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classification and expansion or modification of facilities in an integrated fashion; components for organization and management of the system, for evaluation of the system, and then for expansion.

It is really a very complete package that this first project 42 presents.

Some comments about the individual components of the package: First, the organization, Dr. Dimick, a consultant for this review group, is project director. It is obvious that he has provided the very great impetus for the development of the entire program in Alabama.

Planning for the entire program is in three phases. First, there is a demonstration area in the Birmingham area, and then coordination of five contiguous cities, and then the rest of Jefferson County, and then finally the CHP B agency area. That encompasses this county area and further.

The component of consumer education has the usual methods of consumer education and public information plus the innovation of being the first state I think to incorporate into their school system courses on first aid as part of their secondary school education, I think.

They hope to hire a full-time public information specialist. They have a large increase in personnel for the Alabama regional medical program, and we will go into that when I discuss budget in just a minute.

Training, they hope to have seven rescue units in this first small area, training enough elements to staff them, and have a coordinative training program in the area.

They have become very much interested in mobile primary care units, and give some interesting but usual statistics on the number of deaths from coronary disease prior to getting to the hospital, the length of time it takes to get to the hospital, the fact that emergency equipment like the local fire department 90 percent of those emergency vehicles reach the victim -- they use the term "victim" in this circumstance, rather than "patient" -- in less than three minutes.

So, they want to move their entire mobile coronary care units in the direction of having them instantly available, staffed with good communications with physician monitors.

They hope to provide eight mobile units with EMTs and equipment for them, as well as monitoring stations that are portable, with physicians monitoring them.

DR. SCHERLIS: Is this telemetered monitoring?

DR. BESSON: What do you mean by this? Two-way communication?

DR. SCHERLIS: The physician will not be on the vehicle?

DR. BESSON: What are the dedicated vehicles?

DR. SCHERLIS: Purely for coronary care.

DR. BESSON: Yes.

DR. SCHERLIS: Purely for coronary care?

DR. BESSON: No, they are emergency rescue vehicles, but they are called coronary care unit vehicles and I suppose they are equipped for more than coronary care but I can't really answer your question.

DR. SCHERLIS: This is a critical question, at least in my mind.

DR. BESSON: They are equipped for it. I don't know.

DR. SCHERLIS: Maybe I can dig that up.

DR. BESSON: I get the impression that -- they are called coronary care unit vehicles but I think they are equipped for that plus other emergencies.

They go into great detail giving plans for hospital coordination, for management, for intercommunity relations, for legislation, for description of existing systems, the accomplishments in the past, and go on for 247 pages of what is really a very well thought out program and for which Dr. Dimick certainly deserves high grades.

Let's talk about budget information a moment. The components of the budget which come to a total -- project 46, this first project -- 1.2 million for the first, 1.0 for the second year,139 for the third year, and a total of 2.2 million for the three years are made up of central operations.

I won't go into too much detail, but central

operations requests 394,000, of which the bulk, 128,000, is made up of salaries for project director, executive officers, administrative officers, and so forth.

And operations center equipment, equipment for coronary care, 54,000. Consultant fees, 87,000.

The component of public information is going to be subcontracted. It just said subcontracted to a consultant firm experienced in the field. They don't go any further than that except to say that that amounts to $107,000.

Emergency medical training will be the Dunlop 18-hour course with three programs, 20 students each.

Mobile CCU will have monitors and two medical residents, if you please, as riders on the mobile CCU vans, hoping to give EMTs training right on the spot, as well as providing medical care.

The $30,000 that they have programmed for two second-year residents as monitors, two second-year residents as riders on these things, I have some question about that. I am not sure that this is the question raised here on our funding sheet, tuition charges should be disallowed for project 46. So, whether that refers to another one, I don't know.

They speak of career ladders moving there. People up in the junior college system from EMTs to higher things, and thereby they hope to pay some junior college salaries, which I have some questions about. But if it is okay with staff, I

guess it is okay with me.

They have a program for rescue training which I think is all right, communications. They have some 80,000 -- purchase and maintain system over a three-year period, that is going to come to approximately 80,000.

Transportation, they want to buy eight ambulances for 112,000, and pay 48 EMTs, 75 percent of their salary while they were on a training basis and the ambulance people, will pay 20 percent of their salary, and that comes to a total of $82,000.

So that while this is an extremely ambitious program, it is very comprehensive, and it is very ambitious fiscally.

I would grade the program as a 4.5 or a 5. I think it is a very comprehensive program. I will defer making a decision on numbers unless you force me to.

DR. SCHERLIS: I won't force you to do anything. We will need numbers --

DR. BESSON: Do I need a secondary reviewer on that?

DR. SCHERLIS: Let's have a secondary reviewer of that project, if we might, Dr. Roth. Do you have any comments?

DR. ROTH: No, I have nothing to add. I have to admit that I did not have these with me. I had 80 pounds of these things the day before I left to go to the west coast and back to Georgia, and then to Texas, and then here and I just couldn't carry them.

DR. SCHERLIS: There are certain questions maybe

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you can clarify. We'll get to that, I guess.

DR. BESSON: We can take them up separately.

DR. SCHERLIS: What is your funding recommendation on this, then?

DR. BESSON: You want a funding recommendation? I will bring that up in context of the project 43.

DR. SCHERLIS: Fine, however, you prefer doing that.

DR. BESSON: Project 43 is an entirely different kettle of fish and it is a very elusive proposal. I spent several hours before I got the drift of it and I may not have it right yet. It apparently begins historically with a 1964 State Department of Health medical self-help training course which tried to improve training of individuals and also set up an ambulance training program. And then 1967, Birmingham developed an EMS committee which was chaired by Dimick. 1968, the State Health Department did a survey of EMS and recommended some legislation regarding ambulances. In 1970, apparently the Regional Medical Program discovered Dimick, following a study of cardiac resuscitation efforts by the University hospital that Allen became involved in. They became involved then, ARMP, in a study of cardiac deaths, and that lead to very deep involvement in EMS. They set up councils in other areas and began to coordinate various EMS activities.

Along came the Health Department in 1971 again that influenced the passage of an act which created the authority for the Department of Public Health to develop standards for

ambulances. They said, well, if we have to develop standards for ambulances we'd better get some advisory committees so they appointed a statewide advisory committee which was also chaired by Dimick, and his impetus then led them to move from the development of ambulance regulations and standards as authority for this act to the establishment of an interest on a statewide basis in training programs, communications, transportation, and equipment.

Now, this program, then, is to enable the State Department of Public Health, via this extended authority, which they really don't have, but nonetheless it is good that they are involved, to contract out these various aspects of their interest, a training program at 104,000, the development of a demonstration area at 125,000, to provide what they call a contingency fund for the development of local EMS councils, to provide training of emergency vehciles, to provide communications and evaluation systems.

Now, that is the meat of the program but there are a lot of fuzzy edges to it and if I were to read from the proposal summary, the proposal summary in our project says, "To create through planning, training and development the regulations and standards a solid foundation upon which to build an effective, statewide EMS. To continue planning and training activities, supplemented by acquisition or necessary equipment and material needed for effective operation of the

EMS."

And they say that will be accomplished by staffing the Department of Public Health, beefing it up for creating their division of EMS. They are developing some kind of statewide plan which they are not very explicit about to draft regulations which will implement this statewide act for ambulance standards, to train the general public in medical self-help, and American Red Cross, to extend the EMT training of the 81 Dunlop programs throughout the state, hopefully, and to contract with hospitals to develop courses for their emergency room personnel, to inform the public by creating what they call road shows, to coordinate various agencies involved in EMS, and to develop a demonstration area which will produce full scale EMS.

Now, this effort is, in their words, to complement the previous project, 42. I think their budgeting program is very loose and totally unseparable, as far as I am concerned. I am particularly concerned about their $250,000 slush fund which they say they will use for very worthy purposes. They have very loose contract statements for the subcontracting they are going to do for all of these component parts. I am not sure, although I asked Dr. Margulies the question about our authority to fund public agencies, and he said it was perfectly all right if it was an essential part of the system. I am not so sure this isn't a bottomless pit to begin funding

state health departments for things that are rightly theirs.

So while we have two programs that are said to be complementary, that I would be much more inclined to look to program No. 42 as being the nucleus for a statewide program, fund generously, and then let it spread.

However, the area, statewide area, has had such a momentum that I would at the same time hate to discourage it by not providing some funds for 43. So I would compromise by providing some funds for Project 43, the statewide program, as follows.

DR. SCHERLIS: Is 43 the same at 46?

DR. BESSON: 47.

DR. HINMAN: That is the same as 47.

DR. SCHERLIS: 46 is the same as 42.

DR. HINMAN: Right.

DR. BESSON: Right.

DR. SCHERLIS: 46 is 42 and 47 is 43.

DR. BESSON: Right. They request 640,000 for the year 1. I would eliminate most of the salaries, eliminate the money for the demonstration project which I think is going to take place in Birmingham anyhow, eliminate that 250,000 for contingency. I would recommend funding them at a level of 150,000, providing they give us sharper budgetary figures for the EMT costs and sharper figures for how they mean to develop local councils, sharper figures for the public education

program and an indication of how the EMT program is going to be cost-shared with the institutions and the ambulance services that are going to use these people.

DR. SCHERLIS: Before you go into the figures, could I ask Dr. Rose, have you had some contact with the Alabama group?

DR. ROSE: Yes.

DR. SCHERLIS: Could you answer a question I had before, is this dedicated for pure coronary care?

DR. ROSE: They do carry other equipment on the vehicle but it is specifically set up for such things as --

DR. SCHERLIS: If somebody calls and they have chest pains, that ambulance goes out.

DR. BESSON: Yes.

DR. SCHERLIS: Suppose somebody else has call, the vehicle does not go out for that?

DR. BESSON: It does go out.

DR. SCHERLIS: If is is coronary care --

DR. GIBBLE: It is also carrying a medical resident, so it sounds like it is dedicated.

DR. ROSE: It can go out in times of disaster, a large number of emergencies, but generally it would not be used for purposes other than suspected coronary patients.

DR. SCHERLIS: How many are they planning, how many vehicles?

DR. BESSON: Eight.

DR. SCHERLIS: Is there any justification for that number of vehicles and the staff necessary for all those vehicles, any justification that they need and will have enough calls to make that item that can be justified in terms of costs? Most communities have moved away from this, the concept of a dedicated vehicle. That was an excellent concept at the time when there were materials being collated on a research basis but at this time most thinking is in terms of upgrading training to other people, not to have the physicians on board. It was very expensive to have this expensive a vehicle devoted purely to coronary care. I would be very much in favor of eliminating what fraction of this appears to be related to that. I think they have eight Holter Avionics tape recorders present at the cost of $10,000. I think that is guilding it a bit.

There is enough information now from the supporting units to give us the information necessary, Dr. Nagle's group, Dr. Warren's group, the Vincent group. You can go on and on. There is plenty of information.

DR. BESSON: They are using this in an operational fashion, rather than a research fashion. I agree, having monitors on these vehicles -- eight ambulances for 112,000, I don't know. I would be willing to cut that down. I don't know how big Birmingham is and I don't remember the

justification for that number, how they picked out that number. I think we can make an arbitrary cut of this whole program, I think, at 3.2 million, although it is an excellent program, that is far too much.

DR. SCHERLIS: The nearest of eight mobile and coronary care --

DR. BESSON: The sequence of events that leads to the justification of this is that three minute time they go to great length to point out is the time that fire departments can get to a person, and they figure the number of lives that they can save if they can match that kind of distance. Whether it is cost effective or not, I have my doubt.

DR. GIMBLE: That points out the basic flaw. Let's use the ambulance system performing well already. Why build eight special ambulances? Why mimic it when you can use what you have? I think that is the basic flaw of the proposal.

DR. SCHERLIS: Let the record show that I agree with Dr. Gimble.

DR. BESSON: I would make a condition for the award, then, to delete the mobile CCUs, therefore, perhaps, deleting a significant portion of the costs of the monitors and riders and a portion of the EMT practical training.

DR. SCHERLIS: My concern is that this really casts some doubt on the entire system they have drawn up when

they have gone that route.

DR. BESSON: I understand what you are saying.

DR. SCHERLIS: Because I think a few years ago this would have been something that would have been looked at with a great deal of interest but certainly for the last few years the emphasis has not been on the dedicated vehicle but an upgrading of existing emergency systems. And this is why that rosy glow that you imply pervades Alabama might be fading a bit.

Dr. Joslyn?

DR. JOSLYN: I was reviewing these two applications and I think I feel as Dr. Besson does, that they are two quite different applications, although they are complementary. I share his concern about the fuzziness of the statewide, No. 43, and the beauty and completeness of the Birmingham, No. 42. I guess I feel No. 42 was designed for complete funding at the $3.5 million level and I think it was designed to be submitted upstairs. I cannot judge whether they really expected us, in RMPs, to fund that, or whether they sent it to us to show you this dovetails with the other one they have or what. But it seems to me we could cut away at different parts of this beautiful large system, but I feel the system is designed to demonstrate almost everything you can do, short of complete helicopter services, in one area, and it is not really designed to spread out and affect the state, although they

talk about this. It is designed for a complete system in Birmingham and a few areas right next door. I think that is the reason there are two applications, because the second application, as Dr. Besson pointed out, comes from a completely different point of view. It is more of a grass roots, broad based application that is having trouble knowing exactly where it is or what they need because they don't have the expertise and the quality. And I just wondered whether RMPs is in any position to fund the Birmingham one, since the Birmingham application says right off, they have a superb EMS system right now, far better than most places in the country. They just want to make it perfect and they want to answer some of the questions that people are asking about, you know, what is the direction we are going.

DR. SCHERLIS: I think --

DR. JOSLYN: I don't know. I am throwing this out in terms of the relationship of these two programs and wondering how the committee can react to both of them and look at them also in relationship to what was said earlier about using the RMP's money to nurture the seedlings everywhere rather than give to the rich.

Now, I am not saying that Birmingham can't make good use and probably better use of a block of money if we were sending it to Alabama. I don't know what the resolution to this problem is.

DR. SCHERLIS: What steps of the total program do they actually cover?

We have heard a great deal about the transportation system.

You said it is a total emergency system?

DR. JOSLYN: In Birmingham?

DR. SCHERLIS: What else is incorporated?

DR. BESSON: Employee training, public information and consumer education.

DR. JOSLYN: Transportation.

DR. BESSON: Transportation and communication.

DR. JOSLYN: Rescue operations. They are talking about developing a career ladder.

DR. SCHERLIS: When the ambulance is called, it is from the nearest hospital, is that correct?

DR. BESSON: Not necessarily.

DR. JOSLYN: They are going to look at all of Birmingham and decide where exactly ambulances need to be placed to give the best, shortest in time coverage, if I remember correctly.

DR. SCHERLIS: Are emergency rooms part of the total system?

DR. JOSLYN: There wasn't that much emphasis on emergency rooms in this part.

DR. ROSE: I had the impression, and maybe somebody

could help me with this.

I had the impression most of these ambulances related to one emergency room.

DR. SCHERLIS: This is what I was driving at.

DR. ROTH: Since I did not have a chance to go into this in depth, I don't want to prolong this discussion, but this relates in a fascinating fashion to me to the opportunity that some of us had to go into depth in the Russian plan, with its dedicated vehicles of eight varieties.

I might say that I believe this is more coronary emergency units than supply the whole City of Moscow. But the figures that come out from the Russian system in terms of theri salvage rate, and so on, are fantastically good, if we can believe them, you know.

We are involved in trying to get some knowledgeable people from this country who know our results, in taking the ambulance out and bringing the patient back to the source of expertise, as contrasted to the Russian system which is taking the expertise out with them.

They have the physicians and the trained specialists on each one of these emergency types of ambulances And to me, this is an innovative feature of this thing, as a demonstration project, that I wouldn't want to slough off lightly.

I think it would be awfully interesting to see this sort of thing done.

DR. GIMBLE: It has been done 20 or 30 times in the last five years, there are similar projects of this nature, currently funded in this country.

DR. SCHERLIS: This is the thing that troubles me. And that is, with the health dollar for emergency services available, the supply we have, I would rather they spoke to a transportation system where they upgrade the existing emergency staff to handle cardiovascular emergencies as well as otehrs rather than going into the dedicated group, because there are a lot of second thoughts, I think.

The lives are saved, I grant that, but I don't think they have to be saved by a dedicated vehicle. I think this is overkill, or oversave, I guess is a better word.

DR. BESSON: May I make a motion?

DR. SCHERLIS: My other concern is -- May I bring this up?

DR. BESSON: Yes.

DR. SCHERLIS: I am scanning this, you have gone through it. I don't see where they relate to the problem of bringing this individual who is getting cardiopulmonary resuscitation into the emergency room. What happens in the emergency room?

DR. BESSON: They drop it from there.

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DR. SCHERLIS: If the staff can't carry on the emergency service, if they aren't geared to handle it, this is why we are talking about a system of care under a regional medical program.

We are looking at a system, not at this phase of transportation. You will frustrate every emergency technician unless you have a system built into it of a continuum of care.

DR. BESSON: I don't pick up where they take over as soon as TER is mentioned.

DR. ROSE: I think this might be part of the constraings of the contract program again.

DR. SCHERLIS: Let them have their constraings. I don't think we have ours.

Dr. Matory?

DR. MATORY: So far as the emergency service is concerned, one of the problems they have is that a significant number of the 13 hospitals in Birmingham do not have emergency rooms. And I am not sure but what that may fortify that need for having better ambulance capabilities.

DR. SCHERLIS: The point I would make that if they spoke of a system of having transportation -- decided they would have three or four emergency rooms in that system and geared to handle the catastrophe when it was brought there, I would subscribe to this as being a way of upgrading it.

dw 5

But if they are just isolating this and having an academic approach in one area and zero elsewhere, it isn't a system.

DR. MATORY: I think they lean towards that because they speak of strengthening the categorization principle.

One other thing, I was just wondering if perhaps, could I offer the alternative of instead of wiping out all of the coronary care units, perhaps there may be some proportion, one, two, that remain as part of that demonstration.

DR. SCHERLIS: Dr. Besson?

DR. BESSON: I think that is a reasonable approach. I share your concern about this degree of money on a program which doesn't need demonstration.

But there is more than just the Birmingham area we are talking about, we are talking about a five-city area, and eventually a larger conglomeration of maybe three counties, is that correct, or five counties.

DR. JOSLYN: Aren't these five cities suburbs?

DR. SCHERLIS: It is Greater Birmingham we are talking about.

DR. JOSLYN: The counties, as I got it to mean, are the counties in Birmingham proper, tapering off, the locale directly around it.

dw 6

DR. BESSON: I don't know what the geographic area is that these mobile CCUs are going to address, but I would be personally happy to cut down both on the number, and maybe if we think in terms of two rather than eight, at least it is the equivalent of what Moscow has. That might be an approach. I don't know what else.

DR. SCHERLIS: The Chair would vigorously oppose any support of a dedicated vehicle, even one, and I am a cardiologist, I would like the record to show that.

But having just spoken of that, there was a film that came out which was supposedly for systems of care, to save a life, and having had the support of American Heart, re-shot in great measure so it addresses a total system of care rather than a dedicated vehicle.

I think to support a dedicated vehicle concept at this time is against the whole concept of making your emergency medical technicians be able to handle that type of situation as well as others.

This is the sort of training we are talking about.

This is the course of training that is certainly recommended, the only one I think we should support.

Furthermore, if we are going to talk here about transportation in bringing them to emergency rooms, which aren't able to handle the level of care necessary, you are going to have them just dying in the emergency room instead

of in the street and I don't think that is commendable as an approach either.

DR. BESSON: Okay. I will accede to the representative from the cardiology section, with greater wisdom.

MR. MATORY: I was aware that we were fighting that battle all along.

DR. HINMAN: Approximately 300, a little over 300 thousand tied up, as best I can estimate, in the dedicated ambulances.

If you use a figure of 112 thousand for ambulances, 43 thousand for equipment, 95 thousand direct costs for mobile coronary care training, half of the other --

DR. BESSON: I will let you do the figuring but if that is one of the conditions for the award, I would certainly go along with that.

DR. SCHERLIS: Another strong condition, they have to survey their emergency room,s and I think we can lay that down, can't we -- survey their emergency rooms and integrate that with their system of care, if any support is given.

I couldn't support just transportation.

DR. ROSE: That is a rather massive effort in itself.

DR. SCHERLIS: My own feeling is that this was put together for a contract and it doesn't fit our guidelines.

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This is the concern I really have.

DR. BESSON: But on the other hand, we are asked to address ourselves to this project as it is presented to us.

DR. SCHERLIS: Surely.

DR. BESSON: My recommendation, as I wrote it down, is that we don't fund this at all and let HSMHA play with it, but that we can't do.

DR. SCHERLIS: Do you have a comment?

VOICE: I was at their RAG meeting when this was discussed and it did come out, this was originally developed for the contract group, and there was some discussion between the Birmingham proposal, the one down state, and during the process of all this discussion, they agreed to submit them both places but it originally was developed for the contract.

DR. SCHERLIS: It really doesn't speak for the total system of care.

DR. BESSON: Well, it has subsystems, and if we eliminate the subsystem of the mobile CCUs with all of the additional funding that impinges on that without giving you a number and have you work that out, with those conditions for the award, A, elimination of CCUs and B, beefing up the approach to the ER, and at least an inventory of ER facilities then I would accept that as --

dw 9

DR. HINMAN: That would be approximately $900,000 for the first year.

DR. SCHERLIS: Dr. Joslyn?

DR. JOSLYN: Another question is, it seems this -- although this is submitted by the state-wide RMP -- addresses only Birmingham, even in Phase II and III.

I wonder about -- in other words, it seems to me it was submitted as a contract proposal for Birmingham and doesn't address the state.

I don't suppose it is my rule to put a condition on but I wonder if one of the things, that they be more serious about the spread of this proposal to the whole state.

I share Dr. Besson's concern that this one is more likely maybe to succeed and spread out across the whole state maybe than the other one because the other one is much younger and much less well formed, but I don't think in the form it is presented, it addresses a state-wide EMS system in the least, it addresses a city-wide system at a sophisticated level.

DR. SCHERLIS: At this point you have suggested for Project 43 $150,000, isn't that right?

DR. BESSON: Right.

DR. HINMAN: One year funding only.

DR. SCHERLIS: I have a feeling what you are trying

to do is come up with some sum of money for this other project and yet we find it hard to justify on any of the guidelines that we have followed to date.

I would submit that if we support this, we are being rather inconsistent.

DR. BESSON: You wanted a number.

DR. SCHERLIS: Some of the numbers that I have at hand are very low.

DR. SCHERLIS: You make your recommendation. I am only functioning as a moderator, with a vote.

DR. BESSON: I think we have a meeting of the minds, and I think it is a double bind that we are in, and we are also constrained by time.

So I think as a proposal, if it comes to nine hundred thousand, that seems like a lot of money for the first year for the City of Birmingham and we can just arbitrarily cut it from there.

They are going to need less central operations, I suppose, if they are not going to have the CCUs to play with, less of the transportation.

DR. SCHERLIS: My own feeling is let this go in as a contract proposal which is what they drafted it for because it doesn't fit our outlines.

DR. BESSON: Can 't we defer action on this and not give a figure?

dw 11

DR. SCHERLIS: Let's not support it.

DR. HINMAN: What do you mean by defer action? Refer it to the Council without recommendation?

DR. BESSON: Without recommendation, to integrate it -- I think council can make a decision based on the conditions that we apply on the award, the conditions on the funding level for 43, and as far as 42 is concerned, if HSMHA is not going to fund it, then I think the Council can operate on the basis of the conditions that we have offered.

DR. SCHERLIS: I don't think they are going to be able to.

DR. ROSE: They won't know at the time that the council meets whether HSMHA is going to fund it or not.

DR. SCHERLIS: Is any of that $150,000 available for general planning of an emergency medical system which is where I think they are at, as I read that.

DR. BESSON: The 47?

DR. SCHERLIS: Yes.

DR. BESSON: They talk about a demonstration area. I assume this can be the demonstration area, par excellence, and I have deleted that from the proposal.

DR. HINMAN: The notes I have about 47 are one year at $150,000 with the advise to sharpen the EMT cost, local councils, public education, with no salaries and no demonstration project.

dw 12

DR. BESSON: Right.

Okay, that we can set aside.

Talking about 42, If the best we can do by eliminating the mobile CCUs is to cut it from 1.2 to $900,000, that still is --

DR. SCHERLIS: I don't see what we get with that.

DR. BESSON: Let me just then arbitrarily give a figure of $300,000, which is 25 percent of their request.

That is hardly consistent with the sharpness of the whole proposal, but maybe I have been led astray by the rhetoric.

DR. SCHERLIS: Dr. McPhedran, can I get an opinion from you on this?

DR. McPHEDRAN: I don't know how you would decide -- I don't know how one decides things like that. I don't see how we are going to decide it any better in council than we can decide it here.

I think if we make an arbitrary award here, that council will probably be relieved that we made this arbitrary award and it will go in.

DR. SCHERLIS: Dr. Joslyn?

DR. JOSLYN: Checking back on the demonstration area for Project 47 or the state-wide one, that is to be a rural demonstration, which seems to me quite different from Birmingham.

dw 13

I am just raising that point in which we are saying Birmingham can be the demonstration area for the state-wide one.

I think they need coordination but I am not sure that was the point they had then they designed it.

DR. SCHERLIS: My own suggestion is the hard one, and that is, it is a good grant request, but I don't know if they are requesting it from the right people in terms of what they are asking for.

This is my view.

DR. BESSON: I would like to defer action but apparently we are not going to do that.

We are going to have action.

DR. SCHERLIS: If we say no, that doesn't prevent them from coming in later?

DR. BESSON: Later when, next cycle? Three months from now?

DR. HINMAN: Four months, we are on a tri-annual basis now instead of quarterly.

DR. BESSON: Defer it to HSMHA funding and if HSMHA doesn't fund it and review it, next cycle.

DR. SCHERLIS: With the limitations that we have placed on it. It must come in as a system.

DR. BESSON: Number 47 with the recommendation that we made.

dw 14

DR. SCHERLIS: Dr. Rose?

MR. TOOMEY: I will second the motion.

DR. SCHERLIS: Yes.

DR. MATORY: Point of information.

Your statement that it was not applicable to the guidelines was based upon what, area involved, or what?

DR. SCHERLIS: I think if we are going to talk about an EMS, emergency medical system, that even though you can support one phase of it, it has to be tied in, as I view it, into the entire system.

And this B specifies it is to the problem of one categorical area, essentially, coronary disease, without the total phases of emergency room on one end, coronary care unit on the other, a stratification of care in these areas, following recommended ICHD contracts, and so on.

To me, it establishes a high priority on one limited aspect of the total emergency system, and the emphasis we have had right along is that it should not be categorization.

This is one of the objections we have had to trauma as an isolated approach, and this, again, doesn't go to coronary care and dedicated vehicles.

DR. MATORY: I am sure those of you who read that -- I didn't read it, but I say coronary care was one of them, and I felt it was dealt to coronary care.

dw 15

DR. SCHERLIS: I think this was its major focus.

DR. BESSON: It is not its major focus.

DR. SCHERLIS: According to what you have mentioned, it is.

MR. TOOMEY: He is talking about the equipment.

DR. BESSON: There are six or seven components, as far as equipment is concerned, yes.

DR. HINMAN: I am uncomfortable.

DR. SCHERLIS: We haven't made any motion yet. Would I accept separation --

DR. BESSON: I am going to move adjournment.

DR. SCHERLIS: You recommended $300,000.

DR. BESSON: I recommended deferring it to the next cycle if HSMHA doesn't fund. If HSMHA funds, we are off the hook, for Project 46.

For 47, $150,000. 3.5 for 47. 4.0.

DR. ROSE: We are likely not to have that.

DR. HINMAN: It is possible.

DR. BESSON: Okay.

If I have to give a number, then, with all of the comments that we have had, and the blush taken off this rose, from 1.2, 25 percent is the figure that I suggested.

DR. SCHERLIS: $300,000.

DR. BESSON: Right.

DR. SCHERLIS: Is there a second to that?

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DR. MC PHEDRAN: Second best one year funding.

DR. SCHERLIS: Who would be in favor for Project 42, $300,00 with a rating of 4?

(Chorus of ayes.)

DR. SCHERLIS: All right, that passes.

And a hundred and fifty thousand dollars for Project 43.

DR. BESSON: Yes.

DR. SCHERLIS: Was that for one year?

DR. BESSON: Project 47, yes.

DR. SCHERLIS: 42 was for what?

DR. BESSON: One year.

DR. SCHERLIS: All right.

We now have the peculiar dilemma of having several more projects to review and time having run out.

I wonder what -- I know we can finish in 45 minutes, but that cuts out the plane travel.

DR. HINMAN: The problem that we have is that we have to go to council two weeks from today, three weeks from today, whever it is, and we have to give them some sort of answers about these applications.

DR. SCHERLIS: Yes.

I have no problem.

DR. MC PHEDRAN: I can stay.

DR. SCHERLIS: Who else has to leave?

dw 17

DR. ROTH: Only plane I have is 5:45.

DR. SCHERLIS: All right.

And you go where?

DR. ROTH: Erie, Pennsylvania. The last plane I can get out is at 6:00.

DR. HINMAN: With three, that still is some representation.

DR. BESSON: How about you, Bob?

MR. TOOMEY: My plane leaves at 9:00, so I am all right.

DR. SCHERLIS: Well, Dr. Roth, you are primary reviewer for some of the remaining ones.

DR. ROTH: Some of mine are real short.

end 21

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DR. SCHERLIS: We are going to do these by divisions. The first is eastern branch, that will be Albany, and so on.

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DR. ROSE: That is the first section in Volume I of your book.

DR. BESSON: Albany is asking for a six-month grant of $109 thousand, direct funding; and then for a two-year grant request of 1.5 million, running from December of '72 at the end of six months to December '74.

The general plan for Albany -- I will just read brief excerpts -- is, from the summary, I am reading, "A three year study to investigate the design and implementation of a PMS for the capitol district, consisting of what they describe to be two major components, external to the hospital and internal.

The external is basically the use of a rapid detection plan and preliminary care in a van. And then the internal system is the establishment of six beds, a four-bed, trauma, intensive-care unit; located, Albany Medical Center; and a two-bed, similar unit; located in a community hospital.

