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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

HEALTH RESOURCES ADMINISTRATION

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THIRTY-FIRST MEETING OF THE

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

- - -

Conference Room M
Parklawn Building
3600 Fishers Lane
Rockville, Maryland

Monday, November 26, 1973

The meeting convened at 9:05 o'clock, a.m., Dr. Herbert Pahl, Acting Director, Regional Medical Program Service, presiding.

COUNCIL MEMBERS PRESENT:

MRS. AUDREY M. MARS
GEORGE E. SCHREINER, M.D.
MR. EDWIN C. HIROTO
DR. LAWRENCE FOYE
JOHN P. MERRILL, M.D.
BLAND W. CANNON, M.D.
MRS. MARIEL S. MORGAN
RUSSELL B. ROTH, M.D.
BENJAMIN W. WATKINS, D.P.M.
MR. SEWALL O. MILLIKEN
MR. C. ROBERT OGDEN

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Washington, D.C. 20002

C O N T E N T S

P R O C E E D I N G S

DR. PAHL: Will the Council come to order, please.

(Discussion off the record.)

DR. PAHL: Now that we are all settled down, including our own staff, maybe we can open our meeting.

Let me first welcome all of you again to a program that is somewhat more viable than when we last met in July.

As we wrote to you, a very short time ago, a number of things have been happening and we have a reasonably heavy agenda for today. I will be getting into that in just a moment.

I do hope we will have representatives from the agency and Dr. Robert van Hoek is already here. We expect Dr. Harold Margulies to be coming and talk to us as Acting Deputy Administrator of the agency, and Dr. Endicott, Administrator of the Health Resources Administration, also expects to be present this morning.

Invitation was extended to Dr. Edwards or his representative. We expect to have someone representing Dr. Edwards here to address us.

Before proceeding, I would like to welcome Dr. Lawrence Foye, Assistant Chief Medical Director for Academic Affairs, Veterans Administration, sitting in for Dr. Musser, and we would like to note, as you will, that our Council grows progressively somewhat smaller.

We have excellent attendance this morning and the usual long table with the empty chairs merely means replacements have not gotten through the official process, but I assure you nominations have been made and the Secretary's office, presumably before our next meeting, will be able to act on these nominations and we will be able to bring the Council up to full strength.

Dr. Ochsner is unable to attend because of a long-standing commitment and Dr. Merrill will be here a little bit later on this morning, will not be able to be present with us tomorrow.

In connection with the membership of the Council, I would like to point out Dr. McPhedran resigned this August because of a changing position and now as a result of a complicated salary arrangement, he is considered to be an employee of the Veterans Administration and as such, he is no longer eligible to sit with the Council. Much to our regret, we have to accept his resignation.

In connection with Council matters, I would like to point out we are fortunate in having the Council meeting, if you will, just a few days before the end of this month, because when November 30th arrives, we will no longer have with us Dr. Cannon and Dr. Roth, who have served since 1969 on this Council.

We also have, because of the termination of their employments, Mr. Milliken and Dr. Watkins.

The latter two are eligible for reappointment and we do hope to be able to call upon their services again; whereas, Dr. Cannon and Dr. Roth, having served more than their share of time with this Council, are not eligible for reappointment.

I know that I speak on behalf of Dr. Margulies and the many administrators of this agency, the staff of this program who have worked with Dr. Cannon and Dr. Roth for these many years, our very best wishes for their future endeavors and to express our appreciation officially and personally for the fine work that they have performed with this Council.

I am sure that they have seen the ups and downs of the programs many times and they have weathered it, and I am sure that even in the course of this meeting, we will be able to again benefit from their advice and perspective.

So we appreciate having you here, Dr. Roth, today. We understand you can't be with us tomorrow. But, again, we look forward to perhaps having your views on the program and assistance, and Dr. Cannon, as we go into the future.

Dr. Endicott was to havebeen with us first thing this morning, but we will arrange our schedule to accommodate his presentation sometime over the course of the morning.

Now a few housekeeping details if I might. I understand coffee will be brought in about eleven o'clock.

MR. BAUM: That is for lunch.

DR. PAHL: About 10:30?

MR. BAUM: Coffee break in the cafeteria.

DR. PAHL: Coffee break in the cafeteria at 10:30.

Then what we have planned today is to have a luncheon brought in to this room. We hope this meets with your approval. We would like to have an opportunity to have the Council members interact with our staff in order that a full expression can occur concerning the developments in the individual's regions and that you will have an opportunity to find out first hand what is happening in the regions.

Following that, we will take up the actual review of applications.

Now, I can go on with the housekeeping details later. I think it is very important, since we have Dr. Endicott here as Administrator of our Health Resources Administration, and Dr. Margulies in his new capacity as Deputy Administrator, to turn the meeting over to Dr. Endicott,to welcome you for your first meeting with our Council at least here in the Parklawn Building, Ken. Wewould appreciate anything you have to say.

DR. ENDICOTT: Well, I think perhaps you might like a brief progress report. would you not, on the way things are going and what the new agency is all about.

As most of you know, on the first of July, the Department reorganized the health functions and after some subsequent changes, ended up with six separate agencies. Two of them are

essentially unchanged, NIH and FDA. And what had been Health Services and Mental Health Administration finally split into four separate agencies. The Center for Disease Control, the old CDC in Atlanta, was split off formally. It always has operated essentially as an independent field station. And with that as a nucleus, several programs were transferred, including the National Institute for Occupational Safety and Health, to constitute the agency primarily responsible for public health, preventive medicine and control of the environment.

What had been the National Institute of Mental Health became the Alcoholism, Drug Abuse and Mental Health Administration. It is in the process of being organized as three institutes, one on alcoholism, one on drug abuse, and one on mental health. That is most recent organization, and the final plans for its internal structure have yet to be announced.

Those programs which either provided direct services to government beneficiaries, such as the Indian Health Service and large grant programs given for the purpose of providing health service, usually in the form of grants to states such as maternal and child health, migrant health, and so on, became the Health Services Administration, which was assigned one new responsibility, that of quality control as a function, backing up National Health Insurance. A special bureau was created for this purpose, Bureau of Quality Assurance, within that

administration.

And then finally the Health Resources Administration, which includes the National Center for Health Statistics, a National Center for Health Services Research and Development, the Manpower Program which was transferred from NIH, and the Hill-Burton Program, CHP and RMP.

One of the major functions of the new HRA is to function as the policy development organization as it relates to the delivery of personal health services, so in a manner of speaking, we become sort of a think tank backing up National Health Assurance.

The reorganization of HRA was envisioned as a two-stage proposition and we are just moving into the second phase.

The reason for approaching it in this fashion was that there were a number of programs, such as RMP which had been scheduled to be phased out by the Administration, but which Congress had declined to phase out, at least for the time being. So we felt that we had to maintain sort of a flexible posture keeping in place the organizations which had been set up to administer these programs whose fait was somewhat uncertain until the final decision was made as to whether they were to be continued or not.

This has turned out to present some management problems, as you can well imagine.

There was a reduction in force carried out at the end

of the last fiscal year. Additional reductions in force were envisioned in the President's budget, to have taken place in September. Another one along about the first of the year.

The reductions in force were at least postponed and all of us are uncertain as to just what our year end ceiling on employment may turn out to be.

I have a rough notion, give or take 300, as to what it will be. And I am trying to get some firmer notion as we go along.

This has a noticeable effect on morale and presents some problems in terms of recruitment, replacement and relocation.

One additional complicating factor, from a management standpoint, was the decision to decentralize the manpower programs. The manpower programs for which we are responsible are operated under four different pieces of legislation, and in aggregate amount to some 42 district programs.

To decentralize these to 10 regional offices creates some 420 decision points. And it is a complicated proposition requiring transfer of some 300 people from Washington to 10 regional offices. Most of them declined to go. So we had to terminate the positions and simply transfer vacancies and try to recruit in the field.

We are still actively recruiting and carrying out orientation programs for the new recruits. It is too early at

this point in time to tell just how all of this is going to work out.

Fortunately the manpower awards are mostly forward financed, so that awards made in the fourth quarter of the fifth year are actually finance operations in the schools the following year, so we won't know how this is going to work really until early next summer.

Now, our future is also made somewhat uncertain by the fact virtually all of our enabling legislation expires on the 30th of June and Congress has yet to act on any significant piece of our legislation except emergency medical services, which I neglected to mention, and I suppose I did because we have decided that this program really doesn't belong in HRA but belongs in Health Services Administration and have just arranged to make that transfer.

As you know, Congress has just passed again -- and this time the President signed -- an ambitious emergency medical services program which is no longer a demonstration program but an implementation program, the net effect of which is to put in place and have operating appropriate medical services across the country.

Now, there are two of our programs whose legislation expires which are relatively noncontroversial. They are the National Center for Health Statistics and the National Center for Health Services Research and Development.

The Administration has not yet sent up a legislative proposal for either of these, but when it does, I am sure that it will contain only small technical amendments.

There is no intention of cutting back either of these programs. In fact, the expectations are both will be strengthened and expanded.

Now, the House has already passed, or has reported out, it has not yet passed, a bill which would consolidate these two organiztions into one, and would place some dollar and project ceilings on what could be undertaken in each area. The dollar limitation is $5 million and 20 projects.

We have opposed this limitation and the consolidation, and I am hopeful that we will get this straightened out in the Senate. But the truth of the matter is that at our present scale of operations, these limitations would not interfere with anything that is actually in progress. It simply limits what one might project for the coming two years.

Now, then in the manpower area, last January a new federal policy was announced. It is a part of the new federalism and proposes for the entire area of higher education, that the federal government get out of the business of supporting institutions and limit its support to student aid aimed at making sure that no one is denied a college education simply for lack of financial resources.

The policy proposes primarily guaranteed loans,

supplemented where appropriate by direct loans, and even scholarships. This to take place of any support of our subsidy through institutions of higher learning.

The policy provides that in those special circumstances in which market forces would not operate to meet the needs, exceptions would be made. And at least for the current fiscal year, the Administration proposed to except from this general policy schools of medicine, osteopathy and dentistry, and proposes to continue several forms of institutional support, including capitation grants as well as special project grants for the support of institutional expenses for undergraduate and professional education.

They proposed to eliminate from capitation support schools of nursing, optometry, podiatry, pharmacy, and veterinary medicine, and proposed to eliminate formula grants to schools of public health and any formal support in the allied health area.

Now, the legislation which authorized support to public health and allied health expired on June 30th, last, and the Administration urged Congress not to extend that legislation.

Congress extended it anyway and so now all of the manpower legislation terminates at the same time, 30th of June next.

The Administration is still considering what its

policy and strategy should be in the area of health manpower. As a matter of fact, I have a meeting this afternoon at 5:30 to work out the details of the package to go to the Secretary for decision. So that it would be premature to report to you what the Administration's policy will be since the Department hasn't yet reached a decision and that, of course, is subject to approval at the White House and OMB.

However, I think it is safe to assume that the Administration will propose a consolidation of the four separate pieces of legislation into one, and that with regard to institutional support, the Administration is not likely to request institutional support for schools other than medicine, osteopathy, and dentistry, at least in the form of capitation.

One assumes that the Administration will seek a broad special project authority of discretionary funds with which to influence the schools to improve curriculum, shorten the curriculum, emphasize team training and encourage the enrollment of minorities and, in general, improve the educational process.

With regard to students' aid, I think it is safe to assume that scholarships will be deemphasized and that student guaranteed loans will be strengthened.

I think it is also predictable that any assistance to educational institutions for construction or capital improvement would be heavily oriented in the direction of the guaranteed

loan perhaps with the interest subsidy.

Some attention could probably begiven to the shortage of doctors for government agencies, doctors and dentists, and I would anticipate some expansion of the kind of scholarship program which carries an obligation of equal time in government service in return for scholarship assistance. But as I say, this is still subject to final decision and it may not come out this way.

Now, that leaves us with RMP, CHP, and Hill-Burton Hospital Construction Program unaccounted for.

There has been a lot of discussion in the Department as to how these might be consolidated. And as Harold I am sure expands upon during the day as he has an opportunity to spend more time with you, the debates within the Department have been intense if not acrimonious.

(Laughter)

And this still is unresolved. Even in the Department, not to say the OMB, there are two general propositions under consideration.

One would simply eliminate virtually everything except regional health authority, nonprofit, private consortium arrangement made up especially of providers.

The other would place rather heavy emphasis on the state function, encourage the development of state health authorities, with the decision being left to the states

as to how they would handle their substate or interstate arrangements.

The second would provide, in effect, that RMP's desired by states could in fact be continued under a somewhat different arrangement, but performing essentially similar functions.

God knows how the argument is going to come out within the Administration, and I would hesitate even more to say how it is going to come out on the Hill.

The Administration has been trying for some years to get rid of the Hill-Burton Program without success. My guess is that any program which does not provide in some orderly fashion for the three different types of agencies, Hill-Burton, CHP, and RMP, any proposal which doesn't take into account all three of these things is probably not going to pass on the Hill.

My assessment of the temper of the times is that there will be some effort to consolidate, but just what form this will take is certainly not clear to me.

We have appointed a task force within the agency to assess the current situation and develop our own plans for orderly transition into some as yet unknown new system. And I hope we will be ready to act in a sensible fashion when the time finally comes for action.

As you are more aware than I, since I was sweating it

out in the manpower area when you went through your spring crisis, you were scheduled to be liquidated on the 30th of June last, and weren't. Legislatively you have been extended to June 30 next.

Functionally the money has been sort of doled out without exactly clear guidelines as to what you are supposed to do. The only thing that is different today is that it is November.

I can't tell you what is going to happen to RMP. I can't tell you how much money we are going to have to spend.

We are in the courts with regard to last year's money and preliminary actions would indicate, as has been the case in all of our other suits, we are probably going to lose this one. But that is by no means certain.

So we don't know yet how much money we had last year to spend and we also don't know how much money you are going to have this year to spend since the appropriation has yet to be acted upon. As you know, it passed both Houses. The Congress finally reached an agreement, which under normal circumstances would have led to enactment by both Houses. But the House recommitted it to the conferees, presumably to negotiate a lower figure which would be acceptable to the President, and which would therefore not be vetoed.

That negotiation is now in progress. Of course, we are not privy to the transactions. We are not even certain as to

what an acceptable compromise figure might be as it relates to RMP, or to anything else for that matter.

So that when you act today, you will be sharing with me the joys of administration in a period of uncertainty.

This is not the easiest thing in the world, but my feeling is that one ought to exercise commonsense, to stick pretty much to your previous standards of excellence, to make the awards with the expectation that they will be awarded for a period of one year from the project period beginning date as we have in the past, and let nature take its course.

If it turns out that they have to be terminated sooner, oaky. We will worry about that when the time comes. But from the standpoint of what is to be done today, I think you have to largely ignore the existing uncertainties. Otherwise you really have no basis to do anything.

I apologize for having to present a picture of this sort to you. It wasn't my idea and I am having my own troubles with it, but, frankly, I see no other way to proceed than the one that I have outlined.

It is no secret that this is a difficult time for us in many different ways. The most recent thing, of course, is the energy crisis, but it is just one more thing in a long list of difficult problems at the federal level.

I have taken much too much time, perhaps spread an undue amount of gloom. Things aren't really quite all that bad.

I think my personal assessment is that the reorganization was long since overdue; that in the main, the decisions were good in terms of how to break up the problem into manageable segments.

I am impressed with the men who have been recruited to fill the various slots. They seem to be working together well, as a team. And I am satisfied that given a little bit more time, perhaps a year, the Department will be stronger in the health area than perhaps it has been in the last ten years.

This is on the encouraging side and it is a thing that persuaded me not to exercise my option to retire, but to hang in there for a little bit longer.

Thank you.

(Laughter)

DR. PAHL: Thank you, Dr. Endicott.

Iam sure Dr. Endicott would be pleased to stay a few minutes and answer any questions on this or other matters that you have.

DR. ENDICOTT: I got off easier than I expected.

DR. PAHL: Perhaps it was not such a gloomy report after all.

Dr. Schreiner.

DR. SCHREINER: Are you saying people who are writing the legislation are contemplating a kind of optional RMP on a state level?

Not federal, but one that would be chosen by groups of states?

DR. ENDICTT: One of the major proposals would have provided support for the kinds of things that are done by RMP, to the states through a state health authority which would then have both funds and authority to enter into agreements with appropriate consortia, with appropriate consortia or things equivalent to RMP for implementation of approved plans.

DR. SCHREINER: Is the thought there would be federal grant funds to encourage this?

DR. ENDICOTT: Yes.

DR. SCHREINER: Or you would then be going only on state funds?

DR. ENDICOTT: Yes, that proposal would provide funds at a fairly generous level through the state health authority. That plan envisioned having within an umbrella several capabilities. One, for planning, which would not have operational responsibilities, would not be responsible for the allocation of sources, federal or state; but would, in effect, be a staff planning organization.

A second function would clearly be regulatory, it is one which the states have anyway, and this would cover a broad range of things, including licensure and accreditation, whatever control there may be over construction facilities and so on, including the control of institutions of higher learning.

And then a third major function, that of allocation of resources, primarily financial resources, both from a federal as well as a state level, this might well include moneys for construction, moneys for health services of one sort or another and moneys for the training of health manpower. That is one concept.

And RMP would, in this new framework, where this fitted in with the desires of the constituents, continue to function. But it would no longer derive its direct support from the federal government, but as instrumentality of a state or states.

DR. SCHREINER: It would be kind of like a sanitary commission?

DR. ENDICOTT: Sort of like that, yes.

DR. ROTH: Do I understand that these two somewhat opposing concepts are being currently debated within the agency and within the Administration, and that these do not particularly relate to the formulations that are now going on in the Rogers subcommittee? Or do these include the Rogers Sucommittee concerns?

DR. ENDICOTT: Well, they are taking place largely independently.

DR. ROTH: I mean, they have announced they have legislative overview of this thing and are putting the three RMP, CHP, and Hill-Burton together. But beyond that, I don't know

much about how they are doing it.

