthcoming, I think this may be a measure of their true worth.
14 DR. SCHMIDT: Well, the question has been answered,
15 so I will limit your answer to what your estimation is that they
16 will seriously attempt to find funding for that on the local.
17 MR. HILTON: If rather emphatic advice is made to
18 them in an advice letter to them, I think that might help
19 to spur them to try again, harder this time. I would not
20 make it strong enough though to make a contingency.
21 DR. PERRY: I have the same question, Sister, and
22 asked about the amount of the developmental component here.
23 This is one of the largest ones that is being earmarked of
24 all the programs. I would like a little fruther justification,
25 you know, that they are really capable.

1 The questions that have been raised on some of the
2 problems that have been developed, I would like you know, a
3 little further comment on just that one part.
4 MR. HILTON: With regard to that developmental com-
5 ponent, as I recall, in our deliberations, we really did not
6 give that particular matter a great deal of thought. We
7 certainly did not feel they should get as much as they requested
8 on it.
9 The question raised earlier, concerning the develop-
10 mental program has been kind of turning round in my head
11 since he raised it, because I can see the direction he is
12 heading, on that. Yes, we are all in agreement that under Dr.
13 Gay's leadership, it all seems to promise real well for the
14 future, but the reason the developmental programs that are
15 listed on page 30 of the site-visit report went -- went the kind
16 of sky thing that we gave them, was because of the -- some of
17 the builtin problems apparently in terms of what kind of input
18 would be made to the program despite Dr. Gay's influence, et
19 cetera, and you know, I would have to, in view of that fact,
20 and in the contention in which it was raised and I would also
21 have to look myself, again, at the component as it now stands.
22 I would, at this point then, perhaps, Frank, can
23 recall some things I am forgetting now, with regard to what
24 your deliberations were on the developmental component.
25 MR. SCHNIOWSKI: I think Dr. Scherlis is concerned

1 with the developmental component. Again, we have to kind of
2 repeat the statement that the region indicated to us, that they
3 were going to control these through program staff, and use
4 them as a line, item budget.

5 Our recommendations to treat these as individual
6 project activities, not as a line-item-budget within program
7 staff, reviewed by the RAG, monitored by their systems, and
8 reviewed by CHP.

9 Thus $222 thousand, which we recommend for these
10 activities in essence, is taking this amount of money and
11 moving it down into the operational project area, not keeping
12 it up at the program staff level.

13 DR. SCHMIDT: I would like to move the group along
14 to making any specific modifications of the recommendation,
15 or whatever.

16 Mrs. Flood?

17 MRS. FLOOD: I don't mean to delay the continuance
18 of our schedule, but I do feel that there is some aspects of
19 the economic picture of the State of New Mexico, that although
20 it has been covered in some measure, should be expressed at
21 this time.

22 I think, if you take into consideration, the sparsely
23 populated areas of the state, with the only large urban
24 impact area being in the City of Albuquerque, with the tremen-
25 dous population of minority groups with underdeveloped educational

1 opportunities, the economy of the state is only dependent,
2 truly, on the military and the many diversified aspects of
3 military input there, Los Alamos, et cetera.
4 That, to put the pressure on discontinuance of pro-
5 grams, even the tumor registry, although I am not in a position
6 to state whether it is a value project at the moment, but to
7 put the burden of pay or maintenance of this type of project
8 on the people of the State of New Mexico, at this time, is just
9 not feasible, it is not a realistic approach.
10 There is not that forthcoming economic base to
11 support programs at home, so I would be reticent to offer any-
12 thing other than a recommendation to not cut program based on
13 the fact that they have not been able to find other methods
14 of support locally.
15 DR. MARGULIES: I wonder if I might comment, because
16 I think the comment just raised is terribly important in our
17 deliberations.
18 This is the most painful type of consideration we
19 have to go through. If an activity, over a period of time, is
20 not able to find other means of support, it either suggests
21 that it does not merit other support, or there are no resources.
22 Now, if there are no other resources available, that is a kind
23 of deficiency of a systemic kind which we are not in the
24 position to resolve.

25 Whether it is the problem of the economic status of

1 New Mexico, or as is much more common, the unavailability of
2 third party funds to pay for a service which is generated out
3 of a demonstration activity, et cetera.
4 If RMP funds, or any other program like ours, which
5 is developmental, remain in support of some project or activity
6 because there are no alternatives, rather than because it
7 belongs there. It very rapidly exhausts our resources, and
8 really cannot move. In the case of the tumor registry, it
9 might be even more difficult to justify, because there are
10 so many doubts about the effectiveness of that as a program,
11 but this is valid even when you are supplying a demonstration
12 activity in a service, and it is especially troublesome, when
13 what you are doing, is really worth doing; but if we begin to
14 supplement Medicaid, or other types of activities with RMP
15 funds, we are lost.
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1 DR. SCHLERIS: I know you are anxious to move us
2 along but my dilemma is I still haven't reached in my mind
3 how I would react to this and I think that is the position
4 of your review committee.
5 Looking at some of the projects for which they are
6 requesting support for the 05 year, some one, two, three,
7 four, five of them began in the 01 year and if we give them
8 funds now to set up new projects, we are going to be faced
9 next time with these being in the 06 and 07 year, as well
10 as the new ones that have come aboard that they can't phase
11 out because of lack of support.
12 My concern is that if everything that is started
13 in New Mexico has to be continued indefinitely because
14 there are no alternative methods for support, we better
15 avoid starting new programs unless we know with assurance
16 that they can be continued or unless we have the feeling
17 that our beuget will be rising proportionately over the
18 years to take care of this.
19 Also, I reflect the concern of the site visit
20 group which was impressed with the fact that many projects
21 go on through core, which means they really don't get the
22 evaluation they should get under other types of surveillance,
23 one way is to move them out of core, the other is to insist
24 that all core projects have the same type of review.
25 I am in a dilemma as far as the $120,000 for

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1 developmental since there are ways of cutting projects out
2 that have been continued now to the fifty year.
3 Will you respond to that?
4 MR. HILTON: Well, I think what you have succeeded
5 in doing is pulling me into the dilemma with you a little
6 bit, however, I did recall some discussion with Dr. Gay,
7 that he has an intense interest in having available the
8 capability and this again harks back to something said
9 either today or yesterday in one of the other programs.
10 He has an intense interest in having the capability
11 to be flexible in programing.
12 I think this is where the whole discussion of
13 developmental component came up in the first place. In
14 fact, we discussed at some point his desire to be able to
15 rechannel funds in areas in which he felt there was great
16 need.
17 There may, in fact, and I am uncertain of the
18 details on the other program, there may, in fact, here be a
19 need for that kind of flexibility in order for NMRMP to become
20 a better program.
21 I have, and again, I think I am speaking for the
22 team, considerable confidence in Dr. Gay's ability to do
23 this in such a way that NMRMP does, in fact, become an
24 asset, whether or not it be done through discretionary funds
25 which he did not question or developmentally, I think that

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1 flexibility ought to be there.

2 I am confident under his leaderwhip it will be

3 used to the benefit of the program.

4 Would you second, or any comment with regard to

5 that, Frank?

6 MR. SCHNIOWSKI: Not to beat it to death, but the

7 Tumor Registry Project has drawn outside support from the

8 National Cancer Institute. They rate this as one of the

9 three best registries in the nation, that is their judgment.

10 The project director, Dr. Key, has approached

11 the area of continued support in the wrong manner. He has

12 been advised by one of the -- Dr. Tucker, who talked to him

13 aside, and indicated it would be much more efficient to

14 approach continued support th rough the medical staffs of

15 the individual hospitals as well as with the hospital

16 administrators which he had been working with in the past.

17 By the end of '73, they will have only three

18 remaining projects which they originally were funding. One

19 of these is the tumor registry project. The other, we have

20 recommended the EMS project that has been going on for four

21 years to be locked with the new EMS activity, which was

22 recently funded from RMPS.

23 The third project is their leukemia lymphoma

24 project which was started in their third year.

25 DR. SCHMIDT: Bill?

1 DR. THURMAN: I just want to add a minority report
2 to what Dr. Margulies has said.
3 A well-run tumor thing is a real asset. Remember
4 during the Civil War we didn't think stethoscopes were
5 any good.
6 DR. MARGULIES: They are now?
7 DR. THURMAN: Depends on the doctor, Harold.
8 DR. SCHMIDT: I presume that resolved everything
9 for us.
10 DR. SCHLERIS: I will listen to him on registries
11 but hardly on stethoscope.
12 DR. SCHMIDT: All right.
13 Does anybody want to do anything in regard to
14 developmental component, then?
15 I will ask for any amendments and we will test
16 out the developmental component first.
17 Does anyone wish to propose an amendment to the
18 main motion concerning the developmental component?
19 DR. SCHLERIS: I was going to suggest two things.
20 One thing, I think we would do this region a favor
21 if we reduced their total grant because it will make them
22 get rid of some of the projects they have had ongoing for a
23 long period of time.
24 If we want to give the coordinator of the New
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25 Mexico program some potential mobility, we wouldn't give it

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1 to him if we give him money for projects which EMS might
2 want to phase out.

3 I guess I also suggest reducing the developmental
4 component. I was thinking in terms of droping that 1.3
5 down to 1.15, the second year, 1.2, the third year, 1.250, but
6 even that is being generous, but I think developmental
7 component should be significantly cut.

8 DR. SCHMIDT: Would you make --

9 DR. SCHLERIS: Drop it down to 80 thousand, 80
10 thousand for each of the three years, developmental component
11 and the first year, the 05 year, 1.15; second, 1.20; third,
12 1.25.

13 DR. SCHMIDT: Do you make that in the form of
14 a substitute motion?

15 DR. SCHLERIS: Yes, sir.

16 DR. SCHMIDT: This includes approval of the
17 triennial status obviously.

18 Is there a second?

19 It is seconded.

20 Discussion then will revolve around the substitute
21 motion and we will limit discussion to the impact of this
22 level of funds and their ability to do what they want to do.

23 Are there any comments?

24 MR. HILTON: Is there an assumption here that
25 there is an inordinate number of programs that will be running

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1 beyond the 05 years?

2 DR. SCHLERIS: Both the number and quality of them.

3 They are going into the 05 year now, and if we are going

4 to talk about a triennial status for a region that is

5 attempting to, as you say, get mobility, I don't think you

6 have mobility if you continue these projects and I think

7 this puts on them the onus of deciding what they are going to

8 continue.

9 Also, you have looked at their developmental

10 programs, it was apparent you thought many of them were

11 markedly overfunded as far as what they were requesting. I

12 think this gives them the opportunity of sharpening up what

13 they are looking at and I think $120,000 is an excessive

14 amount, particularly since they are involved now with helping

15 implement the Emergency Services Medical Program, which will

16 absorb a great deal of staff and time because they are

17 funded for two years on that, aren't they?

18 And this is going to absort more than they

19 recognize, as far as being involved, even though they may

20 not be the contractual agency.

21 MR. HILTON: At this point I am inclined to

22 agree with you on developmental component, which I might

23 move as a motion after we defeat this one.

24 But on the matter of continued programs, as I

25 understand it, there are only three projects that will be

lor 7

1 continued beyond the 05 years, one of them being the tumor
2 registry.
3 MR. SCHNIOWSKI: I don't see any tremendous
4 hangover of dead weight in that regard.
5 DR. SCHLERIS: They are requesting for the 05
6 year, the continuation, besides the tumor registry, of
7 five projects. Now what we will be saying is beyond the
8 05, but we are talking specifically about 06, 06, 07, isn't
9 that right, five projects which add up to something like
10 $170,000 is being requested into the 05 year, isn't that
11 correct?
12 DR. SCHMIDT: Dr. Ellis, do you have a comment?
13 DR. ELLIS: Yes, I do, Mr. Chairman.
14 I just wanted to point out that this is such a
15 poor area and it seems to me that perhaps the developmental
16 component moght give them the opportunity to work toward
17 methods of health delivery that would really mean something
18 in the lives of some of these pepole, and I w as thinking
19 about the opportunity to develop nurse midwives and
20 pediatric assistants and assistants for the elderly and work
21 within that frame.
22 But I was thinking that technical assistance,
23 it seems to me, might be helpful in getting them to make
24 the right choices in terms of program without necessarily
25 penalizing them.

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1 DR. SCHERLIS: I just want to make one comment.
2 I am aware of their needs, and I would agree with you. There
3 are certain programs they might move into but I don't see
4 any assurance that we have been given that this is the
5 direction that they will take, as far as the expenditure
6 of their funds and the continuation of projects they have
7 had, do not seem to be in that direction.
8 This is the other reason for my statement, not a
9 failure to recognize their needs.
10 DR. ELLIS: Would you think that technical
11 assistance might provide this way so we wouldn't have so
12 much lag between the time that these problems appear?
13 Some of these are very long-range problems.
14 DR. SCHERLIS: Right, but we are talking about
15 developmental component and triennial status, it seems
16 beyond a little bit in time as far as telling them they need
17 a little bit of technical assistance, this is my concern.
18 DR. SCHMIDT: We are assuming that staff is
19 listening to this and that, technical assistance will be
20 offered and provided and so on.
21 John?
22 DR. KRALEWSKI: I think technical assistance will
23 be useful, I think this budget as being proposed here,
24 however, under the new recommendation will give them room to
25 run and develop that new thrust, and if this is a new order,

1 I move we curtail debate, is that an order or is that --

2 DR. SCHMIDT: Yes, it is. I will call the

3 question on the substitute motion unless there is a violent

4 objection from the committee members.

5 All right, then, we will vote on the substitute

6 motion, which is triennial at a level of 80 for developmental

7 component and 1.15, 1.2 and 1.25 for the three years.

8 All in favor please say aye.

9 (Chorus of ayes.)

10 Opposed, no?

11 The ayes have it so the substitution motion

12 carries.

13 And I believe that the necessary assistance will

14 be arranged for by staff following this discussion.

15 I would like to move on to Northern New England

16 before we break for lunch.

17 Some of the committee members sneak some pie or

18 soup or something like this. So the record will show that

19 Northern New England left the room, Bill Luginbuhl.

20 Dr. Thurman?

21 DR. THURMAN: This will be surprisingly short,

22 mainly because the conclusion of our total visit was that

23 this whole RMP is just like starting a first year.

24 I would point out that we had representation from

25 the Advisory Council and Mrs. Wycoff, Tom Nicholas and

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1 and Roger Warner from operating RMPs, both of whom were
2 valuable to a new RMP in that sense of the word.

3 Particularly a word of the staff, in that I
4 think that C. C. Conrad and Spencer Crobin, as well as the
5 others with us were quite helpful to this group of people.

6 I might give you one quick work of history
7 about this about this group because that is where the real
8 problem has arisen in the past with Northern New England
9 RMP.

10 It became operational, had a planning grant in
11 '66, with its first operational year at '69. At that point
12 in time a committee from the University of Vermont Medical
13 School actually ran the program.

14 The man who is presently coordinator arrived in
15 the fall of 1969, but throughout all this period of time,
16 their primary emphasis was on developing a data base.

17 Some of the questions that arose went high enough
18 to get to the administrator of HSMHA, for some type of
19 resolution and that RMP and CHP tried to arrive at a merger type
20 situation, too, so that there would not be an overlap of
21 any kind.

22 This was partly at the request of the governing
23 bodies of the state itself, to further complicate it because
24 the state was small and because of this experience with RMP
25 in the past, had been largely in the data base development

1 experiment in health service delivery money, they requested
2 one dollar and received $932,000 for supplementary health --
3 mental health services delivery, so obviously they were not
4 ready to use it.

5 This created even more of a conflict bet ween the
6 RMP and CHP merger.

7 What happened was that they began to listen more
8 and more to the signals from this committee and others, and
9 RMP actually began to change to a true RMP, roughly in
10 January of this year, 1972, with the appointment of Mr.
11 Danielson as coordinaror, reinstitution of RAG, as we know
12 a RAG, with removal of a lot of situations that had gone
13 on before, I would not leave you with the feeling that there
14 aren't still problems, because of the fact that some of the
15 boards still overlap betw een RMP and CHP, the divorcing of
16 the whole business of the health services delivery syst em
17 contract is still not a complete divorce, even though they
18 changed the name a little bit.