Let me just refer to budget, for a moment. There are -- for the six beds, they are requesting, there are some 50 people that are being asked to be taken on as part of their larger budget. Twenty-six of these are listed by name, with a budget of 529,000; and 24 additional people, with a budget of 584,000.

They are also asking for the purchase of equipment which comes to 230,000. They are asking for computer funding in one form or another of 90,000. They are asking for the purchase of ambulance and communications, coming to 30,000.

In addition to this, they are asking for 300,000 for what they referred to as a variety of incidental expenses. Basically, this is a request for funding a continuation of Dr. Samuel Power's research in trauma physiology. The general thesis is that the physiological -- meticulous physiological monitoring of massive injury has focused on the posttraumatic respiratory distress syndrome as a cause of death.

The literature-morbidity rate of 40 to 80 percent in this situation has been reduced in this particular research, intensive care unit approach, of careful physiological monitoring, to one of the last ten patients with massive injuries, and the research unit says -- and they make a categorical statement on page 21 of the application -- death from this cause has been virtually eliminated, although the basic cause of death is still unclear.

This entire program in Albany is to continue that research effort. Now, in reading the application very carefully, it is a magnificent piece of work, but I think that there are a variety of ruses used by Albany to trigger funding.

For example, this is called a demonstration unit -- it is hardly a demonstration unit, but a continuation of a

physiological research program. It includes two trauma, intensive-care unit beds in a community hospital, therefore cloaking the entire project with a mantle of it being a community project, which it hardly is.

It pays lip service to external hospital care by physician-communication with onsight ambulance personnel, but very cursorily mentioned. It also pays lip service to evaluating the cost, morbidity and mortality, with what are called "ordinary ICUs," presumably comparing them with what Dr. Powers can do when he is there.

It pays lip service to outfitting a Winnebago Camper as a mobile ICU to demonstrate its values. It has one sentence in the entire proposal on community education. It proposes to establish a committee, and lists in one sentence, ten groups which can be triggered as "okay," groups, that will make up this committee.

It talks about accident epidemiology as an extension of a package at Rensselaer Polytechnic Institute, which is said to analyze emergency events as predicted models, but I am not impressed with the detail in that predictive model comment. The 129,000 which is modestly requested for the first six months of funding gives me the impression of being kind of a Gulf of Tonkin Resolution, with a $1.5 million request in the background.

It seems to be only the beginning of a limitless

and insatiable investment that is irrelevant to the problems that need solution in this area. When I talked to Dr. Scherlis, a week ago, about how this might be set up, he suggested maybe the best we could do is grade them "A" to "E" on the basis of what we have been told this morning, and from what I divined, I would grade this as "E."

Incidentally, the technical review gives this proposal high marks, but it is with so much technology in its approach, it really does not address the right question. While this is, then, a remarkably, progressive approach to physiological monitoring of death from massive injuries, I think it is wide of the mark of what we intend to do with RMPs funding.

So, I would recommend no funding for this project.

DR. SCHERLIS: Secondary reviewer?

MR. TOOMEY: I think that is me, and I could only agree with what Dr. Besson has said. It looks to me as though it would be a great piece of research, and would be very interesting and very desirable to be continued, but I just felt it was wide of the mark as far as the emergency medical services were concerned.

DR. SCHERLIS: I guess the rating, according to our preview criteria --

DR. BESSON: I did not see these sheets. Maybe I will have to look at this sheet and see how we are doing this.

DR. SCHERLIS: Can I ask a question at this point?

Perhaps I am the only one confused on this. Albany is listed as the primary reviewer, Dr. Besson, and Mr. Toomey, on this form.

If I look at the other one, it is Dr. McPhedran and Dr. Besson.

DR. MC PHEDRAN: For Albany?

MR. TOOMEY: I had it done. I was secondary.

DR. BESSON: I think I was primary.

MR. TOOMEY: That is right.

DR. ROSE: All of these were reviewed by these reviewers. That is a mistake.

DR. SCHERLIS: I see. This is divided among the four, but this is the individual assignment.

DR. BESSON: I would recommend, Mr. Chairman, that in accordance with this worksheet -- I assume that our final decisions will be on these sheets, is that right?

DR. SCHERLIS: Yes.

DR. BESSON: These white sheets?

DR. SCHERLIS: Yes. What I suggest is that the primary reviewer hand that sheet to Dr. Rose, and that he be responsible for the formulation of that sheet. Would that be satisfactory?

DR. ROSE: Yes.

DR. BESSON: Do we each fill out each sheet? The white sheet that comes in this book?

DR. SCHERLIS: I would suggest we not have individual votes but a committee vote, and only the primary reviewer fill it out, and that it recommend the concurrence of the secondary reviewer and of the committee, unless of course, we have another situation.

But, I would suggest that you have the responsibility for filling this out, reflecting the committee decision.

DR. BESSON: I would recommend, then, a, no recommended funding, no conditions for award, and rating five -- or one, excuse me.

DR. SCHERLIS: Rating one?

DR. BESSON: Yes.

DR. SCHERLIS: Does the secondary reviewer concur with that recommendation?

MR. TOOMEY: Yes.

DR. SCHERLIS: Any other comments from members of the review group?

I will accept that as being a motion which has been seconded by the secondary reviewer.

Any further discussion?

Those in concurrence, signify by saying "aye."

(Chorus of ayes.)

DR. SCHERLIS: Opposed?

That took care of Albany, I would guess. May I suggest this: If, for any reason, as part of the discussion,

if any of the task force of the staff which has been involved either in summarizing these, or as part of the DOD Branch, wishes to make any comment, I would appreciate that. So Dr. Joslyn and Mr. Nash, if you would like to make any comment -- Dr. Joslyn?

DR. JOSLYN: I concur.

DR. SCHERLIS: We would like some facts presented, rather than a strong opponent or antagonistic point of view.

DR. JOSLYN: All right.

DR. BESSON: One other question, Mr. Chairman. This distillate will mean nothing to me after I am done. It may be helpful to the staff if it is legible. There is no reason why I have to take this home with me.

DR. ROSE: We would appreciate very much, having that if you are not going to need it.

~~Have we used up all of our twos and threes?~~

~~DR. ROSE: Right, several times over~~.

~~DR. SCHERLIS: All right.~~

Arizona. We are now on the western branch regions.

The first one in that area is Arizona. Arizona has requested the sum of $116 thousand for one year for the organization and development of an EMS to provide accessible, adequate, and appropriate emergency care to all residents of Pima County.

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It proposes to adopt existing technology to produce a comprehensive plan for development of an integrated emergency medical service for Pima County, Arizona.

The primary goal will be the development of a cost-acceptable organizationa. structure for the provision of EMS for the semi-rural communities, and adjacent, sparsely populated rural areas outside of the Tucson metropolitan area.

The second goal will be developing methodology for the organization of specific alternatives, for the implementation in principal metropolitan areas.

The staff request is approximately $85 thousand, for a breakdown of the budget. The direct costs are $160 thousand. The approach seems to be a reasonable one. It does build on existing needs and they intend as they go along, to even define these much more fully.

I think they have indicated what their planning

process will be. It is a well organized program which will cover some 350,000 population area, of something like 90 to 100 square miles. The organization sponsoring it is the University of Arizona College of Medicine. They have the endorsement of the Comprehensive Planning B Agency and the Governor's Highway Safety Coordinator.

It is a rather clearly stated project. I mention the figures that I did because I think, in terms of what they are talking about, they are asking for a somewhat higher sum of money than they might require in terms of what they are looking at.

I suggested that they be rated at a level of three, that in terms of the funds which they are requesting, as I said, this is just for Pima County, and a population of some 350,000 -- I think they are asking for an excessive sum, but I would suggest that they be funded to the level of $65 thousand.

This is essentially the planning phase at this time, one which I think will be a profitable use of the funds.

Is there any member of staff, here, familiar --

VOICE: I am here.

DR. SCHERLIS: The question I was going to ask you is a question in terms of the involvement of the people of Pima County.

I went through this in some detail. My own feeling is that they look as if they can move it along but essentially

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at a planning phase which is what they are looking at and I think with the help of the people they involve in the school and the act of involvement of their B Agency, they should be able to get this off the ground.

Are there any comments as far as other members of the review group are concerned.

Then the motion I would make has been made in terms of funding at 65.

Is there a second?

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DR. MCPHIDRAN: Second.

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DR. SCHERLIS: Well, we are now going to have Arkansas.

Arkansas submitted a total of six projects, which I and Mr. Toomey have been asked to review, and these are a varied group. The sum totals of these, $5,000, $20,000, $113,000, $10,000, $33,000, $47,000 -- a total of some $307,000.

If I can try to put these in some semblance of order -- actually if you will look in the back page you will see that it comes out to an excess of $1 million.

The first speaks to establish a coordinate education system of emergency medical services for Arkansas, and this is settled with the VA hospitals. I'm trying to get these numbers in order.

The application to support the state-wide emergency medical services system to include medical services council, consumer education, transportation -- in other words, the entire support.

It is designed to include some regional development. A preliminary work schedule was presented to allow time phased method and then present the entire methodology for this. When you go through this, it is really very difficult to determine exactly what is specifically requested.

This is a very ambitious program but the entire request is really very poorly organized. As I went through this I felt repeatedly the need for a more detailed budget

and more indication of exactly what was being planned.

The application itself to me seems to be, in a word that I used for it, excessively padded.

It emphasizes both planning and operational activities. Funds are requested for developing of a pilot project as well as developing a state-wide emergency medical system and both of them are heavily oriented towards the purchase of hardware.

The salaries are something like $75,000, consultants come to $76,000; the equipment to $40,000.

They have asked for rennovation of part of the VA facility. They have included replacement of medical supplies.

As I went through this, I felt that part of it should be supported, namely that which emphasized essentially the training aspects more than anything else, and I'll come back to that as I review some of the other programs which were part of this.

Project 42, which again is part of this overall Arkansas program, is asked for by the Arkansas Health Systems Foundation to improve emergency health services for a six-county area in Arkansas.

The attempt is to upgrade emergency services to the critically-ill or injured not only within this community but outside as well, and they discuss this as being achieved

by rural involvement through the establishment of a hospital-based ambulance, regional communications system.

They speak of ambulances being placed in each rural hospital staffed on a 24-hour basis, and this would be the responsibility of the rural communities. They emphasize that there is no communication transportation from the rural hospitals in the six-county area with the local regional hospital.

Again, the request here is in terms of a great deal of funding for actual hospital personnel. Salaries come to something like $95,000, mostly for this, and the equipment to $60,000.

It is a three-year operational request which is aimed at improving emergency room facilities, general emergency services, major emergency services, upgrading emergency services.

There is no really good description of just what is being planned, although they do ask specific support for emergency room personnel and equipment.

One problem here is that there is no real system of care which is discussed. As you go through the sheets -- and I did this to again evaluate what specific items were present -- you will find that they have really not directed themselves adequately to the criteria as outlined by the actual requests that they had received in terms of the -

outline which they should follow.

My feeling on this was that it was a very poor request and I questioned whether any support should be given to it.

The next one from Arkansas was again for a six-county area, the development of an emergency medical services system. It was for a one-year planning project.

This particular instance, again, it was a very brief application. They only requested funds for planning this in the Little Rock area.

The approach appeared to be a reasonable one, but they had asked again for what I thought was an excessive amount of funding and although they did follow the guidelines more carefully, I gave this a rating over the others, but again do not recommend full funding for it, and I'll give the numbers on that in a moment.

The next request was again for Arkansas.

As you gather as I go through this, this is not an overall, well organized project. There are bits and pieces applying to different parts of the State, rather than being a well-coordinated education program.

This one was an in-depth study to determine the need and approach to emergency care and to establish such a program in a 10-county area.

They asked for one-year support in order to plan

an emergency medical system for this 10-county area. This was given in more detail, but again, there was a lack of adequate information.

This was a rewrite of what appeared to be a grant -- this was a rewrite of the whole guidelines, so at least they did follow the guidelines more adequately than the others had but, nevertheless, there were a great many omissions.

There was nothing new or innovative about it. I felt there should be some support for the program because it did address itself to planning, and I think they at least defined what their needs were.

The next was, again, part of a program just for Southeast Arkansas; in this particular one, they asked for funding to establish a plan for an emergency medical service system to involve the districts, 11 hospitals, establish new ambulance services and upgrade those which were then in operation.

Again, although there is evidence of a real need as there is in all of these, one can't help but be impressed with the fact that there is very little documentation, that the application reports themselves are really very sparse.

And if one funds this, again it would be a priority which is rather low, and I would restrict the funds here as well for the planning phase.

I think to move into any further step at the

present time would be unjustified.

In summary, looking at all of their applications --

MR. TOOMEY: I think you skipped one, Doctor.

DR. SCHERLIS: Did I skip one?

MR. TOOMEY: East Arkansas Planning and Development District?

DR. SCHERLIS: That was omitted from mine.

MR. TOOMEY: Okay.

DR. SCHERLIS: Do you want to give that?

MR. TOOMEY: It is a one-year planning grant for the Eastern Planning District, comprised of 12 counties, which is the second largest area in population of the State, with 371,000 people.

Ambulance services in the area are operated by funeral homes and private concerns. The primary objective of this request is the development of a direct ambulance service linked with radio communication.

The narrative speaks to the requirement of vehicles and communications equipment with no overall planning mechanism for the formation of development of a coordinative system within the district or with the state EMS plan.

It shows little understanding of a total emergency medical services system. The monies are requested primarily for the purpose of equipment. Community needs and resources have not been assessed.

There is no reference to linkages with the system other than radio communications.

Of the $142,000 requested, $94,000 relates to vehicles purchased, and $33,000 for communications equipment, and $4,000 budgeted for training purposes.

DR. SCHERLIS: All in all, I was extremely dissappointed with the Arkansas application. There were bits and pieces. Maybe they didn't have the time, but I don't think the program as finally put forth was one which really reflected an overall coordinated effort and I thought the funding requests were certainly -- what support might be given would be more for planning and hopefully on a more correlated basis.

Yes?

VOICE: Project 45 was omitted. It did not have Reg review, it was returned by the Reg for further revision.

DR. SCHERLIS: That's why I don't have it. Is that to be considered by us or not?

VOICE: We didn't get it.

DR. SCHERLIS: The one just reviewed is really not part of our consideration; is that correct?

All right.

The part just discussed is not a part of our consideration, the last one reviewed, No. 45. So we have to consider then the other ones, No. 41, which had requested

$300,000 for the first year -- is that correct?

Yes. My recommendation on that was a funding only for planning at a rating of 2.

The next one, No. 42 -- my recommendation was that only be funded for planning to a sum of $30,000 with a rating of 2.

The next one, Item 42, I recommend action on that one, that there be no funding for that one.

No. 43, I felt that should only be supported to the terms of planning. My recommendation was $25,000 there with a grade of 2.

Project 44, for which $31,000 had been requested, I felt this one at least had some fuller data, and I thought it should be supported for the funds requested for planning, with a rating of 3.

No. 45 is not subject to our consideration.

No. 46 is. My rating on that was only for planning, to a total of -- what they had here, $15,600, with a grade of 2.

Secondary reviewer?

We can be wide apart on these, given the funds requested, and the competency of draftsmanship.

MR. TOOMEY: I was looking at something -- as you were going down the requests on the planning, I was in agreement, and I figured you were going to -- I don't know

where you were.

DR. SCHERLIS: Project 41, I recommended $30,000 for the first year with a rating of 2.

MR. TOOMEY: That is the $300,000?

DR. SCHERLIS: Yes.

Now, then, Project 42 I did not recommend being funded.

Project 43, I recommended $25,000 with a rating of 2.

MR. TOOMEY: That is the $45,000?

DR. SCHERLIS: Yes.

The request had been for 45.

Project 44 had requested 31, and I thought that was an adequate figure for planning. I gave that a little higher rating of 3.

No. 45 we have been asked not to consider.

No. 46, I agree with $15,600, at a rating of 2.

Are they about what you were going to suggest? Or what was your feeling?

MR. TOOMEY: I didn't make the suggestion, but I would be in agreement.

DR. SCHERLIS: Would that be all right?

MR. TOOMEY: Yes.

DR. MATORY: You have studied this a lot more closely than I, but I was a little concerned in that first one,

they indeed were setting about to begin to get some personnel trained.

I was wondering if perhaps out of the $300,000, if -- I am not satisfied with your justification for only a tenth funding. It seems they are about to get personnel training and organization.

DR. SCHERLIS: What I was going to suggest was this as a follow-up-recommendation. All of this comes to over $100,000 for State, and what I think should be done is that the State has to put together a thoroughly coordinated program to encompass emphasis on training in an overall plan.

What we have been given is individual plans that have very little coordination and I would think the Staff comment here would be that all of these should be coordinated into an overall view. Because a sum of $100,000 gets to be a very significant sum to work with in setting up, at this stage, planning and training.

Would that answer your question?

DR. MATORY: That answers it, but I just wonder what a State can do with $100,000? I am very much -- of course, now you have the 45, and I suppose given better consideration, that might be another plus.

But I am impressed with their realization that those funeral ambulances have to go and I don't know how we are going to do that unless they get some funding and support. This is

one of the big things we're all trying to get rid of.

DR. SCHERLIS: That is a nation-wide program, isn't it?

DR. MATORY: Yes. But Arkansas seems to have its share.

DR. SCHERLIS: I am open to any suggestions.

DR. HINMAN: I agree with you, Bill. I haven't seen the application.

DR. SCHERLIS: Who is familiar with the Arkansas grant?

VOICE: I was on the site visit. Is there a specific question that you would like to ask about this?

DR. SCHERLIS: What do you think their ability is to mount this effort? What is their total funding at this time, in Arkansas?

VOICE: 1.5.

DR. SCHERLIS: $1.5 million?

VOICE: As you know from the site visit, that was rather recent, they are one of the better regional medical programs, and seem to have the capability to plan a program.

I suspect -- Mr. Says is the primary Staff person on this, but I suspect that the time constraint had its affect on the development of this.

DR. SCHERLIS: This is one thing that bothered me, is that as you go through this, as apparently they are very

thick brants, the requests that you deal with are very small proportions of them, and one of the problems that I had in going through them is that these were in great measure, I assume, all prepared for other requests.

Are they going to part of that $8 million?

DR. ROSE: Yes.

DR. SCHERLIS: These weren't really prepared under our guidelines, they were prepared for something else. While one can question however one can go by this sum, nevertheless, if we are going to buy the guidelines, we have to follow them.

You are right what you can do for $100,000, you certainly can't replace all the hearses with adequately-staffed and equipped ambulances, but I would think if they don't get their other fund, at least this is a good start in putting together an overall program.

I know their coordinator who I think is one of the best I have ever had the opportunity of site visiting. I am sure he can use these funds very adequately at least as far as planning and coming in later for implementation.

He can come in in the very near future for implementation.

Any other comments?

A motion has been made and I guess seconded. All those in favor, say "aye."

(Chorus of "ayes.")

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DR. SCHERLIS: Opposed?

DR. ROSE: Do you have an overall rating?

DR. SCHERLIS: The overall rating comes to 3.

DR. ROSE. 3. Okay.

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DR. SCHERLIS: All right, Bi-State is the next one, Mr. Toomey.

xxxxx MR. TOOMEY: This is an application from Washington University in St. Louis.

The funding is requested at $707 thousand for the first year, 293 for the second year, $314 thousand for the third year. I have a total of $1,316,000.

The grant application covers an eight county region consisting of almost 50,000 square miles around and including St. Louis. The area population is about 2.5 million people, in 200 municipalities.

Despite their separateness, their residences are linked to St. Louis through medical services patterns. There are many deficiencies in medical services because of the 200 independent, political jurisdictions. Concern over the deficiencies of an emergency medical service initiated this grant request as mechanism for coordinating the emergency medical services with governments cross-sectoring for management of the systems operation.

The objectives stated were to establish an emergency ambulance central dispatching system which is under, by, and readily accessible to the public served, to supply the area with a sufficient number of ambulances, to train the ambulance crews to the level of efficiency, sufficient to qualify them for registration as emergency medical technicians. supply

essential equipment as defined by the American College of Surgeons, to categorize hospitals and designate receiving stations on the basis of emergency backup capabilities; and to establish communication links between all components of the emergency medical services system.

The plan is to be implemented in two phases. The first phase of the system to become operational in the core. sector of St. Louis, in addition to gathering information to extend the system to the rest of the eight county metropolitan St. Louis area.

Extension of the system to the rest of the area for a total emergency medical system will constitute Phase 2. The proposal is a three-year funding for phase one with implementation of phase two, within the year following activation of Phase one.

In the terms of my evaluation, the applicant demonstrated good knowledge of a total EMS System including how the various phases would be integrated and has noted the deficiencies in the presystem which must be overcome. The specific geographic area was well described, and the proposal is community based, with broad representation of providers, public agencies, planning agencies, and community interests.

Existing medical services have been taken into consideration with edification of facilities, equipment, and medical services available within the area. Additional -

resources have been identified and there is a clear assessment of needs and resources based on statistics.

The plan makes reference to how the operating components will tie together and how additions to this system will be coordinated. The only weak area of the narrative relates to the improvement of quality care and linkages with local health care systems. The applicant only partially describes these linkages and briefly refers to followup of non-emergency patients, and community disaster planning.

Techniques are described for utilizing financial resources, in addition to obtaining additional financial support at the expiration of this grant. While this is my -- this is my summary. While there are no outstanding or innovative approaches to the development of the EMS within this area, the application appears to be well conceived, a well conceived plan, a good organizational structure which will coordiante and administer the system. It reflects comprehensive planning for bringing together the key elements and a disaster and EMS system.

However, a large portion of the grant is used for the purchase of ambulances and the equipment. Comments by the reviewer, Dr. Kaplan, "This basically is a well-thought out application." It has identified problems and has made an attempt to solve them. The one defect that I would see here is no mention of the Department of Transportation's support of

ambulances. They appear to be coming 100 percent in support of ambulances in this application.

In their defense, however, cutting back on ambulances support would greatly weaken the basic concept of this proposal. There is very little attention made to the emergency room's themselves and the followup area. I classified this application as a very good application.

However, I am concerned about the amount of funding. I would like to hear the discussion before I make the recommendation.

DR. MC PHEDRAN: So am I. This was one of the early ones that I read and I thought that what was described about the ambulance service was good, but that on reading it and rereading it, it really does not measure up to our notions about a system.

I think it is a well designed ambulance service and the amount of money to be spent out of that first year budget, 707, 568, on equipment; including equipping the ambulance for 16, 641 -- that is nearly half a million dollars on the ambulances, and on the communications equipment, the emergency care equipment, and other things that have to go in the ambulances, in order to make them serve this function.

And there is nearly 200,000 in personnel. Of course, the costs drop off sharply, the next year because of the initial -- in the proposal, the initial cost for the ambulances.

DR. SCHERLIS: Two ninety-three and 314 in the subsequent years.

DR. MC PHEDRAN: When I think of this amount of money being requested for the first year and then put it beside the tri-state application, what was requested there, for the first year, it seems to me that -- now I understand why I feel that way in the tri-state application, because so much is the development of planning, and linkages; whereas in this one, a portion of the system, I thought was well designed, but I really wonder if we ought to support it not because it is not a good part of the system, but because it is not really the whole system.

That is the way I feel about it. I wonder whether we ought to support it at all because it is such a portion of the system. That is what I am concerned about. I mean it just is not the whole thing. We do not know whether the emergency rooms are going to be coordinated at all to prepare for what these ambulances will bring, for example.

I guess they could be with the system as described, but we just do not know.

DR. SCHERLIS: All right.

MR. TOOMEY: I thought it was extremely well written.

DR. MC PHEDRAN: I thought it was well written, but I thought it was just a piece, that is the trouble.

DR. SCHERLIS: Is Dr. Caplan or Mr. Poster here?

DR. ROSE: Dr. Kaplan is not here.

DR. SCHERLIS: I gather there are differences of opinion. Would you want to respond to this, Mr. Toomey?

I do not think we have had a rating yet, really, for this.

MR. TOOMEY: My rating of the application would be probably 3.5, between three and four.

DR. SCHERLIS: How do you feel about it?

DR. MC PHEDRAN: I think for what it tries to do, it is a three, but I do not think it is a system, and I do not know that we ought to rate it as a system. That is my complaint about it.

DR. SCHERLIS: How much of it is requested for planning in the overall, or isn't there any?

DR. MC PHEDRAN: Well, I do not think there is very much. I can tell you in just a second. There is an evaluation of the project, $30 thousand. One of the field system planners, total support is requested for him.

That is 17 thousand direct costs, or 19 thousand total, together; and secretarial help for the field systems planning.

DR. SCHERLIS: Is what they are going to do essentially set up the prehospital phase? Is that correct?

DR. MC PHEDRAN: That is the way I view it.

MR. TOOMEY: Yes.

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DR. SCHERLIS: If you are reading this summary, it certainly seems the emphasis is on that, without there being further involvement of the actual provider areas.

Do we have a motion?

We lie somewhere between $700 thousand and no dollars at this point, if I read it correctly.

MR. TOOMEY: I remember now, the personnel involved in this for the first 12 months was $188 thousand. Then the ambulances were 416 thousand. I do not see there was anything specifically in the area of planning in terms of funds for this.

DR. SCHERLIS: There is some training, is there not?

DR. MC PHEDRAN: Yes.

MR. TOOMEY: There is considerable.

DR. MC PHEDRAN: There is training equipment for the ambulance -- it seems to me there was some training for the ambulance attendants but I am not even sure that that is true.

DR. SCHERLIS: They do have a duplicate-contract request in, according to our worksheet.

DR. MC PHEDRAN: They do?

DR. MARGULIES: I think it will be visited.

DR. SCHERLIS: It has not moved that far along.

DR. MARGULIES: Right.

DR. MC PHEDRAN: I feel this is not enough of a system. I thought it was a good proposal as far as it went, but

that it is really not a EMS.

DR. SCHERLIS: I can understand that.

DR. BESSON: On the sight-visit, I am wondering under what circumstances --

DR. SCHERLIS: Contract.

DR. BESSON: For a contract?

DR. MARGULIES: Yes.

DR. BESSON: Is there going to be any sight-visiting of these proposals separately?

DR. MARGULIES: No, we would not have time for it.

DR. SCHERLIS: I think what we are finding is that some of the programs we fault, on the basis of not being a system have been submitted under different guidelines for a contract. I think this is what hung us up on Arkansas, to a certain degree.

We sort of try to see what in that program is RMPs guideline material, rather than being part of a system that might, for example, fit into the contract mechanisms.

DR. MARGULIES: Of course the contracts are all supposed to be total systems.

DR. BESSON: Much more than ours.

DR. MARGULIES: So the criticisms I just heard would be applicable to the contract.

VOICE: I do not know that much about the total system that is proposed in the application, but they have

gotten a large number -- practically every group possible, together. The mayors of the different muncipalities, the different civic groups, they have done some planning. As I say, I cannot speak for what shows up in the application, but they have been working on this, and the experimental health system application for planning for St. Louis has been approved, and there is some tieup between the two applicant agencies of these two.

DR. HENDRYSON: May I ask one question about this?

DR. SCHERLIS: Yes.

DR. HENDRYSON: Is there any evidence of any community funding, joint funding, local funding, to go with this plan?

DR. SCHERLIS: Does anybody have a comment?

DR. MC PHEDRAN: No, I did not see any evidence of that.

DR. SCHERLIS: Okay.

DR. MC PHEDRAN: And as it was pointed out in Dr. Caplan's note, there might be other possible sources for getting the ambulances. It was looked into, but not spoken of in the application.

DR. SCHERLIS: I think our criteria have to include the guidelines, certainly.

Yes?

DR. HINMAN: In answer to Dr. Hendryson's question -- according to Dr. Caplan's review, he checked "yes" under the

first three questions of financial support, which had to do with utilization of other potential funds.

DR. SCHERLIS: Yes?

DR. ROSE: I do not have anything.

DR. SCHERLIS: Do we have a recommendation from one of the reviewers so we can move ahead on this?

MR. TOOMEY: All right. I am a little bit hungup on the fact that despite what you said, Dr. Margulies, as far as total systems are concerned, we have also looked at, and it says in the guidelines, to look at systems and subsystems, and I look upon this as part of the subsystem.

I also remembered being concerned with the amount of money being put in for the ambulances. I also did check back, and there is provision for training people for a period of somewhere in the neighborhood of five or six hundred people during the course of the three years for this particular program. And my problem is the same thing that was opened up earlier, and that is, that the program is dependent upon the ambulances and to have the people without the ambulances really would ruin the project.

I do not know how you cut it back in terms of the fact that this is a total subsystem within the whole system. I do not see how you cam pick a piece of it. This is my problem in recommending funding. I have no hesitation in recommending a grading for it interms of 3-1/2 or 4, somewhere

in that range, as a project. But I do not know how to pick out the dollars for it.

DR. MC PHEDRAN: Could we not recommend that they try to get support for some of this equipment elsewhere? I mean, at least that would help out some, if they could get some from the Department of Transportation? Could they not do that? Is that not conceivable?

DR. SCHERLIS: And then what recommendations would you make? Let us assume if they could get the equipment elsewhere, what would you say?

DR. MC PHEDRAN: It still is not an emergency medical system. That is what you are trying to tell me?

DR. SCHERLIS: No, I am not.

DR. MC PHEDRAN: But I feel that way about it, it is a real problem.

MR. TOOMEY: I recommend approval of funding on -- with the contingency that they secure the funds for ambulances elsewhere.

DR. SCHERLIS: My concern is if we talk about the 700 and we talk about the 800, that is one point five, and that is a good fraction of the total available, and if they go by our strict ranking, that is it.

And that would exhaust most of the funds.

DR. MC PHEDRAN: Let us say, we support the people for the first year if they can get the ambulances and then

they can come back and see about the second or third year.

DR. SCHERLIS: I doubt if they would have time to gear up to get the equipment in that period of time.

DR. MC PHEDRAN: You do not think so?

DR. MARGULIES: It just depends on how far they have gone with DOT, what the potentialities are. If they can get it here, like all these situations, they are not going to get there. I think we can easily find out how far they could go in the other direction.

DR. SCHERLIS: Well, the recommendation --

DR. MC PHEDRAN: I would favor supporting it for just a year to support the personnel costs. Maybe they -- I do not know whether all of the kinds of personnel they described would really be useable under these circumstances if they did not have the equipment, but supposing, for example, they had -- they wanted to get the project director and secretarial support, who would -- or the planner, whoever would be required; to see what sources of funds could be tapped for getting the equipment.