DR. ENDICOTT: Well, there have been no hearings yet.

There is one bill, only one that I am aware of, and that is the Roy bill which has been introduced.

I don't believe Mr. Rogers, or Staggers, or Kennedy, or Javits, or any of the other major figures, have actually introduced bills; at least if they have, I am not aware of them.

There are always, of course, informal contacts and discussions, especially at the staff level. Committee staff with people on my staff, for example. But this is in the very early stages so far as I am aware on the Hill.

I think the more intense discussions are probably occurring within the Department at the present time, but it is unresolved and there are very strongly held views. I think we have a reasonable concensus within HRA which leans in the direction of the state health authority. But the Assistant Secretary for Planning and his staff are very high on the regional consortium probably and have not really spelled out in any great detail what they would do with Hill-Burton RMP and the existing CHP.

So it is still in the talk stage.

DR. SCHREINER: What happens if they don't get it resolved by June 30th?

(Laughter)

DR. ENDICOTT: Well, I suppose we will have another extension.

Now, it is difficult for me to see at this point in time how anybody can resolve this thing without providing at least one year of continued support in the existing framework while we sort these cats out and come up with something else. So that I would assume at the very least we will have a six-month extension of the legislation pretty much as it is while we work out what is going to replace it and take the steps to effect a transition.

With every passing day, it would appear more rational to have a full year of extension rather than six months.

DR. SCHREINER: Has this been a recommendation?

DR. ENDICOTT: No. Nothing as firm as that.

(Laughter)

But, you know, common sense often prevails, after all, at debate.

(Laughter)

MRS. MORGAN: Thank God.

DR. ENDICOTT: So I wouldn't be too surprised if that is what happened.

MRS. MORGAN: Dr. Endicott, what division do these PRSO's or insurance come under in the organization, or has this been decided either?

DR. ENDICOTT: Yes, it has been decided simultaneously

in about three different ways.

(Laughter)

One way is that the primary responsibility is supposed to be in the Health Services Administration's Bureau of Quality Assurance. The second decision is that it should be, the responsibility should be located in the Office of Assistant Secretary for Health. The third decision is that it should be in the Social Security Administration and Social Rehabilitation Service.

There are several different committees on the Hill involved, especially the Senate Finance Committee, and they have sort of bought the concept that it should be in the Office of the Assistant Secretary for Health.

Now, at the moment, the Deputy Assistant Secretary for Health, Dr. Henry Simmons, has among his other duties responsibility for PSRO.

We are building, developing within HSA staff, there are staff also in SSA and SRS.

There is continuing effort on Dr. Edwards' part to consolidate and coordinate these things. And I suppose it is coming along about as well as anyone could expect with the jurisdictional problems that are built into it as a result of assignment of health insurance to the moneys committed in the House and Senate rather than to the Health Committee.

It is interesting that so far as we can tell, in this

long battle, the Health Committee in the House seems to be winning out since ostensibly it will have the primary responsibility for legislation on national health insurance. But that battle has not yet been completely resolved even in the House, and I don't think it is fairly joined in the Senate yet.

Now, HRA has managed up to now at least to stay out of the regulatory aspects of PSRO and to concern itself in a more, I hope, detached and objective fashion with how do you really go about assessing quality; what techniques, devices, and so on, should one use; what data, what sets of data need to be collected in what fashion in order to permit PSRO's to make an objective evaluation of the quality of services?

We are continuing to work in that area and to provide quite a lot of technical backup to HSA as they try to get their program off the ground.

There is a certain nightmare quality, though, about all of this, especially as it relates to data. I can envision really tremendous data collection activity with archives after archives being filled and memory bank after memory bank being stuffed with data on every hospital administration and discharge, patient contact, and so on, with even these modern mechanical brains blanking out under this just staggering weight of it.

I hope this won't come true. But it could get away from us.

DR. PAHL: Are there any other questions?

Well, thank you very much, Dr. Endicott. I particularly appreciate having our own staff here to hear some of the comments, so the government's position is clarified on RMP and CHP.

I would like to emphasize that from the point of view of trying to manage the program in this environment, it has been difficult, but we have been receiving very excellent support of everyone within the agency.

From my own point of view, this has been invaluable over the preceding months.

I think that we would like, if we may, to have a report from Dr. Margulies, who, as you know, has been serving as the Acting Deputy Administrator, therefore working extremely closely with Dr. Endicott.

Before, Harold, having your comments, in order to put them just into a little perspective, I would like to refresh your memory of two points which I think we wrote to you, one of which was discussed at our July meeting. This has to do with the priority oroption areas that wediscussed in July, and the second point has to do with what the Department has chosen to place a restriction on local RMP's in terms of their expenditures.

First, with respect to the priority or option areas, you will recall that in July there was much interest on the

part of the Department to have some information from RMPS as to what areas expenditures would be made by RMP's, using fiscal '74 funds. And as a result of much internal dialogue to the Department, a set of priority suggestions was made which over the months became rather than suggestions, restrictions. And these five priority areas were ones that we discussed with you in July and also I believe listed them in the materials which went out to you immediately prior to this Council meeting.

This has turned out to be quite a restriction on RMP's, particularly as more funds become available, and the program has become extended and staffs have had to be recruited again at the local level. And RMPS has been very busy in recent months making formal appeals within the Department to have some decision relative to both these priority areas as well as to broadening the program to include all of those activities in addition to the priority areas that RMP's formerly engaged in. And I expect Dr. Margulies will be addressing this point, because it is one of major interest to this Council, and particularly with respect to the action to be taken by this Council at this meeting.

The second point which, Harold, I hope you will amplify upon and which Dr. Endicott touched on has to do with the time or the lifetime of local RMP's. Since we last met, the Department has formally indicated to us at the program

level that not only would RMPS terminate June 30th, but that expenditures by local RMP's could not be continued beyond this coming June 30th. And as you will appreciate, this has also placed a severe restriction upon the program.

In addition to being contrary to government tradition whereby although a program is being terminated, grantees are permitted to expend funds awarded prior to that date for a period up to 12 months, in this case the Department has chosen to place a restriction of June 30th. Again, over intervening weeks and months, we have been formally appealing this decision to the Department and I was most pleased to hear Dr. Endicott indicate this morning to you what the perspective is relative to this matter.

I would hope, Harold, you might be able to amplify a bit upon this on the basis of recent understandings which have been arrived at within the Department. Because both of these are very severe restrictions on the program and certainly would compromise both what the RMP's can do between now and June 30th as well as what they would be able to accomplish in terms of evolving into those kinds of organizations which would be necessary under either of these proposals that are being discussed within the Department.

So with that as an introduction and hopefully not restricting you to those two points, I would like to have you address the Council and have as much time as you care to

present matters from your point of view as well as to have any questions and discussion by the Council.

Harold.

DR. MARGULIES: Thank you.

I explained to Dr. Pahl not long ago, when I was Director of RMPS, we didn't have these kinds of problems. I don't know what happened after I left -- but it is very complicated.

(Laughter)

DR. PAHL: Come back, Dr. Margulies.

DR. MARGULIES: I will address those issues specifically Dr. Pahl raises. I am not going to make a long statement to you, because I think Dr. Endicott covered the missues of primary concern very fully. However, I would like to come back a little to the question of what kind of legislative proposals are under consideration, because I think they require a certain kind of amplification.

Fortunately, or unfortunately, depending upon your ivew, and from my point of view it is fortunately, one cannot prudently discuss new legislation for RMP in a combination with other programs without also having clearly in mind the implications of National Health Insurance and any of the associated regulatory postures which government must adopt and procedures which it must develop. And I will just touch on those in passing and respond to what extent I can.

I think you may all remember that I tried to follow the general practice of telling you what I knew and telling you when I didn't know something, so that I didn't have to strain my memory to remember what it was I said when it was something I cooked up at the moment.

So let's talk first of all about the issue of the termination of the program. Well, first of all -- small glossary, it used to be we operated on the basis of decisions and those were replaced by agreements. Now what I will report to you will be understandings.

(Laughter)

So at least we have some understandings; there are no decisions.

(Laughter)

The June 30th date was adopted because there was to be termination of legislation and there was to be no new legislation sought and no new appropriations sought and presumably passed.

That, when referred to other similar situations, becomes a little difficult to defend, because the same situation is true of programs across the board.

As a consequence, there was a formal request to reconsider and replace that June 30th date with something which made a little bit better sense, particularly as time passed and it became apparent that any increased grant award of the kind

that you will be considering in this session would be designed in such a way that it would not be available to RMP's prior to the beginning of the next calendar year under any circumstance. And if they were then to close shop by June 30th, it made it a little difficult to defend.

This request for a change culminated in a meeting in which I represented Dr. Endicott and H.R.A. with Under Secretary Carlucci and others.

I think Dr. Endicott may have been referring to that and my presence there when the word acrimonious entered his presentation.

(Laughter)

We had a fresh understanding as a consequence of that discussion, and it really evolved around two issues. One of them was the June 30th date and the other was the question of the option which had been selected.

I left that meeting with the understanding, as did the others who attended, that the June 30th date was not a wise one that there should be an extension which is appropriate to the needs and to effective management and to good use of federal funds. That is how I left the meeting. That is the understanding Dr. Endicott and I have and that is why he said to you that we would act on the assumption that a grant award is as usual for a period of one year.

Now, that is not different from the understanding that

we reached with the Under Secretary. I am told by telephone which is a level of communication which my glossary couldn't cover at the present time because it isn't even seeing somebody directly, that this particular decision may run into some problem with the OMB.

I can't react to that fact. I can react to a Departmental position, a position in HRA and basis upon which you can make your kinds of decisions, which is that we are talking about a grant award which would be available for use by the RMP's to cover a period of one year.

Now, what are the understandings within that? Well, one of them that I think is perfectly fair and I will get back to that for a second, not much longer, is that this may be altered by the passage of new legislation, whatever that new legislation may be. For example, if there is a new combination of the three programs under discussion today, this may influence the use of grant awards for RMP's and maybe a reason for redesigning of activities sometime during the course of the next 14 months.

There also is the possibility that the legislation would be rewritten in a different fashion or that new appropriations would occur, or new purposes for appropriations would be assigned by Congress. All of these would, of course, affect the subsequent use of grant awards.

But in the absence of anything definitive, what we

will have to say is that what was put out by HRA over Dr. Pahl's signature as areas of primary interest for RMP's remain areas certainly of high priority insofar as HRA is concerned, insofar as the Department is concerned. They should, however, not be looked upon as exclusive areas of grant award. Those options are probably best described -- and this is a fresher understanding that you will have to live with it -- these options should be understood as areas of continuing high priority in the view of the Department and in the view of HRA.

Now, the reasons for those are I think readily apparent if you consider some of the potentialities for new legislation and some of the on-going issues of concern in the Department and throughout the country. The question of PSRO has already been raised. PSRO would need to have variety of kinds of support mechanisms and HRA in its various kinds of programmic elements will have some concern for a very close working relationship between us and HSA, and specifically the Bureau of Quality Assurance as Dr. Endicott has indicated.

There also is the major new and extremely important program under 299I of the Social Security amendments, that is the amendments to Social Security which make end-stage kidney disease a defined disability and provides for payment for renal dialysis and transplant.

That program is important not only because it provides services of a critical kind for people who have

end-stage kidney disease, but because it represents the first great opportunity, we have had to develop a systemetized, regionalized program which has the full backing and cooperation of the scientific nongovernmental community, in cooperation with federal and local systems. It is, therefore, of considerable interest. Consequently, it should be of interest to the RMPS and other programs at HRA.

Beyond that, if there is to be indeed some combination of RMP and CHP specifically along with Hill-Burton, it means two things which have to be looked at seriously and continuously.

When Dr. Endicott indicated some differences within the Department, he was describing a situation which is reaching resolution and probably will be resolved in the next week or two.

One of the things which is of pertinent interest now is that there are some points of complete agreement which I think would be all through the Department and would include OMB, and that is that there is a growing state responsibility for certain regulatory activities. One of these has to do with another kind of amendment in Social Security regulations which requires a plan for control of new hospital construction, which is linked in with reimbursement under Social Security amendments.

This becomes a very important mechanism which will

be supplemented by plans for certificate of need legislation in the states and it becomes necessary if one is to control hospital construction in a logical fashion to have some basis for doing it. There will be increased concern as there is a plan for the extension of hospital beds or construction of new hospitals for evidence that there is a service requirement and that there is manpower available to be linked in with those hospitals.

There also will be along with that a continuing requirement for rate regulation. And there will be a continuing requirement under the Cost of Living Council for the kinds of controls which have recently been announced and which are obviously of profound interest to hospital administrators, and others concerned with health care delivery.

Beyond that comes National Health Assurance and with the combinations of National Health Assurance, control of hospital construction, control of all physical construction, and with the Cost of Living Council concerned with the general problems of inflation, there will be most certainly sober consideration of a mechanism for dealing with rate and fee control in this country. It will be almost certainly agreed that this is primarily a state function and that there needs to be strengthened state systems, state competencies, to deal with those questions.

As a consequence, when we look at RMP's as one of

the partners, potential partners, in a state structure or an intrastate structure dealing with planning, allocation of resources, and with regulation in some manner, the options which were described in the process of developing material for this particular meeting become at least issues of high priority.

Now, I am sure I am not telling any of you anything that you are not aware of, at least in some general way. But I think the specifics as they become clearer have, if not an aura -- feeling of inevitability about them, at least a feeling of plausability in terms of Department having some general agreement within itself and with this being fairly consistent with what is being under consideration in Congress.

Dr. Roth asked about whether we are describing in the combination of three, perhaps, in one legislation, which is consistent with that which is being developed by the Rogers Committee.

I think in addition to the answer which Dr. Endicott gave that committee is having its own difficulty drawing up the legislation from my understanding and so they have about reached the point of impasse that we have. And that is the question which was debated during the last 2-1/2 years here in government, never very well resolved, the effective relationship between the planning function and an implementing function, and a direct program planning function. These are different kinds of modalities and when wise people begin to look at a planning

function and realize we have and wish to continue with a private delivery system, how you work out an effective planning function and then carry it from there to a voluntary -- mixed voluntary state and local system is one that always causes people to pause a long time and have final problems in coming up with specific legislative specifications.

That is, I think, where they stand and I suspect it is where we stand also.

I would like to say just one other thing. In the discussions that I have had in the Department, when there has been an increased attention in the Department and in OMB with what they call consortium activities, it very frequently represents some of the best elements of RMP, our version of an area health education center, regional systems for kidney dialysis and transplant. Our methods of getting people to act together to improve the effective use of what is there, rather than adding unconscionably and continuously to it.

But I often have the feeling when the people who are proposing consortium activities avidly discover that it is a little like the experience I had when I was a youngster in South Dakota and used to work occasionally out at Mount Rushmore during the summer and there would be people from the hinterlands who would come out and look at those faces of Washington, Lincoln, Jefferson, and Teddy Roosevelt, and say, "How far did they have to dig before they found the faces?"

(Laughter)

Well, sometimes when I listen to the discussions in the Department, I get the same feeling that they think that all of that was out there to be discovered if you would somehow go out and discover it and make use of it.

And back of it lies a tremendously well organized, thoughtful shrewd exercise which made consortia of people acting together a reality and that reality, so far as I am concerned, continues to depend upon some kind of systematic approach which makes it exist and function and prosper. And that is just being discovered, I am afraid, rather late.

But how the legislation will finally come out and what the final effect of it will be, as Dr. Endicott has indicated, is still uncertain.

I think I have answered most of the questions you are concerned with, Herb.

DR. PAHL: Thank you very much.

Are there questions?

DR. ROTH: Harold makes an interesting projection for National Health Assurance and to me this is an extraordinarily vague term covering everything from what the Administration has proposed, might propose, on through to the Dellums bill.

Now, what do you mean when you say that it has got to be tied in with National Health Assurance and what sort of a time frame are you talking about, Senator Long's this session

of Congress, or Russ Roth's ten years hence?

DR. MARGULIES: Let me give you two answers to that, Russ.

Clearly nobody knows when and if there will be National Health Assurance, what form it will be in. No doubt about that.

Everyone now has his own view of it and I wouldn't begin to guess at what the time will be for it to pass. I can't imagine it happening very soon.

The impressive point to me, though, in trying to get this in terms of program review and action is that we are quite well committed in the development of forward plans and in the creation of budgets based on those forward plans in the Department to the concept of National Health Assurance coming at sometime. So what occurs as a consequence is not so much what it will be and when as the very powerful effect that it has on our thinking, legislatively and programmatically.

We do operate in those kinds of terms. And if it is true that there will be some kind of National Health Assurance, it will be most injudicious for us to do anything other than for us to prepare for it.

On the other hand, if it isn't going to happen at all, it will have been injudicious for us to strain too much in that direction. It is not an easy one.

We also, as you recall, prepared avidly for sometime

for HMO's which were about to pass next week.

(Laughter)

DR. ROTH: Little tiny HMO's.

(Laughter)

DR. PAHL: Are there other points to be discussed?

Well, thank you very much, Harold. I appreciate the comments.

DR. MARGULIES: You are welcome.

DR. PAHL: Before we go on, I think I would like to merely state we do have several members of the public sitting in today. I don't know how many are present, but we do welcome you. I would like to identify three I recognize.

Dr. Sparkman, who is our Director of the Washington-Alaska RMP, and Chairman of the National Steering Committee of RMP Coordinators, and Dr. Reinschmidt, Director of the Oregon RMP, and Dr. Rikli with the Missouri RMP, they are members of our Steering Committee and are attending here, and pass on the comments directly, of course, of Dr. Endicott and others, and I am sure will have something to say at the appropriate point in our agenda prior to the executive session.

Even though we have an energy crisis, I think we do have to refuel, so perhaps it might be well if we have a 20-minute coffee break.

I would appreciate if we could return at about that

time, because we have a number of things to do. And before doing that, also I would like to welcome Dr. Merrill to the Council. I am sure we are all pleased to have him present.