19 In this change it did make it possible for RMP
20 to get rid of some of the people who have been moved to the
21 other corporations to help continue the data base in related
22 areas but in this reorganization, they have been -- it has
23 been necessary for them to bring about some of their staff
24 and RMP losing their job.

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25 All of this has been accomplished reasonably well

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1 by the people on board, and I think, in essence, represents
2 now, since January of 1972, a nine month, eight month period
3 of time when we were there, of reogranization, along
4 traditional RMP lines.
5 Dr. Luginbuhl was present for much of the
6 situation because of significant questions in the past,
7 in reference to the RMP to the medical school. I think
8 they have well understood the strong staff support and our
9 review committee and council comments about what was wrong
10 with their RMP in reference to collection of a data base
11 rather than anything else.
12 At this point in time, I think they have well
13 understood that our feedback session was particularly good.
14 Their request for specific staff assistance, C.C. and
15 othe rs, was very significant and meaningful, I think.
16 And it represented, for me, at least, the
17 opportunity to say very stronbly that this is an RMP that
18 is still back in 1966 and that is hard to accept, but that
19 that, the 1966 constitution of this group in 1972, leaves
20 little question in my mind whether they will succeed.
21 The present chairman of the RAG is a little bit
22 still out of step and out of consonance with the new
23 direction of RMP but he is a very educable individual and
24 they have not developed goals and objectives in the feedback,
25 they actually asked us in a way how much time they had to do

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1 it and we left them with a figure of 90 to 120 days, which came
2 off the tops of the heads of the site team rather than
3 having any other direction.
4 I think the whole question of minority interest
5 in Vermont was raised and we were not able to speak to that
6 very well because of the particular structure of Vermont.
7 The only way a minority group could be constituted
8 would be to have somebody who was born out of the state and
9 then moved into it, because there are no other minorities
10 in that sense of the word.
11 The poor are not the minority in Vermont. If
12 we are going to get on another New Mexico, it is here.
13 But I think that in general, in speaking to all
14 of the other segments we normally speak to in review of an
15 application, I could say they presented to us a very good
16 approach of taking the best of what they have had in the
17 past, not related to development of a technic al data base,
18 have coordinated it now with an approach to the future that
19 looks to be well structured and well organized and that we
20 are now in the transition period.
21 This transition period is entirely different
22 from the one that is usually bandied around here about going
23 from categorical to noncategorical, and instead, the
24 transition from data collecting group to a true health care
25 delivery group.

If we are going to ever be able to evaluate any RMP, we ought to be able to evaluate this one because they have got the best data base you have ever seen to see now what is going to happen in the future in all of their areas.

I think this will be meaningful, not only to us, but alto to other branches of HSHMA and HEW, because they do have a truly significant data base and if you look at the end of the site visit report, you will get a feel, and this does not represent all of the things they published.

You get a feel for what the they have done since 1966 in collecting information, so we should be able to very quickly evaluate almost any program that is brought about in the delivery of health care in this area.

I think that as we look at the process of their organization, the coordinators very firmly moving to take total command of the situation with strong assistance from the RAG, he is the one who has been responsible on going face to face with every single person and saying, "You are not really contributing, why don't you resign," or "We really need you badly, you are the kind of guy who we hope can help us make the change in the future."

Although the RAG is very small at the moment, it is open-ended in reference to their by-laws, and I believe the additions we have brought about will be significant.

The RAG chairman clearly is a university man,

dor 15

1 but he is a university man who has pioneered community health
2 programs throughout Vermont, which is a reasonably tight
3 structured state.
4 So I have no concern about him carrying too much
5 of the idea of the university.
6 In speaking to the university and its relationship,
7 one of our fellow committee members has led the charge to
8 get the offices of RMP off the grounds of the university to
9 cut down a tremendously spectacular overhead rate, and he
10 has now succeeded in this and they are moving and they will
11 now have an off-grounds place, although the university will
12 still be the grantee.
13 We have no concern in any way about the management
14 or effectiveness of funds because they are moving very
15 comfortably in their structure to make sure that all of their
16 so-called advisory committees, which is their mechanism of
17 action, have a very firm budget.
18 T hey have a definite plan, with each budget
19 there will be a timetable and if that timetable is not met,
20 that the money will no longer be there.

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#12

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1 Going back to our earlier discussions, money is
2 one of the clubs that we have, and they are using it well in
3 their approach to programs. I think that the program staff
4 is presently being realigned, as I indicated, they are phasing
5 out a total of 11 jobs, actually more than that, but 11 are
6 being phased out, some going to other opportunities and some
7 just being phased out. They have brought on a young physician
8 to work in the area community development. And his
9 enthusiasm and capability both are significant, and I think
10 on that basis we don't have any real concern that they will
11 begin to derive programs from throughout the state that
12 have a strong community base and meet the need for delivery of
13 health care in an entirely different way.
14 This is his cup of tea. If they can keep him in
15 the program, it will be great. I have some concern that they
16 may lose him because his type of talent is in bad need all
17 over the country today and so he may go. The RAG understands
18 the way to go.
19 I think that they have -- will make future
20 appointments on the basis of knowing exactly what should be
21 done before they get into it. They have pulled again, as
22 I indicated, not only at RAG, but committee management, they
23 have pulled their best people from the best and have let
24 most of the dead wood go.

25 They have done this very, very well which is a real

ar2

1 tribute to the coordinator in that I think his experience
2 in the program for over two years before he became
3 coordinator made it possible for him to get an honest
4 evaluation of what is going on.

5 I think our only concern is the site team, about
6 his role, was that in the area of continuing education and
7 manpower development, if he has a blind spot, this is it,
8 and we tried to emphasize that pretty much in our site visit.

9 I think staff is well aware of it as a reasonable
10 blind spot. It is emphasized enough in the feedback session
11 to make everybody else well aware of it, and I believe that
12 will probably answer the most significant problem that
13 exists at the present time in their entirely new development.

14 I believe I would stop now in this discussion because
15 there really is nothing else that I can firmly put a hand on
16 at this point in time to say about this program because I
17 think we should look at it as a program that really developed
18 a coordinator, no coordinators in January of this year.

19 The RAG is working well, though small, to make
20 itself meaningful. And they really have nothing else to
21 present except a truly significant data basis accomplishment
22 and now with the opportunity to turn around and move on.

23 Rather than recommend, we might listen to what
24 the secondary reviewer has to say first.

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25 DR. SCHMIDT: The secondary reviewer is Dr. Lewis.

ar3

1 who is not here. So, Spence, do you have any comments on --
2 let's move on then to your recommendation.
3 DR. THURMAN: Spence, you don't have anything to
4 add, let me add, do you agree with what I have said? No,
5 C.C., I don't know whether you heard about what I said of
6 the possible blind spot of the coordinator being in man-
7 power coordination and education, and we leaned very
8 heavily on that with the hope that we would do away with his
9 blind spot.
10 MISS CONRATH: Yes, I think one thing the review
11 committee might be interested in. The Kellogg Foundation
12 has made a grant to the University of Vermont Medical School
13 for the introduction of the problem of oriented medical
14 record in medical practice in Vermont. This offers an
15 opportunity for the northern New England RMP and the medical
16 school through the department of continuing education to join
17 forces in a way in which they have not been able to join
18 forces before.
19 I think this offers a mechanism and advisability
20 as to how the continuing education resources can be addressed
21 in a meaningful way that is a very real promise, I think
22 in terms of case history, maybe of interest to know that
23 one of the graduate students of the University of Vermont
24 did a master's dissertation on the case history of the

25 northern New England RMP. This person is now on the staff.

ar4

1 So if you need a good case history, there is a 100-page
2 dissertation.
3 DR. SCHMIDT: Recommendations, then?
4 DR. THURMAN: The recommendation of the site
5 team was that triennial status not be granted at this time.
6 This was quite honestly discussed with the entire group, but
7 that it receive two year approval so they understand, or we
8 understand they understand we understand they have turned
9 the corner and are ready to develop a good RMP at this period
10 of time, but with this two year approval at the level of
11 $850,000 each year that we also grant them developmental
12 component or discretionary funds, and our recommendation for
13 the first year there would be 10 percent of the present fund;
14 for the second year, continuing 10 percent of whatever the
15 funding is for the first year.
16 DR. SCHMIDT: We will have to label that discretionary
17 and that amount is within the 850,000 obviously.
18 Is there a second to that motion?
19 DR. ELLIS: Seconded.
20 DR. SCHMIDT: It is seconded by Dr. Ellis. Comments?
21 DR. JAMES: I would like to have one to explain to
22 me the relationship of the research and development of health
23 systems incorporated which is the recipient of HSMHA's
24 experimental systems contract.
25 I see where they were awarded $900,000 to develop

ar 5

1 experimental delivery system there. It occurs to me that
2 with the geographic and demographic information we have as
3 far as Vermont is concerned, that there will possibly result
4 some kind of conflict -- well, can't say conflict, but I
5 wonder just how much overlapping of effort in such a small
6 state, that Vermont represents.

7 It seems to me that there might be some turf
8 interference, and I get the feeling that one is going to take
9 precedent over the other in view of the fact that the popula-
10 tion is small.

11 DR. THURMAN: I might respond to that by saying
12 this is the one dollar they requested for which they received
13 932,000. And it is very clear in everyone's minds that there
14 will continue to be some degree of difficulty in understanding
15 the role of each of these because of the fact that RMP in
16 Vermont has had an image of a data system and it is this
17 divorcing of the data system from RMP as we think of RMP now
18 that the new program actually represents.

19 The overlapping of boards, who will do what, all
20 of that is still a bad situation. I think this will not be
21 clarified over the next several years because of the fact
22 that RMP actually helped with the development of all of the
23 plans for what is now the experimental system to the tune of
24 roughly $150,000. Isn't that right, Spence, over the years?
25 Okay, 350,000, missed by 200,000. It is a piddling amount.

ar6

So I think there will continue to be some real problems with this. The medical society is well aware of this,Dr. James, and their concern, the board, they have actually changed the name of this now to call it a Vermont, it now has VHSI to get around some of their problems and their board is made up of providers, politicians, public and the payers. This is part of the thing they are going through.

I think Dr. Danielson as coordinator and the early development of the present RAG, nine to 12 people, are so burdened by this whole situation that I would not be concerned about RMP being hurt. I am more concerned, not truly that concerned about it, about HSI being an ineffective program because of the emergence of a strong HCP.

I think staff will have to continue to look at it and I am sure the northern New England RMP will be coming back to staff and saying why can't you do something with those other guys in Washington, because that is the way they feel about it right now. Point out that one person who's been not so burdened, but very concerned about the situation, is Dr. Luginbuhl because he and others wonder what they are going to do with this $932,000.

DR. SCHMIDT: I will comment just briefly. I don't think that blame, with the word "blame" in quotes, for the situation can be laid at the door of RMP at all. RMP is a victim of essentially HEW muddling and meddling

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1 in the state of Vermont, and if somebody's got red ears over
2 this, it is the Secretary of HEW. And this is an incredible
3 blunder by HEW, and in effect a manipulation of a state
4 plan.

5 I think that the RMP and people in Vermont are going
6 to have to kind of recover from a reeling blow that was
7 dealt to them by feds coming up there and manipulating the
8 state, and I think the RMP will be in great part, part of
9 the solution of this problem.

10 My words are quotes from HEW people who have been
11 investigating what went on in Vermont and how a request for
12 one dollar got turned into a forced upon the state 1 million
13 by HEW. It is an incredible story.

14 Are there other comments or questions then?

15 DR. ELLIS: We don't understand the $1 request.
16 Could you tell us?

17 DR. THURMAN: They were told that with this
18 tremendous data base in hand, where else could you -- could
19 really you document what you were doing with experimental
20 health services delivery and other approaches, and so they
21 said don't you want some of our money?

22 And in essence, the answer back was we are really
23 not ready for it, which is an honest statement, so they said
24 at least put your hand in the pot, and they put their hand
25 in the pot for a dollar, and were showered with greenbacks.

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ar8

1 DR. KRALEWSKI: Aside from who would apply for a
2 dollar, I am hesitant to vote, I like your funding
3 recommendations, but I am hesitant to vote that two year kind
4 of thing since generally we deal with a triennium, or say
5 look, here's another year, you can try to work out an applica-
6 tion. Would you comment on this? Do you think we have to
7 go give them a two-year kind of period?
8 DR. THURMAN: We discussed this at some length
9 and Spence can comment when I finish.
10 Our feeling was that they really had made a marked
11 change in their approach. They had the people now who under-
12 stood what the story is all about. And therefore that if we
13 would seriously inhibit particularly the development of their
14 community-related program under Dr. Robins and he would not
15 be able to add additional people, he could only talk to them
16 on the basis of one year, and that then triennial status if
17 everything continued to go well.
18 There's been so much problem and so many people
19 like our chairman's referring to, so many HEW investigating
20 groups that have passed through the state that the crown
21 sits on uneasy with so much money.
22 We felt strongly that if we just went for one
23 year with this group that he would have real troubles continuing
24 to develop what he wants.
25 DR. SCHMIDT: This would not, you know, by the two

ar9

1 years -- are you saying that under no circumstances next
2 year could they come in with a triennial?
3 DR. THURMAN: This was discussed at the feedback
4 session, nothing prevented them from coming in for
5 triennial status next year, but we wanted to give them the
6 feel for two years for continuing development.
7 Spence?
8 MR. COBURN: It is built into the recommendations --
9 DR. SCHMIDT: It is part of the recommendation.
10 DR. THURMAN: Yes, it is.
11 MR. COBURN: They are not going to be able to write
12 you a triennial application after the site visit. This will
13 be then applied in the second year as you are suggesting here.
14 If we go in with the recommendation that here is a base
15 for a couple years, and although we'd like to have you move as
16 rapidly as possible in formulating a program thrust and
17 developing a three-year program, and sending that program
18 in here for approval, I'd be agreeable to it.
19 DR. THURMAN: I think to finish it off, we said
20 there would be a site visit next year. This they understand,
21 and if they wanted to before that site visit actually prepare
22 a triennial application, fine, but if it looked like they
23 need another year to actually go on as they were, that was
24 one of the reasons for the recommendation of level funding,
25 that they would then know that they had to talk to that group

ar10

1 or some group again next year about an increase in funding.

2 But we felt that the security of this program with

3 its past problems and the actual divorce now of HSI with a

4 whole change from RMPS staff that they may or may not be

5 ready to try triennial application this year in order to meet

6 site visit next August again.

7 DR. HESS: I would like to think that with this

8 recommendation we are coming very close to a leveling off

9 of funding for this particular RMP. So it happens with your

10 recommendation they will be funded at about $2 per capita,

11 which is the highest, as far as I can recall, the highest

12 funded RMP, on a per capita basis of anywhere in the country.

13 True, they do have scattered population, but no

14 more so than Arizona, New Mexico or the mountain states.

15 Low income, yes, but no more so than Mississippi.

16 I would think there ought to be a point where

17 certain RMPs begin to level off while others are coming up.

18 Particularly when so much other federal money is coming in

19 which is addressing itself to health care systems, so I am

20 just concerned that we don't get into a situation more and

21 more simply because they got in and got something going.

22 Seems to me that we have just about reached a plateau.

23 DR. SCHMIDT: Other comments prior to a vote on

24 the motion then?

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25 If not, I will call for a vote.

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1 The motion is understood. All in favor, please
2 say aye.
3 Opposed, no?
4 And I hear no dissent.
5 It is 1:15. Cafeteria is out of soup, but there
6 are a few other things left.
7 We will reconvene at 2:00 o'clock sharp.
8 (Whereupon, at 1:20 p.m., the hearing was recessed,
9 to reconvene at 2:00 p.m., this same date.)

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1 AFTERNOON SESSION

2 (2 p.m.)