I would support that for a year, and see where they go after that. This is the kind of approach I would favor.

MR. TOOMEY: I think within the context of the resources that they have, that there are steps that can be taken to make a smoother emergency system out of it. And I would agree with Dr. McPhedran's recommendation.

DR. SCHERLIS: You mean -- we still do not have a number on that, though. This is one of the problems that I have.

DR. MC PHEDRAN: Okay.

MR. TOOMEY: You have 188,000?

DR. MC PHEDRAN: That is their total personnel request, which includes a project director at a total of forty grand, a jeep dispatcher for 15 and a half, ten dispatchers, for a total of 100 -- they cannot use them all. We do not have the ambulances. The dispatchers, we cannot use. The secretary, he can use.

DR. SCHERLIS: I share the concern about putting all this amount of money into one aspect of a system of care without putting significant funds into the total planning, and what happens when these patients hit the emergency room, and hit the rest of the medical echelons of care.

Now, really, --

DR. MC PHEDRAN: How about supporting the project director and secretarial help, that is 48,000, and a field system planner, 20,000, that would be about $70 thousand, all together.

DR. SCHERLIS: Even if you raised 100,000, in terms of at least working on a system of care, this, I think would be a more viable use than buying all the ambulances.

What about some funds for training?

MR. TOOMEY: I think they have 52,000 down here, as I read it.

DR. SCHERLIS: That comes to about 150.

DR. BESSON: A procedural question, Mr. Chairman.

If we are arguing about hiring secretaries and dispatchers for each application, we would not get anywhere.

DR. SCHERLIS: I agree. I am trying to say that 700,000 seems like an inordinate number.

DR. MARGULIES: If I understand what you are saying, what you are talking about -- giving them whatever is necessary to extend their planning and develop a fuller system; and if they can amplify it in some other way, fine, but if you want to talk in those terms, and give us freedom to negotiate at a reasonable level --

DR. SCHERLIS: We are talking about a sum of 150 thousand to 200 thousand, at a rating of three?

Is that satisfactory?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: All those in favor, say "aye."

(Chorus of ayes.)

DR. SCHERLIS: All right.

Now, intermountain areas, Mr. Toomey and Dr. McPhedran.

end #15

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DR. SCHERLIS: Any further discussion?

All right. I guess that takes care of Arizona.

Next is Hawaii.

DR. HINMAN: California.

DR. SCHERLIS: I am sorry, California.

Mr. Toomey.

MR. TOOMEY: California has two projects that they are proposing. The first one I have here in front of me is the South Central Multipurpose Health Services Corporation, project No. 92, with funding requested of $292,000 in the first year, $309,000 in the second year, and $291,000 in the third year.

The grant covers 33 square miles in central Los Angeles, a population of 330,000, 80 percent black, 10 percent Mexican American, 10 percent other groups.

Between 30 and 35 percent of the families receive welfare assistance, 40 percent are in the income category of $4,000 annually.

The median age is 24 years with unemployment of 40 percent for males, ages 16 through 19 years, while 15 to 20 percent for males over age 20.

The median educational level is eight years, eight years of school.

Infant and neonatal death rate in the target areas are the second and third highest in the country.

It is a poverty area and medically under served with

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a considerable deficit in the emergency services. The bulk of the emergency care is provided by USC, L.A. County General Hospital, Harvard General Hospital, and the new Martin Luther King Hospital with which support from the grant will provide facilities and services.

The objectives of this application are the establishment of a neighborhood treatment and transportation service through development of a four-pronged effort which will include providing improved emergency services by coordinating emergency services now existing, optimal use of existing emergency personnel, consultation from highly skilled professionals to improve communication between hospitals and emergency vehicles by training and upgrading capabilities of emergency care personnel, develop a cadre of 24 physicians to handle emmergency in medical care centers and hospitals and to upgrade emergency car people by creating career ladders, development of community educational programs, and a research, development and evaluation system to assess, upgrade, design, measure, and improve the emergency care existing in the operational aspects of this project.

The plan will be implemented through a four phase program over a period of three years with initial efforts in research activities for detailed planning, purchasing equipment, training personnel, developing community educational programs, and organizing community committees.

sw3

The second phase effort will include operational aspects of the plan for operation of communication system, and emergency vehicles.

The third phase involves training of personnel and implementation of the long-range planning efforts.

In summary, this application appears to be developed as a community outreach program, involving many community agencies in predominantly a black and Mexican-American population.

The project is not developed very well or factual in content.

The applicant does not display a very effective or working knowledge of the components of an emergency medical services system. There is little identification as to the existing resources and components now in operation or how those components will be integrated into a totla emergency medical system.

Specific resources are not identified and there is no reference to communication resources or ambulance services available within the area.

There is not integration as to the various linkages in the approach to the delivery system.

This application represents a haphazard compilation of unrelated data with no apparent overall plan for the development and implementation of an emergency medical system in the

sw4

area.

The project should require additional clarification, more indepth analysis, as to identification of needs and a definite plan for the development of the emergency medical services system.

I don't think there is any doubt from reading the application that there is a need for services in the area.

My memory as I remember the budget is that a tremendous amount of money was provided in terms of salaries to people in each of these phases to work in the emergency rooms, and if my memoryis correct, Dr. McPhedran, they were expecting RMP to provide not just the training, but the employment of people to work in the emergency departments.

I think as an application, it probably would get a 2, a 2.5 as a rating, and I would feel very strongly that further planning in picking out the areas in which the application is deficient and making an effort to develop a better and more adequate plan would be a desirable action.

I would recommend that this be done.

I would recommend that $50,000 be allocated right now, or at this time, for that kind of planning.

DR. SCHERLIS: Dr. McPhedran?

DR. MC PHEDRAN: I think that is reasonalbe.

I didn't think that the thing as written was satisfactory, but I would hate not to provide any funds to assist

sw5

with planning, because it is quite evident that a lot needs to be done.

I think the need is tremendouw. It puts something together, but it isn't really a system, and I think that it would be suitable to -- of course, if we give a rating of 2 and recommend that money -- I guess it is unlikely that any will come, right?

DR. HINMAN: Is that recommendation $50,000?

DR. MC PHEDRAN: We will give it a rating of 2.

DR. SCHERLIS: You concur with a rating of 2?

DR. MC PHEDRAN: Yes. Either 1 or 2.

The plan as proposed is I will say 2.

DR. SCHERLIS: Is that stated then? $50,000, one year?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: And a rating of 2?

DR. MC PHEDRAN: Yes.

Is that all right? Is that okay?

MR. TOOMEY: Yes.

DR. SCHERLIS: Is that concurred with?

MR. TOOMEY: Yes.

DR. SCHERLIS: All right. So be it.

MR. TOOMEY: I believe the comments from the staff survey also would support this.

"The project needs" -- this is the concluding

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statement -- "The project needs, truly needs, further reworking and some indepth analysis of their problem."

The second California project is from Loma Linda University School of Medicine and the California RMP.

The funds requested are a total of a hundred and --

DR. HINMAN: $170,350.

MR. TOOMEY: I have $162,000 for the first year and nothing for the second and third year. I don't know what happens on that. That is from the application itself.

Well, this grant covers region 6 of California, which includes four counties of some 45,000 square miles of mountains, desert, agricultural land, urbanized community, 26 percent of the state.

The resident population represents some 6 to 10 percent of the total California population.

During weekends, holidays, and vacation, the populations of the more populas remote areas may increase ten-fold.

Due to the isolation of much of the area, serious obstacles are presented in providing adequate emergency health care services.

Communication services provided to this four-county are are linked by a common communication network for emergency vehicles, which includes highway patrol, local police, fire and anbulances.

The specific objectives which have been listed in

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order to reduce the morbidity and mortality by increasing availability and accessability of emergency medical care, to improve communication through a central dispatch system.

The system is here. Two-way radios in all ambulances, an emergency radio telephone system for remote areas.

To facilitate rapid and effective patient handling and evacuation by use of helicopters, and fixed wing aircraft, military air-lift capability.

To publish listings of all available emergency care of services in the region for personnel involved and transportation of patients, to formalize agreements among hospitals in handling of emergency patients and among ambulance drivers for effective transportation.

To increase and upgrade manpower by refresher courses for anbulance drivers by offering associate degrees in coordination with other programs for traning employees.

The project plan is -- "Project consists of mounting a number of smaller projects," each of which appears to have relevance to the entire four-county area, but many of which will be executed in only one county.

The project includes the establishment of a central emergency communications center, a WATS line, a year-long test of the helicoter operation based in a remote desert area, a 20-hour medical refresher course for anbulance drivers, and two Associate in Arts degree courses at two local community

sw8

colleges.

The narrative participations discusses the various components and elements of an EMS system, however, it does not indicate how the various phases will be integrated, nor does it identify the deficiencies in the present system.

The specific geographic area has been identified, however, there is little discussion as to broad representation of providers, public agencies, planning agencies, and community interests.

The narrative only partially delineates the various community needs and resources.

There is limited data as to the assessments of these needs and resources.

Within the project description the applicant delineates how operating components will be coordinated with existing components already in operation.

Linkages with local health care systems have not been described nor is there evidence of involvment with community disaster plans.

The applicant partially describes techniques for utilizing existing financial resources and methods for obtaining additional financial support after the grant expires.

The narrative does not give evidence of assurance of quality of car being provided or the delineation after plan to evaluate the effects of this system.

sw9

This project was developed to serve a four-county covering 40,000 square miles, but eliminated the primary area having the highest rate of traffic just as delineated in the statistical section.

Emphasis appears to be on providing services to San Benardino area for the establishment of a central emergency medial communications center.

There are many facets to this plan which contradict other areas in the developing of the total EMS system. Contradictory areas includ the methods of financial suppport, the coordinated working relationship with community agencies in subregional areas.

There is no evidence of any plan for the integration or coordination with the areas documented as having the greatest need for an emergency medical services system.

This plan should be reviewed in more depth and further documented with clarification of the contradictory points.

The summary by the staff, Dr. Kaplan, says, "This project purports to be interested in a four-county area, but in fact appears to be only interested in San Bernardino County and those parts of Riverside County which can be conveniently included.

"The evidence for this arises from the fact they are only setting up one central emergency medical communications

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system in San Bernardino County."

In addition, their statement on page 29 concerning Mono County and the simple two-line endorsement from Mono County further supports this.

Further, the letter from the 17th states that thier review and comments are based on a November 18 communication. It would seem if Mono County were truly involved the letter of endorsement would have been based on a much more recent review of the plans.

This is also applicable to Marin.

There are other comments, but he ends by sayind, "Finally, thre is no indication in this plan of any integration or coordination with other parts of the surrounding area or potential state plans."

I felt that this also was -- should get a rating of 2.5, and I felt also that the funding should be for the continuation of the planning with particular reference to including those counties that were more remote from San Bernardino.

DR. SCHERLIS: What was the sum?

MR. TOOMEY: $50,000?

DR. MC PHEDRAN: That is more than their 01 year request that I have.

DR. HINMAN: The 01 year request was $44,000.

MR. TOOMEY: I have it down as $162,725.

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DR. SILSBEE: I think that is probably in terms of the project director looking at the first year, and his form 16 relates to the regions' year.

It is a six month figure.

DR. HINMAN: $44,000 is only a six-month figure?

So your recommendation is for $50,000 for the first 12 months of the project?

DR. SCHERLIS: Is that right?

MR. TOOMEY: That is correct, sir.

Dr. McPhedran?

DR. SCHERLIS: Dr. McPhedran?

MR. MC PHEDRAN: Yes.

I haven't got anything to add to the discussion. Where they have identified the greatest need because of remoteness and so forth, it hasn't been addressed in the application, how this proposed system would connect up with any other parts of medical care.

Of course, I suppose there really isn't very much, but it just isn't clear.

So,I have rated it low. I gave it a 2, and I am going to plead ignorance about how big a sum $50,000 for the first year would amount to.

Is that a reasonable figure?

DR. SCHERLIS: I think in terms of what we have been discussing, it is very reasonable.

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DR. MC PHEDRAN: Okay.

DR. SCHERLIS: Is there concurrence from both reviewers?

DR. HINMAN: Is there a disparity between their ratings?

DR. SCHERLIS: What was your rating?

DR. MC PHEDRAN: 2 and 2.5. That is not a big disparity.

DR. HINMAN: I just want one figure.

MR. TOOMEY: 2.25. I think both these projects are really critical projects as I read them. I think they need further study.

DR. HINMAN: Do you think they ought to be 3, then, for the planning phases?

Is that what I hear you say?

MR. TOOMEY: I said 2.5.

MR. HINMAN: You wnat 2.5 for both of them?

MR. TOOMEY: Yes.

DR. MC PHEDRAN: Okay.

DR. HINMAN: I had it down for 2 for the 92. I will change it.

I am getting a little fatigued.

DR. SCHERLIS: Two point five rating for both, and five thousand for each of the plans. Is that correct?

DR. SCHERLIS: Central New York? Besson and Toomey, again.

If any of the consultants would like to enter the discussion as far as any of the technical aspects of this, we would appreciate their patience, if you have any familiarity or help you can give us with this.

DR. BESSON: Okay. Six projects for this applicatio requesting funding from July '72 to July '73 of 306,000. The six projects are:

1. The development of a regional council for EMS.

2. The development of council components in B agency areas.

3. The development of a communications systems.

4. Advanced MET training.

5. Public education through the American Red Cross.

6. Public education through the American Heart Association.

The total objectives are as is indicated here, plus a few other subcomponent parts, inventorying ambulances, evaluating EMS components, public education, first aid, general courses in first aid education, improvement of detection, notification and feasibility of an air-medic evaluation program. There are seven counties involved in this central New York area with a population of two million. The specific components, first the regional council that they propose to

develop is -- this will be the group that develops and coordinates the model program in the Syracuse-Cortland-Binghamton area for training, communications, equipment standards, system of detection notification and dispatch. All of these will be to test the program components, evaluate them, and if and when that is done, expand them.

There is a relative poor history of regionalization in this area and a history of a lack of general coordination. But this is a proposed effort at $40,000. This is probably worthwhile.

Second is they hope to expand this to develop area councils, as well as a regional council to inventory the local needs and resources and relate to the regional council for meeting these needs. They want to develop a plan for the locals to do what the regional will do regarding detection, notification, and so forth. They are going to split costs here with Comp planning and RMP's bill will come to $57,000 for a year.

The third component is advanced MET training. They have had one group, a RMP group, talk about the training of MET, but there are very scant details. It is only referred to in one small aspect of this application. They request 29,000 for one year. This includes stipends for two students at 17,500. Are stipends disallowed in this program? There is some comment made in the guidelines about that. I am not sure

where we stand.

DR. MARGULIES: I think we could allow them if they are essential to the program, yes.

DR. BESSON: A fourth program is developing a radio communications system in this Syracuse-Cortland-Binghamton area, so that a physician may be directed -- "Physician may direct care at the scene and enroute."

Now, this includes the purchase of 11 base stations at $4600 a piece, 17 mobile stations at $1600 a piece, six tape recorders at $900 a piece for hospitals, branches and so forth, for a total cost of $99,000, all of which is very laudable, but there are endless costs involved in hardware purchase for private institutions.

Nonetheless, I assume that is okay with this committee. It is essential to the development of a funcioning program. So in that light, I think that is probably reasonable.

Then, there are two major public education programs in first aid. That is Red Cross first aid. There are 25 chapters of Red Cross. Is Red Cross right? I feel as though I should be saying Blue Cross. Between June 1970 and 1971, they trained 3,000 people, and there are many more informally trained, perhaps an equal number. So if we guess there are 6,000 people trained in this effort at first aid, they are requesting $6,000, so at a dollar a piece, that is a bargain.

The Heart Association also is mounting a public

education campaign on cardio-pulmonary resuscitation. They have had 30 classes between 1970 and '71 and 453 certified CPR people. They want 50 additional courses at 29 -- at 20,000. In general, this is an attempt in central New York to produce a coordinate education program. It is very sketchy and very slapdash but it is far better than nothing and though it is inadequate on a grade of one to five, I would grade this three. And I would recommend full funding. It is of interest to note that the hectic pace that was engendered by the submission of this application between April 19 and the time of the February 24th letter sent the coordinator to a hospital with what was described as nervous exhaustion.

And then by 4-26 when the application finally came in, there was an addendum saying, "P.S., he is much better, thank you." And somebody finished the application and sent it in.

DR. SCHERLIS: That is for one-year funding?

DR. BESSON: Right. The emergency medical services through integration of its components into a total working system through a 17 county area. The plan, I think, has been developed as an evaluation. Perhaps the most essential element of this system is a development of a radio communication network with an interhospital and ambulance communication on a regional basis, which accounts for one-third of the funding requested. The review indicates the program description is

weak in the area of quality assurance and evaluation. There is a need for local and regional organization which will spend approximately two-thirds of the money requested. Potential resources not documented, however, the model program area and services are adequately listed. The application centered around two major components, an advanced emergency medical technician training program and a communications system.

The application appears to be innovative in the area of EMT training due to the lack of physicians and emergency room facilities in the north country. Applicant stresses the priority of training over equipment for proper implementation and coordination of the total system. It appears that a total communication system in this region is needed and the applicant has planned for an effective implementation.

However, applicant refers to how the areas should develop a communication program but little emphasis is placed on the funding mechanisms for future expansion into rural areas and appropriate training of personnel prior to the implementation of the equipment facet. The application is a -- it lacks in department planning, identification of resources, utilization of present resources, methods of future financing for rural areas, and a plan of action for the total implementation based on the results from the model program. I think on

this basis, that I would agree with the three rating.

DR. SCHERLIS: Would you suggest full funding? Do you think they can utilize that effectively from some of the points that you have made?

MR. TOOMEY: Yes.

DR. SCHERLIS: Who would be in charge of this overall plan, the RMP itself?

DR. BESSON: They will develop a regional council.

DR. SCHERLIS: That will be it?

MR. TOOMEY: And then subcouncils.

DR. BESSON: And then subcouncils, in coordination with the Comp planning, local areas.

DR. SCHERLIS: Dr. Joslyn?

DR. JOSLYN: I just wondered whether the committee has the right or the intention in any of these where there are multiple facets that are clearly separated, to make any distinction as to which programs warrant funding and which do not? In other words, this has a total budget of a little over 200,000 but it is clearly broken down into six projects in four areas.

Now, you know, does the committee have any intention as they go along in different regions to say that certain projects warrant funding, others do not?

DR. SCHERLIS: I would assume we do. Am I correct in this? I would have no hesitation in supporting a

recommendation that a certain project not be funded or another project be cut significantly. I think in this type of review, we would have that ability.

DR. BESSON: Mr. Chairman --

DR. SCHERLIS: Not necessarily the wisdom but the ability.

DR. BESSON: I think Dr. Joslyn's point is well-taken in that as I went through the six components, I made a comment about the individual funding request for each. To reiterate, the regional council should be funded, the local councils should be funded, particularly since we are splitting costs with Comp planning, the advanced training for technicians, if stipends are okay, and I think they are, should be funded.

Radio communications, I have some hesitation about the purchase of all this equipment, but I think that it is an integral part of their system. Public education, I think that is where I mention a bargain at a dollar a piece for Red Cross training and 20,000 for American Heart Association program also.

One of the problems with central New York is the fact that they need something to get their teeth into, to do things on a cooperative basis. This is the first indication that they might be able to mount such an effort. I think they should be encouraged. And in passing, too, I might make another comment.

As I have reviewed all of these applications and wondered about how RMPs can assist in this national neglected disease, I thought our function would probably be best served by our acting as a catalytic agent and be generous in our funding of seedlings, rather than single, massive programs. In that sense, if there is a program that I encountered which had any merit at all which wasn't just a ruse for getting some bucks out of the Feds, and would produce an opportunity to do just what RMPs started to do many years ago in planning and developing an organization for creating regional concepts, then I thought it was meritorious enough to get at least some monies, rather than turning them off completely.

In that light then, I think central New York needs help. This may be an indication of how we might do it.

DR. SCHERLIS: This speaks more of a system of care certainly as compared to the --

DR. BESSON: Yes. It addresses components parts and integrates them.

DR. SCHERLIS: The recommendation is a rating of three with full funding. Any conditions for the award? Obviously the question of stipends for training you wish to look into.

DR. BESSON: I don't think that is conditioned.

DR. SCHERLIS: As far as you are concerned, this is a one-year --

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DR. BESSON: It is a one-year request. They have a three-year request -- no, it is all one-year. The only conditions would be to do a good job.

DR. SCHERLIS: Any other comments from members of the committee? I will accept this as a motion and a second. Any further discussion?

All those in favor say "aye."

(Chorus of ayes.)

DR. SCHERLIS: All right.

Do you have any comment at this point?

DR. MARGULIES: The only comment I would make here, now that your action has been completed, is that I think that the reasons for doing it make very good sense. It is a region which has had problems in the past. It is under new leadership and this will give them something they can bite into. We will have to talk with them about what they intend to do in the future, whether this is a part of the future program development. But for this region, it is just as well they don't go beyond a year.

MR. STOLOV: The reason they are asking for one-year funding is that the regaional advisory group and executive committee asks they only come in for one-year funding due to the nature that there is no appointed full-time coordinator.

However, I believe that since they actively recruited a consultant to help them with their EMS planning,

and their plans for their application which is due in here July 1st, that they may, in all likelihood, continue this as a major part of their overall program, should they have a three-year plan. But that was it.

DR. SCHERLIS: Next is Connecticut.

DR. BESSON: One other comment I would like to make in this connection that struck me about this application and one other application, Illinois, when we come to it, is that as RMPs has moved into -- since the St. Louis meeting, and I don't know what has been happening in the past year -- new areas of focus, and if our area is health delivery, throughout the country we are seeing perhaps a reaction to that movement on the one hand in the turbulence in the core staff, with people who originally came on to RMP in a categorical fashion now having to look at a much broader view of health delivery, and also, on the other hand, on the private sector, where there are groups that we thought were very strong who are now beginning to question whether RMP has a role in health delivery. Witness some of the telegrams we got, in at least the application that I have, California and Rutgers, where the private sector is perhaps stiffening their resistance to RMP's intrusion.

Now, emergency medical services, I think of all of the areas that RMPs is moving into, that is one less highly charged, I think, than some of the other potentials, like HMO

and quality of care. Therefore, I think wherever we have an opportunity to develop linkages with the providers, particularly, which are very weak in many parts of the country, in this non-threatening area, for example, we should encourage it.

Now, for an area like central New York that can mean a great deal. So whatever encouragement we can give them in dollars, even though we don't give them encouragement in dollars for other programs that may be just as meritorious, I think we should.

DR. MARGULIES: I would like to recognize Dr. Kelley from Ohio State has arrived, one of our consultants.

DR. KELLEY: Thank you.

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DR. SCHERLIS: All right. Connecticut, Dr. McPhedran.

DR. MC PHEDRAN: The Connecticut request is for one year, total funds, 328095, and it is mainly organizational and exploratory. I'll say at the beginning that I rated this at three, perhaps lower than the staff review, and I'll state at the outset the reasons for this are, I have some questions about why no interrelationship between this and another program, another project I reviewed, that is, Tristate. I am not sure I really understand that. And also there are some intrinsic problems within the region itself.

The intent of the project is to, as stated on the Form 15, organize statewide EMS systems -- develop and organize, through regional regulatory and management mechanisms, and to launch an operational EMS demonstration in the south central region, that is, metropolitan New Haven, and surrounding regions. And they intend to work through the Yale trauma program, which is a going concern.

This is for a one-year organizational period, expected to provide the framework for a statewide analysis of EMS delivery. And, then, of course, the demonstration in the New Haven area.

It is stated that -- it is hoped that the experience in New Haven, the demonstration there, will be such that it can be -- what is learned there can be extended to the rest

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of the state through this EMS consortium. The consortium which is proposed will build on the one which is now working and which is centered around the Yale trauma program.

Now, some of the problems, questions that I had about this, are now well -- what can be learned -- how much one can expect to learn from the New Haven area to extend to the rest of the state. I wonder whether this is a realistic idea.

I don't really understand also why, if they could propose this activity for one year -- I don't really understand what is going to happen after the one year. It seems a little strange to me that these monies are requested for one-year activities. I don't really see exactly what is going to happen after that. There are plans for funding from other sources spoken about on the application, but that part of it didn't seem definite or detailed enough for me to understand exactly where they are going from there.

So this is essentially a planning and organizational period for which funds are requested. Some general plans for the state as a whole, some specific plans, and a demonstration project for part of the state are included. I have already given the amount, I think. I recommend its funding with reservation.

I hope that we can discuss this matter of inter-regional planning and cooperation. It is difficult for me as

someone who was born and bred in the northeast to understand why there isn't evidence in these two applications, Tristate and Connecticut, of more conversation between the two of them. I would have thought there would be some pertinent issues they should discuss together. But I don't see any evidence of that. Maybe it would just make the application too big.

DR. SCHERLIS: Let's have the secondary reviewer and then we'll throw this open for discussion. Dr. Besson.

DR. BESSON: To reiterate some of what Dr. McPhedran has already presented, they do want to organize a statewide EMS program through what they describe as regional regulation and management, and then create a single demonstration program in the south central portion of New Haven. Number three is to develop an EMT training program and then create what they call a consortium between the Yale trauma organization, New Haven Health Care, Incorporated, which is a newly funded experimental health services delivery system, apparently, and Dunlop Associates, who are now nationally famous, to organize, train, and produce and implement an action program regionally.

And then the final program is to have a year to organize an analysis on the content of this demonstration program.

Now, as I looked at the budgetary breakdown for

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this $300,000 - $328,000 they request, pages 14 to 16 of the application, are the only places where a budget is mentioned, and it is extremely sketchy and no breakdown.

The New Haven Health Care, Incorporated, program is also described in a very sketchy fashion. They merely mention it, that they will consider it with the newly funded experimental health services delivery system, and they describe it, but it is apparently a new organization that has a very fussy goal. While I haven't seen the EHSDS, I am not sure how much they can cut the mustard. They have very sketchy information, as Dr. McPhedran has pointed out, on the development of either statewide, regional or interregional program.

Their information on their EMT training, which they describe as one of their component parts, is described in one line, practically. They speak of the implementation of an EMS system component to facilitate, organize and direct EMT training throughout the state, although Dunlop Associates, of course, has a good track record, and presumably will help them in their developmental portion.

They have no information on how they will relate to the Yale Trauma Program. And then they very poignantly state they want funds because the Department of Transportation may phase out their funding. And they say besides the Department of Transportation funds probably should better be

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used for highway accidents and purchase of related equipment, and "we have a broader mission."

I think the entire application is very limited in description, and I would be interested in funding them only on conditions that they provided more details on how they expect -- there has to be some more meat on these bones they present.

But again I can be charitable and say the application was just put together in the usual case for this whole series.

DR. SCHERLIS: May I ask a question? As I view the document, apparently this was really put together for the Department of Transportation in May of '71, with some introductory statements at the front. Is that correct? Because I was looking for the budget, I was curious how they were going to spend this in a year and not tie up people who entered the program, wondering about the second or third year.

And again I could find no budget here at all except for the sheets which are surprisingly specific about salary and wages, $172,312, but yet nothing that in any indicates how they arrived at that figure.

DR. BESSON: They had an ongoing program with the Department of Transportation, and the Yale Trauma Program, and this is an extension of that, basically.

DR. SCHERLIS: Dr. Gimble? Do you have any concept

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of how those numbers were arrived at?

DR. GIMBLE: I found the whole application was very scant in detail and though their general motives looked like they were in agreement with RPS goals, most of it lacked detail of any sort, including the budget.

DR. BESSON: The other thing, Mr. Chairman, that might be appropriate with this application is that since -- the bulk of this application involves a continuation of the Department of Transportation program with the Yale Trauma program, and since this is just a tentative exploration of the development of an EMS system on a statewide basis with a demonstration program, with the experimental system, it might be that in asking for more details on how they expect to go about it, that we might ask them to use other funds for this, for the year, and see whether they are really going to add to what has already been done with the Yale Trauma program of the past.

DR. SCHERLIS: Is all this trauma-oriented, if we are going to speak about a system of care?

DR. GIMBLE: The current Yale Trauma system is, but I was a little hesitant about how applicable what they are going to do in the Yale-New Haven area, not being very familiar with Connecticut in general. But I am sure the rest of Connecticut doesn't resemble the New Haven area and this system is going to be modeled very strongly on the New Haven

area. I was hesitant about how applicable it would be to the rest of the region?

DR. SCHERLIS: Dr. Rose?

DR. ROSE: Would you like comments from the branch, the general terms, about RMP? Might that be helpful, how this might tie in?

DR. SCHERLIS: I think it might be helpful if we had some general background. My concern has been voiced by both reviewers.

The budget, and is this going to be essentially trauma with the Yale-New Haven area as a model, with less overall system involvement?

DR. FAATZ: I think generally for years and years New Haven has been probably the most heavily studied town on the east coast, and I think RMP is probably following that same tradition.

The New Haven south central area of Connecticut is being set up as a demonstration for the rest of the state because Yale is there, and it is the easiest to get to.

DR. MARGULIES: I am curious, in this application, about the fact Connecticut has in its RMP this general design of linkages between hospitals which cover the entire state and from what you have described to me, it seems to me they have ignored their basic structure and have set up something quite different. I don't understand that.

I would have thought that that hospital system that they are trying to design would have been quite a good vehicle for statewide emergency medical systems.

DR. MC PHEDRAN: It is not clear that they have set up something so much different but they have set up something just with no relationship to that. It doesn't have enough specific details to tell if it is different, really.

DR. BESSON: That is the impression that I get. I am very restless about the fact that again -- and I may say this a few more times,Len, over the next eight hours -- that now that RMPS is moving out into the area of health delivery, we are really going to be testing whether the linkages that we speak of in such glowing terms in RMPS are really there.

Now, if they are really there, Dr. Clark should have just fallen right into the skeleton that we talk about that is going to be so useful. If they are a sham, which I personally believe they have been in Connecticut for some time -- I think they have been a ruse for the medical schools to buy some additional salaried people -- then the linkages don't really exist for putting this kind of delivery system onto that skeleton.

Now, I don't know how else to look at Connecticut. Clark is a pretty bright guy and I think that they are just not equipped to move out into a broad-based community organization and get into health delivery.