So perhaps if we could take no more than 20 minutes and reconvene in here, we can then proceed with Dr. van Hoek's presentation.

(Whereupon, a short recess was taken.)

DR. PAHL: May we reconvene the Council, please.

We would like to turn to Dr. van Hoek's presentation for a few minutes dealing with some of the reorganization matters and those activities in which he has been engaged relative to our program.

You will remember that Dr. van Hoek has been serving as and continues to serve as the Acting Chief of the Bureau of Health Services Research. The reorganization plan is still under consideration by the Department but it has taken its major form now and we in RMPS are one of the major components within this Bureau.

Dr. van Hoek.

DR. VAN HOEK: Thanks, Herb.

Much of what I anticipated discussing was covered by either Dr. Endicott or Dr. Margulies, but I would just like to, in general, review with you some of the Bureau activities which relate to Health Services Research and Development.

In the reorganization of the Bureau, which is still

pending, the phase I portion of it included in addition to the National Center for Health Services, research and development, the regional medical programs, the emergency medical services demonstration activities, and the long-term care improvement program, nursing home improvement program activities were transferred to the Center. These were primarily in the areas of training of professional individuals and nursing home activities and long-term care programs, and some other demonstration activities.

In phase II, with the passage of the emergency medical services legislation, that program is being transferred to the Health Services Administration. But the remainder of the programs and activities will be part of the Bureau of Health Services research.

The major portion of the activities of the Bureau, aside from RMP, rests under the section 304 authority of the Public Health Services Act; namely, Health Services Research and Development.

As Dr. Endicott indicated, this legislation received a one-yearextension and expires this coming June along with the authority for the National Center for Health Statistics.

In the Congress at the present time in the House Subcommittee, there is a bill pending which calls for the extension of those authorities, but with significant changes in the program. It calls for the combining of the National

Center for Health Statistics and the Health Services Research and Development activities into a single National Center for Health Services and Statistics, and there are a number of other major provisions.

For those of you who are interested, the bill is H.R. 11385.

There is no comparable bill at the present time in the Senate. There is another bill in the Senate which was passed, so-called Bell bill, which called for the establishment of a National Institute of Health Care Deliveries.

What the resolution of the conflicting legislative proposals will be is uncertain.

In the spring the Administration did submit a legislative proposal which would extend the National Center for Health Statistics and the National Center for Health Services R&D legislation for an indefinite period and with no specific authorizing -- no specific dollar authorizations. In other words, in essence, an open ended legislative authority with the funding to be based on appropriations.

There were no hearings held on that legislation at the time and we did have hearings in the spring on the recodification of the Public Health Service Act, which was HR-7274, a portion of which then became the new legislation for health statistics and health services R&D.

I will for the moment not include RMP in some of the

information I am giving you. At the moment the Bureau's budget, excluding RMP, would be approximately $60 million, of which a little over $15 million was in the President's budget identified for emergency medical services activity. So the basic budget for health services research is approximately $45 million, and of that amount approximately $38 to $39 million is available for grants and contracts to conduct research and development.

With the reorganization, we realigned some of the primary activities which had been up to now centralized almost solely in health services research and development.

One is that the Center had begun research and development effort in developing improved health data systems of a national scope. The responsibility for this R&D effort will now rest primarily with the National Center for Health Statistics, which had been collaborating in the development of that program.

Another area of health services research is in the manpower field, which is felt to be more appropriately conducted in the Bureau of Health Research Development, which includes the former Bureau of Health Manpower, particularly the areas of research which deal with manpower utilization and professional education.

The health services research activities of this Bureau have been outlined or categorized into three major priority areas. We have developed a program statement which

we can make available to the Council members which go into great detail on the research questions that we feel need to be addressed from the standpoint of national need, not just from the standpoint of the Bureau's program activities. And this program statement has been disseminated to all the major institutions and investigators in the country to stimulate ideas for research in the field of health services delivery. But the six major categories are, one, studies dealing with the planning, licensure and regulation with particular emphasis on studies on the impact of certificate of need legislation, and studies to improve planning techniques which would lead to strengthening of the capability of comprehensive health planning or whatever planning mechanisms develop in future years.

A second area is in quality of medical care or health care, and here, as Dr. Endicott indicated, major effort is in developing better methods for assessing the quality of medical care and for developing methods for disseminating those findings.

But in addition, very practical considerations are involved in dealing with the implementation of PSRO's, implementation of the kidney disease provisions under the Social Security amendments, and also implementation of the HMO legislation should that pass.

One of the major difficulties currently with the resolution of differences on the HMO legislation between the House and the Senate is the question of the Quality Commission, which

is in the Senate provision which deals with mechanisms for monitoring under utilization and quality of medical care rendered by HMO's. And the staff have been working with other departmental staff in identifying ways that quality assessment could be carried out in HMO's regardless of a Quality Commission provision.

Similarly, studies or ideas for projects are being developed in the area of implementing kidney disease legislation.

Two other areas which are related deal with studies on the financing of medical care and the productivity of the health care system, particularly productivity dealing with manpower productivity. This has been carried out as a part of a development of a manpower legislative proposal for the Department.

Similarly, a number of the economic and financing studies which have been supported have been used in analyzing the various health insurance options and have been used to develop the Department's position on national health insurance.

The final item is in the area of data, in which it is clear to us and, as Dr. Endicott indicated, with the data requirements that might develop during the implementation of PSRO, one of the critical areas in health services delivery at the present time and being able to monitor and evaluate system performance is the inadequacy of the current data systems,

the tremendous fragmentation and duplication, and in many areas gaps in having adequate data to make appropriate decisions.

However, as I indicated earlier, a significant portion of this activity will be assumed by the National Center for Health Statistics and our major effort will focus on the development of improved medical record systems in the ambulatory and institutional settings.

Finally, one priority area that we are involved in, based on the reorganization, is the whole area of long-term care in which we have major efforts under way with the Social Security Administration and with Medicaid in improving the nursing home and other long-term care programs, both those that are financed by the HEW funds as well as long-term care in general.

Now, one major policy issue, decision rather, which affected us last year was the policy on support of research training. And the Bureau, in the same way that NIH was affected, was directed to begin the phase-out of the training support for health services research, and that policy has in effect been implemented and the only support that is currently under way, either through training grants or fellowships, are those commitments which have already been made and they will continue to be met until the individuals supported by the training have completed that training, but no new training or fellowships have been awarded since early this calendar year.

Now, as you know, the Department or Administration did reverse the policy decision and is in the process of implementing a modified policy with regard to the support of biomedical research training.

We have submitted a specific proposal to reinstitute health services research training and also the training of individuals in health statistics and health data, because we feel and are able to document the fact that there are insufficient numbers of individuals working in these very important fields and have also been able to have some evidence that the curtailment of the training support has already begun to show a decline in the number of young individuals entering the field of health services research.

So this proposal to change, to reinstitute a form of training, it might not be in the same-- be administratively handled in the same fashion, but at least to reinstitute some form of training is currently under review.

Now, with regard to our responsibilities in the Bureau both in health services research area as well as with regard to regional medical programs and its future, two areas, two activities seem to me to be-- or responsibilities seem to be most important. One is it is clear to us and many individuals in the field that a major problem has to do with the dissemination of researhc findings.

We find that a number of activities that the Center health services R&D have supported in the past which could

significantly assist organizations and institutions in dealing with health services delivery problems, have not adequately been brought to the attention of those individuals. They just don't know those programs, those studies have been carried out, nor what their findings were, and in many respects are repeating the studies over again with significant delays in implementing changes which have been shown to be effective.

This ties in with the whole question of technical assistance and the role of departmental staff in the regional offices, as well as the role of other programs that we support, particularly regional medical programs. And I had always viewed RMP as having that as one of its primary missions, and that is the dissemination of research findings at both clinical research findings, biomedical innovations, as well as health services research findings.

I consider this is one of the key issues we need to address in the Bureau with regard to the future of our program. As I say, both the RMP and health research efforts.

Another major responsibility that I see is somewhere there has to be a focal point for carrying out studies or supporting studies which can answer questions of the effectiveness of the medical care process.

This is particularly important at the present time with regard to the increasing movement toward regulations of the health care, of health care and also such implementing

legislation as the PSRO, the catastrophic health coverages such as kidney diseases, and the need to develop or have an understanding or develop better indices of standards of medical care and also the effectiveness of the medical care process.

Dr. Edwards' office has established an interagency committee to, over the next -- during the remainder of this fiscal year, to, in essence, develop a plan for a program which would begin to deal with the question of clinical effectiveness. And we would keep you informed of the status of that activity.

That has only been under way a little over a month. It is just getting organized. But it relates as well to the role of RMP in other activities, such as the disease control activities of the National Institutes of Health, and the educational programs that are being developed and supported through those institutes for disease control. We have representation on the committee from NIH from the Food and Drug Administration, from CDC, and from all the health agencies.

DR. PAHL: Thankyou, Bob.

Are there questions for Dr. van Hoek?

Dr. Roth.

DR. ROTH: Yes. I think my question is, in the quality assurance programs, this is specifically in BQA, as far as your remarks go, or is this separate from BQA?

DR. VAN HOEK: No, it is basically a joint effort.

BQA has the primary responsibility for implementation

for quality assurance, or processes which are legislatively authorized.

In other words, BQA has the responsibility for providing the professional input and standards on Medicare and Medicaid, also for implementation of PSRO, and implementation of the kidney disease provisions of Medicare.

Our responsibility is to participate with them in carrying out some of the research that needs to be done which would either substantiate or modify those standard settin g functions.

DR. ROTH: Then that gets to my question, which is really are these two efforts basically a dollar funnel, through which grants are put out like, say, the current half million dollars to Kaiser for a three-year study on quality assurance? Or do you have actually a substantial staff working and doing the individual research or is this all granted out to operating programs?

DR. VAN HOEK: At the present time it is almost entirely grants and contract funds through the Bureau.

DR. PAHL: Dr. Schreiner.

DR. SCHREINER: Yes. You know, the Department told everybody who had training grants, as late as March of this year, thatanybody who was registered before the twenty-ninth of January would be continued through to the end of their training grants.

But when I called last week, they said no money spent after June. That since most training programs are two-year programs, that becomes pretty hypercritical.

It seems to me we are wasting an awful lot of money on planning expanded facilities when all of these people are going to be dead as of July 1.

How can you plan if the commitments of five months ago don't hold five months later?

DR. ROTH: That is what you have got to plan for.

(Laughter)

DR. MARS: Planning element.

DR. VAN HOEK: Dr. Schreiner, are you saying you have been informed that there would be no training funds?

DR. SCHREINER: For people who began programs which they won't be extended beyond July 1, I was told.

DR. VAN HOEK: Even those who had commitments prior to January?

DR. SCHREINER: Right.

DR. VAN HOEK: That isn't the rules by which we are playing the game.

DR. SCHREINER: That is the rules they are explaining to those who are working in the field.

DR. PAHL: We are accustomed to these dilemmas, Dr. Schreiner.

(Laughter)

I don't know, however, we can offer you very much advice.

Are there other questions or points to be directed to Dr. van Hoek?

If not, I would like to thank you and hope you can stay as much as possible today, Bob.

DR. VAN HOEK: Thanks.

DR. PAHL: In the interest of time, because we have much material to cover, I would like to ask Mr. Baum if he would hand out a sheet to you which summarizes some of the budget information and while that is happening, I would also like to inquire whether each of you on the Council received I think about a five- or six-page letter immediately prior to Council in which we went over anumber of points of information?

Have you received it and had an opportunity to read it? Because if you have, I think that what I would like to do is merely ask whether there are questions pertaining to any of those items.

We don't mean to gloss over the many, many things which have been happening. Giving this in written form was an attempt to shorten this report of mine, but we are willing to have any one of staff or myself expand on any of those topics.

Dr. Roth.

DR. ROTH: Well, I got it and I would like at some point to raise a couple of questions about it whenever that is

appropriate.

DR. PAHL: I was going to go into budget a little bit more at the moment. But if you would care to discuss other points -- all right, let me just summarize for you -- are those handed out, Ken?

MR. BAUM: Yes.

DR. PAHL: Let me summarize for you some of the items on budget.

It has been very convoluted since July and I won't attempt to give you an exact chronology, but rather an overall summary I believe might encompass the following major points.

As you recall, at the end of fiscal 1973, there was a balance remaining of $6.9 million and this balance was distributed to the RMP's, but instructions from the Department that each RMP not use its portion until such time as so instructed by the Department, presumably for those priority areas or options that we indicated to you earlier.

There is no lifting at this point in time of that restriction. Thus the $6.9 million is still within the local RMP's, but unavailable to them for expenditure.

We, of course, have appealed this both in specific instances and on a generic basis, but the position that we have at the moment is that that money remains unavailable.

Fiscal 1974 has proven to be most difficult and again suffice it to say you will recall a number of RMP's were

scheduled to terminate over the summer and fall months. But it has been possible for us to work with the Department and OMB in acquiring sufficient funds to keep old RMP's viable and as of today we still have 53 RMP's, the large majority of which are in good to in some cases very excellent shape.

There are a handful that are quite understaffed and that have some problems, and I believe we will be discussing these as we go through the individual applications, but by and large, the RMP's are recuperating and are in many cases in very good shape.

Now, the fiscal 1974 picture has been one of, again, delay and uncertainty.

I believe it was late August, early September, that we had $17.1 million released to us for distribution to RMP's and this was done by a formula arrangement.

You will recall we have no review committee, this having been abolished in June, and an allocation mode was devised which is described in the material that we sent out to you which we and I believe the coordinators feel is as equitable as is possible under the time constraints and lack of full information that exists concerning the status of each RMP.

We had submitted in August a spending plan to the Department which requested a total of $41 million for distribution to RMP's, or a total of $46 million by the time we take into our own operational costs at headquarters and other

matters, and this spending plan has been under consideration for quite sometime and I am happy to report to you that very, very recently the Department approved the release of the total of $46 million to us, and so we actually had in hand at the time of this Council meeting the total of $41.2 million of fiscal 1974 funds for RMP's, of which $17.1 million were distributed earlier this fall. And in addition to which $2 million has been earmarked and most of it distributed for support of specified pediatric pulmonary centers, those being identified again in one of the attachments to the material we sent you.

The National Association of Regional Medical Programs has entered a class action lawsuit, again described in the letter, and this hearing will be scheduled I believe for December 7th, and asks for the total of whatever is appropriated in 1974, of fiscal 1974, as well as some $94 or $95 million of unreleased fiscal 1973 funds.

The Department at the moment has approved our spending plan of $46 million, so depending on what happens over this next month, we may have considerably more money to spend, both from fiscal 1974 funds as well as possibly fiscal 1973 funds.

We will have some discussion in a few minutes about some action which we would ask you to consider relative to this funding status.

Now, it has been most difficult for both the local RMP's and RMPS to go through this past few months with the

uncertainties from day to day and week to week, and I think I would like to merely say it is to the credit of the RMP's staffs as well as to a good number of people on our own staff, and within the agency that the RMP's, 53, have been able to survive this period and approach some level of stability.

At this point in time, we do have funds so that after this Council meeting, we will be distributing the remaining parts of that $46.4 million total fiscal 1974 allotment to us to the RMP's.

Each RMP has received a ceiling figure for fiscal 1974, on the assumption that we would have gotten and in fact now have received the $41.2 million for support of RMP's, and they have been able to plan their activities and staff levels for the remaining portion of this fiscal year on that information.

As you heard this morning, it is the Department's position now that RMP's have these funds available not only through June 30th, but through December 31st, that is through the calendar year, not through this present fiscal year.

It is not at this point clear what OMB's -- Office of Management and Budget's position is relative to this, but I am pleased the Department sees our funds to the RMP's as being available to them for expenditure through December 31.

There have been some moneys this year devoted to its activities. We had a contribution of $338,000 to continue

certain HMO contracts which you will recall sometime back had been initiated with RMP funds, and there is an interim measure. We do not anticipate having to place more money into these contracts or other HMO activities.

We also have received moneys to carry out evaluation studies, but at the moment RMPS is not carrying out evaluation studies, although I think this is still under discussion with the Department.

We have set aside some moneys, of course, for those kinds of contract activities and direct operations activities so that RMPS can go through June 30th next and after that, it is unclear, of course, whether we will be extended as RMPS or be combined or merged with some other organizational unit.

Now, that is what I wanted to summarize, I think, as to the budget status. But I would like to say we have a problem in a sense which we would like to share with you, and while I do this, I would like to have two more handouts come to you if I might. Numbers two and five.

In the current fiscal 1974 appropriation measure, which is in conference, there is a level of $81.9 million being recommended for fiscal 1974 for RMPS. We now have had released to us $46.4 million, thus if we do get the full amount that is appropriated and if that amount is $81.9 million, we will have approximately $35 million additional out of fiscal 1974 funds to distribute to RMP's.

We would propose that this additional fiscal 1974 moneys be distributed to RMP's in the same manner as we have distributed the present fiscal 1974 funds; that is, through the use of this formula that I referred to and which has been employed with those fiscal 1974 funds already distributed, and those under consideration by the Council today.

This would be quite appropriate in our opinion because with the use of these moneys by RMP's through the calendar year rather than through June 30th, this would merely keep the RMP's at approximately the same funding level as we are attempting to do during the first half of this year. In other words, it would merely be compensating them for the kinds of activities which they are engaging in over these coming few months and continue them on from June 30 through Decmeber 31.

Thus our position within the agency is that any additional fiscal 1974 moneys that might become available to us would be distributed to RMP's, through this formula arrangement.

Now, when we look at what may occur as a result of the lawsuit which asks for release of the fiscal 1973 moneys, we have something of a different problem. Because if you will look at the total picture, we may have close to $80-$81 million out of fiscal 1974 appropriations, we already have $6.9 million held in reserve within the regions from fiscal 1973, and regions have zero to significant balances at this point, depending upon a number of variables. And if now we have an additional fiscal

1973 release of up to some $94 million, you can begin to see that there is a different type of problem which faces us.