3 DR. SCHMIDT: It is two o'clock. I have been asked

4 to remind the Review Committee members to be filling out

5 your rating sheets. All of the regions that are under review

6 should be rated by Review Committee members. So be sure you

7 fill these out. We have three left to do, Texas, Indiana

8 and Memphis. We will begin with Texas and Miss Kerr.

xxxxx 9 MISS KERR: Thank you, Mr. Chairman. I think we

10 want the records to show Mrs. Flood has excused herself. She

11 was an important part of this visit, so. The visit to Texas

12 was made in August of this year. The State of Texas makes

13 up the region and it consists of 254 counties with a population

14 of 11,200,000 people. I feel somewhat pressed for time here and

15 I think this is unfortunate, not because it is so big but because

16 it has accomplished so much and has so much potential that I

17 would like to share it more in detail than I will be able to.

18 The grantee institution is the University of

19 Texas at Austin. It is made up of 17 institutions of higher

20 education, three of which have medical schools. Dr. Charles

21 LeMaistre is Chancellor of the system. Physical agent is

22 the same institution. The coordinator is Dr. McCall, central

23 office is in Austin, with projected ten subregional offices.

24 At the moment six exist, at El Paso, Houston,

25 Tyler, Abilene, Laredo and Lubbock. They expect to add to this

1 list San Antonio; Dallas will then leave two to develop. In
2 Texas there are 21 CHP "B" agencies, 19 of which have councils
3 and have been funded from between $10,000 to $20,000 per agency
4 by state funds. The last site visit was made in
5 July of '71. Dr. George Miller is Chairman of that group. Also
6 on that site visit team was Alfred Pompa. And I say this because
7 these two gentlemen were on the visiting team one year later.
8 The region appreciated this continuity. As Chairman of the team,
9 I appreciated this continuity.
10 In the meantime between the last site visit and the
11 one in August, there were four interim staff visits to the Texas
12 region, on an introductory visit from Buddy Says here on
13 my right, one relative to health services education
14 activities, one relative to health services activities.
15 Also the members on the team in addition to Dr.
16 George Miller and Dr. Al Pompa were Mrs. Muriel Morgan of the
17 council, and Dr. John Low, director of the South Dakota
18 regional medical program. Regional medical program staff were
19 Mike Posta who is present in the room, Joe dela Puente and
20 Dr. Roberts who is here. And I am hopeful that they will feel
21 free to contribute after I am through with the initial report.
22 In addition to this group, we had David Eubanks
23 from the HEW region 6 as program representative. The purpose
24 of the site visit was to assess program progress, processes
25 and the proposed triennial application.

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1 Now, following the last site visit a year ago in
2 August of 1971, there was an advice letter sent out following
3 council meeting which contained five major concerns for this area
4 relative to this area. I will visit those in a moment.
5 However, I would make it clear that we had a team
6 visit the night before at which time the team decided
7 that while we were focusing and basing our observations on all the
8 criteria for review, we would focus primarily on these five areas
9 to be sure that we were probing deeply enough to have answers
10 for this review committee and council when we returned.
11 The five concerns and there is somewhat overlapping,
12 at the time of a year ago, it was identified that this region
13 needed to establish priorities under its new program direction.
14 The subregional staff members, it was felt, needed more assistance
15 and support from the central office and RAG members in the develop-
16 ment of specific program activities. It was felt that there
17 needed to be more and better representation from allied health,
18 one more, additional representation from minority groups, the
19 fifth one, some of the reviewers felt the process seemed to be
20 more of a central office academic review rather than peripheral
21 involvement in input.
22 In developing into these more deeply, I think
23 they will come out as I progress along through the report,
24 just how we did find these five concerns being based and attended
25 to. From the time of the last site visit until December, it is

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1 unbelievable what this region had done with the development
2 of goals,objectives and priorities, not only the amount of work
3 done but the process in which it was done.
4 It involved not only the coordinator and staff, but many meetings
5 of the regional medical program, representatives from the
6 subregions, the executive committee, and it was a well-organized
7 process coming out with seven priorities well understated
8 by pertinent goals.
9 There was only one question about this whole area
10 of goals, objectives and priorities and this was
11 Dr. Low who felt that perhaps the objectives could be stated
12 somewhat more in measurable terms. Didn't seem to be a glaring
13 omission but this was a suggestion for improvement. The RAG
14 was divided into seven major committees, each one responsible
15 for one of the priorities and they worked individually in
16 task forces coming back at intervals to compare notes and
17 finally came up with the seven priorities accepted by the
18 total group.
19 The objectives by testimony during the site visit
20 are understood by all of those participating and they are supported
21 by all those participating. Chief of program development evalu-
22 ations to be employed and more expert consultation will be
23 sought in strengthening the evaluation committee. They did have
24 a man on staff full-time on evaluation but in the process of
25 further developing the subregions and giving them the kind of

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1 assistance they felt necessary to come from central office,
2 this agent who is a very capable person was put in a position
3 to coordinate and assist with the activities of the subregion
4 programs and, as a result, it vacated the position of one
5 full-time evaluator but this is in their plans to replace this
6 person very shortly.

7 It is very clear that the subregional offices are now
8 providing more input into the system and this was verbally
9 supported by every one of the subregional representatives
10 that was there including Mrs. Flood. They all were very vocal,
11 very supportive and very appreciative of the kinds of
12 assistance that they were getting. The issue of advisability
13 which was done by the council and sent back to the advice letter,
14 the issue of advisability of developing local advisory groups
15 was discussed and the concensus was that the CHP "B" consumer-
16 oriented planning councils are being developed and that potential
17 activities of local RMP advisory bodies would constitute
18 duplication of effort.

19 It seems it would also be detrimental to community
20 efforts in Texas because not all potentially effective,
21 articulate and well informed consumers have been introduced
22 into the system. An effort to train consumers in participation,
23 however, is presently being supported by RMPS.

24 In addition, five contracts for developing an environ-
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25 ment for Chicano health consumer participation is being supported

1 by RMPS in Texas, California, Colorado. These priorities
2 when appropriate have been followed in the funding
3 of operational activities. They are addressed to regional needs
4 and reflect the possibility and instrumentality for continuous
5 development and improvement. As far as implementation, there
6 is much evidence of continued accomplishments by RAG committees
7 and staff.

8 For example, support of planning effort toward
9 comprehensive proposal with reference to renal disease has
10 resulted in promising activity. If successfully funded, it will
11 bring to Texas one of the first efforts addressed to compre-
12 hensive care of a particular group by regional basis. Without
13 a doubt, in my experience of project proposals, whether it be
14 RMPS or any other, this proposal for the kidney program was
15 probably as well thought out, planned through a committee,
16 advisory committee, bringing everybody across the state of Texas
17 aboard that could have any input to its implementation and it
18 was exciting really to hear about this. It has been so well
19 done.

20 While many traditional projects have been supported
21 in previous years, these are now being terminated. A new
22 generation of projects as was presented to the visiting team
23 promised to deliver improved accessability. Representatives
24 of various multi-discipline professional organization testified
25 favorably on behalf of RMP. I bring this out primarily because

eak 7

1 historically this has not been true. The relationships,
2 the acceptance of RMP by the medical association has
3 improved. I would go a step further and say that the executive
4 director of the Texas Medical Association was the one who was
5 there to speak with us. And what is probably a little more
6 reserved in his openness and acceptance of RMPS than I
7 understand about 90 percent of the physicians in that state are
8 so this was encouraging. But the other thing about the change
9 in the predominance of physicians can be told, I think, relative
10 to the adivsory committee. The advisory committee at one time
11 was almost entirely MDs. At this point in time, numbering
12 51, there are 29 physicians on it. And it was recognized
13 that the region serving an effective role toward the delivery of
14 health services because it, for one thing, it is serving
15 as a bridge between what we call on the site
16 visit among ourselves in family, town and government.
17 In other words, it is bringing together the practicing
18 specialists and general practitioners.

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1 As far as continued support is concerned, in
2 response to questions by the visitors, the regional representa-
3 tives reviewed the continuing status of the activities fund
4 trhough 1970 to 1972. Of 22 projects supported, only two will
5 continue after the close of the current period.
6 Eight will be supported by self, or other support
7 that has already been arranged. Seven will be discontinued.
8 Either because they have been completed or because through
9 evaluation they have proven to be not worthy of continuance.
10 And there is a question about the continuance of
11 three others. Relative to minority interests and you will recall
12 that this was one of the concerns of the last advisory group,
13 and we went armed for bear to find some answers to this, and
14 I would have to say, that as we looked at the advisory committee
15 constituency there was some concern and a little more than
16 concern, that not as much has been done in this area as wehad
17 hoped would be in the entire interim period.
18 However, there has over the period of the last five
19 years been an increase in minority groups to the number of 11,
20 which seemed not too bad in view of the fact that they only
21 had a quarterly turnover with replacements. And we can't
22 expect an unusually rapid increase in this number through --
23 but there are also some other reasons.
24 I think we all acted like generals for two days in
25 this area and I think Dr. George Miller's hat was the hardest and

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Reba 2

1 the biggest. Having been there before, being the one that made
2 the recommendation for increased involvement of minority
3 groups, he really peppered away at this.
4 We even checked this out with Dr. LeMader relative to
5 their civil rights compliance and so forth and so on. They had
6 as I say improved the minority representation on the RAG, not
7 as much as we would have liked but there is a strong commitment
8 to do this.
9 And words can be words, but it is in print. Their
10 procedure for employment of people with a focus on employing
11 those who are of the minority groups. I think at this point
12 I will say that Dr. McCall, as forthright as he is, we could
13 not back him into the corner on this because he was so honest
14 about it and said, "I am looking for these people, I have been
15 looking for these people. I will continue to look for these
16 people and bring them to the board as soon as possible but I
17 will not commit myself to bringing aboard a black face or
18 Chicano or a white person unless they have the competency and
19 capability that we can build on to make them an active con-
20 tributing part of our staff and RAG."
21 The minority groups are extremely well and consumer
22 groups in the subregions. Much of the program is arranged around
23 the inputs from these people. There are a significant number
24 of minority personnel on project staffs. I would want to tell

25 you this:Dr. Sid Geroa, who sat there, and he is not a very

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Reba 3

1 vocal person, but he rose to his feet after much probing
2 in this area, and this was the second day, he rose to his feet
3 and in a soft kindly way, a Chicano, made it very clear to us
4 that the RAG, the Executive Committee and indeed the grantee
5 institutions as they moved ahead in their pgoram planning and
6 implementation, he felt and it was like a sermon, he felt that
7 they had the well being of everybody in that state in mind
8 regardless of race, color, creed, age or anything else.
9 And it was beautiful to hear. If he had been more
10 vocal before I don't think it would have been quite so impres-
11 sive. Relative to process, Dr. McCall, the coordinator, has
12 undoubtedly provided some of the strongest leadership with able
13 administration in his three year tenure that one could expect.
14 There is a very viable regional advisory group and he
15 has utilized them, diversified talents of its membership, in
16 establishing the plan as presented in the triennial application.
17 Dr. McCall has excellent rapport with members of the RAG and
18 many other health representatives throughout the state. Agencies
19 and associations, individuals, and so forth. As an aside, at
20 this particular time Dr. McCall was being interviewed for a
21 Coroner's position in my own state and as a member of the college
22 and faculty there I was aware of this, somewhat involved in
23 this I think he and I treated it with very low profile, inten-
24 tionally.
25 The review committee was aware of this. The possibility

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#14 Reba 4

1 of changes, I would say, despite the fact we knew change was
2 possible, we felt that Dr. McCall had developed a staff, had
3 allocated responsibilities or delegated responsibilities
4 and given it the authority to carry out these responsibilities,
5 and if he had, we felt that Mr. Ferguson, his deputy could very
6 well move in and move ahead with the program they were planning.
7 I hasten to add before you get excited he has
8 decided to stay in Texas. I think Texas is fortunate and I
9 think we would have been fortunate to get him but we will carry
10 on. Relative to program staff, the staff consists of 19
11 professionals, all but two of them serving 100 percent of the time.
12 There has been almost no turnover in the last two years.
13 I think this speaks well both for staff and for the
14 coordinator, and six additional professional staff members are
15 requested during the next year and include a director of edu-
16 cational programs, chief of public development and evaluations,
17 nursing education and three subregional representatives.
18 The site visitors believe that these positions as
19 budgeted are justified. The program staff reflects a high
20 quality of broad branch of professional discipline, particularly
21 impressive was the quality of subregional representatives
22 to demonstrated thorough knowledge about their responsibilities
23 with respect to geographical assigned areas.
24 The 51 member RAG group was very active from the
25 time of the last site visit through December and continues to

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#14

Reba 5

1 be but were particularly active at that time with attendance
2 never going below 70 percent, and with people coming from all
3 over that state of Texas to work on RAG meetings, that attendance
4 of 70 percent seemed to us to be very good.
5 Geographic distribution of its membership was con-
6 sidered to be satisfactory. However, as with many regional
7 medical programs physicial representation proportionately was
8 high while consumer interests remain relatively low. I alluded
9 to that earlier but I need to go a step further I think and
10 indicate again there are still 29 of the 51 who are physicians.
11 This question was raised as to why. And the chairman
12 of the RAG, S. T. Bradshaw, not Bradshaw, Dr. Eastwood, who is
13 a Ph.D. and director of the medical center at Houston, quite
14 a personality, highly respected by the group who relates well
15 with the RAG group, and in staff and the rapport seemed excellent.
16 But anyway Dr. Eastwood explained that with the four
17 -- with the three medical institutions within the system, and with
18 Baylor and one other medical school in the state, ---
19 MR. SAYS: University of Houston is the medical
20 school.
21 MS. KERR: Getting underway. If they were to have
22 representation from general practitioners and so forth so on
23 they could see that this could not be cut too much more if they
24 were to keep the good faith of the physicians that had taken
25 so long to get it built up and he convinced us that this was
true.

#14

Reba 6

1 And after our visit I think we felt that this too
2 was proper, too.
3 The executive committee meets more often than the
4 RAG committee and provided ample guidance for the coordinator
5 and staff. Effective in providing leadership in the process
6 and in utilizing regional advisory groups, 51 committees and
7 task forces. These were not left in limbo, they were well organ-
8 ized and coorindated task forces and committees.
9 Development committee assumed an active role by
10 establishing short term objectives. The Chairman of each
11 program committee is a RAG member and serves on the executive
12 committee. General program activities for each of the seven
13 priority statements and funding allocations projected for use
14 of growth funds in the second and third year of the proposed
15 triennial event application. All this is to go to say that there
16 has been much planning, thinking, brainstorming, and so forth
17 prior to the submission of their level of request for funding.
18 I have talked about the grantee organization.
19 There was some feeling at one time that perhaps there
20 was a little bit too much control from the grantee organization.
21 We came away from their having probed rather deeply on this
22 too to find that the coordinator, the RAG, feel very free to
23 move ahead with decision making with absolutely no interference
24 or control from there, from the grantee institution.
25 And they feel very comfortable with the physical

#14 1 arrangements, as far as participation is concerned. Many
Reba 7 2 health interest groups are actively participating in the region
3 as evidenced by the number of persons who attended this two
4 day visit.
5 No major group has captured a controlling interest.
6 In preparing the budget request for that of last year there
7 was a complete turn around with respect to funding the major uni-
8 versities and institutions. This accomplishment has made more
9 funds available for the community. But -- as a result it has
10 not brought about less cooperation from major health institutions.
11 The political-economic power of the regions involved in the
12 regional program, the CAP agencies and local -- not only this
13 but there is CHP representation on the RAG, representation
14 from RMP other RMP on the CHP Council. CHP and B agencies
15 are involved in the process.
16 I have already talked about the CHP's, and their
17 situation. During the last RMPT the review cycle there was
18 ample evidence that the RMP's minimum review requirements and
19 standards for local review have been carried out in a very
20 satisfactory manner and this continues to exist.
21 As far as the assessments and resources there was
22 ample evidence the region is conscientiously accumulating a
23 great deal of data as evidence by (inaudible) -- the data is
24 utilized in identifying specific and measurable needs of the
25 region.