So they flounder around and look for an organization that is not even funded, and want to contract with them to do it. Well, all I can say is, this is what core staff, if the linkages are there, should be able to just move right into.

So the fact they are not makes me a little bit leary that they do have the linkages competence.

DR. SCHERLIS: Yes?

DR. FAATZ: I think the Connecticut regional medical program was only peripherally involved in developing this project, if at all. I think it was developed by Yale trauma and other people.

The RMP is being used as a vehicle to get funding, and Dr. Clark and the Dean of Yale and those people signed off on the request, and it came in. But RMP I believe was not involved in the development of the program.

DR. SCHERLIS: I ask this only for information.

Is my interpretation of the indirect costs, 66 percent at Yale --

DR. BESSON: Yes.

DR. SCHERLIS: Is that right?

DR. BESSON: That is correct.

DR. SCHERLIS: I guess I hesitate over this one to get more direction for myself and the members of the Committee.

Is this a system of care? I would think that with all the studies that have gone on in that area -- those of you

who can see, this is a thick document filled with questionnaires but no data. Isn't that correct?

DR. MC PHEDRAN: That is correct.

DR. ROSE: Can I comment for just a moment?

DR. SCHERLIS: Yes.

DR. ROSE: Actually the questionnaires represent a statewide survey. I tried very hard to get some results from the survey figuring that you all would need this.

DR. SCHERLIS: Yes.

DR. ROSE: It turns out they will not be available until next month. So, the questionnaires have been used.

DR. SCHERLIS: I was curious how they arrived at need in terms of this request for funds.

DR. BESSON: They have some preliminary idea. They have a preliminary analysis of this survey which is the thing that has been ongoing between the -- funded by the Department of Transportation.

This was submitted May 1, 1971 -- submitted by the Yale Trauma Program to the Department of Transportation, this entire thing. But they do have a preliminary analysis, and I just can't --

DR. SCHERLIS: You have all agreed on a grade 3.

DR. BESSON: Oh, here, excuse me, Mr. Chairman. The preliminary analysis of all of this data has pinpointed five areas: Lack of trained EMS personnel, lack of community

organization, uninformed public, no linkages, and no objective standards to evaluate.

Now, if they were to address, even on that preliminary basis, some of these objectives, they would have an entirely different program.

DR. SCHERLIS: I have some concern at this point, in that while you have recommended a rating of 3, you have also recommended full funding -- would there want to be some reconsideration of whether or not if you are going to make a recommendation we might not restrict this to just some seed money to begin to set up some developmental --

DR. MC PHEDRAN: That was my recommendation. I don't know whether Dr. Besson concurs on a rating of 3.

DR. BESSON: I concur on a rating of 3, or maybe one as low -- maybe two-and-a-half, but my suggestion was to approve the application but request that RMPS have no new funding and fund it out of core.

DR. SCHERLIS: In other words, you are saying it is a pretty good application but you aren't recommending any new funding?

DR. BESSON: They have plenty of money. As I remember that Connecticut application, it was in the seven figures.

DR. SCHERLIS: Are the niceties of that recommendation appreciated by the primary reviewer?

DR. MC PHEDRAN: Yes. I don't know whether -- can we do that? I am not sure we can.

DR. MARGULIES: That actually would pose a problem because if there is anything that that program needs, it is a stronger program staff. That is one place where they don't have any fat; they are very weak. And we have been pushing them hard to strengthen that program staff.

So, you might look for other sources of funding than that, if you want to. I think that would not help that program.

DR. MC PHEDRAN: Maybe that program -- maybe the Connecticut regional medical program shouldn't have let this come in under their name if they weren't going to have more input into it. Maybe they can be faulted for that.

But as stated in the note from the eastern operations branch, they apparently -- this is not something that has been central to their interests, this kind of activity, in the past. And maybe -- I don't know, if it hasn't been central to their interests, it perhaps would be a disservice to them to say it is a good thing to do, go ahead and do it, with your present moneys and present staff. That might just injure the rest of the program, or they might feel it would injure the rest of the program.

Perhaps it would be better to approve it with some funding that would seem enough to enable them to get started with part of it at any rate. I don't know what that would be,

really.

DR. SCHERLIS: There isn't enough?

DR. MC PHEDRAN: There isn't enough data to tell.

DR. SCHERLIS: If they had a gross figure here of 120,000 or 450,000 I think we would be just as lost as to how they were going to spend the money.

DR. BESSON: They don't tell us what they are going to do with the money. They don't have any budgetary breakdown; it will be all going into the Yale slush fund. Excuse me. And besides, the EHSDES Program, if it has been funded -- and I assume it has been -- that is what this experimental system management board is supposed to do anyhow, so what is RMP putting money into that pot.

DR. MC PHEDRAN: Experimental health services delivery?

DR. BESSON: Yes.

DR. SCHERLIS: Any other comments?

DR. BESSON: What is the motion?

DR. SCHERLIS: There is no motion.

MR. MC PHEDRAN: I wonder if there is some mechanism that can be suggested by RMPS that we could arrive at a figure that would be realistic to help them, say, for example, get the statewide consortium, since the application ability of the New Haven model seems to be, what there is, the most questionable part of it; what would it cost them to get the

statewide consortium that they described going for a year, and then as Dr. Besson suggests, maybe the experimental health services delivery people would find enough of their own money to begin the demonstration model.

Could we say that we would approve it for that part of it which would put the statewide consortium into operation?

DR. SCHERLIS: I think that is a reasonable request.

DR. MC PHEDRAN: I don't know about the numbers, how to put a figure on that.

DR. SCHERLIS: I think we need a dollars figure on that, to know what kind of a staff they would need to implement that.

DR. MARGULIES: The situation with the experimental health service delivery system is that it has only been recently approved, to the best of my knowledge. So if it depends upon that, there is also a question of whether it might not be better to limit what they do until that develops into some better relationship. Because it did go through with the Coordinating Review Committee just the last time.

So nothing really has happened yet, although they have been working at it for a year.

DR. BESSON: I second that motion.

DR. SCHERLIS: In other words the motion is to the effect, number one, the rating is two-and-a-half or 3, somewhere in that ball park, and that the support be limited to setting up

a consortium as its major effort.

What was the other --

DR. BESSON: Not consortium, the statewide EMS.

DR. MC PHEDRAN: When they say consortium, that is what they are talking about.

DR. BESSON: Consortium is used as the key word for the trauma unit, New Haven Health Care Incorporated, and Dunlop Associates.

DR. SCHERLIS: Shall we say a total statewide EMS.

DR. MC PHEDRAN: Planning, development and planning phase.

DR. SCHERLIS: That would be limited to a planning, developmental phase for total statewide EMS. Is that correct?

DR. BESSON: Yes.

DR. SCHERLIS: What level of funding, just so we'll have a number here. They have been arbitrary in their request for funds, so we can be arbitrary here.

DR. MC PHEDRAN: The total amount they asked for was 328. Do you think a half or a third of that is reasonable?

DR. SCHERLIS: That is extremely generous for this developmental planning phase but that may speak of my own Monday morning feeling, as far as funding goes.

DR. GIMBLE: I have a feeling it is going to lead to the same problem. Can you word it in such a way to preclude money falling back into the Yale Trauma --

DR. BESSON: I thought that was part of the motion, that the conditions were that these moneys only be used for these purposes.

DR. MC PHEDRAN: Statewide planning.

DR. SCHERLIS: Statewide planning development phase for total EMS.

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: This is not limited by any means and in fact it should not be under to be trauma-based, but a total system base.

Is that separated from the present orientation of the Yale funds?

DR. GIMBLE: I'm not sure, if the people that are doing the planning are in this, in the Yale program.

DR. SCHERLIS: Would you say that the planning be centered through the regional medical program core office? Would that give them another loan?

DR. MARGULIES: That it be done by the regional medical program.

DR. SCHERLIS: It be done by the regional medical program and that ceiling be 50 to 100.

DR. FAATZ: I have a feeling in the discussion, maybe I have something nobody else has --

DR. BESSON: You have the only extant copy, I think. If that is a breakdown of the programs, I have never seen one.

DR. SCHERLIS: I have that front sheet but that is all. Is that why you've had that knowledgeable look on your face?

DR. BESSON: They come up with 19,000; I guess that is their component.

What is this Connecticut State Deparpment of Health? Is that their statewide program?

DR. MC PHEDRAN: I think that is the statewide -- wait a minute; that is the EMT part of it.

DR. BESSON: The EMT had been previously put together.

DR. MC PHEDRAN: It will be continued through the Connecticut State Department of Health.

DR. BESSON: Connecticut Regional Medical Program is requesting 19,000. You were about ten times too generous.

DR. MC PHEDRAN: Right.

DR. HINMAN: We can put a ceiling of 100,000 and ask staff to negotiate the actual figure necessary to do it. I think that would be a fairly clear directive.

DR. SCHERLIS: Is that an adequate directive for staff?

DR. MARGULIES: Yes.

DR. BESSON: I think 100,000 is too much in the light of this budgetary breakdown.

DR. SCHERLIS: We do not have those copies.

DR. BESSON: Here, organization and development of

state and local.

DR. MC PHEDRAN: EMS.

DR. BESSON: EMS.

DR. MC PHEDRAN: This is also Connecticut State Department.

DR. JOSLYN: How much were they asking for the organization? Is that still 19?

DR. MC PHEDRAN: No --

DR. BESSON: They speak of this as components but they don't tie the components to what we have had here.

DR. SCHERLIS: I suggest you look at that, and the rest of us will help ourselves to coffee.

Perhaps you can come up with a figure. Apparently you have the only copy extant here of that document.

(Recess.)

DR. SCHERLIS: Let's get started.

Dr. Besson and Dr. McPhedran, have you worked out a joint resolution?

DR. MC PHEDRAN: The figure we found from sheets which were supplied, the direct cost figure was 19,000. This was a figure specifically for the statewide planning for EMS through the Connecticut Regional Medical Program. That is the institution affiliation which is listed.

It is component 5, Roman Numeral 5, of this budget breakdown. That is the figure there, 19,000 direct cost.

DR. SCHERLIS: The recommendation is for --

DR. MC PHEDRAN: Funding of that.

DR. SCHERLIS: Funding for that?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: The funding would be restricted to that item as specified in the budget? We don't have to have excessive working on that. That has been seconded by the secondary reviewer.

DR. GIMBLE: Nineteen thousand?

DR. SCHERLIS: Yes, direct. We have lost two of our reviewers. While we are waiting, will each of you please fill out your lunch requests. Restrict your items to those listed on the form.

The motion has been made, reviewing the budget, that they be funded for that item which is in terms of helping to plan their total EMS Program which came to 19,000.

That was seconded by the secondary reviewer.

Any further discussion?

All those in favor say aye.

(Chorus of ayes.)

DR. SCHERLIS: Opposed?

MR. TOOMEY: What was the rating?

DR. MC PHEDRAN: Three.

DR. SCHERLIS: The rank was what?

DR. MC PHEDRAN: We said two-and-a-half.

DR. SCHERLIS: Two-and-a-half.

DR. ROSE: Is that for the approval as presently set up?

DR. SCHERLIS: I don't know. Is that for the total program or as presently set up?

In other words --

DR. MARGULIES: It was for the total.

MR. MC PHEDRAN: For the total.

DR. SCHERLIS: What range would you attach to that present, limited, restricted recommendation?

DR. MC PHEDRAN: I think that was satisfactory. I would give that 3 to 4, that part of it, myself.

DR. SCHERLIS: Would that be satisfactory, then?

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DR. BESSON: Three. I would agree to three.

DR. SCHERLIS: Dr. Roth? Which one would you like to begin?

xxxxx DR. ROTH: Florida. I hope I can dispose of this very quickly, because on the basic assumption that funds are not available for the satisfaction of all grant requests, I would take the position that Florida is not being discriminated against if the request is denied, because Florida is a resubmission of a grant which has gone throubh council, which has been approved by council as a regular RMP operation.

The Florida position is that they should not be discriminated against because if they could get the funds from this, it would liberate the other funds for them to carry on some other, unrelated projects.

I think this would be nice if you had unlimited fund ing but my sentiment is to say that that is too bad, not to fund it. It is an excellent application.

DR. SCHERLIS: I thought it was a rather plaintive statement to say that got the money before they knew they could get it from another source. But I concur with you completely, that they are already in this and what they want is double funding in a way so they can spin the money for something else.

Staff have any comment?

VOICE: Dr. Sloan concurred in that feel.

MR. TOOMEY: She did?

DR. SCHERLIS: Fine.

Florida is taken care of.

VOICE: What kind of rating?

DR. SCHERLIS: No money, no rating.

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~~remain until the bitter end.~~

DR. HINMAN: We haven't finished up the South Central Branch. Illinois, Georgia.

MR. TOOMEY: Wisconsin. How did Wisconsin get in the South Central Branch?

DR. HINMAN: Central emphasis. Georgia should be next, I believe.

DR. SCHERLIS: The Chair would be in favor of entertaining a suggestion we have a five-minute break.

MR. TOOMEY: I so move.

DR. SCHERLIS: So ordered.

(Recess.)

DR. SCHERLIS: We will do Georgia, now.

I am the primary reviewer for Georgia.

Georgia posed a dilemma for me. They state that in Georgia, large areas of the state do not have adequate emergency medical services available and those services which do exist are indeed substandard.

So in conjunction with the Office of CHP, Emergency Service Division of the Georgia State Public Health Department, State Highway Safety Coordinator, they developed a plan for a comprehensive EMS system for the region.

They are aiming at supporting emergency room service, backup facilities and specialists to apply definitive care, transportation, communication systems, training of

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personnel, development of physical mechanisms, so on, and the Georgia regional medical program will provide initial salary support and training for emergency medical technicians to supplement ambulance and communications equipment provided by the Highway Safety Bureau to provide intensive care capability, life support systems, monitoring to enhance the ambulance capabilities. They would charge fees for the ambulance services in the subsystems.

The project in a bit more detail asks for -- as far as funding is concerned -- a level of $242,000 for the first year, 343 for the second, and $356,000 for the third. Most of the support is actually for ambulance personnel. I had some serious questions about this, because first of all there is the problem of what happens when this grant subsides. I see no more reason for there being any likelihood of support 2-1/2 years from now as compared to the present time. They ask for equipment in terms of dispatch equipment which comes to approximately $30,000.

There is excellent documentation in the request as far as the needs for the funding. My concern is that this essentially relates to ambulance support, rather than being a total system. When one looks at the budget, the requests that were originally put in appear to be aimed at another source for funding, rather than to the type of emergency medical system which is being looked at the present time.

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They have already purchased some 40 ambulances. As I have said their aim is to develop and demonstrate the effectiveness of a multi-county emergency medical service system. The yellow sheets were reviewed by Dr. Sloan, and part of her comments state, again, what I have reiterated. She states that they havetouched all the basis of government and local support, reiterates the sums that have been involved as far as requests are concerned.

My biggest problem relates to the fact that so much of the funds requested really look at the support of ambulance personnel as the main item, rather than anything else. I want to get the detailed budget so that I can document that for you. If you find it before I do, that will be just fine.

Part of the difficulty I am having relates to the fact that the grant is not put together very well.

Here it is, budget justification.

Their ambulance personnel will be in terms of total coverage of the ambulances for a complete, round-the-clock coverage. This comes to a base salary of some $245,000. This concerns me, that in essence, we areproviding the staff support for their ambulance system.

I think this goes well beyond what the RMP should basically be requested to do. It does not address itself as it should to the total system of care but more specifically,

ty 5

as I have indicated, just to mamming the ambulances, and this is where most of the funding is.

Also for equipping the ambulance service.

My own feeling, as far as this grant request was concerned, was that it did not merit support as a total system, that I would be much more in favor of their looking towards a plan. It gets down to what we have discussed previously. I don't think the RMPs can be in the business of staffing the ambulances around the country, as this request, I think, would put us in the position of doing.

My initial feeling had been to fund this at a very low level, and after having heard the various reviews today, I still feel that way.

Do you have any comment? You haven't had a chance to review this, have you?

MR. TOOMEY: No. I have just read this.

DR. SCHERLIS: Who in staff has had contact with the Georgia system?

VOICE: I had a little contact, Doctor.

DR. SCHERLIS: Do you have any background on this grant itself?

VOICE: No, sir, I don't.

MR. TOOMEY: I think from a philosophic standpoint, I agree with you.

DR. HINMAN: I am trying to find the backup, and

ty 6

I can't find this letter.

DR. SCHERLIS: You see, my concern is that the County Board of Commissioners says after 2-1/2 years, we will pick up the support of that staff. And my concern is, you know, why not now? Why should we pick up the 24-hour -- at least the main coverage as far as these individuals go? My feeling is they do merit some support more in a planning phase than actually supporting these individuals. And there is enough element here, as you look through it, of bits and pieces of a total system, that I recommend more limited support, possibly to the sum of $50,000, so they can move this along for the first year.

Do you have any comment on that?

MR. TOOMEY: Just a comment of agreement.

DR. SCHERLIS: All right.

If that is satisfactory, then we will move on.

DR. HINMAN: You are recommending 50,000 for the first year and what rating?

DR. SCHERLIS: But not the support. I suggested three. But not for support of the actual ambulance drivers. I think that has to come from other sources. Most of the funding would be for that and I think they should emphasize the training aspects. It will go much further than paying the salaries of individuals.

All right?

ty 7

MR. TOOMEY: Was there any amount provided for training purposes? Because along with the planning for the --

DR. SCHERLIS: They have a very highly detailed schedule here as far as lectures and background and training, and this would be of some help. They do discuss specific material that would be part of their program. The problem is that they have put most of their money into salary support for the ambulance crew, rather than in the training. I think we should suggest this is the area they should emphasize.

MR. TOOMEY: The planning would provide for the development of budgets for training programs.

DR. SCHERLIS: Right, the training.

MR. TOOMEY: As well as other facets.

DR. HINMAN: Just to understand, this is basically planning and some training.

DR. SCHERLIS: Yes.

DR. HINMAN: 50,000 for one year only with a rating of 3.0?

DR. SCHERLIS: Right.

DR. HINMAN: Okay.

The next one will be on --

DR. SCHERLIS: He can come back in, then. Dr. McPhedran can return.

DR. HINMAN: The record should show that Dr. McPhedran was out of the room during that review.

~~DR. SCHERLIS: Two point five rating for both, and five thousand for each of the plans. Is that correct?~~

The next application is Hawaii. Before I start to review this, I have gone through this at least five times, page by page, to look for a breakdown of budget, here.

Who is Hawaii? Anyone here spoken for Hawaii?

Do you have any breakdown of budget aside from the large folding sheet? Because they come to sums of money that go down to the very last dollar, like $871, and I have no way of knowing -- I can't project their costs, which is a perturbing feature to me.

All right. The proposal, itself, is submitted in relationship to the State of Hawaii, and it comes in from the Hawaii Medical Association.

They have prorated a program over some four years in a very well organized manner, so that they have indicated their goals for each of the specific years in some detail.

There has recently been a forum in Hawaii, a meeting which discusses the emergency medical services for that area, and I reviewed the program in it, they put in a great deal of the content.

It strikes me as having been a very well organized program cooperated with by many different agencies, and this was something that probably helped them a great deal.

The planning committee and their sponsors were

jr 2

widely representative of the State of Hawaii. I'm sure this helped move them along in their total planning phase.

Their detailed program I'll report on very briefly.

What they propose to do, for example, during the first year is to train their ambulance service personnel in EMT before the start of their program.

They discuss this in terms of emergency medical facilities, in terms of their ambulances, in terms of training them with EKG telemetry, cardiopulmonary resuscitation.

They will set up emergency communications during this time, and develop an EMS advisory committee, and develop a comprehensive program for collecting data. This is first year.

The second year they talk in terms of additional training, additional involvement of the neighboring islands, as well as Oahu. There are ambulances being set up as far as advance communications and treatment.

They then introduce the concept of a trauma center and there is contained in their application a detailed discussion of a shock and trauma center, which is at the Queen's Medical Center, which is the large teaching hospital in Honolulu. It is one which apparently has been planned for some time.

The sum of money for this I am not sure of. Somewhere there sticks a figure of approximately $400,000 in my mind but as I have indicated -- here it is -- as I have indicated there is no breakdown of total budget except this one item, that comes

jr 3

from the first year to $253,000 for the trauma unit. And then subsequently, sums of $76,000 for the second year and $79,000 for the third, these are essentially in terms of personnel for the latter two years.

The first year, most of this is in terms of facilities and equipment. For example, remodeling costs, $194,000. Equipment, a total of something like $89,000. I think we'll have to address ourselves to that item specifically.

The trauma center would be the second year, with again the development of emergency medical communications.

The third year, additional training program. A trauma center would then be operative. The fourth year the evaluation of the fiscal analysis would be the most important part of their program.

They request over a period of 3 years sums which are as follows: $777,000 for the first year; second, $982,000; the third, $382,000. And as I read this, I had a gut reaction that their overall planning and program looked very good with the exception of the shock-trauma unit, which requires renovation and construction. I don't know if this could be supported.

The other problem that I had, although I rated this 3.5, was in terms of the support, because I have no grasp of their budget. That is why I asked.

Perhaps it was omitted from my book. But I leafed through this not only at home but here, page after page, and I've done

jr 4

this three and four times. I can find no indication of a detailed budget except for the trauma center which is the one unit that I don't think should be supported because of the renovations to the building.

DR. HINMAN: Three fifty for the trauma.

DR. SCHERLIS: Yes. My own feeling about that is that having visited Hawaii and having surveyed their cardiopulmonary resuscitation program, I had the opportunity of going to their major islands, and I guess I hit at least three or four hospitals in each.

I am impressed with the fact that they have already set up excellent links, that the hospitals work with each other, that they are training their emergency systems to relate to the hospitals.

They do have good CPR programs which again has helped set up a network so when you go with someone from Honolulu he has access to everybody in the islands and it lends itself very nicely for an overall emergency medical system.

They do have the concept of the hub center, there are physicians who go out from Honolulu to the islands in specialities and obviously flying back to Honolulu.

I have an overall good reaction, but I had difficulty in translating that to dollars because there is no budget. I don't know what it takes to work out this program. If I've been narrow in not seeing it, apparently you've not found it

jr 5

either. If they can show with their training program, they have to set up essentially five or so areas, one on each island to work it through -- I can see where they might very readily come to a budget of $3- or $400,000.

But I have a problem saying this is what you should spend when they don't tell me what they want to spend. There was no budget in this that I could find.

VOICE: Dr. Scherlis, we just received in, and I think it is upstairs, the form 16's.

DR. HINMAN: We have a form 16 but it doesn't tell you anything.

VOICE: That doesn't break it down.

DR. SCHERLIS: I have this one-fold sheet, and that doesn't tell me, and then as I go through the back, here and there they set up on the islands emergency vehicles, which they are in need of, with telemetry, but these come to small sums, $10- or $12,000 each.

There is the other item of some $400,000 for the trauma unit, which I don't think should be supported. And then I have problems looking at where the other 300 go to. I give them a high rating but my concern is I can't translate that in terms of dollars because I don't know what they want the money for.

DR. MARGULIES: Perhaps, what you can do is to actually endorse it on that basis with the understanding that

jr 6

we will seek a budget and see if it is a reasonable figure and bring it into the council that way. It may be an omission.

DR. MC PHEDRAN: Excluding the trauma.

DR. MARGULIES: Yes.

DR. SCHERLIS: My own feeling about the level of support would be in terms of $3- or $400,000 for each of three years but I'm arbitrary in that when I don't know what they really require.

Can that be approved on that basis, that we will come up with a number that is meaningful?

Is there a second to that rough motion?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: The rating I gave was 3.5 and I suggested three-year support.

DR. HINMAN: All right, 3.5.

DR. SCHERLIS: Is there a second?

End 26

DR. MC PHEDRAN: I second.

ty 8

DR. MC PHEDRAN: Illinois is next?

Are we to Illinois, now?

Illinois is a proposal -- this is a proposal from the Illinois Regional Medical Program to extend over three years for a total of $1-1/2 million over the three years, about evenly divided. It is for an extension of a current trauma registry, and the beginning of an emergency system for trauma.

The proposal is to build on this system now a system which works through the state health department, department of public health, and according to the application, this is a satisfactory arrangement which they wish to extend for other medical emergencies. They want to categorize hospitals in the first year, they want to decide which ones would be suitable for various kinds of emergencies. They want to improve their transportation personnel, and to establish a coordinated communication network, the exact specifications for that are not given, but they are talking about a common radio frequency, and the use of radios, in emergency rooms and ambulances.

There is an element of training, both for the emergency personnel and also a public education effort. The public education is also to be conducted through the department of public health, and a trauma registry, which they now have, apparently was set up in such a way that the means of putting data into it can be adapted easily to a registry for other

ty 9

kinds of acute illness. They point out that the evaluation of the system can be effectively done through this registry, that is, if standards are set for treatment of a certain kind of medical emergency, when the help should be there, what kind of help should be there, and so forth, they can decide later on whether they got what they thought they should have.

So that this is perhaps one of the attractive features of it, that is, that there is some -- there is a data collecting system which is now working, which can be built upon which would give them this kind of information.

I am a little disturbed because the coordinator, Dr. Creditor, said that the technical review panel in his area, in his region, or the review committee in this region, on the basis of technical merit, gave it a rating of 3.25, which is the reverse scale that we are using here.

In other words, 3.25 is low. Four is the lowest.

They submitted it anyway, they thought that there were defects in details in the application, and there are, indeed, some defects. The ones that I was concerned about where the information on linkages, adequate referral of non-emergency patient -- cooperating in community disaster, and linkage with other non-EMS systems -- that was lacking, pretty much.

But on the whole, I guess I thought that maybe the review committee was harder on it than I would be. I thought

ty 10

that it was better than that rather poor rating, although they give me pause when they give it such a poor rating.

I have a specific exception to make in the proposed expenditure, and that is that some advance are proposed. They have a special name. OCCVs. There is an enormous amount of money proposed to be spent on them. Nine of them in the first year for $126,000.

Now these are not, I think, quite dedicated vehicles in that they can be used for any kind of emergency, or a seriously ill person who would have to be transferred. On the other hand, I am not sure that it is clear that that kind of special equipment is really necessary, and I would propose that with a rating of 3 to 3-1/2 -- I will say 3-1/2 -- and with the exception that we not fund these OCCVs. I don't see they are absolutely essential to the program. Maybe the staff can correct me if I am wrong. If that reduction is made, I think they all come in the first year, isn't that right, the OCCVs?

So that would make the first year reduced to just a little over $300,000.

VOICE: Yes.

DR. MC PHEDRAN: $307,000, something like that. And the 02 and 03 years I guess would stand that way. Is that right?

DR. GIMBLE: I think the expenditure for the OCC was

ty 11

the first year. I am not absolutely sure.

DR. HINMAN: They have large amounts of equipment in the second and third year.

DR. MC PHEDRAN: I may have overlooked that.

DR. HINMAN: 207,000 in the second year and 162,000 for equipment in the third year. I don't know what it is for.

DR. MC PHEDRAN: They certainly do.

VOICE: The equipment expenditure remains constant in the second year and I think that purchase of the vans were to be staggered, Dr. McPhedran.

DR. MC PHEDRAN: I see, okay. Well, it seems to me that -- I really just don't see why in something which is developing like this, that you need to start out with this kind of very expensive equipment. I would still -- I would like to see it deleted from the budget, to see if they can't get along with the same kind of thing with more conventional equipment.

It sounds to me like the rest of the program that they are describing -- it doesn't seem to me that any part of the program would be vitiated by not having these vans, so I would think that they could be left out.

DR. SCHERLIS: They also include patient monitoring equipment for outlying coronary care units.

DR. MC PHEDRAN: That is part of the equipment cost.

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DR. SCHERLIS: Yes. The 220,000. The rest is helpfully oriented as far as training, is it not?

DR. MC PHEDRAN: Training and communications. I must say, I was taken with this matter of the way they handled collecting data, and talk about having standards set up for what ought to be outcome of care, and comparing what does happen with what ought to be, if they can really establish satisfactory standards.

We have been trying to do this just for the care of neurologic patients in our division and I must say, it is very hard. We quarrel a lot about it. I hope they do not fight as much as we have.

DR. SCHERLIS: One of the better publications I have seen on local data is the one from Chicago, on the emergency rooms, transportation vehicles.

DR. MC PHEDRAN: That is the one Gibson did?

DR. SCHERLIS: Right.

DR. MC PHEDRAN: Isn't that so?

DR. SCHERLIS: I think so. I had the opportunity to share a sight visit to Illinois, and their coordinator runs a very tight shop. With the help of his wife, who controls the pursestrings, at home, as well as for the unit.

DR. HINMAN: Should we ask Dr. Gimble what emphasis they are placing upon the critical care van, as part of the system?

DR. GIMBLE: They are not, they talked about the total system. The overland critical care vehicles were not even designed for primary ambulance duties, but for transportation of patients between hospitals.

They discussed the stratified hospital system with primary, secondary, and tertiary levels of care, or words to that effect, and the use of the vans was for transportation of patients between initial-care hospitals, and secondary-care hospitals, and definitive-care hospitals, as part of complete EMS system.

The objection I raised was whether or not a need for such vehicles and the number had been demonstrated. It had not. And they were quite expensive.

DR. SCHERLIS: This can await their demonstrating the need.

DR. GIMBLE: Yes.

DR. SCHERLIS: What sum of support did you come up with?

DR. MC PHEDRAN: Well, taking that 126,000 out -- I do not know which year it comes on. Mrs. Gimble suggests it comes out of each one of the three years. I assumed it came out of the first year. I will see if I can come up with that.

VOICE: I think they hope, after the three years, e each of the nine regions would have three vans. They would start the first year with one van for each of the nine regions

and increase it by one for each of the years.

DR. MC PHEDRAN: So what that means is three times $18 thousand per year.

DR. SCHERLIS: It is roughly about $70 thousand a year that would go to equipment.

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: Is that not right?

VOICE: I wish it were, but I do not think it is. I think they propose to buy nine vans at $18 thousand, each, the first year; nine vans at $18 thousand -- and that is $162 thousand.

DR. MC PHEDRAN: Nine each year?

VOICE: Yes. There are nine districts.

DR SCHERLIS: I was not thinking that big.

VOICE: They want to cover each district with one van in the first year, one more in the second.