It is for this reason that we have drafted for your use and consideration a proposed resolution, which is the longer of these two statements just distributed to you, and I would like to go through this with you and then ask your consideration of this, but make sure that we understand what is involved.

This is a proposed resolution by the National Advisory Council recommending allocation of additional RMPS funds in fiscal year 1974:

"WHEREAS: RMPS has established a mode for allocating the funds for Fiscal Year 1974 ($46.4M), and

"WHEREAS: The balance of $6.9M remaining from Fiscal Year 1973 funds was awarded but restricted for use until further notice, and

"WHEREAS; A lawsuit by the National Association of RMPs requests Fiscal Year 1974 funds be released in the amount of $81.9M, and

"WHEREAS: The same suit requests release of Fiscal Year 1973 funds in the amount of $94.0M in addition to the $6.9M unexpended balance, and

"WHEREAS: The suit further requests release from limitations on the time for, and purposes of expenditures by RMPs,

"BE IT RESOLVED THAT: The National Advisory Council recommends that the Regional Medical Programs Service allocate by the established mode the full amount of FY 74 funds made available, and

"BE IT FURTHER RESOLVED THAT: The National Advisory Council recommends that any funds the Regional Medical Programs Service may be directed to obligate in excess of $81.9M during Fiscal Year 1974 be distributed in a manner that is determined by the Director, Regional Medical Programs Service, to make best possible use of funds in accordance with existing legislation."

End of proposed resolution.

Now, that is rather complicated, but what it basically, again, states and what the implications of it are as follows: Any additional fiscal 1974 funds that become available to us as a result of either decisions by the Administration or as a result of the court action now pending would be distributed to RMP's by the same kind of formula that we have already distributed the present $41 million, or will be distributing the present $41 million of fiscal 1974 funds.

This formula distribution has been determined to be as equitable as we can make it and I believe has been endorsed by the coordinators through consultation with their Steering Committee.

Funds in excess of $81 million, that is if the lawsuit

is successful on the part of the plaintiffs and fiscal 1973 funds of up to $94 million become available to the Department and to us for distribution, pending any requirements that are placed upon us, we would propose that these funds not automatically be distributed by formula but that this matter be left to the discretion of the Director of RMPS in the following sense, there are certain inequities which have occurred in the distribution of these funds by formula to some of the regions, some of the regions were caught in an unfortunate period in their history, and I am sure that there are some adjustments which should be made to specific regions. Again, these can be discussed in appropriate time if this becomes an issue. And some of these excess funds certainly could be used for that purpose.

In addition, some of the regions have continuing needs and additional projects which could well be supported with funds which might become available to us from FY-73.

In the Senate version of the appropriation bill, there is a statement that should $81.9 million become available, up to $4.5 million should be devoted to the planning and development of pilot arthritis centers. If this occurs, this would require special action by RMPS such as we took in the case of initiating the emergency medical services program.

In addition to that, there are certain 9-10 activities which would need continuation funding. Hence, it would be

RMPS's position that we ask the Council to schedule a mid-March meeting date as well as an early June meeting date, and one of the functions of the Council at that mid-March meeting date would be to consider the distribution of any funds that ultimately are available to us in excess of the $81.9 million, which is the level of fiscal 1974 funds. But that prior to that meeting date, should it be necessary for us to make some slight adjustments as a result of formula inequities to regions or as a result of the needing to continue some of these 9-10 activities or whatever, that I, as Director, be given discretionary authority to use a limited portion of those funds to make such adjustments or initiate if necessary the pilot arthritis center program.

The bulk of funds beyond $81.9 million, however, we believe should be a matter of discussion and recommendation by the Council; hence, we believe that this matter could be well handled at a mid-March meeting, which we propose to you, and see if we can schedule one approximately at that time.

Now, this resolution is, of course, open for your questioning and full consideration and I would merely say again, building on Dr. Endicott's remarks and Dr. Margulies' remarks particularly, that the total funding of this program and the uncertainties which continue to exist make planning the program on a day-to-day basis somewhat difficult. And it is our belief that it would be most fair to the regions and in their

best interest, and in the best interest of the Administration, to distribute any remaining fiscal 1974 funds, as I have suggested, by formula, particularly since they now will be able to use those funds at least within the Department's consideration, not only through June 30th but through calendar year December 31, 1974.

But that moneys above the $81.9 million do pose a special problem, because there are review considerations and there are considerations that will be made above my level within the Department and OMB, and because of these uncertainties I am not prepared to indicate to you how as a program director I can best proceed.

I believe it is best to indicate to you my need for discretionary authority in that limited sense which I have indicated to you, but to bring back to the Council in early or mid-March, whenever we can assemble again, the problems and issues that we have, so that the Council can make recommendations for the proper use of somewhere possibly up to $90 millions, which is a significant increase over and above what the program level is at this point.

Now, with that as a background to that resolution, I would like to open it for any kind of discussion and modification, or whatever your pleasure is.

Mr. Gardell is here if there are specific questions concerning budget figures, and we will try to clarify anything,

because it is a complicated issue. So let me throw it open.

DR. ROTH: Is the very last word of the long resolution the right one?

"In accordance with existing legislation"? Or should that be "guidelines, priorities, and options"?

DR. PAHL: I think it would be better if we added to it rather than substituted for it,"in accordance with existing legislation and departmental policies and guidelines."

The reason I say that is we are trying to emphasize the Department's understanding now, if you will, that our priority areas and options are no longer restrictive, but the full scope of activities that are authorized within the legislation, of course, are endorsed by the Department, so I think rather than substitute, perhaps it might be better to add the additional phrase.

Mrs. Mars.

MRS. MARS: I am not opposed in any way to delegating the authority to you to use the funds. But I do object to all these preliminaries, because I think that it makes it appear that the Council is sponsoring and sanctioning the lawsuit that is going on.

I do not believe that we should in any way be connected or involved with that part of the procedure.

DR. PAHL: Well, that is certainly true, and it was not written to imply that it was--

MRS. MARS: This is what it implies and this is the way it appears, and I very seriously object to that.

DR. PAHL: This can be certainly modified.

MRS. MARS: I think all that part really should be eliminated, more or less.

DR. PAHL: The third whereas?

MRS. MARS: Well, up to "the same suit requests," and so on, "further requests," and "Then be it resolved." That is the part that I object to.

DR. FOYE: These are statements of fact.

MRS. MARS: But many things can be read into that which are certainly not there. But if it goes on public record as such, I just object to it, for that reason.

DR. PAHL: Would you care to delete it or to modify it in such a way that it made it clear?

MRS. MARS: I would rather delete most of it and rewrite somewhat the beginning here, the resolution.

DR. PAHL: Is there discussion on this point?

MRS. MORGAN: I agree with Mrs. Mars, I think if we can delete the point as to where these funds are coming from--

MRS. MARS: Funds are coming from.

MRS. MORGAN: -- and say if there is $94.0 million released, this is how it be done.

We say nothing about as to where these funds may be coming to us from, as far as this resolution goes.

DR. PAHL: Surely.

Dr. Roth, were you adding a comment?

DR. ROTH: Well, it can certainly be written just on the assumption there might be additional funds of any amount from any source, without specifying it. Wouldn't even need to be--that specific figure sort of tags where you are looking.

MRS. MARS: Right. Just funds available. Become available.

DR. PAHL: Mr. Milliken.

MR. MILLIKEN: This may be unnecessary, but I am wondering if in the responsibility of Council there exists statements that indeed do give the Council this privilege?

If that could be made a part of this? So that-- of delegating this?

DR. PAHL: This is a recommendation by the Council.

MR. MILLIKEN: It is a recommendation only?

DR. PAHL: Yes, that is why we have phrased it, "The National Advisory Council recommends" that we do this.

MR. MILLIKEN: Okay. I think a lot of people, general public, wonder what the role of authority of the Council is.

DR. PAHL: I think on the basis of discussions with our own general counsel, we purposely used the word "recommends" here, rather than "delegates."

MR. MILLIKEN: All right.

DR. PAHL: The Secretary, I believe, is empowered to

delegate authority to those he chooses, but the Council certainly does recommend on policy and the distribution and awarding of grant funds, and makes recommendations on those points.

MR. MILLIKEN: Okay.

DR. PAHL: Yes, Dr. Watkins.

DR. WATKINS: You are going to add to this proposed resolution the fact we will meet mid-March to distribute those additional funds? Are you going to add it to this?

It is not stated here.

DR. PAHL: It is not stated here and we certainly can add it.

DR. WATKINS: Fro example, the formula grants which I believe you will be responsible in making decision, but that we will meet for anything over and above the formula grant?

DR. PAHL: Well, what that last paragraph says is that there was discretionary authority, or is discretionary authority being given to me to act in the interim period, as I have had to do over these previous months. And I am trying to give you a sense of what that discretionary authority might be without a very clear understanding on my part as to just the circumstances that will occur between now and mid-March.

I want to make it perfectly clear for the record and for your understanding that what I am asking for is limited discretionary authority to carry out those kinds of special adjustments for a few regions that we find may be necessary, because

of inequities in application of the formula, or to initiate if necessary that new program which is in the Senate report and which is termed a planning and development of pilot arthritis centers. We can discuss this more fully with you.

Nothing has happened at this point beyond some discussions, but if the appropriation comes through in the full amount, I may have to make some kind of special effort before our mid-March Council meeting. But I was trying to indicate that the bulk of the funds that would become available within fiscal 1973 release would be brought back to the Council for recommendation, discretion -- recommendation as to how to distribute these.

Now, that is the sense I am trying to give you rather than to spell out the detail, because, I really am not sure of the details.

Dr. Merrill.

DR. MERRILL: I certainly agree with what has been proposed here. I would like to recommend that.

I wonder, in view of what we have heard this morning, in view of the uncertainties which have been expressed, whether there is really any viable alternative to delegating this, other than a series of emergency meetings of the Advisory Council?

DR. PAHL: Pardon me, I would like to respond and say, of course, we would be most pleased to suggest some

alternatives to you.

I am not overly happy, personally, about having to bear, if you will, the responsibility for making wise decisions on multi-millions; even with a good staff to assist, it is a somewhat indefensible position for a government official to withstand the kinds of pressures, and so forth, that obviously come about from those decisions.

We also have the difficulty of calling together the full Council without announcements and certain time delays that I don't know-- Ken, what are the time delays now, a few weeks?

MR. BAUM: Yes. You mean getting the Council together?

DR. PAHL: Yes.

MR. BAUM: I would say usually it would take about four weeks, three weeks, or so.

DR. PAHL: There is something in the neighborhood of three and four weeks.

Unfortunately when these understandings are reached within the Administration, sometimes immediate action is required, so we don't have the luxury of calling emergency meetings.

I would be very pleased if you would care, from among your number, to have an executive committee that could be empowered to act within the interim.

Is this possible under our federal--

MR. BAUM: With the Federal Advisory Committee Act, I imagine -- I am not a lawyer, but, again, it would have to be a public meeting.

DR. PAHL: Announced.

MR. BAUM: Announced in the Federal Register, six weeks required for that.

DR. PAHL: We are only in a time requirement of calling together a group without going through what are now the federal regulations of weeks of notice, and so forth, and one doesn't have the opportunity to wait for that period of time before acting.

DR. CANNON: You are here. We appoint you as our Council representative, George.

(Laughter)

DR. PAHL: I might say that is a very great restriction in terms of program management.

We would have to honor those new regulations; so that, in essence, what I am asking for is discretionary authority, but trying to give you, therefore, a sense of what I believe to be reasonable limits on RMPS of this discretionary authority, recognizing that either departmental or OMB actions may modify these as you have heard this morning from Dr. Endicott and Dr. Margulies.

MRS. MARS: Couldn't this then just be rewritten today,

simply, and stating that fact, and present it to us again later in the day or tomorrow morning?

DR. PAHL: Yes, I think so.

MRS. MARS: I think that is really what we are getting down to.

DR. PAHL: Yes, I think these are all very good points and we certainly would be very glad to redraft this with all of this discussion and present it to you again.

Now, we have to present this in an open session. I just have to indicate that. And so prior to the close of the day, we will have to decide when we can have the open session so that people can comment on this action by the Council if they choose to do so.

Mr. Ogden.

MR. OGDEN: Herb, I think when we come down to the additional comment," additional legislation, existing departmental policy and guidelines," I would like to have some statement made in there that you are also to hew to the Council's policies and guidelines.

DR. PAHL: Yes.

MR. OGDEN: And whatever you do should be brought back to the Council for its review and approval.

MRS. MORGAN: For passage.

MR. OGDEN: Even if you have to contact us within a relatively short sequence, in order to bring it back for review

of the Council.

I suspect we have very little authority to delegate to somebody else our responsibility for the allocation of funds.

I am not quite sure we can divest ourselves of that responsibility merely by recommending something be done.

I think it is a very complicated field here. I don't think you have ever had any direct set of by-laws of this Council, and I don't recall that we have ever had any authority to appoint an executive committee of this Council.

Perhaps that is an oversight on our part, but I think it has come up before over the years as I remember.

I do agree with the comments made here a moment ago that your whereas clauses are statement of situations. I don't think this necessarily applies to any kind of approval on the part of this Council for existence of a lawsuit. It does recognize the fact it is there.

Nevertheless, if you choose to rewrite it, we would be happy to review the proposal.

DR. PAHL: I appreciate those comments and we will incorporate them as appropriate into the redrafted resolution.

Yes.

MRS. MORGAN: This December 7th hearing will a decision be made at that time or could this go on for sometime before decision is made?

DR. PAHL: It is my understanding from consultation with Department General Counsel that the government will decide to appeal any matter within 20 days after the December 7th hearing.

So presumably if no appeal does take place, then we would know no later than December 27th as to the ultimate disposition; and if an appeal is made, I am not certain as to what the time table is.

On this point, I am not certain -- is anyone from General Counsel Office here?

Dr. Sparkman, do you have any information relative to the timing as seen by the lawyers for the plaintiff?

DR. SPARKMAN: Nothing beyond what you have said.

DR. PAHL: We do expect to have a final decision from, as I say, our conversations within the Department as to the month of December as to how many funds we will have out of fiscal 1973 and what the disposition of fiscal 1974 funds may be.

MRS. MORGAN: Should we look towards maybe having the National Advisory Committee meeting earlier than March if this is the case?

DR. PAHL: Well, that would certainly be a possibility.

The reason we had tentatively set it for mid-March was because we thought it would be completely resolved by that time.

MRS. MORGAN: Right.

DR. PAHL: We were trying to give ourselves-- because of this publication of the committee deadline, if we miss by a week or so-- but we certainly could schedule a mid-January or late January meeting and one again in March and subject to cancellation.

It is very difficult to determine these dates and, unfortunately, it is then very hard to rearrange it.

MR. OGDEN: Herb, would you ask counsel to give you an opinion as to whether or not you have to establish dates for a subsequent meeting or would it be possible at this meeting for us to say that in the event that this lawsuit is a successful action and the government chooses not to appeal it, that we here at this meeting give notice that we will immediately thereafter hold a special meeting of this Council to consider what to do when such funds become available and that this action at this meeting then constitutes that legal notice of six weeks or whatever is required?

DR. PAHL: We will take that up with counsel.

MR. BAUM: I have to check that.

DR. PAHL: We had invited them to attend the meeting and apparently conflict--

MR. OGDEN: I don't think they would give you an opinion off the cuff anyway.

DR. PAHL: No, it is an unusual situation, but we

will try to take that up and come back to you with it.

Regardless of that activity, if you feel the need for it, we would be pleased to have a meeting in January anyway.

The reason again that we had thought at least of having a mid-March meeting would be helpful, it would follow the President's message and we hope at this time the Administration's legislative package would be known and this would be something then the Council could discuss and take appropriate action and make recommendations to the Department.

Dr. Foye.

DR. FOYE: I am wondering about this resolution.

Typically the national advisory councils, to ensure the necessary continuing administrative flexibility and responsiveness of program staff, you delegate certain similar authorities to program staff.

Where it involves the granting of funds, usually it is limited in the sense that program staff may adjust a grant within plus or minus 10 or plus or minus 20 percent,--

DR. PAHL: Yes.

DR. FOYE: -- of the Council approved level on something like that.

It seems to me the danger of this resolution that might compromise the recommendation above is that it is in a sense an unlimited one.

DR. PAHL: It is open ended.

DR. FOYE: It gives the Director authority, let's say, conceivably, if 100 percent of the funds become available, regardless of their amount and regardless of their relationship to the funds already allocated to the ongoing program.

DR. PAHL: That is correct.

DR. FOYE: It seems that might threaten its acceptance as a recommendation. It falls so far outside the ordinary limits of such delegations.

DR. PAHL: This we recognized and troubled with some language and the reason we left it open ended was merely because the circumstances are difficult and therefore I was trying to give a sense. But you are quite correct, in fact I am glad you made it explicit, as written it is open ended and perhaps we can try our hand again at some limiting authority. Because I certainly intend that, as I have indicated in my remarks.

It is difficult to know, because these aren't going just for adjustment of existing grants but for other matters, but your point is well made and we will see if we can perhaps accommodate some language which will certainly make it more acceptable to both you and us.

DR. FOYE: I certainly know of no time when such flexibility and delegation of authority has been more needed, so I am in favor of it.

(Laughter)

MRS. MORGAN: I wouldn't like to see this March meeting, coming back and serving as a rubber stamp of $90 million that had already been spent, you know.

DR. PAHL: We recognize the limitations of the draft, perhaps we can try again and have some additional assistance if we don't try to get-- if we don't meet all the points you have made.

Now, if we may turn from that, I would like to mention two points, which have to do with our plans -- three points, which have to do with our plans for the future, which is apart from the funding. That is, now we know we hafe fiscal 1974 funds available regardless of the level, and whether we get fiscal 1973 funds or not is immaterial to the point I am mentioning. We have as a central headquarters staff we believe a responsibility to reinstitute certain activities which will be of assistance to the regions and which we, as a more limited staff than we formerly had, can accommodate.