#14 1 Management, the capability of the region continues

Reba 8 2 to be excellent. Program staff and project activities are

3 well coordinated including monitoring by RAG members and sel-

4 ected ad hoc members. Progress and financial reports are required

5 on a quarterly and monthly basis respectively. Relative to

6 evaluation as I indicated earlier at the present time there is

7 no full time evaluations director in the program.

8 I have talked about the termination of funding on

9 some projects that come about by evaluation and the limited

10 funding being put on others as a process of evaluation and

11 their need and expectation to fill this position shortly. As

12 far as program proposal the action plan is comprehensive,

13 priorities have been thoroughly prepared with much review

14 and are clearly congruent with national goals and objectives.

15 The proposed activities relate to stated priorities and objectives

16 given to the needs of the region. Methods of reporting accomplish-

17 ments and accessing results are proposed but address individual

18 activities really more than they do program achievement but

19 period review and updating of priorities are planned.

end # 14 20

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1 As far as dissemination of knowledge is concerned,
2 most programs have focused on appropriate groups and
3 institutions that will benefit. Knowledge, skills and
4 techniques to be disseminated everybody identified to
5 varying degrees among the projects.
6 There is a notable degree of involvement of
7 health education and medical institutions. Better care to
8 more people is a goal to which projects are directed. Some
9 solid measurement of result remains to be seen. However,
10 they are also addressing themselves to moderation of costs
11 of care.
12 Utilization of manpower, the regions utilize
13 community health facilities and it is apparent in the
14 projects that are proposed.
15 Allied health personnel utilization has improved.
16 Although new types of health manpower is a sensitive issue,
17 further attention is being given to this and this statement
18 revolves around the fact that the medical profession in the
19 State of Texas is not yet ready to accept the position of
20 assistance. Maybe this will change but this was why this
21 particular statement was put in there.
22 Improvement of care, access to health care, is
23 their first priority and projects are being addressed to this
24 issue.
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25 Primary care will probably be strengthened since

1 this is an important element in several of the projects.
2 Less attention is given to health maintenance and disease
3 prevention in the proposed activities.
4 As far as short-term pay?off the proposal is
5 directed more toward the ability of access to services than
6 simply gathering more information about health problems.
7 The need for feedback is projected. Support of
8 projects not planned beyond three years. Plans for
9 transition to other sources of support are included in their
10 proposals so that three years is the limit of funding.
11 As far as regionalization, we have talked about
12 the different regions. It is a major goal of the program.
13 They do share existing resources when possible and new
14 linkages among providers are indicated in the three-year
15 plan.
16 There is ample evidence that the region has and
17 will attract funds from sources other than RMPT. Though not
18 discussed in detail the region account provided the staff
19 with a document which indicates non-RMPT funding, to be
20 new and continuing projects and terminating projects
21 $150,380.
22 It was the feeling of visiting team that Texas
23 has much going. That it is well on its way to doing some very
24 exciting things based on sound priorities and objectives
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25 which have been developed cooperatively with a great deal of

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Take 15
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1 consideration by all people involved. They have been accepted
2 by all people involved and it seems as though they are
3 collectively ready to move out and do something with these
4 things.

5 We also felt that the region is under excellent
6 leadership from the coordinator, who uses well his central
7 staff of people who do bring to the central staff competencies.

8 We have before us the funding level requests and I
9 think we can all read that the site visitors did recommend
10 that they be approved as requested.

11 Now, I would draw your attention to the fact
12 that these do include the kidney project and that there are
13 questions about that.

14 Dr. Roberts pursued that more in depth, but it
15 was the unanimous opinion of the visitors that they be
16 approved at the level requested.

17 It was also the unanimous feeling of the visitors
18 that Texas kept its A rating.

19 DR. SCHMIDT: All right, John.

20 Dr. Kralewski: Just a couple of comments.

21 I didn't visit Texas on the site visit. As a
22 matter of fact, I have never visited Texas RMP, so I really
23 don't know the program.

24 I am reacting to the application; I am reacting to
25 the site visit report.

1 Unfortunately, the reports are striking me a
2 little differently than they apparently struck the group
3 that visited Texas, but let me just give you my impressions,
4 then we can go from there.
5 First of all, it looks to me as though that RAG
6 is still dominated by producers of services even after the,
7 you know, team previously had been very concerned over it
8 and wanted to make changes.
9 Changes have been minimal, and the addition of
10 women to the Regional Advisory Group, and then putting
11 minorities on there, to me, is a cop-out and, secondly, it
12 is a cop-out, I think, to say we don't want to take someone
13 because he is a minority group, we have got to wait until
14 we get that fantastically qualified guy.
15 I have had about three programs tell me that and
16 it is a strict cop-out, because they don't look. There is
17 plenty of good guys out there if they search for them, so
18 I think they are not doing the job in that regard.
19 Secondly, when I look at the projects, I think
20 this shows up because, of course, in their screening of the
21 projects, this is the group that sits down and sets the
22 priorities and determine what should be in and what should
23 be out.
24 If you look at these projects, a good many of them
25 are self-serving to the group that is on the Regional

1 Advisory Group, self-serving to producers of services.

2 I know this is a conservative state and they

3 will have to chip away a while before they can do things.

4 I find, on the one project, they are going to help

5 someone develop an HMO, and I was looking that over to see

6 who it was going to be, and sure enough, it is the Medical

7 Society.

8 So, now we will have another foundation developed

9 at our expense for the Medical Society more than likely.

10 Well, you know, these are leaving me some real

11 questions.

12 Also, I note in here that it appears that a fair

13 amount of projects are carry-over projects, they are not

14 being phased out. It may be that this again is an indication

15 of some excess money that was given to them in the middle

16 of the year and it just doesn't reflect that in this

17 application.

18 Well, on the basis, on that basis, of my feelings,

19 as I read through this and the feeling that I get, you know,

20 for what they are doing, I can't really recommend that level

21 of funding, nor an A rating.

22 On the other hand, as I said, I have never visited

23 the program. I am acting on the basis of information that

24 might be limited.

25 I respect the site team's wishes, obviously they

dor 4

spent a lot of time with it, therefore, I am in a bit of a dilemma.

DR. SCHMIDT: Let's see. Let me see. Would you second the motion that was made?

DR. KRALEWSKI: For that funding level?

I couldn't second that, no.

DR. SCHMIDT: All right, there is a motion on the floor for approval at the level requested.

Is there a second to that motion?

MR. HILTON: Second.

DR. SCHMIDT: All right, it is seconded.

All right. Further discussion?

nd 15

Dr. Luginbuhl?

ake 16

DR. LUGINBUHL: I was interested to check the population of the area.

I think it is 11 million people, and I don't really feel that coming up with per capita figures should be t he way in which we determine allocations. I do think, on the other hand, that we have to give some consideration to the size of the area and the numbers of people that are being served.

I think that the amount of money proposed works out to something like 22 cents per person.

I know in one of the other programs, we have given probably five times as much on a per capita basis.

dor 5

1 My question is, if it is an A rated program, why
2 isn't it a bigger program in view of the size of the state,
3 the diversity of income levels, the magnitude of the problems,
4 why aren't they able to utilize more funds and meet some of
5 these needs that are there?

6 DR. MARGULIES: I think that is an interesting
7 kind of a question to raise. It is more a matter of history
8 of program development than it is geography or population.

9 It is a problem that we have wrestled with at
10 various times in RMPS.

11 This particular program was one with a miserable
12 record up until the time of the last sit e visit, when George
13 Miller was down, sort of astonished at the change about it.

14 On the other hand, if you are asking the
15 question, why, if this program is as strong as it is and
16 has that many people it is not able to identify more
17 activities of value to those people, that is a perfectly
18 valid question.

19 I just don't want to mix the two issues in the
20 discussion.

21 DR. LUGINBUHL: Well, my major question really dealt
22 with the last issue. I can't help but wonder, in view of
23 the population, why isn't it a larger program, and to lead
24 me to question the wisdom of having a single program cover
25 such a very large geographic area and such a very large

dor 6

1 population.

2 I am not familiar with the California program

3 because we have not reviewed it at this time, and I gathered

4 they have dealt with their large population by some sort

5 of great division and I know that New York, which may not be

6 the best example of how to run a region, has divided that

7 state into several different regional medical programs.

8 The question I am really raising, is this too big

9 an area to manage through a single program?

10 Is there enough emphasis being placed on the sub-

11 regions or on dividing up the problem so that it can be

12 addressed?

13 MISS KERR: There was consideration given to

14 having three -- Texas make up three regions originally,

15 and it was decided to go with one.

16 The other thing is the regions are comparatively

17 new, with their representatives just getting out there and

18 getting involved, and I think that to use Mrs. Flood as an

19 example in the El Paso area, where there are many Chicanos,

20 she knows their problems, they relate well and there is a

21 Sister Strohmeyer down in the lower valley who is equally

22 as -- and I assumed, all of them were, from the way they knew

23 their subregions as they discussed them with us, they were

24 identifying problems.

25 I am not sure at this point in time, though I

1 am sure that they, too, will want more funding eventually, but
2 I am not sure at this point in time but what the coordinator
3 and the RAG feel that at this particular time perhaps that
4 "We better take this much money and do well with it and then
5 go the next step."

6 DR. MARGULIES: I would like to pick up something
7 John commented on, he used the same words in my mind when he
8 said "cop-out".

9 I react, I guess, with some suppressed violence
10 to this business of, "Oh, yes, we are interested in
11 minorities and women but they must be of the best kind and
12 of the finest kind of qualifications."

13 Well, I have a couple objections to that. One
14 is that it can easily be used as a facade for inaction.

15 Secondly, if there was absolute equality as
16 equality is usually measured, then there wouldn't be any
17 minority problem in the first place, that is really what
18 we are talking about, and

19 The third is I doubt very much that a program
20 which has to deal with issues of the kind that they have in
21 Texas, particularly with the issues of Mexican Americans,
22 migrants, and so forth, can do so from the kind of experience
23 that they get from people who have never had anything in the
24 world to do with those problems.

25 I think it is a programmatic weakness but what I am

dor 8

1 real ly wondering about is, if you believe in general in
2 these concepts, at what point does this become an issue of
3 priority in determining what grant levels should be?
4 Now, we have identified on several occasions in our
5 review that there are deficiencies but there are signs of
6 progress, and so on.
7 This is one of the criteria. The weight one
8 gives to it, I supposek can be put down in some kind of
9 arithmetic form, but I think there is more to it than that.
10 And I think it is only fair to say to you that our
11 own kind of judgment is going to be very strongly influenced
12 by just how much evidence there is of commitment to the issues
13 of fair play with minorities, with women. This is so
14 inseparable from the concept of an effective Regional
15 Medical Program that I find it impossible not to be
16 influenced greatly when we come to the question of grant
17 award.
18 Obviously, if there is a marked disparity in my
19 view and that of the review committee, we will yield to the
20 position of the review committee and council, but I do hope
21 that question is being given as much consideration as it
22 should.
23 DR. SCHERLIS: I just wanted to take up some more
24 questions about the recommendation of the site visit group,
25 since apparently it, in giving all the funds that were

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1 requested, apparently decided all the funds were to be
2 wisely expended. Looking over some individual projects,
3 they are of interest. I question, though, how much impact
4 they will have on health care delivery systems.

5 The health project Number 69, Health Evaluation
6 Access and Resources Development, Ector County Medical
7 Foundation, as I read it, it is a computerized effort to
8 aid in diagnosis and seems rather expensive, it is
9 $118,000 for each of the years, look at some six thousand
10 people. If I read this correctly, have a standardized
11 medical history questionnaire in English or Spanish, and if
12 anyone has tried to set up computerized methods for getting
13 histories to go beyond that, this is a tough area.

14 Perform basic physical workup, which consists of
15 urinalysis, blood pressure, visual test and hearing test.
16 These are the only ones that are listed.

17 You will then have electronic data processing,
18 printout, a physician will look at the printout, and decide
19 whether any medical care is necessary.

20 Then from that point, I sort of lost track
21 because they say diagnostic and treatment services will be
22 obtained from public volunteer and private sources without
23 charge when possible, and health delivery is dependent on
24 that vehicle of access, if it is, it is really a very thorny
25 type of project to look at.

1 Yet, it is one hundred eighteen for each of
2 two years. It is fairly routine.
3 I was wondering if you could tell me what GRO
4 is, or GRO are, since it is taking place in five places.
5 MISS KERR: Grass roots.
6 MR. SAYS: This essentially is seven to twelve
7 in each group that get together. The whole idea is a
8 sharing of services. Thus far, about the extent of the
9 actifity has been sharing in service training, but we
10 believe that it will go far beyond that. They are now looking
11 at this.
12 It certainly is an activity that is popular
13 among the consumers as well as the providers.
14 DR. SCHERLIS: The other program is an electrical
15 safety service, one which seems similar to many of the others,
16 except here they are paying $50,000 for manuals, I guess to
17 be put out. Then to have it self-supporting, I question
18 if at this period of time, knowing what we do about safety
19 hazards, since all this is so well documented and available
20 through many agencies and otherwise, I just question if this
21 should be part of what RMP should support.
22 MR. SAYS: Well, this is a pickup on an activity
23 supported by program staff for about a year.
24 DR. SCHERLIS: But they plan to support that again,
25 don't they?

dor 11

1 MR. SAYS: No, it is a little different.

2 The core staff activity, they demonstrated the

3 feasibility of this in six hospitals and the Texas Hospital

4 Association, which is very progressive, very cooperative

5 with the RMP, as well as other prior organizations, has seen

6 fit to take this activity, asking for support for one year

7 only, after which it will be continued through fees.

8 It goes far beyond putting a manual for hospitals,

9 but offering them assistance, actually going in and taking

10 a look at the way they go about checking out their equipment,

11 and so forth, and possibly, even in some of the smaller

12 hospitals, sharing electrical engineers, where the single

13 hospital may not now be able to do so.

14 DR. SCHERLIS: Well, the lutline doesn't go that

15 far.

16 MR. SAYS: If you look at the full-blown

17 application, it does.

18 DR. SCHERLIS: I guess you had the raw project.

19 I question if this is the way to do it, since there are other

20 ways of approaching it. This was the question that I had.

21 DR. SCHMIDT: Mr. Toomey?

22 MR. TOOMEY: I couldn't find any mention of an

23 HMO proposal, but I would like to comment that if there is

24 such a proposal, and if it does concern itself with a

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25 medical care foundation, then I would recommend that it be

1 supported.

2 I am concerned about the medical care foundations

3 that are established on A as a defense mechanism against more

4 and different and, if you will, innovative kinds of pro-

5 visions of medical care, and to use the foundation for

6 medical care as a mechanism to defeat something which is new

7 and different turns me off, but to fund a project which has

8 as its base and concept great numbers of people or

9 representatives of hospitals, public health agencies, CHP

10 agencies, RMP people, physicians, medical schools, and so

11 on, it would be very refreshing and as a matter of fact, it

12 might just possibly come up with something which would

13 be very worthwhile in terms of an HMO foundation for medical

14 care kind of proposal and would be different.

15 I would like to see it.

16 MISS KERR: I am not sure but what there is some

17 misunderstanding about this because the HMO activity has

18 been as a result of RMP involved staff assistance, but it

19 is being funded by HSMHA, county medical society, but the

20 region itself is not involved in any funding of the HMO.

21 DR. KRALEWSKI: My comment to HMO was along the

22 lines that this is the way they devoted some of their

23 discretionary funds, I believe, and core staff effort, and

24 it may be appropriate. It only occurred to me that I suppose

25 there was a lot of different areas that could have used that

dor 13

1 kind of help, and as I was reading through it, where they
2 talked about the fact they were giving help to groups to
3 reogranize the health system, lo and behold, it
4 happened to work out that way, and it may be good.
5 I don't wish to speak against it, but I think that,
6 you know, this is a big region, they have got a lot of people
7 they are trying to subregionalize, and I hope that that will
8 help a bit.
9 The site team obviously thought that they have
10 some strength and will be able to grow and so I guess,
11 really, though, that my reflections on this is that I feel
12 it would really be giving them a bit too much of a pat on
13 the back to go one hundred percent of what they have asked,
14 both in light of the accomplishments that they have achieved
15 and in terms of what has been made on these projects.
16 Therefore, I guess what I would really like to do
17 is offer a substitute motion, of funding at levels of 1.9,
18 2.1, and 2.3, with developmental funds in the range of 80
19 first year, one hundred and one hundred for the second and
20 third year.
21 I think this will give them an increase in funds,
22 and as has been pointed out, this is a large population
23 group and probable that budget is not out of line.
24 Y et, I think it will indicate to them that we
25 still have some questions about exactly what is going on and

dor 14

where that money is going.