DR. HINMAN: And there is an additional cost of $20 thousand a year for the telephone lines to support it. So you are talking about subtracting 182,000 out of each year, is what I hear you suggesting.

DR. MC PHEDRAN: That is what I do suggest, then.

Are you sure the phone lines are just to cover that?

DR. HINMAN: Telephone lines for OCCV Network, $20,000. And, then down on the budget sheet, it says -- I thought I saw an expanded part of the budget sheet -- under

"other," it says IRMP telephone lines, 20,000, training, communications equipment, lines, etc.

VOICE: I think the 45,000 is related to the two.

DR. HINMAN: Outlying coronary care units.

VOICE: I think they are hooked to these vans.

DR. HINMAN: Yes., they sure are.

VOICE: I hate to say this.

DR. SCHERLIS: Do something to help this.

DR. MC PHEDRAN: Do you think that is also, forty-five?

VOICE: I think all of the equipment -- could we have a motion that we could find these out, and if they are, they could be deleted?

DR. MC PHEDRAN: Why do you not suggest that what we would do is say, we would like to delete the equipment costs entirely, until we can see which of these are unrelated to the OCCVs, okay? If they can just do something unrelated to that?

DR. SCHERLIS: You are talking about 262 thousand.

DR. HINMAN: It is 242, because we took the telephone lines out, too.

DR. MC PHEDRAN: 242 for the first year?

DR. SCHERLIS: We would not even let them talk to each other.

DR. MC PHEDRAN: I gave it a rating of 3.5. I thought that except for this large expense in equipment, I thought it was kind of a good system.

DR. SCHERLIS: And your recommendation is as was just repeated?

DR. MC PHEDRAN: 242 the first year -- is that right, Ed?

DR. HINMAN: 242, 974.

DR. SCHERLIS: 330, 573, 351, 780. And the rating?

DR. MC PHEDRAN: Three point five.

DR. SCHERLIS: Is there a second?

MR. TOOMEY: I will second it.

DR. HINMAN: Total of 889, 327.

DR. SCHERLIS: Are you seconding it because you agree?

MR. TOOMEY: I am seconding because I agree.

DR. SCHERLIS: Let the record show that was voted upon and it passed.

DR. SCHERLIS: Intermountain. Time is getting tight.

Mr. Toomey?

MR. TOOMEY: I had that but I can't find my summary. I am sorry. Will you give me a moment?

DR. SCHERLIS: Will the secondary reviewer like to begin on that one, for variety?

DR. MC PHEDRAN: I will say that I thought this was a good proposal. Indeed it was a system. It is for a portion of the region, the State of Utah.

In going through the check list, the yellow check list, I felt that it met most of our requirements for a system quite satisfactorily. The numbers that we are talking about are shown in the back.

The first year, 250. The second, 226. The third year, $193,000. I thought there was at least evidence of some satisfactory performance in virtually every category in assessing needs and resources, and in community organization.

The representation of consumers as such is not any more in evidence here than in perhaps just one or two others, but I thought that it was at least as good as most.

So, to be brief about it, I thought it was a good proposal for a system, really, in Utah: a health emergency care system for manpower training, communication systems, coordination of the ones which are now operating, and a formal organization for coordinating the subsystems.

It would be the regional medical program itself, I think, that would do this, if I remember correctly. Here it is. There is a county in Utah which would be the first phase and which would serve to some extent as a model for the others. That is called Wasatch Front, Emergency Medical System. That is in the first year.

And the second year, the other comprehensive health planning district would be involved in the same kind of plan as had been set up for the Wasatch Front.

And in the third year, it was hoped that the type of model that was developed in this one county would apply to all three.

Mr. Toomey?

MR. TOOMEY: Yes. The objectives that were derived that I took from this material, they include the establishment of a legal body with the authority and responsibility to plan a and implement a statewide emergency medical system through a network of district EMS councils, and to establish a statewide communication system which will meet the needs of the area; to establish a rapid and safe emergency transportation system which will meet established standards; to upgrade the quality of hospital emergency departments; to establish a manpower training program which will provide an appropriate type of adequately trained personnel, to design and implement a standard data collection system which would provide information needed for

management operation planning, evaluation and quality control, to assure high quality emergency care and to evaluate and compare emergency medical systems with other systems of emergency care, to provide a stable source of financial support for EMS, beginning after the third year, and as Dr. McPhedran said, it was planned in three staged phases.

Phase one involves the development of a council to form the nucleus organization to employ a staff, and that was the Wasatch.

Phase two involves the organization of the EMS network into an effective operational plan, to implement emergency services in each district.

Phase three involves the formation of a statewide EMS authority to provide leadership for continuation of the program.

My own evaluation was that the application demonstrates knowledge of the total system and has identified deficiencies in the present operating system.

It is a community-based program involving providers, public agencies, planning agencies, and community interests.

Existing community needs and resources have been documented and we will define as to how each element will be coordinated with components already operational.

Linkages with local health care systems are not well described; however, reference is made to enhancing preventive

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medical services. Specific plans have been delineated for obtaining additional financial support and the prime area emphasis of this application is through the provision of various continuing educational training programs, limited to specific conditions.

The population is sparsely settled; the terrain is mountainous.

The approach for developing this system has been well thought out, has clearly defined objectives, and I think as I read it the thing that impressed me more than anything else was the potential for measuring the various accomplishments, methods of measuring whether or not they have accomplished the objectives.

DR. SCHERLIS: How did you rate this proposal?

MR. TOOMEY: I rated it as very good, good, which in my opinion would be a 3.5.

I saw no reason, really, not to provide them with the funds that were requested.

DR. BESSON: Second.

DR. SCHERLIS: Any further discussion?

This then is for three years, 248, 222, 293.

Both of you were impressed with this as a system of care as well as the other points.

You have heard the discussion; all those in favor say aye.

(chorus of ayes)

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DR. SCHERLIS: All right. That is Connecticut.

The next program is the Lakes Area.

DR. MC PHEDRAN: Formerly Western New York.

DR. SCHERLIS: Lakes Area, thank you.

DR. MC PHEDRAN: This is formerly Western New York. This is a proposal, the request is funds over a three and a half year period to document emergency medical needs and to develop appropriate emergency medical services in Erie County, New York.

The proposal proposes a great deal of confidence in a man that has recently come on, an evaluator and planner, by the name of Dr. Geoffrey Gibson.

Dr. Gibson did a study in Chicago, where he was before, I gather, which I read in the course of doing other resource, it is a study of Chicago emergency medical services needs. It certainly is a good piece of work, I thought. I was very much interested in it.

So, I can understand why the Lakes Area regional medical program is pleased to have him.

The proposal that has been developed here is developed by an emergency medical care committee, which advises the Commissioner of Health. The committee has fairly broad representation from hospital people and medical society and community leaders.

The proposal includes one component for communications,

an education component for training medical emergency technicians, and of course, this research or this study into the effect of the whole program on emergency medical services.

Now, the breakdown of the budget, for the first year there is really a very large expenditure on communications equipment. The total first year budget requested is $348,000. Of that, communications equipment eats up $207,000. M.E.T. training, the communications equipment is divided in budgetary breakdown among the several people, several groups, who would receive this communications equipment.

That is roughly 60 percent of the total M.E.T. Training consumes $63,000 and the research and evaluation component just about the same, $63,000.

The whole argument in presentation is that the communications scheme or the thing they want to develop is central to improving emergency medical services in this region.

I think the argument is made with some effect. I find it difficult to quarrel with the figures that they ahve developed for the communications. If this is the central feature of developing this proposal, as they see it, I suppose that one would have to take the whole thing all together.

The figures for communication equipment dropped down sharply the second year, 78,000 against that figure of over 200,000 the first year, and the third year, 29,000.

There apparently are other sources for funds for

nb-3

keeping it up. and there are other -- there are other sources, large contributions, to communications component. Not as large as what RMP is asked to withstand, but nevertheless large.

I think that as I say, the argument was made, at least to me, with good effect, that this would be an important direction for this regional medical program to take, and I would rate this proposal as a three and recommend it be funded if the funding can be found. That is my own feeling about it.

That is 348,744 for the first year. The figures that are shown here on the sheet -- I won't bother to read these -- they would be on the record on this sheet.

DR. SCHERLIS: How many ambulances do they plan to putfit at the very onset? Do you have any --

DR. BESSON: Forty-four.

DR. MC PHEDRAN: Forty-four.

DR. SCHERLIS: How many?

DR. BESSON: Forty-four ambulances, participating hospitals.

DR. MC PHEDRAN: Wait a minute. I am sorry, isn't it just 30?

DR. BESSON: That is just the first year.

DR. MC PHEDRAN: That is the first year.

DR. SCHERLIS: Are these hospital-based ambulances?

nb-4

DR. MC PHEDRAN: I think many of them are.

DR. SCHERLIS: Do they coordinate one with the other or do they just service individual hospitals?

I just happened to pick up a sheet that says St. Francis Hospital and then lists --

DR. MC PHEDRAN: They would be coordinated through central dispatching, that is one of the points, of course, about all of this elaborate communications equipment.

It is a central dispatching type of arrangement.

DR. SCHERLIS: Right.

DR. MC PHEDRAN: So that whether they -- how they would be based seems not so important, they could work that out.

DR. SCHERLIS: Have they already worked out the assignment of channels and expressed a willingness to cooperate one with the other?

DR. MC PHEDRAN: They speak about that, that there would be an assigned frequency that would be used by all the cooperating parties.

DR. MARGULIES: That is an area in which they are rather expert.

DR. MC PHEDRAN: Is that right?

DR. MARGULIES: Yes.

DR. MC PHEDRAN: You mean expert -- who is expert, the police?

nb-5

DR. MARGULIES: RMP has had a lot of experience with the use of radio communications.

DR. SCHERLIS: Dr. Besson?

DR. BESSON: Yes, this program had its genesis in the appointment of the Blue Ribbon Committee, so-called, which was an advisory committee to the Commissioner of Health.

As I have looked over the application and the minutes of the Blue Ribbon Committee, I see that the subcommittee on communications takes up the bulk of this application. And my only thinking is that some communications expert must have gotten to this subcommittee and really laid out a program for the development of a communications network that is maybe a little bit overkill, but I suppose that is what communication gear costs. The details are just astounding for an application like this, and I think that has been the heavy emphasis, as Dr. McPhedran has already put, not only physical but so far as there interest is concerned.

But I suppose I will have to live with the fact that we are equiping ten hospitals -- participating hospitals, one regional hospital, and forty-four ambulances, for all this communications money of $270,000, since the system just doesn't go unless you have that component part and if they are on the ball to lay out this kind of elaborate system, I suppose more power to them.

They are linking that to a good training program

nb-6

for technicians, training 5,000 over a three year period with 36 hours of formal training to be given throughout the region, hopefully. And they anticipate that this Blue Ribbon Committee will continue as a coordinating committee to expand the effort from this original area which is around in Erie County, around Buffalo to the rest of Erie County and then throughout the Lakes Area Region, developing local committees as they go.

I have difficulty in swallowing the whole thing, but I suppose that if that is money going to a good cause I would agree with the recommendation implied in Dr. McPhedran's presentation of a C rating and full funding.

DR. MC PHEDRAN: I want to just say, one of the concerns that I have is a concern I have about all of them, really, that evaluation has to do with whether or not they will be able to get the things equipped, whether or not they will be able to get the people on the same frequency by such and such a time.

But again there isn't anything here that tells how they are going to decide whether or not coronary lives were saved, or accident victims were saved.

I suppose they are hoping Dr. Gibson can design them a study. But that sure isn't in any of these applications that I have been able to tell, and it is not in this one, either.

nb-7

DR. SCHERLIS: Do you think they are ready to start a system involving so many ambulances, or do you think that we might not suggest -- I am just asking this -- might not suggest they start with a small group, and feel their way --

DR. MC PHEDRAN: I think the idea wasn't they couldn't serve the whole region unless they tried to do this, and they want to try to make it a regional network from the beginning.

DR. SCHERLIS: Something has to come first.

DR. MC PHEDRAN: I guess, you know, if it is simply setting up central dispatching and then putting equipment into ambulances and having everybody use the same assigned frequency, there might not be much need to time phase that.

DR. SCHERLIS: But the training would be a problem. In other words, what do they communicate? If it is just dispatching, that is a questionable facit of the total system, unless training is with it.

DR. BESSON: Mr. Chairman, I think this is an example of an application which suggest to me that knowing about the so-called neglected disease, can be enhanced by getting involved in this. I don't know if Dr. Dimick had started out that way, but he sure became an expert from having become involved and getting them involved in communications is going to make it obvious to them that that is only one link in a chain.

nb-8

And I think they will be self-corrective and the more they get to know about it, the more they will recognize that communications can't possibly function without having the other pieces of the puzzle. So while it is heavy in one area I think it is an entry point for this region to get involved.

Now, we reviewed Maine, and there big handup is transportation. They are spending all their money on transportation but obviously they will have to get to the other parts as they recognize the state of the art and become more familiar with it.

DR. SCHERLIS: Dr. Keller?

DR. KELLER: It would seem in looking over and listening to a few of these, that the particular component that is stressed depends upon the enthusiasm of some individual or a small set of individuals on the particular site.

The leap from that to deciding whether this is a legitimate priority for the region is another thing entirely, and I don't know whether anyone but someone on the scene who can really look over each of the components carefully and maybe acquire data not currently available, could possibly assess.

What troubles me is not that particularly, because I think I would agree that almost any legitimate entry will bring along some of the other components, but I am a little concerned about the relative position of the RMPs.

nb-9

Granting mechanisms as against Department of Transportation and other groups who have been very heavily hardware orientated. This is the sort -- I have also had an opportunity to review and look over a great many things that have come to the Department of Transportation. This is the sort of thing that ordinarily falls into their granting area, for vehicles and hardware associated with communications between the vehicles in various areas.

I am wondering why this is directed to this particular group. I haven't been able to fathom, in the guidelines, whether this group was that hardware oriented.

DR. SCHERLIS: I think that is a facet of Sutton's law. S-u-t-t-o-n.

DR. KELLER: I am not that familiar with it.

DR. SCHERLIS: That is why he robbed banks, because that is where the money is.

DR. MARGULIES: In defense of what they are doing, we talked before you came in about this problem of equipment. It reminds me of one of the earliest issues that I saw when I came to RMPs, in which there was an absolute standoff because the question was how can you hear the expert unless the equipment is there, and then they said, well, we can't get the equipment unless the expert is there.

Now, at some point, you say, well, we are going to train people. We don't have anything to use them in.

nb-10

Or you say you are going to have some equipment but nobody trained in them.

There has to be a point of entry and some assurance that something will happen. Our problem, our responsibility, is to make sure that it does happen.

One of the things we will clearly have to do very quickly after this exercise is to get out to those programs and carry to them the message you are talking about.

We will be asking, among other things, members of the review committee to assist us with that kind of direct visit to these programs that are going to be granted funds.

DR. BESSON: I wonder if Dr. Dimick can comment on that since he is one of the people that puts it all together with all the component parts.

How do you view the review committee's approach to maybe encouraging the thinking of emergency medical care as a total system by funding a little piece of it and hoping they will move the rest of the way?

DR. DIMICK: I think, depending on the whole environmental situation, where they are in the state of the art. And as you said, our emphasis has been on training and then put in the hardware. Because if you put in the hardware first and they don't know how to use it they compound the injury, so tp speak, so depending on what is there right now, it sounds like from what I hear of the application, that is where the

nb-11

deficit is, is communication.

However, if they have good transportation, they can utilize this already. It would depend on what is existing in this area already. I wonder if someone could speak to that?

DR. SCHERLIS: The comment was made they are going to train 5000 emergency technicians over a three year period and my concern there would be that certainly if they have that great a need, what are the untrained individuals going to do in a highly integrated system communicationwise unless they have been trained.

We have to start somewhere but my feeling might be more of starting with both gradually instead of the budget beginning with all the hardware.

Perhaps we should phase this in over a stepwise period. I want to get your feedback on that. You have been through the grants in more detail than I have.

DR. BESSON: Well, I think too the facinating thing about watching RMPs relate to the regions is a paradigm of the way the center relates to the periphery, in that we are permissive, we are unabling, we use the leverage of our funding, and our advice to encouraging a pluralistic response to a natural problem.

It has to be pluralistic and I think RMPS is doing it as I would do it, and when you look at this region and see what there is about it that got them involved in communications,

nb-12

this Blue Ribbon Committee decided that one of the problems that they had was people having to wait in emergency rooms. So they said how can we correct that, and they said well, we will devise a system of creating red, green, yellow alert. And well, how do we know what group is doing what? Well, we'll check with each emergency room.

Well, they found when they did that by phone that they would get busy signals and they wouldn't be able to call, and they had 44 calls a day, and they found it was very complex, and along came this communications expert and said, I could solve it all for you.

That is the genesis of their emphasis on communications. And they say if communications is this vital, we had better put our money on this horse. So I can't fault them for that. That is their uniqueness.

And I think with Gibson coming on board, who is really an expert, they will obviously look to the other four component parts within a year, I am sure.

They will find they have all this hardware and they had better do it right.

DR. MC PHEDRAN: Because that is certainly well brought out in the Chicago study, he lookds at all parts of it.

It is a good study.

DR. SCHERLIS: The requested funds were on the order

nb-13

of 348,000, 231 and then 245.

DR. BESSON: That is correct.

DR. SCHERLIS: Would you like to make your recommendation in view of the discussion?

What is your original recommendation?

DR. MC PHEDRAN: I recommended funding at the level, because I can't quibble with the figures, really. I don't know how to revise them downward. If I though that was necessary, that is. So I would recommedn it as requested.

DR. BESSON: One year funding?

DR. MC PHEDRAN: One year funding? Well --

DR. BESSON: Three years is 824.

DR. GIMBLE: Can I raise a question?

I have no doubt with the money you give them they will be able to set up ambulances and equip a communications system.

I was unsure that they had looked into what they needed. I am sure they can tie them all together but after they tie them all together, is that going to be adequate? It seems like they are putting a lot of money into something without having data to support it.

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: My other concern is voiced by the training aspects of having the hardware and not the software to go with it. I do have concern on that point.

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MR. TOOMEY: How many counties were involved in this document?

Was this the whole area?

DR. BESSON: No, not by a long shot.

DR. MC PHEDRAN: No, it is Erie County.

MR. TOOMEY: Erie County?

DR. BESSON: I believe it is just this county, and then during this period of time they are going to expand it beyond Erie County, presumably to the whole state.

But I think for the time being, it is just Erie and contiguous counties. Not even the whole county, the Buffalo area.

MR. TOOMEY: They had a fellow named Dr. Sults, S-u-l-t-s, who has done a very complete analysis of the whole medical hospital emergency services.

Do they mention that in application at all?

DR. MC PHEDRAN: I don't recall.

MR. TOOMEY: This is kind of in answer to your commint. This Dr. Sults has --

DR. GIMBLE: There was an initial survey done but they concluded from that, if I remember correctly, that they needed a more in-department study, which is why they request add larger amount for R & D. So the questions asked on the first survey were superficial and did not provide enough answers for a total system.

nb-15

Despite that they are spending a lot of money to put in equipment on a system they haven't analyzed thoroughly. That made me a little leary.

DR. MC PHEDRAN: This is the region shown here and here is Erie County in there. This is -- it includes Erie, Pennsylvania, and McKean County, Pennsylvania.

The rest of them are New York counties.

DR. JOSLYN: This project and the funds, the 800,000 is just for Erie County. Is that true?

DR. BESSON: It is for less than that, primarily for the Buffalo area. And they speak about expanding it.

DR. JOSLYN: That is not included in the funding at this point.

DR. MC PHEDRAN: That is right.

DR. BESSON: They speak of EMT training as being over a larger region and -- from their abstract, and they say, "Counties surrounding Erie, New York, have expressed interest in participating, and the Erie County Commissioner of Health has informed them that, "Courses would be open to individuals throught the region. But so far as the communications are concerned the ten participating hospitals are in the immediate area around Buffalo, one regional hospital, and the 44 ambulances serve just that area.

DR. SCHERLIS: Mrs. Faatz, can you help us on this?

DR. FAATZ: I did not hear the last comment.

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DR. SCHERLIS: Do you have any comment at all as far as the total application is concerned, their ability to carry this out or their degree of regionalization as far as the Lakes Areas are concerned?

DR. FAATZ: I think the feeling on the Eastern branch is that they can probably do what they say they would like to do. With regard to Dr. Sults, I don't know his degree of involvement with this particular application, but I know he is still working with the RMP there and is quite involved in a number of their activities so I don't imagine he was shunted off to the corner.

DR. SCHERLIS: I would like the record to show that Dr. Roth left the room because of his involvement with the area.

Yes?

DR. DIMICK: I would like to make one comment regarding project summary. As Dr. Besson indicated a moment ago the radio system is supposed to alleviate overcrowding of emergency room facilities. And I seriously question, as one who is in charge of a university busy emergency department and trying to coordinate 13 other hospitals in our city -- I am not so sure radio communications is going to alleviate overcrowding of facilities. The same question you are raising, the radio system is no panacea for these types of problems.

I am sure it will help direct ambulances to less

nb-17

crowded facilities but not alleviate overcrowding.

DR. BESSON: I agree with that, it doesn't address the basic question of what creates overcrowding. All they want to do is facilitate knowing what the green, yellow or red allert state of each emergency room is and direct people elsewhere, maybe. But that is in theory.

DR. SCHERLIS: Is there any feeling from the reviewers as to how many emergency technicians are trained at this point who could man ambulances if they were fully equipped and put into that area?

DR. MC PHEDRAN: I don't know.

DR. SCHERLIS: My big concern remains the fact that all these ambulances will be equipped at a time when the technicians would not be trained. I think it is an over generous request in terms of what we know about that area and what organization is there, what still has to be done to get a system of care into that area.

DR. GIMBLE. I would like to raise the question also of do they know how many ambulances they need?

Are we going to equip 44 ambulances with communications when they only need 30?

That would be an awful waste. Do they have data showing that they need 44 ambulances or are they just picking the number of ambulances they currently have to have operated.

DR. SCHERLIS: My suggestion would be one way to

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approach this might be with the first year being budgeted less, and let's see where they get with a few ambulances and some training, and then make the second and third year contingent upon evidences of performance and having set up a system of care the first, year.

I would be much more willing to vote on that favorably than on giving them what they have requested in view of the discussion of points that have been raised.

Would that be acceptable?

DR. MC PHEDRAN: I would go along with that. Maybe reducing it by half, to half of what it is, as a reasonable figure? Just reduce that part of it.

DR. SCHERLIS: For the first year?

DR. MC PHEDRAN: Right. And the second or third year --

DR. MC PHEDRAN: Make it just for the first year, if they can be equipped as Dr. Besson suggested. Perhaps that would be the best way. Because by the end of that time they should see if they can get enough people to run the ambulances.

DR. SCHERLIS: What we are discussing is $150,000, but the conditions of the award, including the facts that both the equipment and training would run hand in hand, and that the second or third year would be considered as based upon what they have accomplished and also upon evidence of setting up a true emergency medical system -- would that be more in

nb-19

line with some discussion?

DR. MC PHEDRAN: For the first year you would want to cut the communications equipment in half?

DR. SCHERLIS: Yes.

DR. MC PHEDRAN: That would take it down to about 103 for that, communications, and then leave the others, which are the M.E.T. training and research and evaluation component, intact.

DR. SCHERLIS: How much is that?

DR. MC PHEDRAN: In round figures, 231.

DR. BESSON: Plus another 14,000 for project personnel.

DR. MC PHEDRAN: Okay. I'm sorry.

DR. HINMAN: 245?

DR. MC PHEDRAN: 245.

DR. BESSON: 250.

DR. HINMAN: I have a question for staff clarification. Do I understand you correctly that you feel that in all liklihood, that the region could use the total amount requested over a three year period if they progress satisfactorily, and that you are limiting the first year recommended amount to 250,000, and the rest being contingent upon performance during the first year?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: I think it has to be reviewed after the first year.

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DR. MC PHEDRAN: Yes.

DR. HINMAN: One year approval only?

DR. BESSON: One year approval only, and re-review.

DR. HINMAN: Okay.

DR. SCHERLIS: When you say, could they use it, I don't think there is an area in the United States that can't come up with a paper plan of communications and the need to train emergency medical technicians.

I think we have to show that there is a need and an ability to utilize these funds.

And I think we have the feeling here that the area, at least probably can use it. We aren't quite satisfied with the total demonstration of need in terms of numbers of vehicles and so on.

I think the recommendation made at least would move them towards justification of this.

DR. MC PHEDRAN: Okay.

DR. SCHERLIS: What was the rating?

DR. MC PHEDRAN: Three.

DR. SCHERLIS: Three. That has been seconded?

DR. BESSON: Yes.

DR. SCHERLIS: Any further comment, Mr. Toomey?

MR. TOOMEY: No.

DR. SCHERLIS: Is there concurrence on this, then? All in favor, say, aye.

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(Chorus of ayes.)

DR. SCHERLIS: All right.

I guess Dr. Roth can come back in the room.

MR. TOOMEY: I had not read this material, but I was on a site review there a year ago and I was impressed by Dr. Sults and I was also impressed with the lack of services in the innercity in Buffalo. These two things kind of stood out.

(Chorus of ayes.)

All right. Louisiana, Dr. Besson.

DR. BESSON: Louisiana is presenting a program for -- that involves four projects, with a total funding of 363,000 over a three-year period.

The four projects are updating of an existing EMS system in the state, which was previously drawn up, a training proposal for EMTs, two-way communication systems, and a developmental study to determine feasibility of medical helicopter evaluation services in New Orleans.

Apparently in 1969, the Highway Safety Commission of Louisiana, in an attempt to coordinate EMS programs statewise, asked the Gulf South Research Institute to do a study of the emergency medical services program in the state.

They did submit the study and it is really an excellent study. It encompasses the entire statement of the problem with a good inventory of needs, resources, identification of shortcomings in the state, and a plan for correcting them.

The study also suggests training, communications, and now with this RMPS program coming down the line they finally see a way of upgrading this 1969 study and beginning to implement it with specific projects.

The first project they submit is that of updating, which will do just the things that I have suggested, inventory,

develop workshops for the public and for personnel, establish EMS councils among B agencies, develop a program of priorities, and establish mechanisms for implementing the plan which will be updated.

It is a one-year program and includes some evaluation and requests $54,000 in direct costs.

I think it is a good program and I would grade this a 4 on that scale of five.

Number 27 is a training program to train emergency room staff, ambulance personnel, and to produce a coordinated statewide training program and a register as well as developing standards for continuing education and recertification of EMTs.

There is an evaluation included in their training program which is two years under the auspices of the state Department of Hospitals for a total of 72,148.

The state Department of Hospitals has indicated that they will continue the program under their funding at the end of this two-year period.

Also, it is a well put-together program and I would grade this on that same scale, and recommend full funding on that.

The third program is that of communications, project 28. The objectives of this program I'll summarize, in reading this -- they have the notion that before hospital or ambulance services spend the money for a communications system, they must

have information concerning advantages of the system, cost, effectiveness, capabilities, compatibility of equipment, and so on.

These institutions must be shown through a variety of settings throughout the seven CHP areas that the communication system is a nececcity for good and efficient emergency medical services.

It is anticipated that this demonstration project will stimulate and commit hospitals, ambulance services and governmental agencies to support a statewide emergency communication system.

So, they are requesting 94,000 --- 122,000 for the second year -- 94 for the first year -- to approach the problem in this way, which involves purchasing some equipment, and getting the hospitals to all become aware at least of the need for communications and pick up the ball in two years.

That is project number 28, which I also think is well-conceived, and gets us involved in cost-sharing with the hospitals, and although a critique of this by staff felt that the hospitals may not pick up the ball, at least it is a start.

The fourth program, the helicopter evaluation program, has objectives to determine the need for air medical emergency patient transportation in the Greater New Orleans area, establish feasibility of such a service, and determine its mechanism of operation and costs.

mea-8

They consider that since the medical helicopter service has been so successful in the military, this RMP study will aim to determine if this procedure will reduce mortality, and translated to the civilian role, provide a service for the State of Louisiana.

They are requesting a one-year study to do this for $46,000.

So, in summary, we have four projects, 26 is an updating of an already existing comprehensive system and beginning implementation; 27 is a training program; 28 is a two-way communication system in a variety of hospital settings, 29 is the medical helicopter service.

I would grade the program as maybe 4.0 and recommend full funding.

And initially, in their introduction I am impressed with the figures that they quote, which may have been known to all of us, but I will just mention them gratuitously.

Inspection of war figures to determine the value of transportation -- of the whole emergency care system, the war figures in 1969 that were done show that eight percent of casualties in World War II figures -- eight percent of the casualties dies. Four-point-five percent died in Korea and only 2.5 percent are dying in Vietnam, and the implications by these figures is that these casualty-to-death rates imply that we are gaining on it, and the things that we are doing in

Vietnam that we weren't doing in World War II should be replicated in civilian situations.

The figures are impressive, and I think backed with that kind of approach, I liked the program.

DR. ROTH: Jerry, why do they need to do a one-year study to establish the fact that nobody can afford the helicopter services except the federal government?

DR. BESSON: I can't answer your question.

DR. ROTH: There are plenty of cost figures on helicopters.

DR. BESSON: I am perfectly willing to scratch 37,000 from the program.

I'd like to hear from the secondary reviewer.

DR. SCHERLIS: The secondary reviewer, please?

That is Dr. Roth.

DR. ROTH: Well, I have not done any of my second area reviews.

DR. SCHERLIS: Haven't you? All right.

DR. BESSON: I would recommend that we grade them as 4 and fund them at 363, less 37,000.

DR. HINMAN: Disapproval for 29.

DR. SCHERLIS: Disapproval for the helicopter study and the others, grant them at 4? Any other comments?

DR. BESSON: I might add that as the B agency or other endorsing groups were asked to comment on these four-

proposals, they considered that this helicopter program was last in priority.

DR. SCHERLIS: All right.

All in concurrence?

(Chorus of ayes.)

DR. SCHERLIS: Opposed?

DR. HINMAN: $225,615 the first year, and then $100,325 the second year.

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End #16

DR. SCHERLIS: Maine. Dr. McPhedran?