The first and foremost of these I believe is the review by central staff of RMP's review processes.

You will recall that before phase out, RMPS had a program whereby we placed the responsibility on local RMP's for reviewing the merit of their own individual activities and we therefore, as a Council, removed ourselves from project review and got into the posture of program review.

During phase out, of course, this activity ceased

and as of this date, I believe there are something like 17 regions which have never had certification by RMPS of their local review process.

Since we know we now have funds and some lifetime and we do have the staff to accommodate this activity, we propose immediately, that is between now and a March meeting as was our recommendation, to work closely with those regions and to try to get each region's local review process certified.

This is the form of technical assistance which has been of great value to the regions which have received certification, and I believe will improve local regions during this period of their existence as they are trying to restaff and reconstitute their own advisory apparatus.

In addition to that, we intend to reinstitute management assessment reviews of regions. Again, this was one of the most useful activities that RMPS performed, I believe, in helping regions to improve their local management processes, and we have again the capability still in the personnel that we have to work with regions and assist them in this matter.

We would propose immediately to start our program of management assessment visits. Some regions have never been visited at all because the phaseout came and other regions have had visits, but quite sometime in the past, and much has changed in terms of personnel and activities. I believe that we should do this as one responsibility of headquarters.

And lastly, you will note from the July discussion as well as the size of the staff sitting around here today that we have had to discontinue certain functions, one of which has been our monitoring and evaluation of individual activities and program directions of regions.

We have had problems in having sufficient number of staff and also in terms of dollars for travel of staff to regions and consequently we have much less first-hand intelligence about regions than we formerly had.

We now have our fiscal 1974 funds at a level which will accommodate reinstituting our intelligence gathering and evaluation activities.

We do not have a full complement of staff in our office of systems management, which is our information, computerized information network, but we do have practically intact a system of operations and development.

Most of the individuals have stayed throughout this difficult period and have been in touch with telephone and correspondence and, on a limited basis, first-hand visits to the regions.

We would propose to step this up over coming months so that again we have a flow of staff to the region and will be able to know first hand what is going on and provide first hand technical assistance.

One of the things again we believe we would like to

have you consider, because we believe it is important for the regions to know of the Council's interest in this matter, is the subject of this second shorter proposed resolution which has to do with the existing policy by RMPS and Council for having regions comply with the local review process requirements that had been distributed sometime back.

This says:

"WHEREAS: RMPS has established a mode for allocating the funds for Fiscal Year 1974, and

"WHEREAS: Some RMP's still have not complied fully with the 'RMPS Review Process Requirements and Standards' and administrative management requirements, then

"BE IT THEREFORE RESOLVED: The National Advisory Council reiterates the necessity for all RMP's to be in compliance with the 'RMPS Review Process Requirements and Standards' and administrative management requirements as soon as possible, and therefore requests the Director, RMPS, to report the status of RMPs' compliance at the next Council meeting."

Now, we had certainly in mind at that time a March Council meeting, which would give us a period of approximately three months to engage in these visits. But we would amend this by bringing you a status report certainly at the next Council meeting and in March.

Again, the reason that we feel that this is an

appropriate resolution for you to consider is we feel it important that the regions know of the Council's interest in having them meet fully those requirements which have been set for a good local review process.

This is the only assurance that we have quality control will be exerted within the program. Our own staff is less than one-third of what it was. And we do not have the manpower nor the preliminary review committee to engage in projects review again and it is not our desire to do so. But if we are to maintain overall program responsibility, we have to delegate to the regions the responsibility for maintaining quality of their projects.

This basically means meeting the requirements that have been set forth and for which many regions have been certified.

So it is an expression of continued interest in existing policy, that is the subject of the resolution, not the introduction of the new policy.

I would like to open it for discussion and get the sense of the Council on this matter.

MRS. MARS: I think this is a very essential resolution and I move the Council accept it as it is written.

MR. MILLIKEN: Second.

MR. OGDEN: May I offer a comment, perhaps an amendment?

I would just as soon drop the first "whereas" because I think the Council ought to be allocating the funds.

I don't think the first "whereas" is necessary.

MRS. MARS: I accept that amendment.

DR. PAHL: All right. It has been moved and seconded to amend the proposed resolution by striking the first "whereas."

Is there further discussion by the Council?

If not, all in favor say "aye."

(Chorus of "ayes.")

DR. PAHL: Approved.

Now, those are the two actions that I wish to have you take and I would like to come back to Dr. Roth's statement sometime earlier, that perhaps there were some questions on matters within that lengthy letter which we haven't touched upon in terms of budget or these other aspects.

MRS. MARS: You didn't state when the open meeting was going to be to discuss this resolution rewritten.

You said it had to be presented at an open meeting, so tomorrow morning?

DR. PAHL: Our plans for today I believe are such that we will go over into tomorrow, because of really the need, in fairness to the regions, to discuss some of the problems which exist.

Let me just digress, if I might, for a moment, Mrs.

Mars, and say as you are well aware, you have not really seen any application from a region for practically a year, and it is the sense of our staff that we would like to give regions the utmost opportunity to have their strong points as well as some concerns which we would like to present to you to have the time for that.

I believe it would be inappropriate because there are a number of things which you must consider today, before we can take up all of the applications. So that we will be having a session tomorrow.

Now, with that in mind, perhaps we can just set a time and as far as our own staff is concerned, the first thing in the morning to have the open session would be appropriate if that is satisfactory with you.

Would you care to meet at nine o'clock tomorrow or 8:30?

MRS. MORGAN: 8:30?

DR. SCHREINER: Nine o'clock is fine.

DR. PAHL: We are only allowed to drive 50 miles an hour.

Is nine o'clock all right? Let's meet at nine o'clock tomorrow and that will be an open session as long as is necessary to accommodate this and any other matters of open business, and then we will again reconvene in executive session to continue the discussion, actions on individual grant applications.

Are there any other matters dealing with the material we sent to you or points which have been raised as a result of this discussion?

Dr. Roth.

DR. ROTH: Somewhere along the line I would like to give a reaction. As I said to Bland Cannon, I am willing to leave the swan song to him, but maybe I will take the last gasp.

It seems to me that this is relevant to virtually everything we have been discussing this morning, because I came into the program a number of years ago with some obvious enthusiasms which, for a while, increased. And then have been subject to a number of setbacks. And it seems to me that in understanding why RMP as a government program is in the condition it is in now is because of a basic instability -- not in any sense a reflection on the staff, but a fundamental instability in programming and a tendency to shift objectives which started out very close to the beginning.

We made an irresolute start for a program directed at specific categoric ones and it was almost no time at all before the effort was on the program to decategorize it.

Certainly in terms of taking limited numbers of dollars and making them visible locally in programs that would be recognized by the public as contribution to this federal legislation, which would make it acceptable to the health care

industry in all of its aspects and which would make it a source of pride to the legislators who achieved it, this was made more difficult by a diffusion of the areas in which you could dedicate your dollars.

So we rapidly tended to decategorize, we tended to begin lumping things under the 9-10 section which changed the regionalization concept.

Then we began to be tugged towards support of poverty programs and with our very small number of millions of dollars, this could only be an insignificant drop in the bucket among the major poverty programs which were launched by the government.

And then we came along with the interesting thought of extending this into still another categorical disease, renal disease, and this had immense appeal in the public and in Congress and we got into that which further extended our resources.

Along that line, then, subsequently we added emergency services, which put further strains on achieving visibility.

But I think the most disastrous things that happened were when it was put upon RMP to somehow or other get into the health maintenance act, which had a lot of political charisma downtown for awhile, which was really not within the concept of the law as originally passed and which gave us no additional visibility as RMP, and now this has been

compounded by getting us into the act of quality assurance concern which has no visibility.

After all, the PSRO law and its implementation is in a state of chaos at the present time. There will be no operating PSRO's to which we may have contributed and gained any visibility, probably none or almost none for the next six months. And it has got two years to get anywhere and it is going to take most of that time before you get anything operating and evaluations of PSRO have to be retrospective, they can't be made in advance. So this is no way to achieve survival value for RMP.

Now, I happen to think that RMP has done a great many good and useful things. It seems to me that RMP will survive even if the program were terminated on June 30th, as anticipated. Because it launched so many programs and projects which locally become self-sufficient, self-continuing, and therefore it has spawned a generation of plans which have some survival value.

I would like to embrace the concept as I leave the Council of feeling that, all right, we have got some money, it seems to be highly debatable how much we have got. But it seems to me that the jurisdiction, the delegation of authority ought to be in the direction of identifying those good things that the various regions have under way, particularly with a categorical focus, because these lend themselves to the

greatest visibility. And to this I would add EMS.

I think there is a high degree of visibility inherent in EMS where something has been accomplished. An ambulance with a two-way communication system in it is something you can look at, whereas a contribution to planning through a CHPB agency has no visibility at all. At least nobody has been able to see it for seven years.

So I feel that the priorities that are listed here in this material which has been sent out, A and B, and I don't know that they necessarily mean that that is a first and second degree of priority, but I think they are both disasters. And I think we ought to pull out of them and dedicate as little money as possible and to the extent that you can get things of high visibility support in the categorical areas, I think you would improve the survival value of RMP.

It might be that the best thing that could happen to RMP would be no resolution of the problems for the next six months and you get another year on a continuing resolution. Then you have got a year and a-half to achieve more visibility.

I happen to think that there is enough that has been accomplished in these seven years that if we go back to building on those, we will get somewhere. And if we are tagged onto programs which are now the responsibilities of other agencies, after all, PSRO has its own administration somewhere or eventually will come out with one. You have got the BQA, which

has the problem, and in no way is this germane to the philosophy of our RMP or a place to squander our few dollars.

The same thing is true of the HMO legislation, there is some little thing going to come out of Congress, I assume from the conference committee, and it is going to be probably picayune, probably towards the $45 million a year of the scale rather than the Kennedy $805 million a year. And I am sure they will be happy to have RMP money and I am sure that it isn't going to give us any visibility. Because it is a very small amount of money when you consider that HMO's have now been taken over by the commercial insurance industry, by Blue Cross which has a commitment to start 287 of them or something, an outfit out of Los Angeles that is running 50; an outfit out of Saint Louis, investor owned for profit, running 30.

This whole thing is out of our ballpark and we shouldn't waste any of our funds in it.

These are my sentiments and they are directed primarily at those priorities and options which I think should not be determining for the use of any available funds and that is why I specifically requested the question as to whether they belonged in there instead of or in addition to legislation.

Because if they are to be put in there, then I think they are wrong.

DR. PAHL: Well, thank you very much for the statement,

and I don't know that we want to limit Dr. Cannon to later on -- perhaps you would like to add to this, Dr. Cannon, or other members of the Council, since I think it does point up some of the discussion we have had this morning, particularly from Dr. Margulies, relative to the way these options are now seen.

Before, however, opening up, let me say that later we will have a presentation and some material for you to consider from Mr. Gardell, which again will give to regions, regardless of their former triennial or anniversary status, the opportunity to exercise discretionary funding authority.

Of course, with headquarters trying to monitor and keep in touch with what the activities are within regions, but we are not limited again to the options as listed; and we would also have to indicate, as we discuss the kidney program a little bit later this afternoon with that whole activity under SSA and so forth, that this option is not one that is going to consume either many dollars or be particularly productive as it has in the past from an RMP point of view.

We are very instrumental in starting up many things, but we now have to fit into a broader set of federal regulations and positions.

I would appreciate having anyone on Council, though, add to or comment upon Dr. Roth's statement, which I appreciate very much.

Yes, Dr. Schreiner.

DR. SCHREINER: Yes. In a smaller way, I think there are many, many things that are very pertinent that Dr. Roth stated. And I am a little bit bothered by what you just said. Because the real objective of RMP was to provide seed money and facilities in the homes that other people would take over the delivery costs and even to some exsent the administrative costs as the programs become valuable.

Now, what you are just saying to me is that because another agency has been set up to do precisely that, we should back out of the business.

Actually we are in a very critical situation with respect to Social Security Administration; that is, they have the money for delivery of the medical care almost ahead of time before the facilities and the seed money has in fact been spent. And I couldn't think of anything that would fulfill what Dr. Roth was talking about, the traditional role of RMP, other than to see that this great big bloc of federal money is indeed well spent by virtue of having appropriate facilities.

That is why the item this morning, you know, it seems kind of silly on the one hand the appropriating $150 million; on the other hand, taking away the nephrologist for this program, which is being done.

We have the first or second largest program in the country. We have called people and told them they are out of a job as of July.

If you put the cart before the horse -- I am trying to say you are almost in the point where one federal agency has an obligation to see that the other one works properly. And to get the people and facilities on deliveryline where there is assurance.

Many times we have programs where we took the assurances from states or universities, or something like that, that this program would be taken over, whereas we all knew deep down inside of our hearts there was no way it could take over this kind of financial responsibility.

Here we have got a situation where we know it can be taken over and where we can really interdigitate in a very, very meaningful way rather than in a never-never land.

Now, what discourages me a little bit is we went through the great business of establishing our five priorities for the limited money we thought we would have for the phaseout. We look through the yellow sheets, we see this message didn't get through at all. Some have zero percentages in five, in one I ran into-- nothing in two or three of the priorities we assigned.

Now, with that change not even beginning to be implemented, we were asked this morning that we should change and relax the five priorities and start off with something new.

You know, this is like you haven't even got one foot in the air in a hop scotch court and somebody put another square

out.

I agree the instability of the programs has been very, very detrimental to the image certainly in the legislative eyes, what the accomplishments are. I am wondering if we took sometime to set these priorities, if we have the wrong priorities, we should change them, reset them? Shouldn't we stick to them a little while, at least long enough for them to be implemented at least in a few areas?

DR. PAHL: Let me hasten to add, I didn't mean to have my remarks interpreted RMPS should pull out of this area. What I intended to say was that we no longer have an open-ended option, if you will, for doing what we consider to be important in the kidney area without complying with the regulations which are being promulgated by another federal agency.

So that I would endorse what you said wholeheartedly, we certainly should continue putting money into the kidney program, but now we must merge whatever the local activities and desires are with also the realities under the new legislation and federal regulations.

Dr. Roth.

DR. ROTH: I just wanted to be sure George understood that the net effect of my comment was not to start out doing something new, but is to go back to doing something old, to restrict the number of priorities.

I would eliminate that A and B completely and I would

stick with the rest, which basically seem to -- EMS and, as I recall, that hypertension and kidney disease. And the only way I would extend that at all, since that covers heart disease, to a degree stroke, I would get cancer back in there some way or other because I think this program did develop charisma with cancer and I don't think it has been negated by the subsequent legislative appropriations in cancer. I think there ought to be some cancer in RMP.

So I am going back to heart disease, cancer, stroke, kidney disease, and EMS. There I think you have got some opportunities for visibility. And I dont think this is anything new; I think it is a reversion to the solid part of the old.

DR. PAHL: Well, Ithink there are two points I would like. One is in the initial resolution that we offer for your consideration, which will be redrafted, we were attempting to explicitly state that funds could be used in the best possible interest in accordance with existing legislation, which accommodates all of what has been said, but it can be stated explicitly. And the other is it may be that the Council would wish to frame a resolution along these lines and make a recommendation, if you will, as to its position, and a recommendation to the Department.

We would be very pleased to honor and forward any such official statement from the Council. This could be done

so that it could be discussed again, if you wish, tomorrow morning or--

MR. OGDEN: Dr. Pahl, I would hope that if we begin to make statements about categorical activities, that we don't go back to assuming that our categorical activities are going to be limited somehow to continuing education and to training programs.

I think one of our purposes has always been we tried to expand the accessibility and availability of care. And I think it is too easy to categorically simply to say in the area of continuing education.

While I think I agree with much of what Dr. Roth is saying and Dr. Schreiner is saying about the fact that we seem to jump all over the place as to where we put the emphasis on what we are doing, in these days, as we mentioned having coffee, in these days of the dollar crunch, the new baby faced is national, with necessity of spending large sums of money for crash programs on energy; the cost-effectiveness of everything becomes far more vital.

I think we would be amiss if we went back categorical to continue education.

DR. PAHL: The Department, of course, has set forth its opinion earlier in the year relative to so much emphasis on the professional continuing educational aspects and was the rationale by the Department for termination of the program.

This is certainly a key matter for Council discussion and I feel that you should be given opportunity now or again tomorrow morning to either continue the discussion or to phrase something beyond the matter of the transcript in the sense of a formal position or recommendation to the Secretary.

Dr. Schreiner.

DR. SCHREINER: Yes, you get into some conceptional problems, Mr. Ogden. Because you see Social Security says what they are hoping now in their preliminary talks is to have some sort of primary, secondary, and tertiary care arrangement which we have talked about in relationship with EMS and other kinds of facilities.

Well, you know, if you say, "Okay, I am going to hook 10, so many hospitals up to a center, a medical center," for anything, whether transplantation, what have you, to say that you are going to do that without any professional education or some kind of education along the way to develop the proper manpower-- because those people don't exist. There is no nurse specialist, you know, out in the community hospital in a rural area. If we are going to endow them with capabilities of performing, if we are going to hook them up to a medical center, there has got to be some kind of education.

But I agree with you, I think what you are talking about, Ed, is saying, okay, I am just going to train ten people in the hopes that they may filter some way into the health system, that is the old concept of education we were doing and I

agree with you perfectly on that.

MR. OGDEN: I am also saying I don't think you could ignore the necessity of local planning. I don't think you can ignore either the requirement of quality assurance. Even if it is category.

DR. SCHREINER: But putting a man in charge of quality assurance and putting a chart into a computer doesn't give you a nephrologist.

We are expanding facilities and you can put 10 million quality assurance out there, if there isn't a nephrologist in the program you are not going to have it.

I was telling Mrs. Mars the analogy is putting a county agent in a county doesn't get the cows fed.

Over a long haul it helps. But if there is nobody there to feed those cows, it isn't going to be done.

MRS. MORGAN: Can't do it.

DR. SCHREINER: So it seems to me you have this irretrievable amount of training that has to be done.