DR. SCHERLIS: I second that.

DR. SCHMIDT: All right, there is a second, then, to the substitute motion.

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Their level last year?

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DR. KRALEWSKI: 1.58.

DR. SCHMIDT: 1.58, so this would be up to 1.9.

MR. SAYS: Doctor, I know there is a motion, but I think there are some things perhaps you are not aware of, Dr. Kralewski, in this whole situation.

Dr. McCall is an extremely capable coordinator and he understands that to pull off a successful program takes the commitment of the people to whom it is to be delivered, and also those who are involved in the process.

If you look at the application very closely, it took him from July, when the last site visit was made, up until December of 1971, through a very long hassle with his RAG and his development committee. The priorities were developed once and rejected by the RAG. They went back to the drawing board.

They had only two months to bring in some kind of projects for this application, hence, the reason for his growth funding in the second and third year.

I happen to know that since this application got into the hopper, in January, they could use easily a half a

1 million dollars more now.

2 For an example, in Houston, they are now

3 operating, or talking with a group, this program has almost

4 developed, it would take $150,000. It involves two barrios,

5 where they would like to employ six half-time health advocates

6 in each barrio, under the supervision of Chicanos. This

7 dove-tails in with a program by Baylor, the Department of

8 Community Medicine, which is also involved in a hospital

9 district that has the direction of seven clinics from that

10 city that deal with very poor neighborhoods, an excellent

11 opportunity perhaps to examine access or evaluate access

12 and quality performance on a patient population of 60,000.

13 This is just, you know, a couple of programs that

14 have been examined and are in the hopper at this time.

15 This application started almost a year ago.

16 DR. KRALEWSKI: Well, I appreciate that additional

17 information and I feel that if you are correct that this

18 gentleman is a really good manager, that he would be able

19 to take a million nine and probably reorganize some of the

20 things that he is doing and probably, as a matter of fact,

21 go through these projects and come out of there with, you

22 know, ten or twelve or fifteen percent savings, at least,

23 and then devot e that to these very worthwhile activities

24 that you are mentioning, and I suppose he does have also

25 the opportunity to come back with an application a bit later

dor 16

1 for some additional activities as they develop.

2 MR. SAYS: One year hence.

3 DR. LUGINBUHL: I am certainly very much influenced
4 by your evaluation of the leadership of the program, but I
5 think the information about the timing problem is quite
6 significant.

7 What I would wonder about is this: Would it be
8 possible within our ability to make some cutback in terms
9 of the project part of the money, but give that money to the
10 program in a way that they could use it flexibly over the
11 coming year.

12 If he is a really good man, he has come up with
13 good new things, now that he has gotten priorities
14 straightened around, I would like to give him the flexibility
15 because it already is a fairly limited sum of money for the
16 population and problems.

17 I don't see the imaginative approach to the large,
18 unserved segments of that population in this application,
19 and maybe if we could preserve the dollars but give some more
20 flexibility to the director, he could begin to address those
21 programs.

22 Finally, I am somewhat concerned about the RAG and
23 the fact that it does appear to be heavily influenced by
24 professionals.

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25 I am wondering, as I have listened to these

1 discussions, about the size of these groups. This one, I
2 think, is 50 or so people, and I wonder how well they are
3 really able to meet and set some of these priorities and
4 particularly how do some of the underserved get their priorities
5 into the application, if the group is dominated by priors.

6 DR. SCHMIDT: Well, I think one of the points that
7 John was making was that if this is a wise manager, he can
8 get discretionary funds out of the money he has just by
9 simply not spending it for some of the things that in the
10 application he said he was going to spend it for. You are
11 saying can we force him by earmarking discretionary funds and
12 the answer to that is, he can be advised or it can be
13 recommended but we haven't been in the habit of so ear-
14 marking funds.

15 DR. LUGINBUHL: My concern is a little bit
16 different.

17 If I am correct in my understanding of the process,
18 whereby some of these projects get into an application, I
19 think what happens at times is that people propose these
20 projects and they are nominally within line with the goals
21 and objectives and the group making the decision at the local
22 level finds it very, very hard to say no, especially when there
23 is not some other proposal at that point in time competing
24 for those dollars.

25 Frankly, I suspect at times the problem of

dor 18

1 setting priorities is getting passed on up to us.

2 If you have the money or the potential for getting

3 money and you are not forced to set priorities, frequently the

4 easiest thing to do is just not set them.

5 What I am suggesting is that by cutting back on

6 the project money, you are going to force them to set some

7 priorities and you are going to let them reallocate those

8 dollars or force them to reallocate those dollars by

9 increasing the discretionary funds and I would think that for

10 at least some coordinators, this would be a very welcome

11 opportunity to set priorities and to, in fact, strengthen

12 their hand in dealing with their regional advisory group

13 and dealing with some of the priorities that are making

14 demands for project support.

15 DR. HESS: Just a question to further clarify

16 this.

17 It is my understanding that an RMP may shift

18 developmental components into projects but the reverse is

19 not true unless it is authorized, is that correct?

20 DR. SCHMIDT: That is correct.

21 DR. HESS: So the implication of your statement

22 is, would be to approve the developmental component at the

23 requested level and take the cut in the project section of

24 the budget in order to achieve your goal; if that is what we

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25 are after, I think that ought to be specified.

dor 19

1 DR. SCHMIDT: All right, is this acceptable to
2 the mover as a piece of legislative history that will be
3 directive then?
4 In other words, developmental component is given
5 at the 10 percent level, the maximum allowable, but the cut,
6 the reduction down to 1.9 comes out of the project funds.
7 That we can do.
8 DR. KRALEWSKI: Acceptable.
9 DR. SCHMIDT: All right to the seconder, is
10 that acceptable?
11 DR. SCHERLIS: Yes.
12 MISS KERR: I would like clarification as to what
13 the motion of the moment is now?
14 DR. SCHMIDT: It is for approval of the triennial
15 period at the levels, 1.9, 2.1, and 2.3 total funding levels.
16 The original substitute motion was for developmental
17 component of 80, but this has now been changed to a
18 developmental component that would be the maximum allowable
19 under the policy, or ten percent of the award, really,
20 which would give them, what did they ask for?
21 MISS KERR: They asked for first year $160,000,
22 second, two hundred thousand, and the third, two twenty-five
23 thousand.
24 DR. SCHMIDT: Well, that would still be permissible
25 then because it could go up to 10 percent of the award. So

1 that gives them some amounts of flexible funds.

2 All right.

3 Other comments or questions then?

4 If not, I will call for a vote on the substitute

5 motion which we just reviewed.

6 All in favor, please say "aye".

7 Opposed no?

8 Dissent is recorded.

9 Thank you very much.

10 I think that is the first time we have ever

11 completed a discussion of T exas in 55 minutes, 65 minutes.

12 We can conclude a discussion of Indiana in 30

13 minutes.

XXXXX 14 DR. PERRY: The word catalyst has been used

15 so I will just say there has been a most dramatic transition

16 here in Indiana in the past year.

17 A site visit has not been held in Indiana, although

18 an August site visit was set up, it was canceled by RMPS

19 for the following valid reasons:

20 Dr. Stonehill, the coordinator of Indiana resigned

21 effective April 30, 1972. The triennial application that was

22 submitted was submitted without really the assistance of a

23 coordinator, was reviewed by the staff here at RMPS, did not

24 clearly present a three-year plan, thus the site visit was

25 cancelled.

1 RMPS recommended the submission of a one-year
2 anniversary application which would lead to a much stronger
3 triennial req uest next year and this has been done.
4 Dr. Schmidt, the second reviewer and I have been
5 on two separate site visits at Indiana. Dr. Brennan and I
6 in 1970, representing the council and the review committee,
7 were there, We were not welcomed back for the next site
8 visit.
9 Dr. Schmidt was in Indiana in 1971 and I am not sure
10 of his reaction about being welcomed back for a site visit
11 this time, but the purpose of the site visit and which was
12 communicated at the site visit periods, I believe have led
13 to the most important decisions for change in this region.
14 If there is anyone thing that I would say was
15 probably the greatest strength of all is this attitude of
16 desire to change that is recorded in this, not only in the
17 application, but by other means.
18 I am delighted that Bill is here at the table
19 with us because members of the staff, since we have not been
20 there during this period of thime, there are members of the
21 staff that have been in the Indiana region and it is some of
22 their reflections and their reactions and certainly the
23 recommendations of RMPS that will be a part of my recommenda-
24 tions here today.

25 To evaluate Indiana, let's look at some of the

dor 22

1 strengths and then some of the weaknesses for, indeed, even
2 with the problems and dramatic changes that have taken
3 place, there are strengths that can be indicated here.
4 With Dr. Stonehill's departure, which was
5 requested two months earlier than his date of resignation by
6 the RAG, I think this tells a little about the story there.
7 I am putting this as a strength and it must be
8 taken as a plus, as far back as the time of the, of this 1970
9 site visit, in which I participated, there was a great deal of
10 antagonism expressed between many Indiana Medical Associations,
11 and by various groups, representatives of the Medical School
12 at Indiana, have stated to Bill and to others that they have
13 been misinformed on the status of IRMP.
14 And that the tight ship that had been identified
15 and I guess these are words that both Al and our group used, that
16 this man was running what was evidently heading for very
17 rocky shoals.
18 With his departure, Dr.Behring, Associate Dean of
19 the Medical School, has been appointed the interim or acting
20 coordinator and a search committee has been set up for his
21 replacement.
22 I recall Dr. Behring, he has served with this
23 group and with the RAG for a considerable period of time,
24 perhaps an indication, however, that this RAG was not that
25 active and not that involved.

dor 23

1 Already the relationship, and I would put this as
2 a strength, already the relationship of the Medical Society
3 and other health agencies have indicated a marked improvement
4 in the few months recorded since the resignation of the
5 coordinator.
6 Dr. Behring reports, as the interim coordinator,
7 that there are improved relationships wit h the Indian Hospital
8 Association, many of the health associations that have been
9 identified in relationship to this program, that they are,
10 indeed, sharing with them their request for help in putting
11 this region into better shape.
12 The RAG, with many of the problems, I will list under
13 weaknesses.
14 I feel, however, the complete review that is
15 taking place with the RAG today is absolutely essential. It
16 is still in the process of major revision. Although the
17 larger number are from Indiana University, and there have been
18 comments on this from the beginning, Indiana, in that setting
19 and in that state, certainly Indiana University deserves and
20 should be in a major relationship to this RMP.
21 But in addition to this group, we find here other
22 institutions, other groups, their relationship with CHP,
23 which I will speak to further her e, other organizations
24 throughout Indiana are being represented in some of the
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25 planning that is going on.

dor 24

There is no question about the still great need for consumer input. Representatives of some of the other health professions, the health professions are physicians and nurses only. Dr. Behring, however, again has expressed his eagerness to the members of the RMPS here. He plans to answer the criticism that IRMP has received and that, indeed, the Medical School will assume a different kind of relationship on the RAG and in relationship to the total program.

end 17

CR 7149

#18

Peba 1

1 Perhaps the most exciting strength to mention is
2 the regionalization that although begun several years ago
3 has culminated in the past few months with some very strong
4 effects. Nine area action groups have been formed and the
5 formulation of active relationships with five existing CHP agen-
6 cies has been carried out.
7 The formulation of two other CHP's are being planned
8 with IRMW now in a working assisting relationship with them.
9 On just a personal level I had the opportunity of speaking
10 at my home town which is Richmond, which does not have any
11 I guess problem here in terms of interests in the project.
12 I was speaking to the Medical Society of Wayne County
13 and it invited Liberty County to this meeting. They did not
14 know my relationship to RMP in any way and in the business
15 agenda of that meeting it was pretty exciting to hear them
16 putting together, having received a request for Indianapolis
17 for the first time to get involved, to select the people to work
18 with them.
19 To be a part of action groups. There was certainly
20 to me as I look back and as I read this application, an indi-
21 cation of the little small town out there of 40,000 that had
22 been asked for the first time to participate in this project
23 and this program and really their excitiement that Indian-
24 apolis was looking out to them for them they felt for the
25 first time.

#18

Peba 2

1 So this regionalization plan is a most important
2 plus. Development of effective comprehensive data base
3 which is one of the major concerns of the 1970 site visit which
4 deplored the lack of any really major statistical basis for
5 planning priorities and needs, this has been accomplished al-
6 though there are parts of it that need to be looked at out in
7 these separate parts of the areas that are being put together.
8 The state-wide basis has been accomplished and listed
9 in this. I am sure Dr. Brennan will be happy to see that since
10 this is one of his major pushes at the 1970 visit.
11 23 now major data sources have been obtained.
12 These have been obtained through contract sources and such
13 there in the state. And certainly there is a working set to
14 work with here in looking at the regional characterization.
15 Their set of objectives, broad objectives that have been put
16 together certainly has to be better defined than they are at
17 the present time.
18 But they have this basis for the first time to look
19 at it and really to work with it. The strengthening of the
20 program staff has been looked at as one of the major commitments
21 and needs of this program. And already there is a reassignment
22 of responsibilities of some of the people on the program staff.
23 This is a relatively small staff those of you that
24 are looking at any of the material and whether one considers
25 that the amount of money at an annualized level for the program

#18 Reba 3

1 staff is around $379,000, this has been a small staff that
2 the former coordinator wanted in relationship to running
3 the program.
4 In the projects area, particularly those of a categori-
5 cal continuing educational nature, it is exciting to find
6 that there has been a transfer of many of the larger funded
7 projects to local funds. The coronary care project that they
8 have carried for years, their stroke project, these have been
9 taken over by the other levels and other kinds of funding.
10 More about this also in the recommendations. As
11 I said you know and I will go back to that as another major
12 strenth attitudinal desire now to change, it is very strong and
13 I happen to feel that they do have the capacity to bring this
14 about.
15 What are the weaknesses? The major weaknesses,
16 program staff, there must be additions to this. There are only
17 two vacancies, in the list of what has been requested. This
18 must be done in certain areas particularly, planning, evaluation,
19 essentially. They have an educational psychologist there, and
20 he needs additional staff help. He needs a model, he needs
21 some help on how really to relate their projects and evaluate
22 them toward program goals.
23 Mr. Smith who I had the privilege of knowing through
24 this project and have had a working relationship in many other
25 ways who was responsible for allied health and nursing has been

#18 Reba 4

1 so succesful in that area and he really got quite a bit going
2 there, he is so successful he has been moved into another job
3 there and he is going to be head of all the active planning
4 in the regional parts of the program.
5 May I say that leaves quite an opening, however, for
6 allied health and nursing there, and they do need staffing
7 up in that area, particularly since they have begun to turn
8 the people on there in that area in relationship to this. As
9 a weakness again, from personal background, they have no one
10 yet from there major division of allied medical professions which
11 is in the medical school at Indiana which is recognized as one
12 of the most broadly developed programs because there is only
13 one medical center in that state, has responsibility for all the
14 community college programs throughout the state.
15 Still they have no voice in any way although some
16 projects in the RAG or in any of the relationships there to the
17 program I do not know for this is an excellent program. They
18 have people of national stature in that setting, some of them
19 serving with me on two AMA committees in relationship to allied
20 health.
21 A weakness, the revitalization of this RAG, a spelling
22 out of responsibilities, certainly a leadership role, planning
23 role, rather than just a reactor role to what has been bubbling
24 up or coming in is essential. Must be a major reassessment of
25 the regions review process. If one looks and one has pointed this

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#18 1 Reba 5

out in the last two reviews there when we have had site visits.