DR. MC PHEDRAN: This is part of an EMS system. The application indicates that in the Department of Health in the state, there is already some interest and ferment about emergency medical care system, and this proposal here is for an ambulance attendant and other medical -- emergency medical personnel training system, and also as Dr. Besson indicated previously, a design for an emergency transportation system to be developed as part of the establishment of coordinated medical care systems.

The wish is to develop a packaged standardized hospital based training course for use throughout the state. And the funds requested in the first year, a total of 123,000. That is broken down -- the equipment part of that, since we can't help but be interested in that, includes some videotape equipment, training aids and so forth, totaling about $50,000.

About 40 percent of the total that is requested for

nb-22

first year and in the second year and third year of this requested three year program, there are no more equipment requests and the budget drops considerably. It also drops because in the first year they propose to do a transportation study using a consultant whose name I have forgotten, now.

DR. BESSON: Chi Systems.

DR. MC PHEDRAN: Chi Systems, thank you.

The transportation study for the state of Maine is proposed for the first year at a cost of $22,000.

Now, I thought that the proposed course of instruction was worthy, and it was probably something that would be quite useful in the state, around the state. I really didn't get the feel at all of the transportation study.

Maybe Dr. Besson has another view of it. But it seemed to me that in the terms that they described it in this application, the terms were so very general that I really didn't get much of a feel as to what they would do, how they would go about it. And I didn't get much of a feel that i wanted to support it.

Really what we are being asked to do here is to give money for support of two fragments of a system, and the total system we really don't see in the application or didn't see, in the application.

And the one fragment seems to me worthy of support. But I am not -- I guess I don't know enough about the Chi Systems

nb-23

study, and their presentation doesn't give me enough of a feel for it in any specific terms.

It is all so general. I don't know whether I want to support it or not. I would like to have help from Dr. Besson about this.

I would have rated this fragment, that is the emergency medical training, as a three, and recommended support for it. But the other I feel very doubtful about.

DR. SCHERLIS: Dr. Besson?

DR. BESSON: I had occasion to review Maine previously and I am impressed with Dr. Chattogee's approach to the entire region and the term used by an individual is in the operations branch is frugality.

I think that is a very applicable term. The average income per capita in the state of Maine is something like 3400, and one-third of the population has an income of under 5000, with over 5 percent of the people over 65 living at the poverty level.

The distribution of its population is extremely rural, 5 percent of the people in Maine living outside of the urban areas.

Now, the emphasis in this application is certainly on transportation. They have developed a communications network which has been vital to keep in touch in that very rural state. A rural and inaccessible state -- they use the term of

nb-24

a trip that would ordinarily take a half hour in the summer time and it might ordinarily take four hours in the winter time and that is applicable to rural Maine.

So they have had a communications in the past which has been developed and it is very functional. They have also developed a use of video physicians, let me just say, use of videotape for physician training which has been excellent in utilizing the scarce time of physicians in being involved in this kind of a program.

they are developing a whole medical school, I understand, from having read an application previously, on this basis.

And it is an extremely innovative approach to the use of scarce teacher manpower. They recognize the short comings in their pretraining program for EMTS, and speak about adding to their training by the incremental approach of block training in extrication, various aspects of EMT training, in house training, AOS hospital base, Red Cross, so forth, with a good systematic training for EMT.

The critique of the application mentions that the emphasis is upon transportation and Dr. McPhedran certainly implies that and I don't disagree.

But I am also impressed by the fact that recognizing that they might get some help in creating a transportation system, they apparently put out to bid among systems groups throughout the country what their problem is, and Chi Systems

nb-25

of Ann Arbor, Michigan, whom I had never heard of before, submitted a proposal for solving their transportation problem.

I am interested in Chi System's approach to this whole thing, approaching it as a very astute systems firm. And I think that their submission of their study approach I am impressed with, and the dollars involved, the $14,000.

I think that is money well spent. That will buy the wheels on an ambulance, but it will be very well spent if the entire transportation system is studied. Then they speak of implementing the system for individual counties, for individual regions, as being an additional 7000, applying this methodology to other regions, and then each additional region is 4000, and so forth.

I like this approach of RMP recognizing that they have limited expense, and buying expertise. I think that $14,000 is money well spent.

Their emergency room problem is also mentioned in the critique as not being addressed and I agree that that is the problem, that is a very significant problem.

But in contrast to many more blessed areas in the country where they have people who can staff emergency rooms and have a plethora of professional physician personnel, Maine has a problem in that they have physician shortage.

The best they can do is get a physician out of his busy office to answer an emergency room call which is relatively

nb-26

impossible. They have a problem in staffing emergency rooms. So I see reason for not addressing that particular problem, but this time I think a region of this maturity will.

So in general I agree that the proposal is a good one and I wouldn't be reticent about funding the transportation subcontract, and I would recommedn with Dr. McPhedran that it be fully funded.

DR. MC PHEDRAN: I go along with you about the transportation subcontract. I just don't have a good feeling for this kind of systems approach. It isn't something that means a great deal to me.

It would mean an awful lot more to me if somebody had written down -- had taken examples from Prestique Isle, or Aroostook, or some place like that, you know.

Then I could understand it, because I know the state and I could understand it. To address it this way it is hard for me to appreciate. But if you think it is okay, I will go along with it.

You know, we have said that it is mostly transportation. It really isn't though, most of the budget has to do with training, and it is a small part of it that addresses this transportation study.

Those are the two items.

DR. SCHERLIS: How do you rate this?

DR. MC PHEDRAN: I rated the transportation -- I

didn't know how to rate the transportation part. The other part I would rate as a four.

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I thought the training was good, the training program was good.

DR. SCHERLIS: You are nodding your head to show concurrence, Mr. Besson.

DR. BESSON: I would rate the whole program as four.

DR. SCHERLIS: You are recommending full funding?

DR. MC PHEDRAN: Full funding.

DR. SCHERLIS: For three years?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: Any considerations or recommendations that go along with the award?

DR. BESSON: Spend it frugally.

DR. MC PHEDRAN: Which they will.

DR. SCHERLIS: Any other comments?

All those in favor say, aye?

(Chorus of ayes.)

DR. SCHERLIS: Opposed?

(No response.)

End of #6

DR. SCHERLIS: All right.

The next is Memphis. Is that right?

DR. ROTH: I have Memphis.

Memphis, again, I don't know whether I got all of the bottom of the hope ones. But here is another one in which I would concur with Dr. Sloan's review comments when he said that if need is to be taken into account, that since this one is starting from Ground Zero, it might deserve support.

But the requested amount is large, and the need is great. It is a fragmentary program in terms of addressing its total development of a full emergency medical service system, and it has a dilemma in it in that it extends over to Mississippi, and into some other areas, and I don't know how we deal with this.

To break it down into components, I tried to do with the elimination of some components. I couldn't come up with anything very satisfactory.

I don't know what to do with this one.

DR. SCHERLIS: Do you think it justified support?

DR. ROTH: I really didn't think it was well enough thought out and presented, -nd 1 gather the Staff reviewers

didn't think so, either.

DR. SCHERLIS: I had reviewed this and this is one that I rated as essentially the bottom of the heap -- it was one on the bottom.

This was grouped together with those which I think were least worthy of support.

Did you think there was any element of this which could be salvaged in terms of helping them to arrive at a plan which would be worthwhile?

DR. ROTH: If they could be encouraged to continue their planning, I think it is manifest that they need it. But again, I think we're going to have this dilemma of giving them a low figure.

I don't see how you could come up with anything better than a 2 in this and if you cut the grant request, it would have to be very sharply, I believe.

DR. SCHERLIS: This is an area with real need, I'm s ure.

Is Mr. Van Wingle here? Do you want to comment on Memphis?

VOICE: Mrs. Kindall is the operations officer.

VOICE: I don't know a great deal about it, other than one thing that may be significant here.

If it seems to be just a portion of a program, it is that the state has carved out roles for certain provider

groups, and the role of the emergency room is the one identified for Memphis, and the activities, and it is quite logical, Dr. Roth, that they would extend into Mississippi, because most of what Memphis does, does extend into Mississippi.

DR. ROTH: It is very logical, geographically, a medical supply area.

DR. KELLER: It would be strange if it didn't.

DR. ROTH: Into Arkansas, too.

VOICE: But it is rather confined, when you think of it in a total programmatic sense, but that is the confinement of the master plan.

The Department of Transportation has a role, and different groups have different roles, and the emergency room has been identified at the RMP's role.

DR. SCHERLIS: Some of the comments, I think, of Staff are important in this regard as far as the narrative is concerned; incompatible equipment, this not being a justifiable system.

My own feeling is that I would like to see something salvaged from it --

DR. ROTH: If it would be possible to give them on Items 1 and 2, the request for planning and administration and survey needs -- that comes out to $67,038; I would support this.

DR. SCHERLIS: What priority would you give that?

DR. ROTH: For that phase of it, in order to give them half a chance, could we go 3?

DR. SCHERLIS: Yes.

Any comments on this Solomon-like decision? Solomon wasn't always right.

DR. ROSE: One year?

DR. SCHERLIS: Yes. I concur. I think in going over this, there are aspects of this in terms of need and planning that I think do justify support.

I would concur with that recommendation.

DR. ROTH: Okay.

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#7

Next area is Metropolitan Washington. The report will show that Dr. Matory left during this discussion.

DR. BESSON: Mr. Chairman, I feel that since Dr. McPhedran and I are the only ones who have done any work for this committee meeting, that we be given special recognition.

DR. SCHERLIS: I would like that expunged from the record.

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DR. BESSON: Metro Washington. This is an application for $95,000 for a 6 month period of time.

DR. SCHERLIS: A question on that. Our white sheets show $79,000. Would someone explain?

DR. BESSON: I suppose the white sheets take precedence.

DR. HINMAN: 94 is direct, or indirect, and 79 is the direct funding.

DR. BESSON: Thank you.

DR. SCHERLIS: Thank you.

DR. BESSON: They're going to contract with an RMP-EMS coordinating committee, which is going to contract for services of resources and data information establishment of needs and development of a plan for the Metropolitan Washington area.

Their application is to a great extent a reiteration of the wording of the guidelines that they have previously submitted to them. It is clearly a planning and developmental request. They have no apparent, intrinsic core competency in

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the field, and they have asked for the subcontracting organizations that they may work with, particularly Block McGibney, and I forget the other one, whatever it is, who are management consultants for health systems of one sort or another -- to put together a program.

And having worked with applications that were put together by Block McGibney, I think this application was written by Block McGibney as a potential subcontract, to taking it on a contingency basis. That may not be a fair statement but I think it is the best method.

C. Can do at the moment.

The staff summary critiques this as lacking a community base for information to be implemented, and it suggests revealing this community base first, and I certainly agree with that. But method C. has problems.

Beyond their soluble problems, but I intend to be very charitable towards Method C in spite of the fact that we have some negative comments by associated department of health in Prince George's County, and the District of Columbia Medical Society, which I would like to read to you indicating the tenuous nature of the effort by the sobcontractor to put together a system.

In letters of support received by the program coordinator of Method C.-RMP, the medical society of the District of Columbia says, "Thoroughly in agreement with one concept of the

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plan. Heartily I endorse it." However, I am somewhat distressed by the fact that that group will furnish the major amounts of the emergency services are not included in much of the earlier planning, namely, the physicians in the area.

They go on to say that, "If this prominent omission can be corrected,"that is, the medical community is not enmeshed in their planning effort, they would be pleased to lend their full endorsement to the program. Now, even the county department of health of Prince George's County says that, "The emergency medical services system coordinating committee is packed with health planners who plan on a technical basis, but have no emergency medical service procedures.

I do not mean to reflect adversly on the members chosen for the committee since I know many of them and they're all capable people," as Caesar was, "But the committee has no physicians who are active in the practice of medicine. The committee has no emergency room physicians, no members from plans or rescue squads, no members from hospitals.

The only MDs taken are from Government service", and I think that is a very touching statement of what is happening in asking the nation to respond in 6 weeks to a problem that has awsome implications.

Beyond what to do with the dilemma any more than the rest of us do, and I am not faulting RMPs. That is the nature of the exigencies of funding.

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So if I put all of these rambling comments together, I say that this application , written by a sub contractor for a RMP that has probably one of the worst management histories, is a planning grant for 6 months. And though I would grade this on the basis of 1 to 5, maybe 2, and I would note the reservations, I would still fund them fully because they need all the help they can get and this is a tremendous problem for the area.

DR. SCHERLIS: Would you state whether or not you have any conditions on that? In other words, would you go along with some of the letters that have been written, or do you just give it without condition?

DR. BESSON: Well, I suppose the conditions are inherent in what our leverage is. All we can do is 2 things, provide money, and assistance, advice, resource assistance. The money we can do easily. We can say yes or no.

The advice is a little harder. Yet, we have been trying to do this for how many years now, Judy, and it is like trying to get blood out of a turnip. There are no conditions that I would specify on these monies except do a good job, fellows.

DR. SCHERLIS: Second area reviewer, Mr. Toomey?

MR. TOOMEY: My comments actually followed pretty closely what Dr. Besson said. The coordinating committee on emergency services including representatives from Maryland, Virginia, and the

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District of Columbia, to contract with a independent health planning organization for the development of the plan. It is an application for a planning grant rather than a program grant.

According to page 9 of the application, the EMS programs have a history of being unsatisfactory and are not effective. This proposal plans to eliminate the causes for these unsatisfactory systems by revealing a plan which will provide the philosophy, guidelines, and methodologies to be followed to insure the development of a regional council on EMS.

DR. SCHERLIS: Philosophy. Identification of rules particularly current and future requirements, maximum effective utilization of anexses to current resources, medical profession and community patience, coordination and control, identification of linkages with non-EMS health care agencies, linkages with supportive agencies, specifications of standards.

I won't go on. The fact is that they apparently are greatly in need of an organized and coordinated program and the indications are that the first step necessary would be such a study as they're talking about. And I frankly don't know where I would rate it but I think that it is the kind of thing that we probably would justified in providing funds for, for this study to be done.

DR. SCHERLIS: I was just looking at the list of members of their coordinating committee. And whether you reviewed

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it, do you share the concerns of those letters? I do, to a great degree.

DR. BESSON: Sure. I think it is the best we have in method C., though, and I suppose I mentioned my feelings earlier, that we are either going to reward the strong or nurture the week. And I think if it is a seedling that we are interested in, my personal approach is to fund all the seedlings and nurture all the saplings, and straighten out the weak ones.

I think we have to be most cost-effective with our money, and rather than saying no to method C, I think for $79 grand, whether we by an ambulance for Albany, or wherever at the same amount of money, that this is money well spent.

DR. SCHERLIS: Would you accept as one of the conditions that they restructure their coordinating committee to make it a much more representative group?

DR. BESSON: Sure.

DR. SCHERLIS: As I look at it, it is a governmental agency that has been transposed to Metro and operating an emergency system. Would that be acceptable?

DR. BESSON: Absolutely. We'll accept this as a motion.

Mr. Chairman, rather than reiterating this, I think that in advice that would go with each of these funding awards, I think that is an opportunity for us to tell them and tell them and tell them again.

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DR. SCHERLIS: Yes.

DR. BESSON: All of them.

DR. SCHERLIS: There are no apparent consumers on this.

DR. BESSON: Don't you agree, Judy?

DR. SILSBEE: I haven't had a chance to read the application, but who is going to be --

DR. BESSON: Block McGibney.

DR. SILSBEE: The subcontractor?

DR. BESSON: Yes.

They are going to put together a plan and come back after the $79 grand are spent with a plan.

DR. HINMAN: Doesn't it bother you a little bit that a professional grant writing group doesn't know to get the right group involved?

DR. BESSON: I have worked with Block, McGibney before, I think they're idiots. But they're the best we have, I suppose. I would like maybe for Kai Systems to have gotten involved in this, or some other more astute organization.

DR. SCHERLIS: If I recall your comments with Kai Systems, you were impressed with their documentation but you don't have any personal experince with that group, is that correct?

DR. BESSON: I don't work with them.

DR. SCHERLIS: Do you know anything about them?

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DR. BESSON: This is the first time I have ever encountered Kai Systems.

DR. SCHERLIS: I didn't want this to be construed on the record as a personal recommendation based on experience. It is just a personal recommendation, right?

DR. BESSON: We'll expunge that one, too.

DR. SCHERLIS: Expunged.

There is a problem with an area like Metro. I think we all know from personal experiences of the tremendous need and we're pleased the're going to do something about it. We are concerned about this frankly being developmental money and we don't know what will come of it but at least it is an attempt.

I would assume that RMP is close enough to the scene that hopefully, there would be careful monitoring of what goes on in the area. That hasn't been the history of Metro, has it?

DR. SILSBEE: That has not been the history of the region.

DR: HINMAN: Their acceptance of previous staff advice has not been high.

DR. SCHERLIS: I would hope that these funds would be supplemented quite definitely as a new funding mechanism, at the least, new funds.

Any other comments?

(No response.)

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This known as a negative halo effect, it comes out favorably. All those in favor say aye.

(Chorus of ayes)

Opposed?

DR. FAATZ: What is it ranging?

DR. SCHERLIS: Two.

DR. JOSLYN: And full funding?

DR. SCHERLIS: Yes.

DR. BESSON: One year, that is all I requested.

DR. JOSLYN: Yes.

end #7
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DR. SCHERLIS: All right.

The next area is that of Missouri and I want to thank Dr. Besson. Missouri submits two projects, Project No. 85, centers around Kansas City General Hospital Medical center. Its purpose is as stated to provide a comprehensive emergency service for Kansas City, and a centralized trauma service for Kansas City.

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The Kansas City General Hospital would be designated as a major emergency facility capable of treating, immediately upon arrival, any patient of a life, or limb threatening condition at any time. The emphasis on this, both in their brief summary and in the grant itself, is highly on trauma.

The hospital is operating as a major emergency facility, giving care and definitive treatment for all emergencies. Early screening for emergency room patients with appropriate specialized treatment in trauma, drug abuse, etc. Early screening, establishing an overnight observation ward adjacent to the emergency room, and conducting a computerized trauma registry for proper recording and feedback.

The sum of money requested for project 85 is 300,000 the first year, 285,000, the second, and 300,000 for the third year.

Reviewing the project, it is centered not on the community basically, but very much about the Kansas City Hospital, itself. As far as I can determine, there is very

little in the way of community involvement. The linkages, themselves are only partial, as best I could determine from the review. Some 250 thousand is requested for salaries for the emergency room and trauma center, which significant sum is obviously for the in-service area of the hospital.

There is very little evidence to me of regionalization in this. It does not speak to a system of total emergency care, but much more to trauma, itself. There is some indication of problems in handling the ambulatory patients which come to the emergency room. But basically, this is oriented almost completely towards the Kansas City Hospital in the in-trauma, and the support of the staff of the emergency area and the trauma center, as I have indicated, comes to most of the sum.

I did not give that any recommendation as far as rating. I do not thing it speaks to a system of care, and I think it is all for the Kansas City General Hospital without being part of what our guidelines would recomment.

The second project is one which centers around the Lester E. Cox Medical Center. This project requests a sum of $1 million for the first year, 1.4 for the second, 900,000 for the third, for a total then of $3.3 million. It speaks to developing, and this is Project No. 87 -- hierarchy of emergency medical service facilities, an integrated emergency transportation system, and to train necessary personnel.

This would be to provide a comprehensive system-

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for 33 counties in rural southwestern Missouri, which would include an emergency transportation network plus emergency medical facilities.

It would include six equipped ambulances, three equipped busses, and one helicopter, and they want to establish at least one major medical facility, and several satellite emergency facilities, train 25 nurses in emergency treatment, as well as other associated paramedical personnel, and to develop a communications system, in addition.

In reviewing this, something like $500 thousand for salaries, 376,000 for equipment, includes 30 ambulance attendants, 25 nurses, and individuals to man the helicopters, as well. There will be three phases in terms of mobile units.

Family health care is discussed as well, and actually when you read about the bus system, this would be three busses which would be used to service non-emergency, medical patients, and also funds are requested for family health care stations, circuit riders.

In reviewing this, although it is submitted as part of an emergency medical system, it really discusses total care, and discusses it in a completely different way than one I think would interpret the guidelines. It is a three-year grant application from a nonprofit community hospital, with requests including, as I have indicated, not alone, emergency vehicles, but funds for family health care stations, busses

to transport patients from the rural area to the hospital, itself.

There are points of value in this, in that there is active involvement of the community. The area served is rural, involving some 700,000 people, but my concern is that it tackles a much larger area than just emergency medical ysstems, and even when it approaches emergency medical systems, there are large areas not discussed, such as the training program, physician coverage, equipment which would be on some of the emergency equipment discussed.

Before recommending any funding on that, I would like to have the secondary reviewer make any comments which he would feel appropriate. That is Mr. Toomey.

MR. TOOMEY: I would -- I felt the same way you did about the Kansas City General Hospital, they were asking funds to improve the services within the hospital but without mucy concern for an emergency medical services system, as far as the area was concerned

I think I felt -- I do not know how you feel, but I felt that this proposal from the Lester Cox Medical Center in Springfield; (a) was very interesting, but it really had only one part of it devoted to providing an emergency medical service for the area.

I felt the family health care station proposal, while interesting, was not really pertinent. I felt the circuit

rider was not exactly pertinent. One thing -- I do not know, did you mention the fact that this is the second time this proposal has been submitted, and the letters of --

DR. SCHERLIS: For '68 and '69.

MR. TOOMEY: The letters written in support of it were dated in '68 and '69 with the statement that the people who supported the thing were supporting it now.

DR. SCHERLIS: They still like it.

MR. TOOMEY: Yes.

DR. SCHERLIS: They have -- the intent is to make health care service available among those people who live in the hinterland sectors. And while I would concur that these are very valuable goals, this is not what we are addressing ourselves to under the EMS guidelines.

MR. TOOMEY: In summary, what I said, the portion of this proposal which deals with the development of a centrally controlled and coordinated system of ambulance services for 33 counties, is a desirable project perhaps, but the health care stations and the physician circuit rider are interesting, would be of some value, but they are not appropriate and related to the project.

DR. SCHERLIS: Did you recommend the sum? What was the sum?

MR. TOOMEY: They are requesting one million, forty-five.

DR. SCHERLIS: A million, forty-five?

MR. TOOMEY: No, I did not recommend the sum.

DR. SCHERLIS: I gave this a rating of two and suggested somewhere between -- I had fully suggested 75,000 to help get the planning going, because I think there are some parts in here that can be put together. But I would not suggest it go to the Lester E. Cox Medical Center, but rather the regional medical program office, for planning.

MR. TOOMEY: I would support that.

DR. SCHERLIS: The motion then is $77 thousand for No. 2, at a rating of two. That is actually application 87, to keep it accurate.

The sum of $77 thousand for a priority of two, and the other Project 85, no support.

Second reviewers?

MR. TOOMEY: Yes, okay.

DR. SCHERLIS: Any comments?

DR. BESSON: I did not.

DR. SCHERLIS: Yes, sir? Dr. Keller?

DR. KELLER: I just want to ask with respect to guidelines, we have had just one or two other projects today that seem to emphasize the interface between emergency medical centers and the rest of the health care system. If I understand our guidelines correctly, that is something we are aiming at, rather than backing away from?

DR. SCHERLIS: Yes.

DR. KELLER: I just had a moment to look this through and it is a very complicated application, and I am sure that there are many difficulties. But, is there something in here that can be funded. That help is to emphasize the desirability and the importance of this kind of linkage? What I am afraid of is that in many of the programs that have been presented, the people who are specifically enthusiastic for emergency medical services will gain such ascendancy in these things, that eventually the linkage between that and the rest of the health care delivery system will begin to be deemphasized.

DR. SCHERLIS: Yes. I view the system as being not just in the emergency aspect and ending in the emergency -- when the emergency is taken care of. But it should certainly go the entire loop.

I think some of the guidelines emphasize this as well. I think in this particular instance, the first one only looks at a very small -- not just aspect, but a physical area as part of the system.

As such, I think it falls outside of the guidelines. The second one has the problem of being a '68 - '69 application, which they say everybody still agrees with. Secondly, it therefore does not have the opportunity to review itself in terms of the guideline, but yet so much has gone into that, that

planning and training aspects look like they should be salvaged. I felt as a secondary reviewer these could best be moved from the responsibility of the Cox Hospital to the regional program office, itself, so we get -- we would hope we would get a better correlation with the other services in the state.

It has aspects that are interesting that might be favorably look upon under general regional medical program supports, like area health centers. but this is not part of what we can support under our present mechnism, at least within our responsibility today.

MR. TOOMEY: Can I comment just a moment?

DR. SCHERLIS: Sure. Yes. Please do, Mr. Toomey.

MR. TOOMEY: The first program was just internal operations of the emergency room, and I do not consider that to be part of our responsibility. The other one is more of a conceptual thought. I am rather amazed at one institution in Springfield wanting to accept a responsibility for coordinating ambulance services and other services to people in a 33 county area, and to the degree that it is my opinion, that the hospitals will be moving in the direction of sharing services and in the direction of finding a major institution who accepts a major role in integrating various kinds of services, ambulance and other institutions,

We may be looking at tradition when we say, "Move it away from the hospital and put it back in RMP," rather -

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than looking at what seems to be coming in the future, which is the enlarged role of institutions covering and with a responsibility for a larger area than they have had in the past.

I do not know what the answer is to it, but I think it is one of those things that is happening.

end #17

DR. SCHERLIS: All right.

Next is Mountain States' three projects. We're on the home stretch now, I hope.

All right, Mountain States' request is for three projects which come to the following: $375,000 for project 26.

DR. HINMAN: That is all three combined.

DR. SCHERLIS: Oh, okay. All right. There are three different components; one from Idaho, the other from Montana, the third from California and Nevada. The general objectives are to develop a comprehensive emergency medical service planning program for Montana, increase the existing emergency council advisory activity, initiate needed training, inventory all emergency facilities, form an area-wide planning committee for project resources. Staff and volunteer would be from other sources, and they have other funding for that.

And for Montana, the following comments were made. This is similar to the other states, as I will indicate. It is essentially the same as Idaho. They give only the barest outline. There is a very poor breakdown as far as salaries are concerned. They requested a total of $142,000 for their program.

They requested specifically to support a staff of five members in the Department of Health and Environmental Sciences, eight in the coordination of five emergency medical service planning committees in the state supporting training of

emergency facility personnel, inventory the state resources, provide ambulances and equipment, and then there is a $70,000 budget item to purchase ambulances. This actually is not in the budget. It appears to come from federal sources.

I would concur in the fact that I would not fund the budget request at this time because, essentially, they should be much more in line with planning. If you go through the yellow sheets, and these are interesting because most of the responses in terms of understanding the EMS system are on the negative side. In fact, most of the comments of staff were on the negative side, as far as the entire project is concerned. This was Montana.

In terms of Idaho, again, this is a very similar one to Montana. They specifically ask for funds for an emergency health services advisory board. They want to provide EMT training, EMS physician and nurse training, coronary care evaluation, emergency rooms, coronary care units and other hospital facilities, classify and evaluate emergency rooms in Idaho, collect and tabulate data.

I rated this more favorably than I did the one from Montana. They had requested some $178,000, which I thought was somewhat excessive. They have requested mobile coronary care vehicles, and I felt this should be under a separate funding. This was on -- if you want to check, it is on page 45 of their application. They do have good data on the ambulances,

good data as far as a lot of their information is concerned. The goals were very well-stated, as well. This looks a little better as far as being more of an emergency medical system. They do have better planning than the others. Although they are emphasizing only part of the EMS system, they do define some of the other needs. I thought all in all this was a reasonable approach.

The third was Nevada and California. This request was for $55,000 for year 1, $62,000 for the second year Here they specifically asked for funds for a program coordinator, EMT training and EMS committees to coordinate their planning of a total system. Actually, although there is a need defined in their grant, the grant request, they don't address themselves very well to a total system.

My feeling here was to give them a low rating, although they need their funds. I felt this was overall a poor presentation.

What I came up with then, as far as California and Nevada was concerned is that that would not be funded, but in terms of the Idaho component where they had requested $178,000, is that this be rated as three with a request for $100,000.

The third, Montana, I had a dilemma on this one. My own reaction was to rate this as two. I thought their request for funds was excessive, and in comparing it to the ones that came in from the same area, it should be refused. I suggest a sum

of $50,000.

DR. HINMAN: Do I understand you correctly? You are recommending one-year planning for two of the components?

DR. SCHERLIS: And zero for the third. The other was 100, and the other 50.

Is there any member of the staff who could speak to Idaho or Montana, as far as how they have moved along with their emergency systems planning at this point, aside from what is present in the grant application?

Do you have any feeling on that?

VOICE: I was out there to a RAG meeting just recently when these projects were pushed through the RAG, and at that time, the projects were were heavily loaded with equipment requests. That was the essence of it, basically, and they had not followed or not had any idea what the EMS guidelines were at the time. Subsequent to staff input they went back and reworked them a little bit, and I think they have taken out most of the equipment and are trying to plan aspects.

DR. SCHERLIS: These look thick, but they are all appendix material, and there is a lot of padding of related and unrelated material.

VOICE: I think there surely is --

DR. SCHERLIS: The requests are scant, and I think more in terms of planning, and I think they can probably move on that.

VOICE: The Idaho one has been conceptually worked out much longer than the other two. I think you hit them in the descending order they ought to be. Idaho, Montana, and Nevada.

DR. SCHERLIS: Right. Is there a second to that motion?

DR. MC PHEDRAN: I second.

DR. SCHERLIS: I think we have struck the coronary units, ambulances, from that program.

Any further discussion?

DR. SCHERLIS: Next is New Jersey.

DR. MC PHEDRAN: There are two pieces here. One is according to their numbering system, 028 Emergency Medical Service System Plan, 029 is a Computerized Shock and Assessment of Treatment.

I would say in summary that these are either rated -- I will rate them as one or "can't rate them," and would not recommend them for any funding.

In the Emergency Medical System Plan, there is simply not enough information really to tell anything about needs or resources, let alone to relate the different resources one to another.

It is a proposal to evaluate these things, but it seems that like the other regions, they might have accumulated enough information sort of to give us a feeling that they had some faint idea what the problems might be, other than that there are serious problems of deprived people in urban centers.

I really -- I couldn't tell much of anything about a state that I really know a lot about, from having been there many times. I just don't think there is enough information, enought detail here, to warrant funding the System Plan. That is the part of it that I think would be -- might be appropriate for RMP's funding.