MR. OGDEN: May not be done anyway.

You are assuming there is going to be a good nephrologist. That is where I disagree, I think, with Dr. Roth; I don't think you can ignore EMT. I really don't.

DR. ROTH: I don't think they do you any good in the survival of the program.

I am looking at this thing as a fight for survival.

The problem, you know, in my capacity in the medical profession, certainly in the last two years, I have been traveling the country, talking to the medical societies and the non-medical people, and with my interest in RMP, I check it out for the visibility that is achieved and what the local profession thinks of it, and unhappily it has not impacted in most of the areas. Even some of the areas we have been giving the RMP's the best marks, the medical community couldn't care less if it vanishes.

I think it is too bad, because I think it hasn't communicated.

I think it has done a great many good things in these areas that the physicians ought to know about and the nurses, and the welfare people. All the people interested in health. They just haven't looked on RMP as having contributed very much.

And you sure aren't going to, in the short space of time that we have got left to fight for survival, or you have left to fight for survival, I don't think you are going to advance it much by getting into this morass of quality control or planning, neither of which has achieved any particular visibility.

If we think we are in trouble, actually the public evaluation of CHP is in general at a lower level than it has been for RMP.

Great concern about the accomplishments of A agencies or B agencies manifested by the fact that many states are now going the certificate-of-need legislation way, as something in addition since CHPS and PHB didn't get very much of anywhere.

It isn't that I don't think these things are important. I think they contribute no visibility, at least effective way of trying to ensure two years from now we have an RMP program.

DR. PAHL: Thank you, Dr. Roth.

Dr. Cannon, you indicated you have some comments to make.

DR. CANNON: Yes. My friend Russell said he was going to give his last gasp. I thought that was sort of typical; he always does that -- and gets everybody else hyperventilating.

(Laughter)

So to follow his usual plan, I suppose that I am not going to have a swan song to say for the both of us, Russell, but I will say, probably because of my visceral reaction for lunch, I do have a gut feeling for RMP and it sort of sums up the whole picture for me, like I came in to sit down to a delicious and pleasant and delightful experience, a fine meal -- and I ended up with hash.

(Laughter)

Hash is not so bad if you are hungry enough, if you

remember, some of us in the Depression years. And I think if we can take that hash and put it where it really is needed, that we may still gain that visibility.

I would agree with everything you have said about the change of the focus and messing around, and about every facet of the health care industry which we have done. But it really hasn't been any fault of ours, Russ.

DR. ROTH: No.

DR. CANNON: It has been the fault of what has come down through the Administrations and others.

Just like we get the directives of where this money is going to be spent before we even discuss it. And that sort of has been typical.

I would just plead that, well, one other thing, the visibility of RMP -- and I have said this before, many years ago -- is that if you are going to paint a picture that somebody sees something in, you can't mix all your paint together before you start painting, because it all comes out gray.

You have just been running around the country finding out that everything is gray, and there is no perception as to what RMP has done. But RMP has done, it is just hard to get that perception.

I would like to see the suggestions that Russell has made to you, I would like to see what is left over now, hash, applied in such a way that the program can get to an area that

not only is needed, but gives visibility.

So far as swan songs are concerned, Russell, we have heard a good many of them -- not many from Council members, but we have had people pass through here like Mahoney, Crosby, Brennan, DeBakey -- really with very few swan songs; but we have had a lot of swan songs from Olson, English -- (laughter) -- Irv Lewis, Vern Wilson, you know, we really have heard real -- so we can see one of the reasons that the stake in our operation isn't all that we would desire.

I really don't have anything else to say on this except I really have gained a lot personally from the staff, they have been wonderful, and friends among the staff throughout the membership.

I have learned a lot about how the government and HEW works -- or doesn't work.

(Laughter)

DR. PAHL: Thank you very much, Bland.

You were getting me nervous there with your listing of swan songs.

(Laughter)

MR. OGDEN: He is saying there is a difference between us sitting ducks and the swans.

(Laughter)

DR. PAHL: Mr. Baum is our local pundit. I am glad to see we have a distinguished pundit.

If we may indulge you in one more short presentation, because Dr. Margaret Sloane has to be over at NIH by the time we will be able to reconvene.

I would appreciate very much if she would present to you the final result of what has been accomplished under the section 907 of our Act, and the publication which I see her trying to bear to the table here.

She and Mr. Robbins have worked diligently over these many, many months to produce a set of volumes which we believe is going to be a reference work that will be of great importance to many individuals, many groups around the country.

With that, Margaret, will you please tell us what you have been doing.

DR. SLOANE: We hope it will be useful.

This is a progress report on the activities that have been carried out under section 907, which most of you will remember started out saying the Surgeon General should establish a list or lists of medical facilities in the country, staffed and equipped to deliver the latest advances in heart, cancer, and stroke, and kidney disease was later added, and responsibility shifted to the Secretary.

Under that section of the legislation, we carried out the various guidelines, contracts which you have heard about before, in the field of heart disease, cancer, stroke, and end-stage kidney disease. And once we had the guidelines, it

was determined the Joint Commission on Accreditation of Hospitals was to carry out the criteria against which lists could possibly be constructed.

As we went forward under the contract with the Joint Commission, it became apparent to establish a list for each disease entity might not be in the best interest of the country, and that actually since each of the guideline contracts had come through with the concept of a stratified system of care with every hospital in the country having an appropriate mission to perform in relation to these categorical diseases, that it would be more appropriate to develop a three-level, at least a three-level set of criteria in each of the disease areas. And that these different levels of hospitals should be linked together in appropriate ways so that referral would quickly bring a patient to the level of care which was most appropriate for him.

Therefore, the Joint Commission decided to develop sets of criteria in each of the disease areas which would provide goals for every hospital in the country to work towards in relation to these diseases.

Four criteria documents have now been completed. The end-stage kidney disease and stroke documents have already appeared in the JAMA in October.

The Heart disease guidelines, or criteria-- I am sorry-- should be in this week's JAMA, and cancer should appear

sometime in December.

These are considered tentative documents and comment and criticism is earnestly solicited.

All comment and criticism and all the discussions which members of the various expert committees are holding all across the country will be fed back into their consideration and revised criteria will be established sometime in the spring.

Now, if any listing of hospitals were to be developed, it was obvious that we would have to have information on what was actually present in hospitals in the country, which would give them the possibility of delivering the highest quality of care for heart disease, cancer, stroke, and end-stage kidney disease. So the Joint Commission, in addition to developing the criteria statements, sent out questionnaires to every hospital in the country, and I thought I would pass around copies of the questionnaires so that you could perhaps take them with you, because I am going to ask each of you to do something for us in relation to the questionnaire.

The questionnaire was sent out in September 1972 to every nonpsychiatric hospital in the United States from six beds and up.

The response was really tremendously encouraging, and I would like to take this opportunity to express deep appreciation to the American Medical Association, American Hospital

Association, for their great assistance in assuring a good response to this questtionaire.

As it now stands, the returns represent over 92 percent of all the hospital beds in the United States. That is all the short-term nonpsychiatric hospital beds. The response in terms of hospitals is not quite so high, because the small hospitals, 6 to 50 beds, which had very few resources for the treatment of these diseases, did not give a very good response. But we were over 95 percent of hospitals over 300 beds, and 97 percent of those over 500 beds, and the response I think has really been remarkably good.

Now, these are voluntary questionnaire responses with some validation; a large number of telephone checks were carried out of hospitals over the country. Any questionable data were verified. But this does not represent a large degree of site visiting to assure the validity of the data.

Nevertheless, the data have now been compiled and, for better or for worse, here they are. (Indicating)

These volumes, we might pass these around too, Bob, you can pass them one at a time, just so you can look at them and see what kind of record these represent.

It is compiled in the same way that hospital guides, American Hospital Association has done, and this represents in these various disease areas and with separate volumes for hospital organization, pathology and radiology, the information

that we now have available on hospitals in the United States.

I may say we have been deluged, really, with requests for various cuts of this information and it has been a considerable problem to us to know just in what form to present the data, that is, summaries of various aspects of the data, so that it could be most helpful.

I would like to thank Mr. Joe Ott, down there, for his excellent assistance in helping us with this whole exercise.

We have received questions of this sort: How many hospitals are there in the United States which provide renal dialysis 24 hours a day? How many hospitals are doing open heart surgery? How many are doing coronary bypass surgery? How many operations were done in each of these categories during the past year? How many hospitals have hospital-based cancer registries? How many of these are physician directed?

There is a great amount of information which is available.

Now, one of the requirements on the Joint Commission on Accreditation of Hospitals was that before the end of their contract, they should make a recommendation through the Board of Commissioners of the Joint Commission to the Department of HEW as to what should be done with this information in the future. And their Board has recommended that this kind of activity be continued with some modifications. They believe it should be broadened, that it probably should eventually include

respiratory disease, arthritis, diabetes.

Actually the questions that we have asked in the laboratory field and in rehabilitation and in a number of other areas have been sufficiently broad to serve the purposes of the other four disease areas, that there is very little additional information that would have to be added to obtain data in these other areas.

The American Hospital Association is interested in working with the Joint Commission on this. The American College of Surgeons is particularly interested in joining courses with the Joint Commission. And in addition to renewing this questionnaire which will be done, will presumably be done within another year or two, it is proposed that the Joint Commission over a voluntary accreditation program, so that hospitals may ask to be inspected by the Joint Commission with the help of specialists in the different disease areas, and to receive acknowledgement that they fulfill the criteria for a primary, secondary or tertiary level hospital in one of these disease areas. Whether they are to be called primary, seconeary or tertiary or A,B,C,D, or whatever, we are not sure yet, but at any rate to offer a kind of voluntary accreditation service comparable to that of the American College of Surgeons has offered in the field of cancer.

If this is to occur, it is possible that the American College of Surgeons may turn over its cancer approvals program

to the Joint Commission or the Joint Commission may subcontract with the American College of Surgeons to do this in the field of cancer, but this is a model of the sort of thing that they would propose to do.

We have had one extensive discussion with Dr. Porterfield on this subject. The Health Resources Administration and Health Services Administration have both expressed interest in supporting the initiation of this program,and at this moment it seems probable that this will be undertaken.

I think it is interesting to note that the State of Massachusetts has come through with a very excellent legislation for hospital programs, for cancer programs in Massachusetts, which embody most of the principles in the cancer document, cancer criteria document, and recommend three levels of hospitals with close linkage in between.

What I would like to ask from each of you is that if there is any question you would like to put to these data, if there is any kind of information you could identify that you think would be helpful to you or to others, let us know and we will try to prepare the information in accordance with your request.

Some of the requests we have had have been to run the data on a single state basis and several of the comprehensive health planning agencies are using the data in this fashion or plan to. We can have special runs for anything in

the field of these four diseases and for general hospital resources.

So we will welcome your requests;if it happens to be something that will cost too much money, we might have to charge for it, but we would welcome your comments, your criticisms, ans any suggestions as to ways in which we could make this data useful as possible.

It is something that regional medical programs must take either the blame or the credit for, and we would like to make it as useful as possible.

DR. PAHL: Thank you very much, Dr. Sloane.

I believe Dr. Sloane was a little overly modest in saying the blame or credit, because it is, I am sure, only credit. It has been a tremendous cooperative effort and we certainly would like to make available to Council any or all of the volumes that you may care to have. Some of you may not wish to have any.

If you will indicate to Dr. Sloane whether just particular volumes or full sets, we will get them to you. But we didn't want to burden you with material unless you would find it of interest and value in having it.

DR. SLOANE: They are being mailed out the thirtieth of November to all the regional medical programs and to a broad mailing list.

DR. CANNON: Council members?

DR. SLOANE: If the Council members wish them.

DR. PAHL: Does everyone on Council wish to have a full set?

Why don't we mail a full set to each of you?

If you have another minute or two before you have to run, I wonder if there are any questions or comments by Council on this matter?

It is something which you have been involved with and it is nice to see the culmination of a complex effort.

I think a lot of people deserve to be certainly commended for it.

MRS. MORGAN: Is there any plan for updating these?

I am sure they change -- this was done in 1972; I am sure--

DR. SLOANE: As I indicated, the Joint Commission has proposed they undertake the updating of this; whether it is done next spring or next fall, or just how soon, we are not sure.

I thinkit is impossible to do this every year. It is too big an undertaking.

MRS. MORGAN: Could this, though, be part of their accreditation of hospitals in updating this?

DR. SLOANE: Yes. The visiting program which would be undertaken -- one of the reasons it was decided not to go ahead with the establishment of lists at this point is that the

Steering Committee of this effort felt very strongly that no kind of accreditation should be given to hospitals, no kind of lists should be established unless there was actual site visit by adequately qualified people. And it is that sort of effort that the Joint Commission would undertake.

They would expect to do the more housekeeping part of the inspection as part of their regular accreditation visit, but they would give a special kind of visit for a hospital that wanted to be accredited as, let's say, a cancer, or regional cancer center.

DR. PAHL: Dr. Roth.

DR. ROTH: I don't know whether it is possible to answer this question, but what did this effort represent in terms of RMP expenditures?

DR. SLOANE: The JCH contract has been about 100 -- first year was $120,000; second year $150,000. So that these seven volumes plus the criteria documents have represented $275,000.

DR. ROTH: In grants out, or is this total?

DR. SLOANE: This was a contract with joint-- this does not include cost of guidelines, with the American College of Surgeons, American Heart Association, American Neurological Association, National Kidney Foundation.

DR. PAHL: What would that have added to it?

DR. SLOANE: Well, each of those came to about four --

not the kidney one, that was done really by the National Kidney Foundation, and we only paid the travel expenses of the experts who came to the meetings really. But the other three have been quite an expense.

American College of Surgeons was the first one, $350,000; American Heart Association is a continuing activity still going on, they are continuing to revise and update, and I think that would come to about $450,000. And the American Neurological Association about the same.

But these represented an enormous meeting, enormous number of experts, top people in the country meeting again and again and again to hammer out materials, not all of which have been published.

The ICHD documents were published serially in the journal circulation and they have now been collected and are about to be published as a single volume.

The stroke documents are still coming out in the journal Stroke, and they will probably be collected into a single volume eventually too.

DR. PAHL: Well, thank you very much.

Are there other questions before Dr. Sloane departs?

Thank you again, Margaret, and to all of those on our staff who have participated in this.

I should say there are a few extra copies of the

questionnaire so if other visitors present today would like to have a copy, or others, I am sure they can get a copy from Dr. Sloane's office.

Now I would like to come back to the housekeeping detail which has to do with lunch.

I am sure we have worked you overly long this morning, but we appreciate your indulgence.

We have not gotten through our public discussion session, but I think what we would prefer to do, if you will, is to have Council members and the staff who have already been identified, those who are working very closely with the regions, have lunch in this room and those so honored may pay Mrs. Handel at the door $2.25 and we hope that the sandwiches that have been ordered and the little side things are cost-effective, let's put it that way. We have to pay for room service.

The other members of the staff and visitors, we ask if you will leave, because this is a closed executive session in which we will be discussing matters relating to specific regions, specific grants. No formal actions will be taken in this session. It is designed to give the Council members an opportunity to get some first-hand information from our staff as to activities within regions, so that as we go through today and tomorrow, you will be better able to understand the status, now, of regions and make we hope better judgments.

We would like to have visitors and the staff who are

not joining us for lunch reconvene, oh, I think an hour should be plenty of time. Let us reconvene in open session no later than five of two, because we do have a full agenda. That will give us a full hour. And at that time we hope to have a discussion of the kidney program by Mr. Spear and comments and discussion by Council, we have a presentation with some actions and considerations by Council and presentation by Mr. Gardell, and we have an overview of matters which will be more meaningful to you, overview of the RMP's by Mr. Peterson as we then go into again executive session to discuss specific grant applications.

So with that, if we may reconvene at five of two for the open session and Council and appropriate staff now adjourn for lunch.

Thank you.

(Whereupon, at 12:55 o'clock, p.m., the meeting was recessed, to reconvene at 1:55 o'clock, p.m., the same day.)

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AFTERNOON SESSION

(1:55 p.m.)

DR. PAHL: Will the meeting come to order, please.

May we reconvene our afternoon session.

This, again, constitutes an open session of the Council and we have a number of items left before we get to applications. So I would like to indicate, first of all, that the discussions that you had during the lunch hour are subject to the confidentiality which Council has always observed in matters relating to specific grants and applications, and therefore should not be discussed apart from the staff and Council members.

The present session is anopen meeting and we expect to have some public participation as well as continued presentations by our staff. Because Dr. Schreiner must leave before too long, I would like to ask Mr. Matt Spear if he would please present to you the status of kidney activities, and then have a general discussion by Council concerning any matter on this point, since it will involve some of the applications that you will be looking at this afternoon and tomorrow.

Matt.

MR. SPEAR: I am not sure what the specific level of understanding of this activity is so with apology for some repetition of things, I know a lot of you are familiar with, let me start from the year one.

HR-1, which was major legislation in 1972 so far as the health area was concerned, finally was enacted on October 30th last year into Public Law 92-603. Those were principally amendments to the Social Security Act. And within that public law was a very short section labeled section 299I, which dealt with kidney disease; and to clarify what I am speaking about, I will give it a name and even though it doesn't show up in print anywhere, I am speaking about what has become a national end-stage renal dialysis program, or as we call it in shorthand, ESRD program.

The provisions of 299I are now incorporated in section 226 of Title II of the Social Security Act, and under those provisions, end-stage kidney disease patients have broader coverage under Social Security, Medicare, than any of the other classes of citizens.

The law now extends coverage to citizens under 65 who require end-stage renal dialysis, if they are currently covered for Social Security benefits, and this coverage extends to their spouses and dependents.

By virtue of those patients who receive renal dialysis ot transportation and supported by Medicare payments, have available to them all the coverage of Medicare, so it is quite a large thing, very precedent setting in many respects.