Many members of the Executive Committee of the program have made all of the major decisions in this. They have a very poor history of turning anything down. The indications are that this review process again being looked at and already in the works, some of the planning and things that must be done. Minority representation in the total program, there are no minority professionals yet on the core staff.

Two professionals are working in some of their projects and three minority people are on the RAG. It is an inadequate representation still but it is an improvement over two years ago. They still have quite a ways to go. However, in the project orientation, the programs they have had and I remember quite well visits with one of the black physicians who was heading up one of the community health projects, neighborhood health projects in Indianapolis, they do have some good projects going in this area.

Of approximately 15 projects implemented in this program only three old ones are requested for continuation. Of these the neighborhood health care center, nurse tractitioners are two of these. There are eight new ones they feel are ready to go. These are, some of them getting away from the categorical.

They have some health care emphasis and relationship

#18

Peba 6

1 to their newer goals. I will quickly make a recommendation
2 to get this on the table then I certainly want Bill and
3 particularly Al, who has been on site visit and Bill who has
4 been there recently to respond to this, but let's get the
5 recommendation out in relationship to this. They are currently
6 funded in this region at $1 million 121,000. They have re-
7 quested a million five hundred thousand in round numbers.
8 The staff having looked at this total plan have re-
9 commended an increase of only around $80,000 to a million
10 200,000. And the breakdown for this. As I said, they are in
11 -- their major needs as I see their projects in this core
12 staff so I am recommending or approving actually the recommen-
13 dation made by the RPM review staff here of approximately
14 $500,000 of this amount for staff.
15 This will give them increases in salary. This will
16 provide for the new director. This will add some to their
17 evaluation staff. It will give them an opportunity to really
18 staff up there where they are really going to need it in
19 staff that has been held certainly to the bare bones. In
20 relationship to one of their other major needs, and that is
21 to continue with the projects as they relate to the regionali-
22 zation and into these areas, they have requested $500,000
23 for this.
24 In contractual services. The recommendation of
25 the review staff here was that this be cut to approximately

#18 Reba 7

1 $300,000. With this they should indeed be able to go on further
2 with their feasibility studies, their expansion of subregional
3 planning, and staffing in relationship to the regional program.
4 They have made a request for approximately $600,000
5 for continuation projects and for new projects.The recommendation
6 is breaking this down to $200,000 each, $200,000 for contin-
7 uation and $200,000 for new projects. Adding this $500,$300
8 two $200 ones, we come up with a total of $1 million 200,000.
9 What this does give this program an opportunity to do with
10 even this small increase of $80,000, which is recommended,
11 is to -- they have turned the corner and made the decision
12 to change.
13 They have a long way to go to make this the kind
14 of program that we really can believe is ready for a triennial
15 review and I believe with discussion with Bill that any recomm-
16 endation that we make with the changes and things that they
17 need to do, rather than insist or even ask for a trieenial
18 review next year, that they be held at this level for two
19 years, during this period of transition.
20 They have turned the corner, they have got a lot
21 of plans going, things they have to do during this period
22 of time. Getting a new director although I am sure they are
23 going to be moving right ahead with this, with the Associate
24 Dean of the Medical School that is working with them but I
25 think they need a period of time and we are not increasing the
amount in the recommendation more than this $80,000.

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CR 7149

#19

F a 1

1 That is my recommendation I put on the board.

2 DR. SCHMIDT: Okay. I am the secondary reviewer

3 and I will try to just bring out the issues as I see them.

4 At the time of the site visit last year there was just a god

5 awful program. They got F's straight across the board and it is

6 a program that if substantive changes had not occurred one would

7 be considering whether to just stop all funding and just

8 declare the thing defunct and tell them to start over gain.

9 Problems with ineffective coordinator who had

10 a small staff they ran tightly and the staff really was not

11 doing the right sort of things. They had the worst kind of

12 possible relationship with the medical school. The medical

13 school completely dominated it. The majority of people on the

14 executive committee than ran the program were from the medical

15 school.

16 The principal person involved, George Lucameyer,

17 Associate Dean of the School, did not and does not understand

18 regional medical programs. For reasons easy to understand

19 the medical school is scared to death of the Indiana Medical

20 Society because their legislative support comes from the Indiana

21 Medical Society. Indiana Medical Society did not like the

22 coordinator or regional medical program.

23 The medical school dictated exactly what RMP could

24 and could not do. The coordinator's primary allegiance was to the

25 medical school.

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#19

Peba 2

1 He said if push came to shove his medical school
2 appointment was far more important than anything having to
3 do with RMP. The Executive Committee was not functioning well,
4 there was no data, no objectives, no priorities, there was
5 no programs, there was no plan, there was some projects. There
6 was no subregional effort. And it was just terrible.
7 The site visit two years ago told them this, they
8 got real mad, said it was an unfair site visit and they just
9 stayed mad for a whole year. And I walked into the biggest
10 trap I have ever seen set by a region that was pulling site
11 visitors up against everybody and the coordinator took a
12 day to realize that we had been set up.
13 And we left essentially escorted to the state line
14 by the highway patrol. And I doubled back to one ray of hope
15 who was a bright and new lady of the regional advisory group
16 and we just did suggest that the program leadership needed
17 to be changed, the medical school put off at arm's length.
18 We had to get the people in the school who did not
19 know what RMP was about out of the picture. And so on. One
20 member of my institution is for liaison purposes a member of
21 the Indiana regional advisory group. Done Casely. And he would
22 come back from Indiana RAG meetings just cackling with glee
23 and hand me the minutes of the meeting which took apart one
24 by one the site visitors and challenged the integrity and so
25 on and so on.

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#19 Reba 3

1 But largely through Haver and some other people,
2 and through the supportive staff I would like to point out
3 to the review committee the importance of staff support and
4 consistency of staff support in taking to the regions the
5 recommendations of the review committee and sticking by them
6 and really accurately reflecting and confirming and supporting
7 review committee in this.
8 They came in to see Harold, they probably came in to
9 see Henry Kissinger, I don't know who all they came in to see
10 but they got the same message each time and there was a revo-
11 lution. The coordinator resigned and RAG decided he did not
12 resign quick enough and threw him out.
13 Baring, I think it is a cop out. Medical school
14 is suddenly saying we did not know. Well, you know it was
15 impossible that they couldn't have known what was going on
16 because they were the program. They just were not paying
17 attention. And I really think that they did know but they are
18 having a change of heart and they are withdrawing.
19 The program is doing some things that I think really
20 are terribly important and if we are going to have a program
21 there, merit the support of the RMPS -- they do have a data
22 basis. They have new leadership there reorganizing the staff,
23 recruiting a new staff.
24 They have a different relationship to the school.
25 They have a very strong and excellent RAG chairman who seems

#19 1 to have taken over. They have the new goals, priorities,

Peba 4 2 and plans. There is an excellent exercise in subregionali-

3 zation. They have phased out projects and they are phasing

4 out projects.

5 They are restructuring their committee structure

6 and they have for the first time a really pretty good relation-

7 ship with the Indiana State Medical Society. Their area, groups

8 are very important, they are finally recognizing the fact

9 that their CHPB agencies are around and they are beginning to

10 interphase with fantastic amounts of dollars that poured into

11 Indianapolis, millions into OEO and RMP just said man, we have

12 to stay away from that power and that influence and all those

13 dollars and so on, because the medical school said we have got

14 to keep a low profile.

15 They are beginning to interphase with the things

16 that are going on in the real world about them. I think that

17 I will support the idea of funding them at 1.2. I think they

18 need this money to do the things that they are doing. I don't

19 know if they are falling into the trap of continuing the

20 old activities.

21 The ones they are continuing seem to be in the right

22 direction. I think there must be absolutely strong word from

23 here that what they are to do with these funds is to build

24 their staff, to continue the subregionalization efforts and

25 put money into that, to use their data base to get specific

#19 Peba 5

1 program plan, to get a specific action plan in conjunction
2 with the agencies and subregional people but to evolve where
3 they are going.
4 That is the third thing. To continue the involvement
5 with Indianapolis OEO and all of the other multiplicity of
6 programs that are active in the State of Indiana which range
7 from a very rural thing in the south and so on up. Finally to
8 keep that damn medical school out of the RMP headquarters
9 and let them be the fiscal agency but get this terribly op-
10 ressive school out of the picture. I would seek the recommen-
11 dation then, feeling that if they do get a good coordinator,
12 I think Baring will bring this program along and he has gotten
13 the word.
14 If they will get a coordinator who will continue
15 what he is doing. Whether they can come up with a triennial
16 next year or not I am not sure. I think it would be good to
17 give them the business of you know here is one year's support,
18 you can have another year's support without a triennial if you
19 need it.
20 We will look at you on a mini site visit in a year
21 or staff site visit in a year to see how you are doing and
22 offer staff support while they are in this transition phase.
23 Discussion?
24 DR. SCHLERIS: Would you like the mostion seconded
25 by a member of the committee rather than by the chairman?

#19 Reba 6

1 DR. SCHMIDT: Let's see. Yes, somebody get me off
2 the hook.
3 DR. SCHLERIS: I second the motion.
4 DR. SCHMIDT: All right, thank you. John?
5 DR. KRALEWSKI: We are moving this then for two
6 years instead of the one.
7 DR. SCHMIDT: That is right, at the level funding.
8 And with, you know, if they can come in with a whiz bang
9 triennial next year, great, but if they can't, let them have
10 the feeling they got a little time.
11 DR. KRALEWSKI: Thank you.
12 DR. SCHMIDT: Other comments or questions? It is
13 an example of a region that was turned around. Florida was
14 another one I can think of and so on. I think the main things
15 that have turned it around were the site visitors, who had the
16 strong support of staff who said yes, they are right you know,
17 quit looking for an out.
18 All right, I will call the question then. All in
19 favor please say aye. Opposed, no?
20 Last but not least then it is Memphis. And the
21 primary reviewer is Dr. Ellis.
22 DR. ELLIS: Thank you, Mr. Chairman. I have been told
23 that I did not have to many minutes to do this by some of my
24 friends and I am going to try to be brief so that they won't
25 be unhappy with me this time.

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#19 Reba 7

1 Memphis is a very interesting region and I would
2 just like to mention before we go into the discussion of the
3 visits something of the background and demographic information
4 because this is a very large region and it is culturally diver-
5 sified.
6 The region actually consists of parts of five
7 states, and it is made up really of what is traditionally
8 a trade area. Also the area that is based on hospital care
9 that is given to people in this 75 county area. 21 of the
10 counties are in Tennessee, West Tennessee. 16 in Arkansas,
11 27 in Mississippi. 6 in Missouri and five in Kentucky. And you
12 know that in this it is extremely difficult.
13 There is a population of two and a half million,
14 that is the 1970. It is interesting also that there is an
15 essentially rural area, except for Memphis which has about
16 800,000 people, 600,000 people, and then the next largest
17 city in this whole area after that is Jackson, Tennessee, with
18 50,000 people.
19 In terms of the racial composition there are 31
20 percent roughly a third, black. A few orientals and the rest
21 are white. Many of these are poor. It is also interesting
22 to note that in the Kentucky section there are quite a few
23 old people, the largest number of people over 65 in Kentucky.
24 With reference to the racial matter while I am here
25 I will say that this 31 percent does not reflect the situation

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#19

Reba 8

1 in some of the counties. In Tunica County, Mississippi, there
2 are 73 percent of the population is black. While in the
3 Ozark area you will have about the same kind of thing with
4 reference to white people. And nine of the 27 counties in the
5 Mississippi subregion having populations of more than fifty
6 percent are black.

7 The infant mortality rate, I will mention this because
8 it is very significant and will have a lot to do perhaps with
9 the long range programs which can bring about institutional
10 change. And while we have here an infant mortality rate this
11 is 28.9, compared for -- to this region and this is compared
12 to the national average in 1970 which is 21.7, it is lower than
13 that now.

14 The thing we want to point out, that in Mississippi,
15 in the subregions in two counties the infant mortality rate
16 was more than twice the national average. When you see an
17 infant mortality rate of 28 and you recognize that there are
18 counties with more than half, I mean twice as much the national
19 average, you really know you have a very, very serious problem
20 and oftentimes this is overlooked.

21 Now Memphis region did not have a site visit. This
22 time. The last, well, I might just tell you in passing that
23 this region became operational in 1967, I mean started its
24 planning in 1966 and 1967, became operation in 1969, and in
25 1971 had site visit in response to the triennial application.

#19 1 I will just go briefly through what the site

Reba 9 2 visitors had to say. The main -- I will point out the main

3 problems. And the main problems that they found in the site

4 visit and that was really known before the site visit was made,

5 was that the RAG, the Advisory Group of a health council, and

6 that this advisory group consisted of about 156 people, and most

7 of these people were in the priors class. And this was a

8 purely untenable thing to have the -- this committee and

9 council combined in this way so that the coordinator of the

10 program really was not in a position to carry out the program

11 in the way that was in keeping with the expectations of the

12 regional medical program.

13 Also the administrator, the coordinator of the

14 program, was thought by everybody to be greatly overextended.

15 And he, Dr. Culverson, was the only medical person in the

16 program. And he did not have a good manager under him to carry

17 out the administration of it, the administrative aspects of

18 the program.

19 So it was felt that because of the conditions

20 existing in the regional advisory group and because of the

21 lack of proper supportive staff, that the -- a developmental

22 grant could not be given. Now there was -- with some definite

23 strengths noted at that time.

24 These concerned the fact that the University of

25 Tennessee had given the program the authority. While the

#19 Reba 10

1 regional medical program grew under the guardianship of the
2 university, it really changed, after the visit in 1969, and
3 made it possible for the RAG to develop on its own.
4 The excellent thing about the program seen in 1971
5 was the fact that five CHP, five agencies and probably five
6 or six B agencies worked very closely with the RMP program. It
7 was described as being a really excellent, because RMP provided
8 staff to help the B agencies with their work, and also worked
9 with them in planning and all kinds of outreach activities in
10 the community.
11 The staff really developed well. And in the community
12 they were described as excellent brokers for the RMP program
13 and also they were not just trying to sell programs but they
14 were really architects, too, after they got over the operational
15 phase in the program. I said that the coordinator over extended
16 himself but the people, the site visitors felt that the
17 program had potential for being one of the best programs.
18 And while they did not fund, I mean suggest a develop-
19 mental component, they did grant triennial status as a result
20 of the visit. Now with the suggestion that there be a complete
21 overhauling of the RAG and the administrative structure and that
22 some effort be made to correct certain things.
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end # 19

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arl

1 Now I have said before that this is a very
2 difficult region to describe with so many people who are
3 very poor. Black and white. But one of the things that was
4 pointed out was that there were -- there was only one black
5 person, female, on the staff. And also there was very little
6 input, opportunity for input from the people being served.
7 Now I will go right on quickly to say that for a
8 year after this visit, after this 1971 visit -- and there's
9 nobody from the advisory committee who made that visit, we
10 did have members of the council who were on that visit, these
11 recommendations were made, and I would think, I said I didn't
12 make it, but I would think from reading the records that Dr.
13 Culverson made every effort to begin to do something toward
14 correcting the things that have been pointed out.
15 The -- there was a site visit made in the summer
16 by staff to take a look at what the situation was at the
17 present time. And I would like to say that Mrs.Kyttle
18 knows this situation very well and can add to it after I
19 have just said a few words.
20 It seems now that the RAG has been reconstituted.
21 I didn't tell you that that 156 member group has executive
22 committee of about 45 members. And it was just absolutely
23 impossible to get anything done that they didn't themselves
24 want because they met every month, while the RAG met only
25 once a year, I guess. Twice. Once or twice a year.