The other is a study as Dr. Gimble correctly -- I think it was Dr. Gimble that reviewed this -- stated. No,

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sombody else, I'm sorry. A study of a method of evaluating patients in shock and using a computer system for deciding on the effective treatment, and it is a clinical study, and I think not appropriate for RMP funding.

So in summary, I wouldn't recommend any funding for either one and rate them both as one.

What they have produced here stands in contrast to what I gather -- eastern operations said this is a region that has had good management capability in the past. And it doesn't come through.

DR. SCHERLIS: Dr. Besson?

DR. BESSON: Yes. I agree with the physiological monitoring.

This is a reflection of the kind of thing Albany wanted to do and I think it is inappropriate for RMP, and nothing further need be said about that.

The other program, the integrated program, so called, means to survey transportation by an inter-agency council, develop a plan for EMT training, assess emergency rooms, and identify the needs of the poor working with model cities and community development cities, 20 in all, to improve the emergency care rendered to the poor.

I view this as a developmental grant, this proportion of it, and I agree with Dr. McPhedran and the reviewer, Dr. Gimble, that the entire program is extremely sketchy and

jr 3

scant, although New Jersey does have a good program coordinator and in general has been a relatively mature region.

Again I am charitable in saying that this was the result of the precipitous nature of the proposal submission, and I am a little bit more charitable in not faulting the region as Dr. McPhedran might be in not giving them any funding.

I think the fact that they do have a model cities program that is working, that is interested in becoming attached to this kind of effort, I think the fact that they are using the model cities in their community development program as an entry point for not only providing emergency services for the poor, but addressing the nation-wide utilization of emergency services as an access point, which is an entirely different question, and one which has to be answered -- we can't overlook it by talking just at the lofty level of providing emergency medical services.

Many people use it as an access point. So, while there is no recognition of that aspect of it in their proposal, and the whole thing is very sketchy, I think it is interesting that RMP is talking to consumers who will rapidly bring this to their attention.

And with their maturity, I would be inclined to maybe rather than not giving them any funding, to give them one-third or so funding of the second component only.

DR. SCHERLIS: How much would that be?

jr 4

DR. MC PHEDRAN: About $40,000.

DR. BESSON: $40,000, yes.

DR. GIMBLE: Are you talking about 28 now? Proposal 028?

DR. BESSON: Yes. Fund nothing for 29.

DR. SCHERLIS: The agreement is zero funding level for the shock study.

DR. MC PHEDRAN: Okay.

DR. SCHERLIS: And now you are talking in terms of getting this off the ground, the general proposal; and you are recommending how much?

DR. BESSON: We have two motions.

DR. MC PHEDRAN: I agree with you, I think that is an important part of it. I think that is an important opportunity that they have. This is a problem everybody has and they did address that as a specific objective more than many of the other plans did, I guess.

Okay, I'll amend mine. I'll go along with that. Still, it is hard to recommend anything for something which I still find I can't rate.

I find sort of an internal inconsistency with recommending any funds at all for something that I would rate so low.

DR. HINMAN: You could rate 29 separately from 28.

DR. MC PHEDRAN: Yes. I've done that.

jr 5

DR. SCHERLIS: I think the rating we should have is purely on that fragment of the approved project.

DR. MC PHEDRAN: Yes. Okay.

DR. GIMBLE: I would like to comment. They mention a specific problem in New Jersey: The independence of the volunteer emergency squads. And most of their application appears to be directed at improving the quality of service rendered by these squads.

The thing I find unfortunate, though I think it is a good opportunity to get all the squads together in terms of getting cooperation, this isn't very strongly put forth in the application. I think that is the most important part of the application.

If they could use this as a vehicle for cooperation between squads and between emergency rooms and hospitals, it would be important.

I get the feeling it is overlooked in this application and I think a recommendation to that effect, rather than just support the squads on an X amount of money for each squad to improve their education.

But somehow they should be hooked into getting them together for a cooperative venture, more than just a training amount.

DR. BESSON: I agree with that. I see the only virtue of this application, $40,000, will be to help them get

jr 6

off the ground, and also to sit down and talk with some urban poor. Once they sit down and talk with them, I'm sure they will get the answer, "Gee, where have you been? We're glad you asked." And from then they will submit a much more relevant application next year.

DR. SCHERLIS: Do you have any comments about the New Jersey area, Mrs. Faatz?

DR. FAATZ: No.

DR. SCHERLIS: What is the rating then, the two of you?

DR. MC PHEDRAN: Well, as part of a system, I guess I might rate these parts as a 2 or 3. But as the whole, -- 028 is this whole plan, that is the number altogether.

DR. SCHERLIS: Yes.

DR. MC PHEDRAN: As a whole, I don't think you could give it that high a rating. But these portions of it, where they talk about identifying and trying to do something about problems of urban poor, to correct this abuse of emergency room systems, to do something to devise some system to do that, to get away from that, we could rate that as 2.

DR. SCHERLIS: Do you accept that as a 2 rating?

DR. BESSON: Sure.

DR. SCHERLIS: Dr. Rose?

DR. ROSE: May I ask whether you would like to consider breaking down 028? You are able to break that down if

jr 7

you would like.

DR. BESSON: You would rate the physiological monitoring as one? As zero? What is the least?

DR. MC PHEDRAN: Zero.

DR. SCHERLIS: Zero.

DR. MC PHEDRAN: It is inappropriate.

DR. SCHERLIS: I think we could accept zero.

DR. BESSON: The other is 2.5. I would go along with that.

DR. SCHERLIS: Is that satisfactory?

DR. ROSE: That is for the whole 028 project? You don't want to place any restrictions as to what kind of activities they will be doing in that project?

DR. BESSON: No.

DR. GIMBLE: I didn't find enough material to break down, unfortunately.

DR. SCHERLIS: We are talking about making a start on a system of care, and trying to get into the ambulance problem and hoping the training might be the wedge to make them less independent.

DR. BESSON: I don't know that it would be appropriate for us to say, "You can only work on component 4."

I think we have to give them this amount of money with the advice.

DR. SCHERLIS: That they try to set up a system of

jr 8

care.

DR. BESSON: Yes, and let them do the best they can.

DR. SCHERLIS: Right. Any further discussion?

All those in favor, say aye.

(Chorus of ayes.)

DR. SCHERLIS: All right. That is New Jersey.

Next is New York Metro.

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DR. SCHERLIS: We now move to New Mexico, Mr. Toomey and Dr. McPhedran and the secondary reviewer.

MR. TOOMEY: The application is New Mexico --

DR. HINMAN: Let the record show that Dr. Hendryson left the room during the review.

DR. SCHERLIS: Don't go far.

MR. TOOMEY: Funding is requested for $425,000.the first year, and $139,000 the second year, $147,000 the third year.

This grant request was from a previous grant funded in 1968 to study the health delivery system of the state of New Mexico. Due to the 1968 grant, quality of existing EMS services have improoved but there are still 11 counties where no EMS systems are available.

Therefore, this request is requesting primarily for the establishment of an EMS by using a model developed in a similar community of New Mexico providing primary medical care, communications, transportation, and hospital emergency linkages for those rural counties without these services.

New Mexico has a 121,000 square miles and is the fift largest state in the nation. The economy peramaters include ranching, farming, mining, oil production, light industry. It has a population of a million, amillion, 20 thousand. It is by sected by the Rocky Mountains of which roughly a third of the central portion of the state is occupied by mountain terrain

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with the remainder configuration of the state being flat plain. The 3 major ethnic groups comprise the population including white, white Spanish, and Indians.

The primary objective of this grant application is to establish an EMS system in 7 rural communities employing the model tested in San Rafael County, and to improve the quality of existing EMS systems in the state of New Mexico, with identification of present weaknesses and other components of the total health care delivery system.

Second area objectives include the development of data relating to emergency ambulance care crisis and to create 2 working pilot projects to attack the problem, to evaluate the efficiences of the plan's training program that concerns time and resources in its delivery; enhance the availability and accessability to the educational experience, to establish a regional coordinating center to standardize and develop training and treatment methods; to influence improvement of the total health care system.

The plan primarily emphasis is the development of more administrative control and internal organization for administering a total EMS. Of the $483,000 requested for the first year, only approximately $80,000 is for equipment. The remainder is $400,000 for personnel training, instruction, and fringe benefits.

The narrative describes a geographical area to be

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served, however, the only portion I delineate is a clear understanding as to how the various elements will be integrated, or the identified deficiencies within the present system overcome.

The application is a community based program, has broad representation and involvement from providers, public agencies, and community interests.

Existing medical service resources and needs have been identified and documented. The plan defined how the various operating cooperatives will be coordinated and tied together with already operational cooperatives. Linkages with local health care systems to assure adequate referran and follow up of treatment.

Emergency treatment is only partially described and briefly referred to in regard to master plans.

The narrative includes techniques to utilize existing financial resources and a means of obtaining additional financial support.

All local state and national operating standards are complied with, evaluation procedures and techniques for determining the effect of this system are perhaps the weakest section of the proposal.

This grant request narrative includes many details about the various counties which require careful sorting and review to gain any understanding of the application, or a thorough understanding of the application, even though the application

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appears wordy and pale, it appears to meet the criteria of an EMS system which is designed to meet the needs of the population and topography in the state of New Mexico, and it is my recommendation that it be given -- I'll wait until we have the secondary reviewer.

DR. MC PHEDRAN: I rated it a 4. I won't repeat what Mr. Toomey has said. I want to underscore, though, the community involvement. There is evidence in this application of community input that I found in no other applications that I received.

DR. SCHERLIS: It isn't just the lateness of the hour?

DR. MC PHEDRAN: No. I think it is very good. This is one of the 2 or 3 best, and I was particularly impressed with that.

DR. SCHERLIS: What level of funding do you suggest, Mr. Toomey? Do you have a suggestion on that?

MR. TOOMEY: I do have a suggestion that. I suggest that it be funded as requested.

DR. SCHERLIS: You both recommend full funding and a rating of 4? That is one of the best reviews we have had in terms of the recommendation.

All those in favor say aye.

(Chorus of ayes.)

Opposed?

~~All right. Next state is Oklahoma.~~

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DR. SCHERLIS: Dr. Besson, metropolitan New York.

DR. BESSON: Let the record show that I can leave at 1:00 as soon as I am through.

DR. SCHERLIS: I give that a reading of one.

DR. HINMAN: Zero.

DR. BESSON: Metropolitan New York is asking for two years funding from July, '72, to July, '74, $225,000 for a problem which may be stated thusly: that 70 percent of visits at the Bronx Municipal Hospital Center, or nationally -- Bronx Municipal Hospital Center is what we are talking about -- 70 percent of visits are to the emergency room. Primary care in the emergency room, we all know, is far greater, up to 10 times as great as costs otherwise, and it ties up facilities.

The alternative I have proposed in this application is to develop what is called a triage M.D., an R.N., or medical coreman or technician and with three months' training, to triage into one of three categories: immediate emergency, the late emergency, or non-emergency. The principal investigator or who has been doing this kind of thing, social work type, says that 1970 at the Bronx Municipal Hospital Center, there were 83,000 patients seen in the emergency room; and in the non-appointment clinic, which are the walk-ins, there were 40,000 patients.

When this system was instituted, a triage, the

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emergency room census fell uniquely throughout the country from 83,000 to 66,000, and the non-appointment clinic appointments rose to 54,000. She says there is a great deal of value in developing this notion of triaging prior to utilization of emergency room facilities.

Now this is a national problem as we all know, and it is nice that somebody is going to do something about it. She proposes to prepare an operational manual, devise a training curriculum for doing triage, do a program analysis, and she describes this in some sketchy detail. A methodology, I think, is self-evident. But I think that the development of a triage methodology in a manual at one hospital for $225,000 is just totally inconsonant with the request for proposal that was sent out February 25. It is a piece of the action, no question about it, but it is a very expensive piece.

I would consider that of one to five, I would rate this three on merit, but suggest they write a nice letter to the National Center for Health Services Research and Development, and ask them for some funds. Because it would be much more appropriately funded by that organization than by this.

So even though I like it, I won't eat it.

DR. SCHERLIS: Mr. Toomey?

MR. TOOMEY: I liked it, too, and unlike you, I think

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I would have at least some bites on it and either part of it. It is an important part of the total system. The utilization of emergency rooms not only in terms of their being brought by plans, but also in terms of the utilization within the emergency room itself, is so frequently inappropriate that any effort in analysis of a subsystem of the total system, it seems to me would be desirable.

I think there is an overriding concern on the part of too many people about the use of the emergency room and the problem is not the use of the emergency room, but its inappropriate use. I think whether it is triage or an analysis of the utilization of the emergency room, that is a desirable facet of the RMP's concern.

Too many of the applications,as I have read and heard them, have concerned themselves with the transportation and communications and not enough of them with what goes on inside the emergency room to take care of the people who do arrive at that room, at that department.

I don't believe there is enough study of the way in which the facility is designed and I don't think there is enough study yet in terms of the services that are provided therein. I felt this was rather sketchy. I felt it was, if you will, typically New York, in that they were going to assign some Ph.D.'s to do in-depth kinds of studies, and I felt that the amount of money requested for the program was too

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much.

But I felt it was something that should be looked at, should be studied and analyzed and consequently I would rate it a little higher and recommend that it receive some funding. I don't know it needs all that was proposed.

DR. BESSON: The salary -- here is one hospital, one emergency room, and they want to have $15,000 for project director to watch the people come in and out and what happens to them, $15,000 for research associate, $3,500 for a technical writer, $9,000 for a secretary, a physician-consultant at $100 a day, for $15,000 -- heck, you can provide all the services for everybody for that amount.

If you would give me a reasonable kind of figure, Roger, I'll take a small bite. They are asking for two hundred --

DR. SCHERLIS: May I ask a question on this point? When they come up with a manual, will that have any relevance in any place except this hospital?

DR. MATORY: I think as all of you have very well stated, there is a desirability of such a study. It is desirable not only so far as the patients are concerned, but also so far as the professionals are concerned. We all feel there is some other way of doing it. We are not all sure that it is safe or desirable to have someone else triage. The whole idea of triage, we have talked about for a long time

but we are not convinced that triage is worthwhile. We are not convinced that a patient, who comes to the emergency room indeed, should be sent away by anybody but the physician.

But, this question needs to be answered. One of the reasons why it is difficult to answer is because we are not sure that there is a body of knowledge which you could entrust, a body of criteria that you can trust to a person other than a physician, and feel confident that this has been done.

This is a medical--ability thing attached to this. If he is sent away by a nurse or corpman, and something happens, we all are liable. So certainly, I think that your criticism of the amount of dollars to be placed, certainly that bears merit. However, I wonder if there is not a need to search the budget to see certain things.

The most important of these is the evaluation of the effect of the triage, in terms of what really does happen to the patient, in terms of propatient disposition, patient satisfaction. The evaluation needs to be done over a significant period of time and in a significant volume. If, within that budget, a significant amount of this money is targeted for evaluation, I would lean closer to one hundred twenty-five.

But, I would be concerned about such a program being supported. The data which is collected, if properly supported by re-evaluation, would certainly be of practical value to-

others throughout the country.

DR. SCHERLIS: Yes.

MR. TOOMEY: What you are suggesting then, is a redirection of the study in terms of the net results subsequent to the triage, rather than the mechanisms for triage?

DR. MATORY: I have not read enough to see how much evaluation is in this, but I think evaluation is a key point in this.

MR. TOOMEY: No, it says that, "This project is not intended to evaluate the triage system as it operates at the Bronx Municipal Hospital Center, in comparison to no system or to other triage. Rather the goal is to document and codify operating procedures of an ongoing system and specify the training program for the triage professionals staffing that system."

And then it says, "Evaluation is not appropriate. Monitoring is appropriate."

DR. BESSON: That is a significant point because what they really are doing is developing a manual, and on page nine is an example of the proposed branching-logic-disposition chart, where they have on the top, "Symptom -- Vaginal Bleeding; and they break it up.

If it is child bearing -- they go down in this fashion for a medical corpman or somebody to make a decision. That is fine, it is no question that it is going to be useful and

the number of dollars they are going to save nationally, will be all right. If it was not for $225 thousand, I would say all right.

I am questioning whether RMPs is the vehicle for funding something like this, though, whether we have the power to be generous if it is needed, whether we suggest they apply for the National Center for funding -- these are the nature of my questions, Dr. Matory.

Otherwise, I agree with you.

DR. MATORY: If you say there is not a significant evaluation of this and they set out stating they are not going to evaluate it; to me, it weakens the whole program. It is very desirable but to me, it has no value unless there is a significant amount of evaluation to it.

DR. BESSON: This is a health services delivery experimental program that has great merit, but lies out of the purview of -- if you read our guidelines, and look at this, they are two different universes.

DR. SCHERLIS: I have some problem with this.

DR. BESSON: How about a hundred thousand?

DR. SCHERLIS: As I read the background of the project director, essentially, it is in the area of statistics operations, research. This is not an accident room or emergency room physician, this is someone looking at the system from the outside.

DR. BESSON: But she is going to use physician consultants to create the branching manual.

DR. SCHERLIS: All medicine is a branching manual. I do not want to be involved with that beyond the point, but I do not know if a simple program is going to be the answer. I was wondering if you might expound on that a bit? I do not know what you have when you are done with this, even if the success is achieved by her definition.

What do you have at the end of the $200,000 plus? As I read it, the proposal seeks funds which will enable us to develop a manual of procedures, to develop a syllabus for training triage professionals, and to asses the triage system.

DR. MATORY: The problem with that, of course, this is available, and particularly the Chicago group have done this. And they have outlines on just what was done. So, again, it would have value if this is developed and utilized and evaluated.

It does not disturb me that she is not a part of the system. Indeed, I think that --

DR. SCHERLIS: That is probably a beneficial effect at this time.

DR. BESSON: What are we paying her fifteen grand for?

DR. MATORY: I thought I understood his question as to the value of having a person who is not really a part of

the physician-care system. But to me, this is a plus. It gives her a better opportunity to make a good overview and if she is going to use consultants liberally, she can perhaps, get the whole program together with less prejudice.

MR. TOOMEY: The thing that impresses me is the fact that this study is not applicable to all emergency rooms. It would seem to me it is very applicable to those public hospitals in the large cities in this country, or the large public hospitals in the larger cities.

I would agree that the monitoring and followup is something that would be desirable. But, while all emergency rooms have problems, I do not think there are any that have as great problems as the municipal and the city-county hospitals that do exist.

I can see this has a value in those areas. Specifically in terms of a manual, itself, and secondly, as far as the ability of -- and I agree with you on the evaluation, I very much agree. Because, even in the small cities where you have relatively active emergency rooms, and you do have shortages of physicians, there is a great reluctance to rely on people other than physicians to do the triage.

And they are not always available. Consequently, I think if this were looked upon as being of value, particularly to those governmental hospitals in the large cities, and added a bit more stress on the evaluation of the triage, that then

it would have value to many other organizations. But I am in agreement, I do not think this kind of study should cost anywhere from $200,000 to $250 thousand. I think you should be able to get it done for somewhere in the neighborhood of twenty, fifty, and one hundred thousand.

DR. MC PHEDRAN: Mr. Chairman, we could spend a lot more time with this. In the interests of expediting, I would defer to the secondary reviewers figure, and if you said fifty to a hundred thousand dollars, I would accept fifty, which is one-third of the requested amount, of 156 for two years.

DR. HINMAN: I have a point, I am concerned about something.

What I hear you saying is that this is information that could be useful in the long run. But, I do not see how this fits our guidelines after attempting to have an RMP work with provider groups to improve care to patients. We are not in the business of funding R&D. I thought.

I just wonder if you all feel there is merit to proposals or other mechanisms and you could request it be considered for a developmental contract in R&D, or someone else to get the information. But I am just concerned as to how this is going to move Metro New York, RMP to improving patient care for the residents of New York City?

DR. SCHERLIS: This is part of what you have suggested in the first place, that you refer it to the other agency.

Perhaps this would be the legitimate answer.

DR. BESSON: But we are the fat cats, R&D maybe does not have as many bucks as we can, and maybe as long as we have a bird in the hand, we ought to take it -- that is what I gather his comments are, that the implications are great enough so that if we could fund a little piece of some program in New Jersey because they are a "red ink," a poor program, we could fund this, even though it is far from the guidelines.

DR. HINMAN: Except with New Jersey, I heard you saying that you were attempting to see to it that that RMP talked more with the usual and the poor and their problems of access to emergency services with the espectations that change would occur as a result of it.

That is quite different from developing a manual that will give you a method of doing triage. I do not see how that fits what RMPs has talked about in the two or three publications that have gone out on EMS.

DR. BESSON: If this is inconsistent with the guidelines, maybe we are just --

DR. SCHERLIS: Let us not prolong the discussion.

DR. MATORY: I think if you go by the guidelines, that you are definitely right. On the other hand, if the author would have indicated that this is the type of development which would indeed, effect the other major metropolitan hospitals in this area, if so coordinated through RMP, it would have that

type of value. But, I do not know that this is made clear.

DR. BESSON: Besides, I think as I read the guidelines, I see -- and as I specifically ask that question, this morning -- that we can fund a component of a system.

Now, we did not argue too much -- some -- about transportation in Maine, but communications in western New York, Lakes area. Here is another problem which maybe does not have the same degree of advisability but is a component.

DR. SCHERLIS: I think the difference is, though, that while this is a component, the question of whether this is really R&D has to be seriously considered.

DR. BESSON: I move we fund them at fifty thousand, and we give them a rating of three.

DR. SCHERLIS: Mrs. Faatz?

DR. FAATZ BEfore you make your final decision, I would like to draw your attention to the eastern branch comments which are to the effect, I think, that metro New York is experiencing rather troublesome organizational and management problems, and they have in fact, projected quite a surplus of unexpended funds over the next sometime.

DR. BESSON: I correct my motion and approve it, but no funding. Thank you very much, Anne.

DR. SCHERLIS: Approve it to what?

DR. BESSON: Approve it with a recommendation that it be funded out of projected surplus of funds.

DR. SCHERLIS: What amount? Is that within our legal capability?

DR. SILSBEE: You would approve it to $50 thousand, and the decision as to funding --

DR. BESSON: No additional funds. This is a supplemental application.

DR. SCHERLIS: I gather as far as EMS is concerned, we should make that a request for funding and not specify where it comes from, and staff will work it out. I do not think part of our consideration should be that we have money therefore, we should fund it, it should be, does this comparatively merit funding. There should be inked into this, the comments made that there has to be an evaluation to a more adequate degree.

DR. HINMAN: Fifty for the two years, twenty-five a year.

DR. BESSON: Right.

DR. SCHERLIS: A rating of three. Any other comments?

MR. TOOMEY: I would like to make one other comment because it bothers me a little bit.

It is hard to, in light of the guidelines, looking at the total emergency medical system, to then focus down on one institution and say, this institution meets these guidelines. If you relate the number of people they serve to the number of people that are served in some of the larger systems,

I think once again, in terms of population, which probably is several million people, utilizing, or in that area, I think you have -- and if I understood correctly, somewhere in the neighborhood of 150,000 to 200,000 emergency room visits in the course of a year, which is probably as much as some of the smaller states have -- I think you can justify it, even though it is a one-hospital problem.

DR. SCHERLIS: One type of hospital problem.

MR. TOOMEY: Yes.

DR. SCHERLIS: Perhaps we should try to finish one more region before we have our lunch break.

End #9

Lunch will be no more than half an hour.

DR. SCHERLIS: Any other comments, pro or con?

Next is Northeast Ohio.

DR. ROTH: Northeast Ohio, this was totally different from any of the other applications I had. It concerned everything except automobile casualties and so on. It was all planning the plan and I would feel that Dr. Sloan probably hit the problem on the head here with a new coordinator, and she ends up her narrative evaluation of the proposal by saying in this respect that she believes he should be asked to try again. And if it is a proper thing I think we should encourage Northeast Ohio to resubmit for a subsequent cycle.

DR. SCHERLIS: All right.

Yes?

VOICE: Dr. Glover did prepare this and submits it back in January, long before our guidelines were out. So if it is not relevant, that is why.

DR. SCHERLIS: I think that explains some of the problems I had in reviewing it, too. I had not recommended it for support, either.

Any other comments?

Now, let me see.

Do you have any other comments on these others?

DR. ROTH: No, I didn't. I apologize.

DR. SCHERLIS: Perhaps we can move to California. We still have a quorum and I gather the three of us will remain until the bitter end.

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DR. BESSON: Northern New England. They are requesting a one-year funding of --

DR. SCHERLIS: Direct and indirect is '74, the other is '72.

DR. BESSON: Now, this has been an ongoing program in northern New England, and they have had three superb studies of ambulance services in Vermont, hospital emergency room services in Vermont, and then an up-to-date study of the entire emergency health system in 1971, as an ongoing program in northern New England in the past; done by the University of Vermont and one particular fellow, whose name, I forget.

In an investigation of the status of ambulance services, they conclude that ambulance services are very meagerly coordinated and prepared in the State of Vermont, lnd need a great deal of help. Their study of the hospital emergency rooms, all but two of the hospital emergency rooms have problems of coverage, operation, and evaluation of their entire program.

The effects of both of these shortcomings, ambulance and emergency room is -- culminates in a state which they mention, that 23 percent of their injuries, survivable injuries, die in prehospital or hospital care, which is a facet of what the national figure is.

This happens to be what they come up with in Vermont. The past activities that I have mentioned of --

progress in Vermont is that there have been attempts to coordinate and develop standards for personnel, equipment, operation, attempts at standards for training programs, communications, and so forth, and what this proposal is to do, purports to do, is to involve itself in four so-called high-priority areas: improvement of the capability of individual ambulance districts to carry out regional coordination, establish ambulance regulation, emergency room regulations, and improvement of existing training programs.

They hope to establish formal health services advisory committees to replace the informally established committees, to establish a central dispatch communications pattern throughout the state, and to increase public knowledge about handling of emergencies.

All of this really is a relatively complete package. Their proposal for training include as package in the first year, for nurse refresher training for enlightening physicians to accept surrogates doing work in the absence of the physician, or on his own, to improve the Dunlop EMT Course, and then to evaluate their training in coordinative functions.

They need funds for the emergency room nurse teaching package for coordination and for teaching aids. As far as their second major activities, the state planning activities, they want to use these funds to devise state plans, to set goals for each district, and to further -- and this is a

comment that you made in relation to the tri-state area -- interstate coordination.

This is one of the few applications where one particular region will look to contiguous regions and use some of its funds for interregional cooperation, which is very laudable. As I have looked over their budgetary use of monies for personnel, I am impressed by the training of the people and their past experience. It is quite impressive. Their general budget figures are in keeping with the frugality of New England Region.

They are asking for 72,000 for a project which I grade as, at least, a "B," if not a "B+." Four, four and a half. Four point five. I would recommend full funding.

DR. SCHERLIS: All right.

DR. BESSON: And it is cheap at twice the price.

DR. SCHERLIS: Mr. Toomey?

MR. TOOMEY: I had only two areas of concern. One was the imposition of emergency room operation regulations by agencies from outside the hospital itself, and the other one was the concern of the Physicians for nonmedical personnel taking care of patients who do arrive in the emergency room.

Other than that, I agree, this is a good application for what it is aiming to do.

DR. SCHERLIS: What would your recommendation be?

MR. TOOMEY: I would say, at $74 thousand, it would

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be a bargain. I recommend it and I would give it a four.

DR. SCHERLIS: Any other comments?

Dr. Joslyn, any comments on this?

DR. JOSLYN: No.

DR. MATORY: I would like to agree with the comment about the professional capability of the group doing this. They are very fine people.

DR. SCHERLIS: Thank you very much.

All those in favor, please indicate by saying, "aye."

(Chorus of ayes.)

DR. SCHERLIS: Opposed?

DR. JOSLYN: What is the final rating?

DR. SCHERLIS: Four.

DR. BESSON: Four point twenty-five.

DR. SCHERLIS: There are so few above two, that this will stand out whether it is four or 4.25, if my memory serves me correctly.

At this time, unless anyone objects seriously, suppose we adjourn for lunch and maybe we can begin at quarter of one.

(Whereupon the hearing was recessed, to reconvene at 1:45 p.m., this same day.)

DR. ROTH: Northlands is a very superior application. They are building on a solid basis. Excellent resources. Major accomplishments to date. And in terms of a program to which RMP is likely to be able to point with pride, I would feel that it is most promising.

The requested amount is relatively small in relation to the population to be served. However, it carries follow-up requests totalling $1,250,000.

But the current request of $63,800 seems to me to be exellent. I would rate it 4 and recommend full funding.

DR. SCHERLIS: For one year.

The second year request was $246,000.

DR. ROTH: Add them all up you come up with $1,200,000 figure.

DR. SCHERLIS: You are recommending approval of the first year?

DR. ROTH: First year.

DR. SCHERLIS: I also reviewed that and felt th[illegible] this would be dollars very well spent [illegible] emergency physicians, h[illegible]

beginning with a solid basis of training personnel first.

MR. TOOMEY: Is this Georgia?

DR. SCHERLIS: This is Minnesota, first.

DR. HINMAN: You are recommending the first year only?

DR. SCHERLIS: 63.

DR. HINMAN: With rating of 4?

DR. ROTH: Yes.

DR. HIMAN: Okay.

DR. SCHERLIS: I agree with that. That was one of the nicer ones to read, I think, in terms of content.

Any dissenting opinion on that?

All right.

That is Northlands.

The next one, alphabetically, for you, at least, is Ohio Valley.

DR. ROTH: Ohio Valley is another one of these things. This is a limited area in Northern Kentucky. Its resources are close to zero, the grant application is very poorly constructed, there is no documentation that they can produce or that they can care for the emergencies they bring in.

I feel probably it is one of those situations where it would be morally wrong to blank them out completely. I would give them some money with which to continue to do

DR. ROTH: Yes.

DR. SCHERLIS: Any comments?

The recommendation has been made, Ohio Valley, $20,000, with a rating of 2. That is one year.

All right.

planning. And I think you have to rate the program sort of minimally, perhaps a 1. I would like to give them some arbitrary figure --

DR. SCHERLIS: They requested $62,000?

DR. ROTH: $63,800, is what they have requested. I know the RPM. I have site reviewed it; I know they have a good core group, and one of their needs is to diversify and regionalize a little further than they have been able to do.

I'll come out with a figure of $20,000, over the top of my head.