Work on implementing 299I began even before enactment of the law by members of the Bureau of Health Insurance in

Baltimore, coming down to RMPS, and discussing with us a number of aspects, and those conversations accelerated in succeeding months. And I think at best one can only state the activity suffered the fait of many things in these trying days; it had several false starts and we hope now we are on the final lap of the race.

The law was effective, the coverage of end-stage renal dialysis was effective July 1, 1973, and by that time the program should have been ready to be implemented, but it wasn't. And so to get the wheels rolling interim regulations were published on June 29th, and the interim regulations established an interim period to begin on July 1, 1973, and to extend to some unnamed date, which is labeled when the permanent program is promulgated.

So we are working with interim regulations in an interim period to provide Medicare payments support for renal dialysis and transplant care.

The interim regulations did several things. It in effect put a moratorium on the development of capability to provide care. It did so by saying anyone in the business of providing renal dialysis or transportation on or before June 30, 1973, would be reimbursed for the services they were providing at that time.

The level of services they were providing at that time.

be considered temporary until the permanent program is mounted.

And the reasons for that I think are best explained further back on pages 2 and 3 in which it is said, well, for instance, in the second paragraph it says with regard to transplantation, there are six criteria provided which are expected to be contained or required under the permanent program. And at the bottom of page 2 are the criteria of which the dialysis facilities are expected to have to adhere to in some respect.

These provisions place a condition on the use of RMPS funds. And the condition is this, that if those funds are being employed in any way to expand someone's services who was already in the business on June 1, or if they are to be employed in the development of care capability where it is not now at a stage to be covered for Medicare reimbursement, those institutions, regardless of the source of the funds with which they are trying to effect these changes, must have that interim approval in order to go ahead.

We need to be sure that investments are not being made in areas where there may be a refusal or a disallowance to perform the service that is intended to be carried out.

The onus for getting that approval falls upon the performing institution.

Now, when these regulations -- even before these regulations were printed, the interim regulations, the Bureau of Health Insurance had queried all of the institutions of their

record regarding their intent to participate under the program. And most have responded with a "yea."

There were also responses as a result of that query from those who wished to expand their program as defined in the interim regulations and certainly many of them who were not yet in business who wanted to start new facilities, new capabilities

All of those people are still waiting for an answer. Hopefully they will have their answer about January, end of January or early February.

What is happening now is that the requirements as they are listed within the interim regulations require for anyone to make a judgment regarding a request for an exception is going to require a fair amount of information from these providers as to just what it is they want to do, and what it is they want to do fits in with what is going on already. And the difficulty has been in pulling together in a package which encompasses or incorporates an application for exception some expansion of the criteria with regard to exactly what do we mean, directions as to how you fill out this application, and certain other forms and documents that go along to help explain what is happening.

Everything is ready to go except the application for exception and as with many of these kinds of documents --

(Laughter)

-- some other people want to approve them and we think we have those approvals in hand, but we are right at the

brink of that. I hope within ten days to two weeks that whole package, application form and all of the associated documents, will be out in the hands of those people who need exception request applications.

I think, Dr. Pahl, I should stop right there. That, essentially, is what it is and where we are.

I would certainly field the questions as best I can.

DR. PAHL: Thank you.

Dr. Cannon.

DR. CANNON: When you say that an institution that has a dialysis program wants to expand into a transplant program, are you saying it is incumbent upon this organization to give its approval for this expansion so it can be paid by Medicare?

MR. SPEAR: No. I am simply saying--

DR. CANNON: Somebody has to.

MR. SPEAR: That RMP that is about to provide the funding for that needs to be aware I think that the institution should have an approval in hand.

DR. CANNON: But you don't know who will give that.

MRS. MORGAN: Who gives that approval?

MR. SPEAR: That institution should make an application for exception.

The approval will be a decision by a body pulled together by the Bureau of Quality Assurance and will be--

DR. CANNON: Separate from this organization?

MR. SPEAR: Yes. The authority for the interim regulations, implementation of the interim regulations is a joint responsibility of the Bureau of Health Insurance and Bureau of Qaulity Assurance, and there are work groups within each components working together topull this together.

The facility will be requested to submit the application in triplicate. Time is passing and everyone is in a hurry on this.

One copy will go to CHPB agencies. At the same time, copy should go to the CHPA agency. And at the same time, copy goes into the Bureau of Health Insurance regional office, which is one of the ten HEW regional offices. That regional coordination will be from the BHI regional office.

The CHP agencies are permitted 30 days in order to do their review and they are to review on the basis of need for that service, and to give their recommendations to BHI, who will collate the documents and review plus their own, and when CHP states the regional review will be a combination of regional advice and BHI people that will come into the Bureau here, and the plan is here there will be representation of the BQA and BHI people and a majority of outside professional people who will sit in judgment on these applications.

DR. PAHL: Dr. Merrill.

DR. MERRILL: Does this apply to an outfit which has

been functioning for several years and which wants to expand?

MR. SPEAR: Wants to what?

DR. MERRILL: Wants to expand?

MR. SPEAR: Yes. An expansion would need the interim--

DR. MERRILL: Any increase?

MR. SPEAR: Yes.

DR. MERRILL: As I understand, in addition to what you said, you also need certificate of need from the State Board of Public Health; is that correct?

MR. SPEAR: Yes. We would really be asking for any kind of licensed certification, approval, that is in operation in that locality. We would like to have it documented as all clearances having been made.

DR. PAHL: Dr. Schreiner.

DR. SCHREINER: Do you recall how many states require certificates?

MR. SPEAR: I don't recall.

DR. ROTH: About 23?

MR. MILLIKEN: Twenty-two I believe.

MR. SPEAR: That is more than I thought. But there is quite a variety.

DR. PAHL: Is there other discussion on this matter or related points?

We are sending the interim regulations to all of the RMP's. As we go through the applications, there will be points brought up for your consideration and in those instances, we will be reading to you a form, short paragraph that will go to the coordinators alerting them to the fact that the activity in question would need interim approval, and RMP funds therefore should not be spent until such approval is obtained. And Mrs. Silsbee, I believe, will read you the proposed paragraph as we get into the applications.

Thank you very much, Matt.

Now we have been able over the lunch hour to locate Mr. Robert Landman, of the Office of General Counsel. While some of you were discussing grant matters, we were discussing with him our opportunities for arranging Council meetings as may be needed, but without at this point specifying an exact date.

It turns out after much discussion that probably the best avenue for us to take at this point in time is to set Council dates for January, February and March.

(Laughter)

And then cancel.

This shortcircuits much legal jargon, which I am sure -- and Mr. Landman can interpret better than I can. But it seems the safest route to establish early to mid-January, mid-February and mid-March meetings, and then we are certain

that we can proceed. Whereas, other avenues may be subject to cancellation by other parties in the Administration.

So if we might look at the calendar, I do that now while all of you are here, if we might look at the calendar which is in your agenda folder and is that teriffic government calendar, I would have to leave to you what dates might be appropriate.

Mr. Landman advises that possibly early January would be a suitable time in view of what he knows to be the current status of thinking, lawsuits and so forth. He can't guarantee us obviously since the matter isn't completely under his control.

I would suggest you look at the second week of January, or failing that, the third week of January, and again not knowing exactly what business will be before us, I would hope that a one-daymeeting would be sufficient. If you care to set two days, we can always cancel the second day if it doesn't turn out to be needed; or, in fact, we can cancel the entire meeting if the time selected is inappropriate.

MRS. MARS: Monday the 15th of January?

DR. PAHL: Monday the 14th and Tuesday the 15th?

Are those ones that are open to Council?

Are Tuesday-Wednesday, 15 and 16, as satisfactory as Monday and Tuesday?

DR. SCHREINER: It is better for me.

DR. PAHL: It is better for you.

MRS. MORGAN: It doesn't make any difference.

DR. PAHL: All right, let's set January 15th and 16th, Tuesday and Wednesday, as a meeting of the Council, and perhaps we might now look at February and again I am not sure what time is appropriate. Again, the budget message will be going to the Congress the end of January, so perhaps again mid-February might be sufficient to know what the Administration's legislative package is.

MRS. MORGAN: When does the holiday for Washington's Birthday fall on?

DR. PAHL: The eighteenth.

Did someone want to suggest? Do you like the 12th and 13th?

MRS. MORGAN: Fine with me.

MRS. MARS: That's all right.

DR. PAHL: The 12th and 13th of February.

I think we have probably tired you out. We have never had such quick consensus on Council dates.

DR. ROTH: You have finally reached a matter of concern on which I have no opinion.

(Laughter)

DR. PAHL: Let's try one more. See how our batting is.

MRS. MORGAN: We might as well try for the 12th and 13th of March.

DR. PAHL: We are missing the exact Ides of March, if we select the 12th and 13th -- does that sound reasonable?

MRS. MARS: That's all right.

DR. PAHL: Teusday and Wednesday, 12th and 13th.

All right, the dates we have scheduled, then, are January 15th and 16th, February 12th and 13th, and March 12th and 13th.

I am certain we won't have to meet on each of those occasions and we certainly will take into account your schedules and our workloads, both, and we will try to arrange matters so that we meet when we have really something we can accomplish and hopefully those dates will come close to the decisions onwhich we will have to act.

Now, I would like to turn to a presentation by Mr. Gardell some matters which must come to your attention relative to the management of our affairs, and I ask that you listen closely because we are going to ask you to accept certain revisions of existing policy which, again, we believe to be in the best interests of the RMP's and the good management of the program.

Jerry, will you please make the presentation.

Mrs. Handel, will you please hand out the materials to Council.

Please don't read these as they are handed to you, but listen to Mr. Gardell, if you will, and he will call to your

attention what the important features are.

MR.GARDELL: Anybody can make this presentation, but I just happen to be the one who was involved in part of the writeup of it, so if you will bear with me, I will try to go through it.

I think that what we are proposing to do here is kind of a companion piece to the resolutions that you discussed this morning, and the situation as it presently exists as far as the support of the RMP's is concerned.

We have been running, as you well know, with some of our grant awards in excess of two years of support in one budget period.

We have in a sense disregarded the budget as submitted originally, because of the phaseout activities we have had to go through. Then we have reinstituted the program because of the extension of the legislation for one year, and we feel that in all of this, plus the development of our allocation mode which we have developed for ease of getting the funds out there as quickly as possible, the termination of the review committee, the lack of a review of applications as we previously did on an anniversary basis. The fact that we have only one year of support instead of three or five years of legislative support, which means that we are looking at our applications on a one-year basis instead of three years.

What I am really leading up to is the fact that it

turns out that we really haven't been applying all of the process involved in triennium versus the anniversary or nontriennium applications, and therefore we felt along with the responsibilities that the Director has through the policies established by the Council, that we should be considering all of our regions at this point in time on the same basis for the remainder of the period of our support, whatever that might be. Whether it be through June 30th or 12/31 -- apparently at the moment we are talking about 12/31/74.

So what we propose to do is take what is passed out now, revise it slightly, have those common items.

I think this is probably the best thing to do at this particular time, because many of the items which we previously distinguished between the two sets of ratings or categories we are no longer applying.

Secondly, or I should say there are several other considerations, and that is that the triennial review responsibility has been watered down for we are no longer applying the rating system, we no longer have a review committee as I mentioned, and to some extent the responsibilities under the triennial have been watered down as I mentioned also. So in view of all of this, we felt if you take a look at this white document, I think we have pretty well explained in the second paragraph what is intended to do here.

We would like to supersede number 17S, which is the

green -- and we gave it to you, here you are -- you have got the governing principles as they were changed on the front and the covering document is in back, and explains what we propose to do.

It is intended to clarify further the authority of individual RMP's under the decentralized method of operation instituted by RMPS sometime ago, particularly in view of recent changes to available funds and periods of grant support.

Two policies relating to decentralized operation have been issued already. These are the RMPS review process requirements and standards, which specify the standards to which the local RMP review process must conform, and the review responsibilities under the triennial review system which among other things delineates the scope of the Council approval.

The attached policy modifies the application of the policy contained in the triennial document and outlines conditions under which RMPS approval of local RMP funding decisions is or is not required.

This was, as we say in our next paragraph, this is assuming that we do get your acceptance. If we do, then we will follow the process required to get a change made to this NID.

We feel this would be most appropriate to continue applying our allocation mode for the rest of the year, whether it be $41,236 or $76 million out of $81.9 million.

We ought to be able to proceed in this fashion, and

certainly advising the Council as we go along, since we are setting up tentative meetings. So all of this can be brought to your attention.

But we don't think in view of the fact we have ceased applying some of our processes, that we should continue to distinguish between an anniversary and a triennial application.

I think it was also pointed out to you this morning by Dr. Pahl that we intend to make certain that those who have not been certified in the review process or who still havemanagement problems in the eyes of RMPS will be corrected to the best of our abilities between now and sometime in March. This is basically what it does.

Now, really the only change in here is in section 3 of the NID, and it really takes what was basically the triennial areas of responsibility and makes it applicable to all of the RMP's, assuming there are no conditions placed on the awards by us.

By us, I mean the body here.

DR. PAHL: Thank you, Jerry.

We apologize for handing you so much material you haven't had a chance to see. We hope that because you have been involved in these policies earlier, that they won't be completely new to you. However, it is not essential that you take action this minute and we are having an open session

tomorrow morning and I would suggest, Jerry, that what we do is, again, indicate to you the essential feature of this revised statement and then ask for action tomorrow morning after you have had a chance to review them and see whether in fact you endorse this.

In summary, we are abolishing the line between triennial and anniversary type regions because in fact it makes no sense any more with the kind of policies and procedures which we have had to engage in over the preceding months and which we are still engaged in, and what we will do is focus our energy on providing technical assistance in certifying that the local review process is approved at the national level and also management assessment visits to give that type of assistance also to the regions. So we see no reason, just as we have abolished the A,B,C rating system and the actual criteria, and so forth, we feel that it is artificial to continue to have this triennial and anniversary status.

We are treating all 53 regions alike in many respects, but we are trying to work with each of the 53 on an individual basis to the extent that our staff permits.

So you may either decide to take action now and merely accept this amendment to the existing policy, or if you care, look at these materials and tomorrow morning take action.

MRS. MARS: I don't see any reason we can't take action right now.

The only thing that we might put in there would be some statement of fact that this could be reverted back to a triennial and anniversary status if RMP is to be continued in the future, or something to that effect.

DR. PAHL: We might incorporate that in the transmittal letter.

MRS. MARS: Right.

DR. PAHL: That would be our interest and intention certainly.

MRS. MARS: Otherwise I move it be accepted.

MRS. MORGAN: On number 2 here, research or other activity involving the use of human subjects, that is a pretty broad statement there.

MR. GARDELL: That is Public Health Service policy.

DR. PAHL: That involves a little bit of everything as you know.

(Laughter)

Dr. Hiroto.

DR. HIROTO: Second.

DR. PAHL: It has been moved and seconded to accept the proposed statement.

Is there any further discussion by Council?

If not, all in favor say "aye."

(Chorus of "ayes.")

DR. PAHL: All opposed?

(No response)

DR. PAHL: It has been approved by Council.

MRS. MARS: Don't forget to put something in.

MR. GARDELL: Transmittal.

DR. PAHL: Yes, there will be a statement in the letter or transmittal memorandum relative to the future interest of the program in reestablishing that distinction.

MRS. MARS: Right.

DR. PAHL: Thank you very much, Jerry.

Again, as a small matter, item of business, let me call to your attention in the agenda folder, on the back cover, we have the minutes from the last meeting, and I would hope that perhaps between now and tomorrow morning there would be an opportunity for you to see if there is anything you wish to alter or modify, delete or add, and we will take action at that time on the minutes.

I would like now to move to our presentation by Mr. Peterson, who has been charged with the responsibility of trying to present to you in very brief fashion a current status and overview of the RMP's. And following this presentation, we will then open the meeting to discussion or comments by non-Council members, and specifically I know there are one or two individuals who do wish to address the Council and make a statement.

So with that, Pete, would you please-- there is a handout you have?

MR. PETERSON: Yes. Ken is handing it out.

Bland reminded me, brevity is like being the principal character in the last act of a [illegible]-play. The audience has been sitting there for six hours, they have gone out for lunch, but most westerners wish they would get on with it and get over with it.

What we have are some data that I hope might provide some insight and feeling as to the current status of the RMP's, their viability, to use that much overused word, and stability. Some of these are summarized in the handout and I will try and briefly, Bland, summarize that.

Before I do so, though, let me make a couple of caveats.

Obviously what we have given you here is selective and limited. In part it is compromise of what was readily available and comparable, what could be easily compiled and counted. And I am always aware that what you can count is not always the most significant thing in a situation.

So that attitudes, outlooks, morale, which are not readily susceptible to quantification, are not spoken to.

Similarly, the figures especially to the extent they are overall figures, totals, averages, et cetera, are likely or in some cases may be misleading. I think you will get a little better feel of that as you get into the individual applications. Indeed, there are striking variations among

regions.

The data itself is essentially as it has been reported to us in the RMP's, either in current applications which you have before you or in prior applications, which was incorporated into our own management information system. And I would also note there may indeed be some small discrepancies or errors in the data as a result of last minute changes.

I came in on Monday morning, having taken Friday off, to find some of the data I had looked at late Wednesday afternoon had had some minor changes in it. I can only apologize for that.

One, with respect to the RMP coordinators, I think this group, most people who have had anything to do with RMP over time recognize that they have been an all-important and critical element in RMP.

As of this point in time, we have 35 coordinators who are the same people that were there over a year ago. Most of these are longtimers. So that roughly two-thirds of the coordinators are the same who have been associated with their individual region for many years.

There are 18 new coordinators, some of them new since a year ago, some more recently. There has been a fairly significant turnover since July, about ten coordinators followed through on plans and did indeed leave. So that there are new coordinators in 18 regions from a year ago, three or four

coordinators are still on an acting basis, that is indicated in the attachment A. Five are now part-time people and again that is indicated. The extent of the time which they are spending with the program.