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ar2

1 Now the situation has changed quite a bit. The
2 RAG consists of 36 members. They are well chosen from the
3 geographic areas. They are old and young, reflect the racial
4 composition, and women. I think that there are nine blacks
5 and six women on this new RAG. And it is a freestanding
6 group, not encumbered by the old pattern. Dr. Culverson has
7 moved immediately to see that guidelines have been developed,
8 bylaws, that is, and also that three committees, policy --
9 the planning committee, and the policy and review committee,
10 and also reference committees.
11 Now, these reference committees are made up
12 primarily of the people who had to do with categorical programs.
13 There has been also a change in focus. The program activity
14 actually is looking at the underserved. In the subregional
15 areas where, like in the crowded areas of Memphis and in the
16 rural areas there is an attempt to extend services to the
17 people through cardiac clinics.
18 Also there is a very important high risk infant
19 component which is regional. I think this is funded jointly
20 with the other agencies, too, isn't it? Yes, it has just
21 started. Also family planning services.
22 It is hard in this brief time to tell you everything
23 that's been done here. I think it is extremely significant
24 that the regional program has applied staff to other agencies
25 in order for them to get very much needed services in the

ar3

1 family planning area and also to do something about getting
2 ambulatory services to these greatly deprived areas that they
3 are working to develop Lee County cooperative clinic in
4 Arkansas and so on.

5 I said before that the University of Tennessee
6 has been supportive, has helped in making decisions, but has
7 not forced its own views. And I think that the management
8 aspects of the program have not been reviewed yet. Right?

9 MRS. KYTTLE: That's correct.

10 DR. ELLIS: But it is expected they will be. I
11 mention this because the visitors in 1971 talked about the
12 kinds of positions which should be filled and talked
13 specifically to the point of not having the staff expenditures
14 be -- grow any larger until some of the operational aspects
15 could be shored up.

16 I believe there was a recommendation that, by the
17 staff, though, that because of the fact that the coordinator is
18 greatly overextended, that he be given an assistant administrator
19 to look at the management affairs particularly.

20 We have said there is no problem with assessing
21 resources and so on. Now the evaluation component is not
22 strong because of the fact that, well, they can't work too
23 well because one of the weaknesses that still exists in the
24 programs, there is not a clear statement of the objectives,
25 goals and priorities. They have stated some broad goals,

1 very broad, to make health care more accessible and to make it
2 more available, and to compare the health costs, lower the
3 health costs where possible in doing these two things.
4 But there are no clearly stated objectives as to
5 how broad goals can be accomplished; consequently it is hard
6 to evaluate the program because most everything can fit into
7 what has been stated as objectives.
8 I think the staff, knowing the whole story, and
9 unfortunately I have never been into this section at all, I
10 just know what people have told me about certain things, I
11 feel that the direction in which this program is moving is very,
12 very excellent indeed. And the staff feels that the changes
13 that had to be made as recommended by the site visitors in
14 1971 have been made in the main.
15 Mrs. Kyttle is here, and I would like her to
16 add a few things because she has visited the area twice
17 rather recently, and has talked with the coordinator and the
18 other people.
19 DR. SCHMIDT: Okay, would you make any comment
20 that you would?
21 MRS. KYTTLE: Dr. Hess has to leave at fourish,
22 so perhaps he would like to make his comments now.
23 DR. SCHMIDT: Okay, Joe?
24 DR. HESS: One certainly is at a disadvantage in

25 trying to evaluate the region from what appears on paper alone.

ar5

1 And I must say when I first started going through this and
2 looking carefully at what was there, the first question that
3 came to my mind is how with all these problems with the
4 RAG and what-not did this region ever achieve triennial status.
5 And, but, however, in talking with Mrs. Kyttle, I gather that
6 what is actually going on down there is probably much better
7 than what was reflected in the paper and so that one has to
8 somewhat separate the activities that are being carried
9 out from the -- what you might call in a general way the
10 organizational structures of the region.
11 But I would like to point out a few things that
12 are of some concern to me in looking at this total picture and
13 trying to render a judgment concerning the funding request.
14 One particular feature of this region we need to
15 keep in mind is that it overlaps with three or four other
16 RMPs in terms of geographical area and population, so that
17 there is the potential for funding coming into certain areas
18 from more than one source.
19 The problems of coordination have been worked out
20 fairly well and a couple of these others remain to be
21 resolved.
22 It is alluded to in the presentation, the RAG has
23 recently been redefined from the original 150 some odd person
24 group to 36 person group and the bylaws have been approved now.
25 But a lot of the further reorganization in terms of factories,

ar6

1 so on, remains to be done, and so that at this point it is
2 unknown to us exactly how that is going to shape up.
3 The new bylaws do spell out certain subcommittees,
4 but there is a broad category of -- appointive committees
5 which we have no information on what is going to happen there.
6 So that the new RAG is one question mark.
7 Another question that came to mind was the size
8 of the staff and the way the staff is organized. In the
9 submitted budget for this upcoming year, there is a place
10 for 59 core staff situations, 54 of them full time, and
11 there are 13 vacancies shown on the staff budget list.
12 I haven't taken the time to go through and enumerate other
13 core staffs, but this certainly seems to be close to a
14 record for number of staff people in relationship to the size
15 of the program and funding and so forth. So that is another
16 question.
17 And in looking at what one can tell from the
18 internal organization of staff, the data that is in the
19 application, I have some question about the tightness and
20 adequacy of internal organization of staff. As mentioned,
21 there are goals and some related objectives, but the priorities
22 are statements which, as one looks at them, may or may not be
23 related to goals, exactly how they fit into their system of
24 logic is not clear to me from the application.

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25 In summary, I perhaps would have to say that I

ar7

1 am taking on faith what I have learned from Mrs. Kyttle's
2 comments to me informally, that they are doing many good
3 things. Some of these are enumerated in their progress report.
4 But I do have some questions about it, what is happening in
5 terms of the program management system, including the RAG
6 and core staff.

7 The new projects which are proposed, there are two
8 of these which stand out in my mind as most consistent with
9 some of the things stated in their goals and objectives.

10 One is project 36, extension of services, neighbor-
11 hood health centers,and the other, 42 --

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1 DR. SCHMIDT: Let's continue on and get a data
2 base, ask Mrs. Kyttle if there is anything she wants to say.
3 MRS. KYTTLE: The Committee work --
4 DR. SCHMIDT: Could you put the mike right in front
5 of you.
6 MRS. KYTTLE: The Committee work and task force
7 structure is ~~not doomed.~~ now done. It was done so recently that it could
8 not get into this document. The staffing pattern is a proposed
9 staffing pattern. It does not list vacancies. Those vacancies
10 are new positions and that is what we intend to have. There is
11 only one vacancy in existing positions and that is the vacancy
12 that Dr. McCall left quite a while ago and it has never been
13 filled and it ~~separately~~ certainly needs to be filled but to say that
14 there are 56 positions in this regional medical program is not
15 quite right. There are 44. One is vacant.
16 I have attended the three meetings of the new RAG.
17 It has kept me down there a lot but I thought if this is the new
18 blood here, then that is where the action will be. It wasn't
19 a redefinition of the regional advisory group. It was creating
20 a new one and it did break off from its parent, which was the
21 14-county CHP"B". To the Memphis-Shelby area, MMCC is just about
22 everything. It was also regional medical programs. And It
23 was not easy to get away from that parent and still have good
24 parental ties. And Drs. Culbertson and Cannon have done it, and
25 in my view done it very well.

eak 2

1 Dr. Johnson at UT was helpful in getting it done.
2 The old regional advisory group was representative of only those
3 14 counties, and that is what raised the legality of the regional
4 advisory group and that was the single factor that disqualified
5 them for developmental component funding when they were placed
6 on triennial status.

7 The big funding issue or one of the big funding issues,
8 I believe, is the middle [million dollar] contract under core. And when staff
9 met to try to identify issues, that was one that came up
10 immediately. Essentially Memphis is pursuing two things, its
11 own concept of area health education centers which it calls
12 model learning centers which it thinks should be in the hospital
13 and then development of the involvement from that rather than
14 developing the consortium and including the hospital.

15 They competed unsuccessfully for health services
16 money last June. Then the second large component of it is,
17 Memphis submitted AEMS application for supplemental funding,
18 received one year planning funds to sharpen a data base which if
19 Memphis has anything it has a sharp data base.

20 Coming from MMCC, it has received as the collector
21 of the data since 1966, so Memphis is writing back saying by
22 January 1, which is their next year, we will have sharpened our
23 data base and they are reapplying for the operational dollars they
24 applied for before for emergency medical services and that
25 ties into something I said before. Their task forces have been

eak 3

1 established and one of them is a task force for emergency medical
2 services. And at a metting of the regional advisory council last
3 week, I heard Dr. Cole who is the new RAG Chairman and Dr.
4 Culbertson feeling this group out on beginning to think now about
5 priorities on funding levels that might not approach the
6 3.2 that they asked for.
7 And where -- beginning to think now about where the
8 emphasis would be. And I heard this regional advisory council
9 say that if we have to make choices under that million dollar
10 contract category, then the choice will be emergency medical
11 services.
12 The whole state of Tennessee, Dr. Turbshen and
13 Dr. Culbertson have worked together quite sometime on the state
14 of Tennessee's program. Dr. Culbertson has all buy revived
15 the Mississippi Emergency Medical Plan that was almost in
16 disarray. No work yet is underway with the Arkansas Department
17 of Transportation, hospital association, traditional linkages.
18 But the State of Tennessee and State of Mississippi -- a scale
19 of 1 to 5 are about 3 on emergency medical services and they are
20 so deep into it that I don't know, it would be difficult to turn
21 back.
22 DR. SCHLERIS: A few questions. A few questions
23 first then perhaps a comment. If I read this correctly, their
24 RAG met once last year, is that correct?
25 MRS. KYTTLE: That is traditional with the old MMCC

eak 4

1 which was their RAG at the time this application was prepared.
2 That is the old RAG.
3 DR. SCHLERIS: Right and emergency health services
4 met accordingly at the time of the application, zero?
5 MRS. KYTTLE: That is the emergency medical group
6 out of the old RAG. That is MMCC. You are right.
7 DR. SCHMIDT: Wait a minute.
8 DR. SCHLERIS: I am trying to get an indication
9 of activity.
10 DR. SCHMIDT: Right but the RAG now, recently has
11 met how many times, the new RAG.
12 MRS. KYTTLE: The new council is three months old
13 and it has met three times.
14 DR. SCHMIDT: Right, okay, so that --
15 DR. SCHLERIS: Well, this is important because
16 I think in terms of developmental component and reaching deci-
17 sions according to priority, according to what would be supported,
18 it is of interest to see what their past record is for the past
19 year and not just for the past three months.
20 DR. KYTTLE: Dr. Schleris, it is not the same group.
21 DR. SCHMIDT: Do you see they have constituted really
22 for the first time a regional advisory group three months ago.
23 DR. SCHLERIS: Well, you see my dilemma. I know
24 this. I try to count the number too of RAG, and the old group,
25 and it is their application we are looking at. And what you are

eak 5

1 doing is supplying us with additional and very important new
2 data. I appreciate it but at the same time, it is difficult
3 to get an objective judgment on this. In other words, the new
4 group which is how many now, 36, but the program here was put
5 together by the old group, isn't that right and the report we
6 are looking at in the application is from the old group, is
7 that correct?
8 MRS. KYTTLE: Dr. Schleris, you can appreciate that
9 a regional advisory group of 151 members that had R&D's
10 experimental contract, CHP and RMP, didn't give a lot of time
11 and this was quite a bit of the Memphis regional medical
12 programs application but it nevertheless had to go through
13 a regional advisory group that had EMS committee that never met.
14 DR. SCHLERIS: I am not trying to put a qualitative
15 judgment on it. I am just trying to get an understanding from
16 this document. Looking at some of the specific proposals,
17 I will ask out of curiousity about the proposal to improve
18 death statistics by teaching, individuals, examinations, post-
19 mortem, where they don't have legal rights to do autopsy and so
20 on. I wonder if you have any more information on what appears
21 to be a very intriguing and difficult proposal, how that cleared
22 RAG and what priority. Did you see that. It is project
23 number 33.
24 MRS. KYTTLE: No, I am afraid -- I can tell you that
25 it must have cleared RAG with a priority that was at least

1 in the first five because it was one that Memphis chose
2 to drag up from an approved but unfunded when they were extended
3 and had money to activate, they activated that one but the tech-
4 nical aspects of it I don't know.
5 DR. SCHLERIS: I don't know what communication
6 you got as far as emergency medical services was concerned.
7 They have applied for let's see, $1,100,000, were given
8 $80,000 for the planning. It goes to more than just
9 data base, I assure you. I don't know the details but, perhaps
10 Dr. Rose does. This was one of the requests for larger amount
11 of funding. It was felt that they for many reasons weren't at
12 that stage. It wasn't just getting numbers of cases. There was
13 a lot of homework that had to be done. Can you comment on
14 that, Dr. Rose?
15 DR. ROSE: Yes, in fact a large part of the concern
16 of the reviewers related to how this Memphis or suburban,
17 if you will, EMS-type activity was going to relate to what else
18 was going on in Arkansas and Mississippi and in the rest of that
19 particular state. In speaking with Loraine subsequently on
20 several occasions about that, I tend to believe that they really
21 did have considerable more information than was included in the
22 application which, of course, the reviewers had to act on.
23 DR. SCHMIDT: Okay then. John?
24 DR. KRALEWSKI: I am not sure we have a motion on
25 the board here or not.

eak 7

1 DR. SCHMIDT: No, we are going to return to Dr.
2 Ellis for proposal.
3 DR. KRALEWSKI: Okay, I will hold up then.
4 DR. ELLIS: The application which is before us
5 requested roughly 3.267 for this year five. The staff
6 reviewing this made the recommendation that the amount to be
7 granted be 2.25, and that this would inlcude $162,700 for a
8 developmental component. Also, in talking about the supplemental
9 request that we have been talking about, staff suggested that
10 $237,000 be granted to support selected new activities, including
11 the expansion of component number 36. That is greatly strength-
12 ening the neighborhood centers and giving them something in order
13 to really build the program and extend it. And then $225,000
14 to pursue selected activities under the contract request, this
15 being primarily to be used for EMS. I would move that this,
16 these recommendations be accepted.
17 DR. SCHMIDT: Is there a second?
18 DR. HILTON: Second.
19 DR. SCHMIDT: All right. That is a second so
20 the motion can be discussed.
21 John and then Joe.
22 DR. KRALEWSKI: I am inclined to believe that in view
23 of the organizational, some of the organizational concerns
24 that have been expressed here even though they are changing,
25 there is a new direction and I know you have new information

eak 8

1 you really believe this organization is going to really do it.
2 But we are giving them substantial developmental component
3 plus a fair amount of contract money and that is placing
4 a fair amount of bucks in their organization without many
5 restrictions on it and that makes me a little bit nervous.
6 DR. HESS: I would like to make a substitute
7 motion.
8 DR. SCHMIDT: All right, before I accept that, I
9 will let Dr. Ellis respond.
10 DR. ELLIS: It is my understanding that the
11 monies which they have now are very tightly budgeted and that
12 there would be very little room for growth and expansion in
13 these new directions. And so it seems that a developmental
14 component of some magnitude might be very desirable in this
15 instance. In order to give the new director, I mean he
16 is not a new director but he is almost like a new director because
17 he does not have all of those 156 people and all of the problems
18 with no committees or anything to work with him. That has been
19 eliminated and I think he does need a chance to show how he
20 can expand the program.