As far as the program staffs themselves are concerned, and this again I think has been another important strength of the RMP and basis for much of their effectiveness and activity, we do see if one looks at attachment A-1, that from a level of roughly 1500 full-time equivalents in the 56 RMP program staffs of a year ago, there was a noticeable drop beginning in the middle of this year with the announced-- well, before the middle of this year, but with the announced phaseout of the program and then the actual approval of phaseout plans, a drop of about 50 percent. We probably -- or the region probably reached the lowest strength sometime in August and September. But even now, we are talking about something like 700-plus people actually onboard in the 53 regions. Based on the application submissions we have in hand, however, suggestions there will be some additions to those staffs and probably reaching 900 or I know some of the data the coordinators have given me, perhaps as many as 1,000. So there would be some recouping by early next year.

The size of core staffs, as I said, have been about half, and that is reflected in the average, average to 14.

More important, I think the range of staff has been

considerably reduced and compressed. Whereas, in about a year ago there were only three regions with 10-1/2 program staffs, there are now 26. And whereas a year ago there were something like 26 regions that had over 25 program staff, that is down to about 5 now. And there are none now, not even California in excess of 50 program staff.

I have included on that table A-1, I won't take up any time of yours with the recitation, a breakdown of the professional staff by one, the functional areas in which they are operating such as program development, research evaluation, planning, and also by their discipline or professional background, physicians, nurses, and the like.

I have also included, because you may want to utilize it in your other activities as a B-2 attachment, listing by region of the staff as reported to us on board now, broken down by professional and clerical, and what they anticipate in the way of additional people.

Another area of activity which we tried to take a quick look at feeling it may possibly be one indicator of continued interest and support of those individual providers and the others, and the groups and organizations they represent in the program, relates to the activity of RMP advisory review and other committees during the past year and some of that data is summarized briefly again in attachment C, handed out to you.

I think it is perhaps significant that we find that

of the 600 committees, other than RAGs themselves, only 10 percent have become dormant in the last year. That is, they haven't met at least once. The remaining have had an average of four meetings.

We find certain kinds of committees, such as executive committees, most regions have such, have been far more active. An average of six meetings during the year of those committees.

In addition, we find that the technical review committees and panels, there seems to have been considerable activity on their part as well during the past year.

I can't isolate that all in terms of the last two months versus six months ago. But it does suggest that not only in terms of coordinators and program staff, but that considerable assemblage of individuals who are contributing to the program on a voluntary basis, many important and influential people, that there is still a high level of activity reflected by those people.

The last two items I briefly want to touch upon relate more to the proposed activities as reflected in the applications, attachment D provides an overview, an overview of how the current applications, the 53 you will be considering, break down in the option areas that were indicated earlier inthe meeting.

One sees that strengthening local planning does

account for a large, the largest single part of the money, with quality assurance, EMS activity, accounting for 50 percent of the activity.

Smaller amounts, percentages at least have been proposed for programming in kidney and hypertension with some additional, there are certain multicategorical activities.

I do think, in view of the discussion this morning, that perhaps it would not be inappropriate to make an aside or two. I think the RMP's as well as the RMPS staff over the years, as Russ Roth and others described it, have been subject over the years to a certain amount of drift with respect to what it was we were up to. I think everyone has become sensitive to and perhaps adept at fitting things into the guidelines which are momentarily in vogue.

I don't say that in a dishonest nature, because I think something such as quality assurance -- there are any number of activities which could just as well have been labeled cancer or heart, but since that is the way they want things categorized this time, they appear that way.

Similarly, strengthening local planning activities, I was part of the very -- very much of a draftsman as opposed to decision maker although as Harold pointed out, there are no longer decisions being made, only understandings reached, in workingon the option area six months ago, you know. We somehow found room based on a dependent prepositional clause

for something called a HAPS.

I would not be surprised to find a great deal of RMP manpower activities interpreted and squeezed into strengthening local assurance or local planning efforts.

I simply say that because I think labels can be misleading and people who have to work -- people who have to work with labels, whether John Sparkman or myself, you know, we make do with what we can in terms of those labels, and I think it is important that the Council as it looks at individual applications, that it recognizes that.

The other attachment that is included was simply intended to give you some idea of the kind of active working relationships that RMP still has with other agencies, groups, and organizations, and this is done essentially in terms of who is going to be sponsoring or conducting the activity that they proposed.

Now, it is true, as you have a chance to look later at E, we have included more than operational projects. We have included where possible, where they were separately identifiable, discreet planning or feasibility studies; that almost a third of the activities proposed, at least in terms of the total number as opposed to dollar value would be undertaken by staff. But if one excludes those kinds of activities, we find that many of the same factors have been involved in RMP from a working point of view are still there. The medical

schools and centers are still the single largest group of projects sponsors.

I think, although I didn't have a chance to make such comparisons, that more activity is proposed to be carried out by CHP agencies this time than it perhaps has been in the past, something a little less than 10 percent.

But here again, I think one does see a working within a set of options, guidelines, call them what you like. If there are any questions, I would try to answer them, but I feel I have already violated Bland's excellent admonition, brevity.

DR. PAHL: Mr. Ogden.

MR. OGDEN: One request, your collator seems to have given, at least to me and I notice Sewell Milliken, duplicate of A-2 instead of B-2. I suggest perhaps they could be picked up and corrected.

MR. PETERSON: I will try to rectify that before the day --

MR. OGDEN: I think probably they are allseparated and have the same problem.

DR. PAHL: Thank you, Pete.

Are there any other comments on this presentation and analysis?

All right, if not, thank you again, Pete.

At this point in the meeting, we would like to have

members of the public make any presentations that they care to. And in so doing, I would ask each person identify himself and the organization he represents.

We have a microphone at the other end of the table and we would ask you to please use this.

Before identifying, since I know Dr. Sparkman wishes to make a statement and we would like to have him do so in just a moment, I would like to indicate that one of Dr. Sparkman's duties is to serve as chairman of the Steering Committee of the Coordinators, and he took over the reins following the resignation of Dr. Paul Duchene, this being a very real and significant loss for all of us. I believe Dr. Sparkman would like to speak to you in several capacities, but I will let him speak for himself, and then I will be very glad to identify anyone else, or call upon anyone else who may wish to make a public statement.

Dr. Sparkman.

DR. SPARKMAN: Thank you.

I appreciate the opportunity to meet with you here to represent the coordinators and I have thoroughly enjoyed the meeting. I have a couple of comments I could make about that.

I would flesh out some of the numbers Pete gave you by saying from my personal observation among my coordinators who met last time on a national basis mid-October, that there is I think a surprising degree of optimism among them, and I

find the same thing, my contact,as I can have it, and completely relative to regional advisory groups, the attitude of constituencies of RMP staffs and programs.

Overall I am favorably impressed, I am sure some of the programs may have problems, I know that you all have your own applications which you are going to be reviewing -- I would point out that these applications were put together in relatively short term with short staff and addressed to five new options, options which at that time we regarded pretty much as restrictions, not just as guidelines. And this provided some difficulties.

I am confident that given a reasonable degree of funding, with removal of restrictions that RMP's will again around the country prove to be effective programs.

Relative to my meeting with you, I would like to make clear to you that my fellow coordinators look to the National Advisory Council as a vital part of the program. I think you know that, but I want to make it clear that you understand that.

They see you as making important policy recommendations and approving projects and in other ways helping to guide the program.

They are grateful for your leadership and they, like I, am concerned that your numbers have diminished and that the Secretary has not taken the time or whatever it is to replace

them.

All of the regions have submitted candidates to Dr. Pahl for new members on your Council. I note from the Washington-Alaska Regions we have submitted three excellent candidates.

I see no reason for the delay in making appointments to fill out the members of your group, particularly now that you will be losing five more.

It is obvious that whatever strength and performance RMP has had in the last six years is due in no large part to the leadership you people have provided.

I was struck this morning by the disparity in the views that some of you have relative to what we should be doing. I don't think this is necessarily bad. But I am conscious of the fact also that since the Administration recommended phasing out RMP, you have not had much opportunity to meet and you have thought that perhaps the program was dead.

Nevertheless, it seems to me that it should be recalled to you that in your meeting of May 1971, you approved a mission statement which had been carefully prepared by RMPS in collaboration with a lot of people, and I consider that a good statement which modified somewhat the earlier mission of RMP, in that it dealt with availability, accessibility and quality. But it also I think subsumed the categorical activity some of you indicated you felt still to be important.

I think it seems to me that this group, at some point, should have opportunity to review that as well as a direction statement paper which the coordinators, in a task force, prepared within the last two months, in order we get to the Congress and Administration our views as to what we think RMPS.

I don't know, Herb, whether the direction statement which we prepared was submitted to the National Advisory Council, but I think it should be.

DR. PAHL: No, we have not.

DR. SPARKMAN: It seems to me, here we are as coordinator, very much concerned, working hard to develop what we think is the role of RMP. You are separately doing this, RMP staff, Administration, Dr. van Hoek, and others also doing this.

I would welcome the opportunity of having some of the coordinators express to you, for example, what they see is the way RMP ought to go and get your response to this.

It seems to me this would be very important. And I am struck with the fact so far we have very little of this communication.

At this point when legislation is in the mill, in Congress, and at which time the Administration is also in the process of developing such new programs, I was pleased with what I think I heard this morning; namely, that the

restrictive language relative to the options is to be removed and that these are simply options, not restrictions.

I hope that your Council will go on record as making this clear. I would like to hear it a little clearer than I heard it I guess from Dr. Endicott this morning.

I would also like to hear it clear and on the record the fact that programs may be extended beyond June 30th as far as RMP spending is concerned.

I don't know whether is presumptious of me, but it seems to me Council ought to go on record to this effect if you think it is appropriate.

The coordinators look to you for this kind of action and lacking it, they are disturbed.

The matter of the release of impounded funds, I would like Dr. Reinschmidt to speak very briefly to the National Association of RMP, just to tell you where it stands.

The task force of coordinators in recent past has also developed a statement of different kinds of alternative organization arrangements under which RMP might continue if in fact it is to be merged with CHP and with Hill-Burton. After considerable discussion we agreed this should not be distributed, but should be held pending the appearance of some legislation at which time we hope to be in a position to respond to that.

I think many of you know we happen to have several

coordinators particularly close to the legislative scene and valued enough by the legislators that they are called for consultation and advice as to development of legislation, which I think is very, very good.

Since we had some question that RMPS was going to be able to develop the ongoing kind of information about RMP perhaps, at our last meeting and after development of a program by task force, we will be in a position to provide on-going information under what is called a public accountability system as to the numbers of people who have been benefitted by RMP, and number of people that will have been trained.

I think I will tie it up with that, just indicate again my appreciate for the opportunity of meeting with you and if there are questions that I can answer, I will be happy to.

If you ever thought about the coordinators and the way the programs are going on, I would be happy to hear these and carry them back to my coordinator colleagues.

DR. PAHL: Thank you very much, Dr. Sparkman.

Are there questions or comments by Council?

We will make available to the Council any of those materials which the coordinators would like to -- we in a sense were observing your confidentiality, not knowing fully the purposes for which you were developing it. So we have no problem in directing these materials more widely perhaps we should have distributed them more widely. Apology is in order. We

will make them available.

DR. CANNON: I think someone should say Council has been aware of the difficulties brought upon the coordinators in continual shift of emphasis, and we recognize you as a bunch of Mexican jumping beans which have successfully jumped in the right direction most of the time.

DR. SPARKMAN: Thank you, Dr. Cannon.

DR. PAHL: Dr. Merrill.

DR. MERRILL: Would it be appropriate for Council to act on Dr. Sparkman's suggestion, that we view these categories as options, not restrictions, officially?

DR. PAHL: Yes, indeed, it would be most appropriate.

DR. MERRILL: I so move.

MRS. MORGAN: Second.

DR. PAHL: It has been moved and seconded to accept the options and priorities as being that and not restrictions which they have heretofore been.

Is there further discussion?

If not, all in favor please say "aye."

(Chorus of "ayes.")

DR. PAHL: Opposed?

(No response.)

DR. PAHL: It is accepted.

Dr. Reinschmidt, I know, wished to make a statement.

Chuck, would you please identify yourself.

DR. REINSCHMIDT: I am Chuck Reinschmidt, of the Coordinators Medical Program.

I really didn't wish to make a statement. I am strictly pinch-hitting.

(Laughter)

I'm pinch-hitting for Dr. Ingall.

I think it is most unfortunate he is not here with you today, because he is the president of the National Association of RMP's and is certainly well aware than I of most of the activities going on.

However, for your information, the National Association of Regional Medical Programs is a nonprofit corporation formed to provide and to promote information and education about the purposes of regional medical programs. Membership is open to interested individuals.

This organization should be able to promote the purposes of RMP by means which might not otherwise be appropriate or possible.

Ithink you are all aware of certain recent events that this would apply to.

(Laughter)

I think this has been mentioned earlier today about some of the action that is going on in the courts at the moment. This action has been brought with the request that it be a class action by two of the regional medical programs and the National

Association of RMP.

I am not sure that I can answer any questions, but Dr. Sparkman and I will try if you have any.

DR. SPARKMAN: May I make one more comment?

DR. PAHL: Yes.

DR. SPARKMAN: The coordinators recognize Dr. Pahl has had a most difficult if not impossible task during this time. Dr. Cannon mentioned our problems. I think his have been even worse. And they took the opportunity at our meeting in Chicago in mid-October to express unanimously their approval and support of his leadership, and of the help of his staff, which has dwindled but has been very effective in helping us.

DR. PAHL: Thank you.

Mrs. M rs.

MRS. MARS: One thing I have been dying to ask, who is paying for this lawsuit the coordinators are bringing?

DR. PAHL: Dr. Reinschmidt.

DR. REINSCHMIDT: This is a nonprofit corporation and contributions and membership which is open to anyone who cares to make such forms of support.

MRS. MARS: Is each coordinator paying into it then out of his own funds?

DR. REINSCHMIDT: Anybody. Otu of any personal funds. Anybody who would like to donate.

It is not restricted to program coordinators or

anyone else. Any member of the public who so wished. Also there are the two programs which themselves have entered into this action.

DR. PAHL: I would like to note for the record I haven't contributed any.

(Laughter)

Is there further discussion by Council?

Dr. Watkins.

DR. WATKINS: I would like to note, with your strong powerful input, what massive approach have you made to the press, not now but over the years?

This might seem like hindsight, but I just wonder how much have you really put into it in terms of publicity? To let people know-- consumers, not providers -- doctors know, I don't even know if they do, but consumers don't know.

DR. SPARKMAN: We have all talked about our low profile. I am sure that our programs are effective, if we do them under low profile without making much of a fuss about the fact RMP is doing it.

When one has to work with three or four different organizations and get them to work together, it works much more effectively if you do this, you know. You hope it will work and if it does, fine, and if it does, they may not be very grateful it has happened.

Nevertheless, your point is a good one. You can

carry on effective programs this way, but when it comes to the end of the year and Congress looks at what you are doing, until you have made some visibility, the word Dr. Roth used repeatedly, you know, you are apt not to be continued.

I think we have done reasonably well as far as public information.

I have had mixed feelings about it, trying not to overdo it, but calling attention in our local newspapers and other places to things that we think are of benefit to a particular community.

I don't know, maybe some of the rest of you have used the fact it hasn't been adequate or perhaps it has been overdone.

DR. WATKINS: The reason I have asked, some of the Congressmen I have approached are not even aware of the exciting programs youhave had. I wonder if you have done a good enough job on that end of it?

You might be too conservative, that is what I am really saying.

DR. SPARKMAN: I think probably you are right.

Did this pass critical nine months -- I think we have done a little better.

I think Board members or others have often been in contact with Congressmen. I must say I have been pleased simply to tell them what we are doing, find their interests,

and indicate that they are approving and supportive of what goes on.

DR. WATKINS: Thank you.

DR. PAHL: Are there other points in connection with Dr. Sparkman or Dr. Reinschmidt's statement?

DR. FOYE: Would it be helpful if the Council went on record as strongly endorsing the position, tentative position, that grant awards or that awards are for a 12-month period starting in January, ending in December?

MR. OGDEN: Wasn't that done in the last--

MRS. MARS: Yes, I think so.

DR. PAHL: I think we have the sense of the Council in the discussion this morning and we do appreicate that support.

We invite other members of the public or anyone present to make comments or add to some of the discussion that was held earlier.

DR. SPARKMAN: As I look at the action of your last Council, I am not sure it was done.

Council in discussing the proposal endorsed the actions taken by RMPS during the phaseout period and recommended use of funds during the full year.

That doesn't seem to me the same thing that the doctor just recommended or I think is important beyond June 30th.

I personally think it would be very helpful if that were on the record.

DR. PAHL: Perhaps I misinterpreted.

I felt the sense of the discussion this morning constituted endorsement by the Council. Perhaps it would be well to have it explicitly stated if in fact you would like to make a formal resolution relative to the continuation of RMP's through December 31, 1974, as discussed by Dr. Endicott and Dr. Margulies.

DR. SPARKMAN: I believe this was referring to the time til June 30, 1974.

DR. PAHL: That was at the July meeting.

Dr. Foye has moved.

DR. WATKINS: Second.

DR. PAHL: And Dr. Watkins seconded, the discussion of this morning, which would endorse the Department's present position that the RMP's be permitted to expend funds through December 31, 1974.

Is there further discussion?

If not, all in favor say "aye."

(Chorus of "ayes.")

DR. PAHL: Opposed?

(No response.)

DR. PAHL: The "ayes" have it.

Well, I think this comes at a very appropriate

time, because it is three o'clock, and I understand there is a little bit of coffee left. I ask perhaps Council members be given the privilege since they are bearing through this. And we will have, let us say, a ten-minute break for coffee, and then we will reconvene in executive session to start the consideration of specific grant applications.

So I ask at this time that all those who are not specifically involved with the grant applications please leave, and the open session will reconvene tomorrow morning at nine o'clock.

(Whereupon, at 3:10 o'clock, p.m., the Council went into executive session, to reconvene in open session at 9:00 o'clock, a.m., Tuesday, November 27, 1973.)

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