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1 MRS. KYTTLE: Dr. Kralewski, the original structure
2 complication arose not so much because it wasn't working, Memphis
3 made it work. And it very quietly went about a very good
4 program. It was the legality that raised the issue about the
5 CHPB, MMCC, with a mandate to serve 14 counties being the decision
6 making body that was serving 75.
7 I would not want you to think that it was a compli-
8 cated, unworkable structure. It was a complicated, of doubtful
9 legality, structure.
10 DR. SCHLERIS: It only met once that year, didn't it?
11 MRS. KYTTLE: The full body traditionally met twice,
12 that year it met once. The real decision making was in the
13 board of trustees, 45 members, still serving 14 counties.
14 DR. SCHMIDT: Let's see, do you have a comment --
15 in order here we have someone who wants to make a substitute
16 motion. If you have a comment on what is being discussed now,
17 please speak.
18 DR. ELLIS: I do. I wouldn't think a program, regard-
19 less of legality, that only serves 14 communities when it is
20 supposed to serve 75, is really functioning and functioning
21 properly. And neither will I think that the guidelines, which
22 they were using in terms of developing the new programs, were
23 appropriate to get services to the underserved, which is part
24 of the thing we are talking about.
25 But I do think that this legality thing was a point

kar 2 1 and I wanted to ask the question, did the regional council rule
2 this out of order legally? I know it was requested that he
3 give a ruling.
4 MRS. KYTTLE: We thought we might work with the region
5 in obviating that necessity and they got a new council and so
6 we didn't have to seek an opinion.
7 MISS KERR: I would like to make a comment, but I
8 would be willing to wait until after the substitute motion and
9 action is taken on that.
10 DR. SCHMIDT: Joe, the floor is yours.
11 DR. HESS: Perhaps somebody might just make some notes
12 of this other paper there. I would like to suggest for program
13 staff, eight hundred thousand. For contract, two hundred thousand
14 and I am assuming here that some planning has gone on and that
15 as far as this emergency medical service is concerned, I gather
16 that that owuld be their priority use.
17 It is somehow, some proven need in the community.
18 That developmental component of a hundred thousand included, and
19 projects of nine hundred thousand. To provide money to accomplish
20 Project No. 36, which I gather is a key project in their strategy,
21 and through re-examining some of their currently funded projects,
22 that they should be able to find money to fund the other projects
23 or two in their new list, which is compatible with the new
24 directions in which they say they are going.
25 That adds up to a round figure of two million dollars.

kar 3

1 DR. SCHMIDT: Is there a second for the substitute
2 motion?
3 MRS. FLOOD: Second.
4 DR. SCHMIDT: All right, Mrs. Flood's second. We
5 are now discussing a two million dollar funding level.
6 Miss Kerr?
7 MISS KERR: While it is late, it is not so late and
8 I am not so tired, but I feel I have to speak my piece. In view
9 of decisions made earlier by comparison and in view of ingredients
10 of a viable potentially exciting program, I cannot, in all con-
11 sciousness, support either one of these recommendations at this
12 point.
13 DR. SCHMIDT: You say either one?
14 MISS KERR: No.
15 DR. SCHMIDT: Lorraine?
16 MRS. KYTTLE: Miss Kerr, this is an anniversary within
17 a triennium and it comes to committee without any site visit
18 report that would give you the flavor of some of the exciting
19 things that this region is doing.
20 But it is a quietly efficient region. It has some
21 very exciting things ongoing and even though it is late, I don't
22 know if you would have the time to hear about them. Can I just
23 tell you about one?
24 Memphis has two multi-phase screening projects ongoing
25 and they just didn't happen. One is a mobile, white northeastern

kar 4

1 Mississippi, two and a half years ago.

2 MISS KERR: Was this thrust of RMPS?

3 MRS. KYTTLE: Two and a half years ago it was started.

4 It is just widening up. The companion one with an intercity

5 Memphis, predominantly black stationary multi-basic screening.

6 In anticipation of this year, they will have completed the

7 targeted screening. The multi-phasing screening activities across

8 the country have gotten together and they met here in Washington

9 to develop a protocol to evaluate what we have done and nine

10 were selected, and both of Memphis' were.

11 Memphis' multi-phasic screening have screened more

12 people than all the others combined. They are going to be a

13 pivot for a contract to evaluate what we have done. And they

14 have just gone about it very quietly.

15 Inter-mountain is in there, Ohio vallies is in there

16 and so is Memphis'. And I just -- if you would like to listen

17 to some of the things that they have done like that, there is

18 more excitement there, but this is not that kind of application.

19 It is not a triennial. It doesn't have a site visit report and

20 I think it is at a disadvantage here.

21 DR. SCHMIDT: Mrs. Flood?

22 MRS. FLOOD: Well, again, recognizing the disadvantage

23 of trying to evaluate on paper, looking at the print-outs for

24 the components sort of descriptor devisions that are provided

25 in the print-out for the staff and of regional functions done

kar 5 1 under the previous contractual fundings we have talked in the
2 history of the region of the tremendous impact of the 21 and
3 under, of the minority groups, yet if you study the print-outs,
4 which is not a very good way to evaluate, but there is no emphasis
5 utilized from the central core staff activities to address
6 these high priority needs of these particular types of populations
7 and as Dr. Schleris pointed out, our point of reference has to
8 be the track record and, again, I will realize staff is at a
9 disadvantage trying to present to us this changing flow. But
10 I am not sure that we are adequate in giving them the requested
11 funding and perhaps even at the level that Dr. Hess has proposed.
12 DR. SCHMIDT: John?
13 DR. KRALEWSKI: Would you refresh my memory again on
14 the contracts, what do they hope to accomplish with that?
15 MRS. KYTTLE: On page 19 of the document, I have
16 written out the five categories of the million dollar contract.
17 And the three large portions of it, one half of it is for
18 emergency medical services and we have seen their application
19 on that.
20 And, here is emphasis, Mrs. Flood. Through the work
21 of the staff, which surveyed emergency rooms, its needs, their
22 uses, the population that they serve, the State of Tennessee in
23 developing a statewide emergency plan zeroed in on the regional
24 medical program as the lead role for the emergency, stemming

25 directly from the staff work.

kar 6 1 DR. KRALEWSKI: Well, have they applied for emergency
2 health service grant?
3 MRS. KYTTLE: Right.
4 DR. KRALEWSKI: And they have been partially funded?
5 MRS. KYTTLE: Right.
6 DR. KRALEWSKI: Why is that showing up as five hundred
7 thousand dollar contract?
8 MRS. KYTTLE: There is no mechanism for them to
9 reapply for the operational dollars.
10 DR. KRALEWSKI: Have they completed their planning?
11 MRS. KYTTLE: The region felt they had completed
12 their planning before we told them to plan. Very strongly.
13 DR. SCHLERIS: Is there anything to prevent their
14 coming to RMP for emergency medical service plan in the future
15 as part of their RMP program?
16 MRS. KYTTLE: That is what they are doing.
17 DR. SCHLERIS: But they are asking for a contract
18 here to do it locally, isn't that right?
19 MRS. KYTTLE: Yes.
20 DR. SCHLERIS: Without there being any documentation
21 of what it is they are actually planning to do. At least a
22 part of their document is concerned.
23 MRS. KYTTLE: They look activate the same plan they
24 presented to us back in June.

25 DR. SCHLERIS: I want to make one point clear; that

kar 7

1 is, there is a great deal of difference between putting something
2 in writing and then verbal reports. This disturbs me a great
3 deal. I know you are familiar with the area, but going through
4 volume one and two, I don't come out with a great deal of in-
5 formation about what it is that they are going to do with these
6 funds and the Memphis application as it came in for emergency
7 medical service didn't reflect all the planning that you indicate
8 took place, and this is troublesome even to be told that well,
9 they had already done all the planning. They thought every bit
10 had been done.

11 It wasn't reflective of what they said. I do have
12 considerable concern about the level of funding. I question
13 whether emergency is the way to go as the first step.

14 MRS. KYTTLE: It is a part of civil steps. That is
15 RMP's role. RMP's role in this state consortium is the emergency
16 room.

17 DR. SCHLERIS: As I see it, if we aprove these funds,
18 we are saying we think that contract is a great idea. I, for
19 one -- if you want me to have faith, believe me, on a Friday
20 afternoon after two days, my faith increases more and more and
21 more and I will become a believer if you like, but it takes an
22 awful lot of conversation even this late in the day.

23 MRS. KYTTLE: No, we didn't think it was worth five
24 hundred thousand, that is why the staff recommended 225,000 for
25 all contract work and they are going to have to make their

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kar 8 1 choice. And they have told us their choice is still EMS.

2 DR. SCHMIDT: Okay. Where we are is with the

3 substitute motion at the two million dollar level.

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1 Are there other points to be brought up? If not,
2 then I will call the question.
3 On the $2 million level with the breakdown of
4 900, 100, 200 and 800, as you see on the board --
5 DR. JAMES: I would like to make a comment, I
6 believe. I think I am still hung up on -- and will be as
7 long as I possibly will remain on this committee, in regard
8 to geographical locations of RMPs, especially as they are
9 related to populations. Like Mississippi. Like New Mexico.
10 Like Memphis.
11 And I think that we have heard that there -- in
12 the Memphis area that there has been a restructuring of their
13 administrative structure, which is too young yet, I think, to
14 have a real impact in terms of what really are we going to do,
15 because we just haven't had time, but I believe from the
16 statistics and information we have received in terms of,
17 again, going back to the neonatal infant mortality which is
18 an indicator of the lack of health services in the area, and
19 I don't think that that needs any further elaboration, I
20 would feel that these are the areas that need the strongest
21 support of staff continuing technical advice to the RMP,
22 to stay on top of the RMP to be sure that it is creating the kind
23 of program that will benefit the people. And this is what I
24 hear are services.

25 I am aware of some problems Memphis had not too

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1 long ago in another area. I don't want to get anything
2 confused, but I realize that this is an opportunity for RMP
3 to begin to shore up some of those ends that were not
4 covered in some other areas that have to do with the same kind
5 of circumstances.

6 I realize that I don't have as much information as
7 even maybe some of the rest of you have, because you are familiar
8 with some of the programs that were going on prior. But just
9 in terms of the situation and the effort that is being put
10 forth and the direction, we may be at a disadvantage when we
11 heard Memphis yesterday morning to start out with, we may be
12 a little bit more, would have been a little bit more under-
13 standing of the problem that exists there.

14 But I think that I can only say that if we can go
15 with Vermont and a 400,000 population, with the excess amounts
16 of money that have been poured into that community and that
17 state, then we can go with Memphis and help them to improve
18 their services.

19 DR. SCHMIDT: There are some issues raised there,
20 Leonard. Do you want to comment?

21 DR. SCHLERIS: Be outrageous to try to answer that,
22 but perhaps I can try only in one way. This is not meant at
23 all as a rebuttal because I share your concerns. Our problem,
24 though, is I think a little different than looking at an area
25 that has needs. I think it is a question also of looking

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1 at whether the funds requested really go at those needs and
2 whether they would be handled effectively.
3 I think RMPS would fall flat on its face many
4 more times than it already has if it were to say that because
5 an area has desperate needs that therefore we should be
6 uncritical in our judgment as far as these needs are concerned.
7 My reason for referring to the fact that it is late in the
8 day is that I think the group is getting more lenient late
9 in the day and not harder late in the day.
10 My concern about these funds relate to looking
11 at the projects as submitted and some of these are frankly
12 experimental. The one about more accurate death certificate,
13 certification, I question many aspects of it. I would like to
14 know more about it. It is essentially a research project.
15 I am surprised it has cleared RAG.
16 The problem with multiphasing screening is of
17 interest, too, because of certain RMPS statements on this
18 sort. Included in this is a project on home care, which again
19 many of these have been supported around the country, there
20 are certain statistics on this.
21 One can go through the various projects and
22 come away with a feeling that RAG has not set its priorities.
23 I am a little unhappy about the response of the emergency
24 medical services and how they are going about this, and it
25 would be better if we had the full information, but again

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1 on faith the contract of 200,000 or part of it, even though
2 there is need and heaven knows there is need all around the
3 country for EMS, $200,000, I don't know how they are going to
4 use it.

5 We are being told we should depend on the group,
6 but if you go about their decision-making capability reviews
7 to what we have been told, RAG met once, the county three
8 times, the EMS met zero, so I don't know what went into that
9 formulation, so it isn't a question of feeling Memphis doesn't
10 have need. It is a question of my inhibition in terms of
11 whether or not they are going about meeting these needs in the
12 most effective way they can. I am just trying to equate it
13 on that basis and I think $2 million as advised here is for
14 what we have seen, I think, a very generous way of meeting it
15 because they still have the developmental components.

16 I, for one, will support the $2 million. I may
17 have come up with a lower sum. If this fails, I might still
18 offer that as a suggestion.

19 DR. SCHMIDT: I think unless there is something new
20 to put before the group, we should call the question.

21 John?

22 DR. KRALEWSKI: I would like to offer an amendment
23 to this alternate proposal here and that is that we strike
24 the contract money, we keep that project money at the 900,000
25 that's being suggested, and we give them a full developmental

1 component to the limit of what that would run wild be about
2 there, essentially what they are asking, 162, maybe a little
3 more than that as it would work out in the final budget, but
4 then out of the contract they can rethink their whole plan
5 of slipping into an emergency program here that might not
6 have been outlined and still have some money under
7 developmental for some discretionary kinds of activities.
8 DR. SCHMIDT: Well, if I am with you, you'd give
9 them the 800, program staff, and the 900 for projects, and
10 that is 1 million 7. 10 percent of that is 170, and that
11 would come down then to 1.87 million. That is an amendment
12 to the substitute motion to the main motion.
13 Is there a second?
14 DR. SCHLERIS: I will second it.
15 DR. SCHMIDT: All right, it is seconded, so now
16 we are down to discussion of the amendment to the substitute
17 motion. Anything not germane to that is out of order.
18 MRS. KYTTLE: I think some of the flavor of the
19 amendment came from comments by Dr. Schleris and we have got
20 to do something about these printouts that led you to think
21 that this home health care is less than winding up. It was
22 something that was started two and a half years ago. The
23 multiphasic screening projects were started two and a half years
24 ago, and if you are going to look at these printouts and not
25 equate proper time with them to realize that that is the part

of this program, that that is the part of this program that is phasing out, then they are misleading.

I have heard this group several times today get hung up on that. That's the phasing out program. The high risk infant. The expansion of the home health center. The satellite clinics. That is the new part of this program that is building up and the part that disturbed you is the part that was started two and a half years ago.

DR. SCHMIDT: The current level there is at 1.627. What is being recommended now is 1.87, which is not too much of an increase. I think we will test the sentiment then by vote on the amendment to the substitute which is 1.87, with a 170,000 developmental and no contract.

All in favor of this, please say aye.

And opposed, no.

All right, the "noes" have it, and the amendment is defeated. We are back to the 2 million level, and I will call the question on that.

All in favor, please say aye.

Opposed, no.

I will have to ask for a show of hands. Please raise your hand.

I have four ayes.

Noes?

Four.

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1 The chairman will vote to break the tie. And vote
2 aye. So that the substituted motion has it.
3 Before we adjourn, I would like to ask the one
4 question. At the request of staff, we did prepare --
5 DR. JAMES: Excuse me, sir, I didn't quite under-
6 stand that. You said the substitute motion passes? You
7 voted aye for which motion?
8 DR. SCHMIDT: The substitute motion.
9 DR. SCHLERIS: $2 million.
10 DR. SCHMIDT: 2 million level, which is 800, 200,
11 100, 900.
12 DR. JAMES: Thank you.
13 DR. SCHMIDT: Is there a question about procedure?
14 DR. JAMES: No.
15 MRS. KYTTLE: I am sorry, which one? The 2 million?
16 Okay.
17 DR. SCHMIDT: It is approved at a 2 million level.
18 DR. JAMES: Yes. Okay.
19 DR. SCHMIDT: Staff has requested that I request
20 the committee recommendations remaining, if there are any
21 comments about this chapter four that I asked you to look at
22 last night. It has to do with the functions of review
23 committee and council and so on. This will go to council.
24 For their essential, essentially their approval. I am asking
25 if there are any substantive queries or comments on that at

1 this time?

2 MR. HILTON: I would say only that I would have

3 appreciated having that document of that upon joining the

4 committee. I have since that time just about figured it out,

5 but it was an awful loss in productivity while I figured it.

6 So I am very glad to see that this will be available to the

7 future members who join the committee.

8 DR. SCHMIDT: I will strongly urge that a letter

9 be sent to review committee members asking for specific

10 comments prior to this going to council. I will express my

11 personal appreciation to a most -- somebody turn off their

12 mike. -- To a most hardworking and understanding committee,

13 particularly for understanding and tolerance exhibited to

14 the chairman. Thank you.

15 Be sure to pull out your rating sheet and have that

16 available for staff pickup. Thank you.

17 (Whereupon, at 4:40 p.m., the hearing was

18 adjourned.)

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