DR. SCHERLIS: That is what I wrote down, off the top of my head. I thought they might rate a 2 on the basis of hope.

DR. ROTH: Yes.

DR. HINMAN: "2" is the figure?

DR. ROTH: That is perfectly all right with me.

DR. ROSE: May I remind you the implication of that is that the $20,000 is now low in priority? It is not likel that the money would be funded because of the priority?

Do you see what I am saying?

DR. SCHERLIS: The statement has been made that with that low priority, $2,000 would probably be the funding; is that the point?

DR. HIMAN: "2", and $20,000, then?

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Dr. Scherlis: All right. The next state is Oklahoma

Mr. Toomey. In fact, you have the next one as well.

You also have South Dakota.

Mr. Toomey?

MR. TOOMEY: The funding is requested for a $104,000 for the first year, $124,000 for the second year, and $64,000 for the third year.

It should be noted this proposal was originally submitted in advance of '72, prior to the development of guidelines for submission of proposals. The proposal was also submitted as part of a regular funding request application to RMP as of February 1, '72.

This project proposal is part of the total anniversary application for the fourth operational year to be acted upon by the 1972 National Advisory Council.

Okay, considered to be a rural state, has half of its total inhabitants in 3 standard metropolitan statistical areas, including Oklahoma City, Tulsa, and Lawton. Of the state population of 2 and a half million, approximately 65 percent live in cities of 10,000 or more.

Topography influence as the location of the inhabitants with the bulk of the population on the axis from the northeast to the southwest corners. The Northwest Quadrant is large wheat farms and cattle ranches and the southeastern, extensive and rugged hill ranges.

The state's medical and health community parallel the

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general population where half of the city centers in the state live in 30 minutes drive of a large medical center. Approximately 20 percent of the inhabitants of the state are located in one third of the geographical area do not have immediate access to specialized services and facilities or live beyond a 30 mile range.

The primary objective of this request is to raise the standards of emergency medical care transportation to each city in the state, to have access to medical services through providing advanced emergency training by physicians for ambulance attendants.

Specific objectives include development of a program providing comprehensive training to evaluate the skills of all ambulance service personnel in Oklahoma. The plan, the mechanish, is the development of a 72 hour EMS training program sustained as a community-based, physician-oriented course to raise skills of personnel commesurate with the emergency medical responsibiliies of individuals already engaged in providing care and transportation services.

This course of instruction includes academic instruction as well as practical exercises in accordance with the curriculum developed by the American College of Surgeons Committee on Trauma.

The evaluations, the application has not demonstrated a thorough knowledge and understanding of an emergency medical

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service system or discussed the various components and elements of this system. Does not describe how the various phases will be integrated into the current system, nor has he identified present definitions in the present system.

The specific geographic area to be served has been identified as a state-wide proposal, however, there is inadequate information to determine community organization and leadership to include a broad repetition of procedures, public agencies, and community interests.

The application has identified facilities and equipment currently rendering emergency service and has briefly identified other resources, and existing medical services. But the current deficiencies have not been addressed. The plan does not clearly delineate how the various components will be coordinated with components already operational or how new additions will affect the total system.

Linkages with local health care systems to assure adequate provisions for referring and follow up of emergency patient needs and in cooperation with disaster planning and long range growth have not been referred to or described.

The application briefly speaks to obtaining additional financial support with the initial grant request and for future support after the grant expires.

There is not adequate information to determine the quality of care to be provided or to determine an effective plan

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for evaluating the various elements.

I have a note to refer to Dr. Kaplan's comments.

"Unfortunately this complete project is nothing more than just a projection. While it is well developed, well organized, competently organized, and stated to be top priority, it does not meet our priority for the EMS application. The Applicant has submitted a state-wide plan. However, this plan, based on criteria that an ideal plan should identify problems, establish objectives, and give details on the ways to meet the objectives, is not in fact a plan.

The applicant does not directly relate his projection to this plan. Furthermore, the project which is designed to train ambulance attendants doesn't give any indication of a communications system which would stimulate these ambulance attendants to act. It does not give any indication as to what type of communications would exist between the ambulance and the hospital or the ambulances home base.

It does not give any indication as to the quality of emergency rooms to with the attendants trained in this project would bring their patients.

Finally, the applicant does not give any indication of how these trained personnel will be deployed in relationship to the needs of the involved communities.

DR. SCHERLIS: Your recommendation then is?

Or Dr. McPhedran?

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DR. MC PHEDRAN: I agree. You recommend no funding, is that correct?

MR. TOOMEY: Yes.

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DR. MC PHEDRAN: I agree.

We have one last state, Oregon. I think we should have our director do that to see if he would like to participate in the frivolity.

DR. MARGULIES: I feel that is completely out of order.

DR. SCHERLIS: All right. The Oregon request is for $532,000. That is a request specifically to establish a state-wide emergency medical communication network, a two-way radio system linking emergency data from hospital to hospital. They say, "In general, hospital emergency room personnel are unable to provide instructions to emergency medical technicians at the scene of accidents." They go through the reasons for justifying this. The project proposes to purchase and instal
the basic equipment for establishment of a
based on the recommendation

emergency medical communications in Oregon.

The communications system will be organized to utilize Oregon's Association of Hospital Councils. An agreement has been drawn up as far as this participation is concerned. This, then, is a straight forward request in that regard. It is purely for the network and it is limited to that approach. It only speaks purely of the equipment. There is no indication actually of anything else in this, and for what it is, it is. But it is extremely limited in its approach.

Repeatedly, as I went through this, my comments were that this did not talk to a broad system at all. There wasn't any evidence that they were going to relate to a broad system. I do not have a favorable response to it. It did not follow the criteria or the guidelines in terms of / even saying how this would fit into the over all program. It is a very limited project in terms of background data. Most of the information is in terms of supporting letters. Then it goes into what the equipment would be. There is very little, if any, support requested as far as staff is concerned because all of this would be through contributed areas.

Basically, what they ask for are the vehicles and equipment and that is about it. I can't find this to be anything more than a circumscribed part of the system.

Now, if this spoke to the entire system and said that this was the area of the greatest priority at the present

time while this was going on, they were stepwise going to do other things, I might react differently. But this addresses itself purely to the package request for some technical equipment, and even though it is part of, they say, the comprehensive plan, I see it in a very limited way.

I do not recommend support of this one.

VOICE: This application was forwarded shortly after the first of the year, and they chose not to revise it.

DR. SCHERLIS: Before the guidelines?

VOICE: Yes.

DR. HINMAN: They did have an opportunity to relate it.

DR. SCHERLIS: They did?

DR. HINMAN: Yes, sir.

DR. ROSE: A number of very specific statements suggested some documentation.

VOICE: A number of telephone calls were made.

DR. TOOMEY: Once again, is this a hospital planning group, basically? It reads like that.

DR. SCHERLIS: It comes in from the Oregon State Health Division.

DR. MARGULIES: It sounds like something the RMP dutifully sent on.

DR. SCHERLIS: I have that feeling because the project coordinators from the Oregon Health Division, hospital

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coordinator, assistant coordinator, are all from that area with all the salaries donated to the project because essentially there is nothing that goes on with the project.

Essentially they buy equipment and install it. There is no evidence on the training.

What are they going to talk about once they set up the communication, because even that -- this isn't part of a total training program, it doesn't relate to emergency facilities. I recommended no support.

MR. TOOMEY: As a hospital person, I get concerned by the limited vision of some of the hospital-based or hospital-involved applications.

That is why I thought that the one you have on Springfield, Missouri, was so different because it was looking at something broader than the inside operation of a hospital.

DR. SILSBEE: Dr. Scherlis, there is an EMT training project in their regular application.

DR. SCHERLIS: Yes, I know.

DR. MC PHEDRAN: I was out to Oregon on a program site visit a month or so ago and I am surprised that they haven't worked this up differently.

DR. SCHERLIS: Do you have their application there?

DR. MC PHEDRAN: I am not disagreeing with what you said about it, I'm just surprised.

DR. SCHERLIS: It perturbs me, because this could be

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part of their total system and what they want is that part of of it but they don't approach it in a well-coordinated way despite the communication from RMPS.

DR. MARGULIES: It does suggest that basically they aren't terribly interested in it.

DR. MC PHEDRAN: I think so. We all thought it was a good program staff.

DR. SCHERLIS: Well, is there a second?

DR. MC PHEDRAN: I'll second it.

DR. TOOMEY: I agree.

DR. SCHERLIS: We ate the whole thing.

(Whereupon at 6 p.m., the meeting was adjourned.)

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AFTERNOON SESSION (1:00 p.m.)

DR. SCHERLIS: We will move right along as best we can.

xxxxx

Rochester is next for consideration.

DR. McPHEDRAN: Yes.

DR. SCHERLIS: Rochester, Dr. McPhedran.

DR. McPHEDRAN: This is a set of four projects for which support is being asked, each project for three years. I think it may be of interest that the total annual RMP Budget in this region is given on the left, a figure that we haven't referred to before. 858, 806.

If you take Year One, these four projects would add a total of about -- not quite $250,000. This would be a big increase in total funding.

A good deal of this is on a contract basis for various kinds of activities. The activities are in really three spheres.

There are four projects in three kinds of activity. One is to develop an emergency care and communication system using some modern communication technology. And there is a fair-sized proportion of the first year expenditure which is devoted to that, $30,000 in equipment out of the $100,000 first-year request for that portion.

That emergency care communication network hopes to set up two-way communications linking hospitals, emergency

rooms, and attendants, and to develop a manpower training progra for continuing the in-service education of emergency personnel, and to develop standard procedures for handling emergencies both outside of the hospital and to some extent inside the hospital.

This proposal lacks details of such important things as how the training program is to be actually constructed, and the assistance in sharp contrast to some of the other programs that I've reviewed in which there was sufficient detail to really tell what it is they intended to do with the training money.

Then, the second kind of activity -- excuse me, that first activity is to be contracted out to an organization which is called the Southern Tier Health Services Corporation, which is largely -- it consists largely of the directors of several hospitals, about five hospitals. But that, again, doesn't seem to really represent the whole region, because that is only about a fifth or a fourth of the total number of hospitals that are in the region.

So that it seems as if there is some doubt that the Southern Tier Health Services Corporation really represents even the hospitals fairly, or proportionately, in the region.

The Southern Tier Health Services Corporation is also a subcontractor for one of two telephone referral services, and for this element, for the first year, $61,000, this is a

general referral service to be provided by this health services corporation, and part of it will be to assemble the necessary data so that an appropriate referral can be made, but the main purpose is a telephone center which would respond to any kind of health information at any time.

The training of the kinds of operators who would perform this service is mentioned but again not described in sufficient detail for me to be able to get much of a feeling for it.

The third of the four projects is another telephone answering system. This is to unify and refplace several crisis phone services, one a poison control center, but also a teen-hot-line and I think a suicide prevention -- I have forgotten if this is in this one or not.

But this is a crisis phone service. It is hard to see from the application why this crisis phone service could not somehow have been unified with the general information and referral services, whether there oughtn't to be some inter-relationship.

This brings up the general point about the whole application, that it is hard to see interrelationships between the several kinds -- the several projects.

The last element in the request is a planning and developmental element, and it concerns itself with developing comprehensive programs for determinations of manpower needs,

facilities needs, transportation, data collection, and analysis; and setting up a model for evaluation.

Now, the phones -- you can break this down several ways, but the first element that I talked about, the emergency care and communications, is $100,000 the first year, 43 and 30 the second and third, or a total of 173.

The two phone referral services, putting them together, come to a grand total of about 270, and the planning and developmental comes to a grant total of 132. Three-year request is 573 -- $573,000.

Their relationship to each other and their relationship to the rest of the program is difficult to ascertain. It seems to me that individually, they have - - each one of them has moderate -- some merit.

For example the emergency care and communications one is certainly no worse than the one that we have funded at a much higher level in Western New York, Lakes area. My feeling about them separately and individually is that they rate "C", that is, a "3" rating for -- I would rate a 3-rating for the planning and development, a 4 -- excuse me; I'm going the wrong direction --

A 2-rating for the telephone services, and a 3-rating again for the first element, that is the emergency care and communications.

I wish that the telephone services could be

combined and somehow reduced and total expenditure, it seems to me, the total amount that is being asked is very high.

And it seems to me it could be done on a more limited basis for much less money, and I would like to recommend that the funding be, instead of now totalling about 265, as I say, closer to $50,000 or $75,000 for the both of them.

DR. SCHERLIS: Is that per year? Is that single years?

DR. MC PHEDRAN: I was thinking about the total amount, but perhaps it would be more intelligent to say that for the first year, that is cutting them to about $10,000 for each of them instead of their projected present level of $16,000 for one and $54,000 for the other.

So I would -- I think I would recommend that the emergency care and communications, which I would say rates a "C" -- that that recommended funding be as is, a $173,787; but the telephone referral services be --

DR. SCHERLIS: Could you give us the number?

DR. MC PHEDRAN: 30B and 30C, that they be somehow combined into a single telephone referral system, and that their support be much reduced.

DR. SCHERLIS: Was that $50,000?

DR. BESSON: There is a little problem there because they are for different areas of the region.

DR. MC PHEDRAN: I see what you mean. One is the

Southern Tier and the other is the Genesee County.

DR. BESSON: They have nothing to do with each other as far as telephone linkages.

DR. MC PHEDRAN: Yes.

DR. BESSON: Maybe it would be helpful if before we get to funding, if I might give some comments on this.

DR. MC PHEDRAN: Please do.

DR. BESSON: Okay.

As Dr. McPhedran has said, there are four parts to this application and at the risk of reiterating some, I'll say there are two general areas of this Rochester regional medical program that are included.

One is the area of Monroe County, which is around Rochester, and the other is the Southern Tier Area which encompasses four counties. The first two projects, 30A and B, are -- first is the emergency care and communication net work for these three counties on a contractual basis with Southern Tier.

The second is a health information referral and counseling service for the same area, contracting with the Southern Tier, again.

If you'll look at the map of it -- in the application on pa ge 3, you will see how removed geographically these two areas are.

So the Southern Tier is the southern portion of this

map, and then Project No. 3, community health information and crisis phone services for Monroe County and surrounding areas, is also on contract to what is called the Health Association of Rochester and Monroe County, which is a consortium of volunteer agencies.

The fourth project is finally getting to the regional medical program of Rochester, planning and development component, for the ten-county region, the entire region.

Now, as I read through the application -- and gear with me for a minute while I give you my sequential thinking to come to my conclusion -- I was impressed with the way the letters of endorsement all said the same thing:

"Please accept the letter in evidence of our support."

There are four letters which say the same thing. I said to myself, where do these letters originate? They were all addressed to Southern Tier Health Services, Inc.

So I thought, this looks as though the Southern Tier Health Services, Inc., acts like some organized group and on page 12, I find that Southern Tier Health Services, Inc., is a not-for-profit corporation which was just approved by the Corporate Commissioner with specific functions being listed on page 12, implementation of community health delivery system, physical management, administrative management, monitoring placement of patients, and initiation of needed

experimental health delivery innovations; so I said this must be an experimental system.

But then I looked at the next page, where it describes Southern Tier Health Services Corporation, and it says, "Board of Directors of this corporation is made up of 12 people from the hospitals and 12 people from the community."

And thereby is sprung the trap of who this corporation is, which is a consortium of four hospitals interested in feathering the wrong nests, it seems to me, and they have the primary objective of developing and managing a comprehensive personal health services system ostensibly of the community, but it seems to me fortunately -- redounding to the ultimate benefit of the area encompassed by these four hospitals.

Now, on this Board of Directors there are four administrators as you say, four board of directors, and four physicians -- they don't say who the physicians are, but presumably I would think they are with hospital orientations, so that this corporation really is not a community effort, although it happens to have 12 corporate members -- community members on it.

So the question that was raised in my mind about these two projects, 30A and 30B, which are going to be subcontracted to this corporation, is how representative can a four-hospital coalition be in speaking for the community with this kind of representation?

Now, that deals with my paranoid nature about these first two projects.

The Project 30C is also going to be subcontracted to a health association which is a consortium of voluntary agencies that is going to work with Strong Memorial Hospital to do something thathas already been on-going, which is the provision of a crisis-care phone and community health information coordinative functions, which has been on-going.

And as they break down the number of calls and what they are about, and who they helped and how many people, it seems to be a useful kind of effort.

I am also impressed that in their budgetary request for this, they are going to be on an extensive cost-sharing program with Strong Memorial Hospital in Rochester.

Finally, the fourth program, 30D, planning and development, is to do what this group should have been doing right along, which is to look at the entire ten-county region and say, what can we do to put together a coordinated system?

Putting that all together, suggests to me that I would be delighted to fund the planning and development and get them thinking in global terms.

I would be leary of funding a four-hospital information and communication network which I think is somewhat of a ruse for doing -- having a hospital buy some equipment

for developing its own internal communications network and linking it with a very meritorious program, namely, inter-hospital communication.

As far as the third program is concerned, I like it, but again, I wouldn't be interested in maybe buying a three-year project, but maybe one-year. So I have somewhat of a different approach to this, Dr. McPhedran, and we'll put it up for grabs.

DR. MC PHEDRAN: You think that the Southern Tier Health Services Corporation, that is the first one, that it is so unrepresentative as to just be unacceptable as an agency for doing this?

DR. BESSON: As I view what is happening to the thrust of RMP nationally, or the experimental systems program, or comprehensive health planning, I see that there are a varieity of consortia being developed to address community health problems.

Now, all of these organizations exist in this area. Why should we fund a four-hospital coalition with a board that is made up of 12 people from the hospitals, and 12 from the community?

I would dare say that the 12 from the community will never be there entirely but the 12 from the hospitals will always be there, so that this is a hospital-directed effort.

Now that wouldn't be bad if these were all

community hospitals, but they are not.

One is St. Joseph's Hospital, one is -- I don't know which the others are. But it has a hospital orientation, which I think is a different slant on what RMP is trying to do in having a broad-based community representation.

Now, that falts them slightly, but I am a little suspicious that this is not the vehicle we ought to be encouraging. We should be encouraging RMP to be the vehicle, or COMP planning, or some kind of group to work together.

DR. SCHERLIS: Yes?

DR. JOSLYN: I don't know whether I should be raising this, but I have not read this application, but just from what we are talking about here, it struct me first that here is a community, whether or not it be hospital-dominated -- and I would like to know what the other hospitals are in this four-county area, and whether or not they are involved, or maybe -- I don't know if there are other hospitals -- but it strikes me that here is an area that is active.

Now I would like it coordinated with, you know, whatever programs are going on in the total RMP but it seems to me one of the things we have been arguing for is that you cannot bring a plan, whether it is developed by the RMP or a consultant, and drop it onto an area.

And I am wondering if, you know, maybe this group that is growing up ought at least to be met halfway, in the

sense that -- I just don't know -- I can't judge from here -- whether this is really a meritorious group or not.

DR. MC PHEDRAN: It is just that there are a lot more people in the area, that is the point that Dr. Besson is making.

There are other hospitals and --

DR. JOSLYN: In that four-county area?

DR. BESSON: I don't know. All I know --

DR. MC PHEDRAN: There are.

DR. BESSON: This is a group of four hospitals that are opportunistic enough to create a non-profit corporation, and I think that we are creating a -- somthing that should be aborted right now.

That is not a community-representative group. It doesn't have the linkages that we are after. After all in the guidelines we say we should have provider, payer, public, and --

DR. MC PHEDRAN: All provider.

DR. BESSON: But this is just a biased group. I don't think they can come up with any community answers.

DR. SCHERLIS: I think we have to keep referring back to the EMS guidelines which were given to this group because these were the bases for which the various offers had been made.

Dr. Gimble, you reviewed this project, I believe?

DR. GIMBLE: The only comment I can make on this

particular point, I had mentioned that of 28 hospitals in the region, five are actively involved.

DR. SCHERLIS: How many hospitals?

DR. GIMBLE: Twenty-eight in the region, and five are actively involved. And much emphasis is the University of Rochester, that's Strong. There appears to be active participation of the CHPB agency.

DR. BESSON: In one project only.

DR. GIMBLE: The other problem as you have already mentioned, is the very poor interrelationship between the proposals. It is alluded to but I think they mention that the emergency care service will be linked to the telephone services and that is as far as the linkage is described in the text.

I had lots of doubts about the entire project.

DR. SCHERLIS: What sort of statement do we get from you two in this regard?

DR. MC PHEDRAN: I guess what we agree on, on 30D, we would recommend it for funding as is. I gave it the A-raging of 3.

DR. BESSON: I will agree with that, full funding.

DR. MC PHEDRAN: On 30C, I was mistaken about where that was, and I think that we -- I would go along with Dr. Besson's recommendation for 01, and not 02 and 03, as is, for 54. -- giving that a rating of C also.

DR. BESSON: Okay.

DR. MC PHEDRAN: Or 3.

DR. BESSON: Okay.

DR. MC PHEDRAN: For 30A and 30B, if it is not sufficiently representative of the community as a whole, the Southern Tier Health Services Corporation, perhaps the thing to do is simply not to recommend them for funding because they don't meet the EMS guidelines.

DR. SCHERLIS: Do you concur in those recommendations?

DR. BESSON: I do.

DR. SCHERLIS: Any other comments from members of the review group?

All those in favor please say "aye."

(Chorus of "ayes.")

DR. GIMBLE: "A" and "B" are disapproved because they don't meet the recommendations of the guidelines.

DR. SCHERLIS: Yes.

DR. GIMBLE: Project "C" is a 3-rating for one year and the next project for three years?

DR. MC PHEDRAN: Three years.

DR. SCHERLIS: I thought that was going to take much longer.

DR. SCHERLIS: All right. Any dissenting voice?

Well, then, go ahead to South Dakota.

Mr. Toomey, again.

Following South Dakota, I assume Alabama. Is that the correct order?

DR. HINMAN: Yes, sir.

DR. SCHERLIS: Alabama will be next, so contain yourself.

MR. TOOMEY: The University of South Dakota is the applicant. The funding is requested for the first year, 470,000, and I have none in the second and third year.

Is that right?

DR. MC PHEDRAN: That's right.

MR. TOOMEY: South Dakota does not have an effective emergency health service; hence this grant will cover the entire state.

The basic problems are those of small rural populations with large geographic directions. There are very few trained ambulance drivers or emergency technician personnel manning the ambulances of the existing emergency transportation system.

There is little public knowledge as to lifesaving techniques in the utilization of ambulance and training techniques.

Generally South Dakota has few hospitals and they

have varying capabilities. It has a high tourist population in the summer months with a high incidence of traffic accidents.

The state geographically encompasses an area the size of Delaware, Maryland, Virginia, and West Virginia, but has only 1/17th the population.

The specific objectives of this project include the establishment of medical technician and training programs, the establishment of hospital technician training programs, categorization of present hospital emergency services, establishment of health consumer education programs, and the purchase of medical equipment for ambulances.

The planning process includes three phases of implementation: Phase one includes planning, demonstration and procurement; phase two, the implementation and utilization of the planning demonstration projects and procured resources; and phase three, the operational phase.

All three phases encompass the total components of an EMS system including consumer education, ambulance purchase and equipment procurement, classification, categorization of emergency health services, emergency medical training, standardization of emergency services, communications development, physicians' assistants program, integration of emergency health services components into the current system.

The narrative does not indicate how the various phases will be integrated into the existing system.

The geographic area has been described. However, there is only partial reference to involvement by providers, public agencies, planning agencies, and communities.

The narrative does not define existing medical service areas in the region. However, it does partially speak to potential resources, and the assessment of needs and resources in the area.

There are not adequate facts to document statements referred to in the narrative. There's inadequate information to determine how the operating components will be coordinated with already existing elements of an EMS system.

The narrative does not describe the linkages with local health care systems nor is there adequate information to determine whether there's cooperation in community disaster planning or preventive medical systems.

The application speaks briefly to the point of utilizing additional financial resources and for obtaining additional financial support after the expiration of this grant.

There is no general, overall innovative approach to the development of an EMS system in this area or any assurance as to the quality of care to be rendered.

Once again, to turn to the staff evaluation -- while this application has many good ideas, as an application, as a plan and as a tool to achieve a total EMS system, it in my

opinion fails.

There does not appear to be sufficient depth in the description of the problem of EMS in South Dakota. Statements are made but they aren't backed with facts.

For example, they state many lives are lost, but don't state how many, where, why, when, and so on.

The applicant talks about utilizing PERT, PPBS, management by objectives. They have demonstrated its use.

The application needs better organization, a clearer definition of problems, needs and objectives and a clearer picture of a total EMS plan and a better interpretation of the EMS elements.

DR. SCHERLIS: Dr. McPhedran?

DR. MC PHEDRAN: I agree essentially with the evaluation, that it is a portion of what we would want to have in an EMS but not the whole thing.

Notice that the projected budget for year one is greater than the total annual budget for the South Dakota regional medical plan.

Is that right?

DR. HINMAN: Yes, sir, but I think there should be a comment made.

South Dakota is in a planning phase, not an operational phase. They have just split from Nebraska last year.

DR. MC PHEDRAN: I was going to bring this out, that

this is really essentially a brand new region. I would not like to recommend that they get no funds; I just think that this is an enormous amount to expect them to spend sensibly at this time.

DR. SCHERLIS: What would be the rating of this?

MR. TOOMEY: I would say it would get 2 to 2.5.

DR. MC PHEDRAN. I gave it a 2.

DR. SCHERLIS: Would you agree on 2?

Two is the rating.

MR. TOOMEY: I think they should be given a planning grant.

DR. SCHERLIS: What sum would you think would be --

MR. TOOMEY: My estimate would be $50,000.

DR. SCHERLIS: Dr. McPhedran, what would your feeling be on that?

DR. MC PHEDRAN: Yes.

DR. SCHERLIS: These are numbers from the air but at least they are based somewhat on the project itself.

DR. MC PHEDRAN: On looking at the figures, that is sort of about half of what they had requested for personnel for the first year.

I think that is a reasonable figure.

DR. SCHERLIS: Do we have comments from the group on this?

DR. HINMAN: Did you say 150?

DR. MC PHEDRAN: Fifty.

DR. SCHERLIS: Fifty?

DR. MC PHEDRAN: Fifty is what I said.

DR. SCHERLIS: All right.

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DR. SCHERLIS: Tri-State?

DR. MC PHEDRAN: I think this is a very good proposal, and I would rate it as a four to five. I think it is one of the two or three best that I reviewed among the ones that I did as primary and secondary reviewer.

xxxxxxx

The proposal is a large proposal. It is a project number 18, and the requested funds are over about $850 thousand on the average for each of three years, or a total of $2.54 million, for the three state area in Massachusetts, Rhode Island, and New Hampshire.

I found in going through the rating sheets, the yellow sheets here, that this proposal really addressed most of the particular questions very well. It was a detailed proposal and took up virtually every aspect of emergencies, responding to emergencies, designing systems of education for emergencies.

It was not innovative, but I do not really find that much to fault it, in any of these respects. It is a detailed proposal. I think all the pertinent factors were intelligently outlined. It has very strong Comprehensive Health Planning B Agency support in Massachusetts, but also a strong working relationship with the state department of public health.

It proposes planning and development activities to establish coordinated emergency medical services in three states. The vehicles, or agencies in the different states are

different in Massachusetts, it is the Department of Public Health, and in Rhode Island, it is largely the Hospital Association of Rhode Island, and also, I think, the Medical Society.

And in New Hampshire, beginnings have already been made in some emergency planning -- actually in all three states they have, but in New Hampshire, some planning for emergency medical systems centering around a project in Hanover have already been begun.

I thought this was a very good proposal in nearly every respect. It is an awful lot of money. My word. And yet I really just do not know how to suggest that it would be pared down. I guess I would recommend that it be funded in each of three years, but it seems to me, inconceivable that we would have anything like the kind of money that could meet these demands for requested funds.

I do not like to be in the position of suggesting just an arbitrary reduction, but I guess that is where I am.

DR. SCHERLIS: I think we have been arbitrary all morning.

MR. TOOMEY: Did not Dr. Margulies say, forget it.

DR. MC PHEDRAN: yes.

DR. SCHERLIS: My concern is the obvious one, that even if this is rated highly, whether that amount should go to one region. Has this been submitted to contract funding?

DR. BESSON: There has been a contract application from Boston.

DR. SCHERLIS: It does not include this?

MR. STOLOV: They are complimentary because they are not included in the projects.

DR. SCHERLIS: All right. Secondary reviewer?

DR. BESSON: Let us see.

This is a complex and a very excellent application, and if I can make a crack at breaking it down, and see if we can come to grips with funding a little bit, I would say that it is composed of three major efforts.

One is to subcontract to B Agencies in the Massachusetts Department of Public Health, its equivalent in New Hampshire, and its equivalent in Rhode Island, for individual project efforts in their areas.

Two, is to attempt through RMP to provide a coordinative effort in the tri-state basis for looking to the tri-state areas as a single, global area that has certain problems in common, and perhaps develop coordinative activities.

Three, to set up a program for planning and evaluation for the entire tri-state program, looking at it globally, again.

Now, if we look at these three efforts, the first effort then breaks down into eight individual regions -- B agencies, each of whom have their own problems: Western

Massachusetts, Central Massachusetts, North Shore, Greater Boston, Middleborough, Amerrimac Valley, New Hampshire, and Rhode Island.

Each of the B agencies in Massachusetts, as well as the Department of Public Health, are going to do a little piece of the problem, as they see it locally. Now, the sophistication of each of these groups varies from the sublime to the ridiculous. New Hampshire has had some work in the past and they are quite mature.

Some B agencies in Massachusetts are just embryonic. And there is a great variation in the degree of competence in each of them. But yet, tri-state RMP is saying, let us let each locality set up its own program while we learn about what to do in viewing the entire tri-state area as a single region and we will encompass their activities eventually into an overall plan, which I think is a laudatory way of approaching the individual pieces without usurping locals' prerogatives.

The Massachusetts Department of Public Health, on the other hand, has had its own little things they are doing, ambulance regulation and legislation, which they have been working with. They have produced passage of a House bill, or maybe it is pending, to set up EMS Advisory Board for the state. They are involved in the development of licensure for emergency rooms in hospitals, and they will be involved in a number of things on a state-wide basis, that impinge on emergency medical

services, and do nto overlap with the B agencies, with what the B agencies are doing.

So that, for this portion of the application, they will subcontract to these groups and hope fully in time, bring them all up to the same level of maturity. Now, they make some interesting comments about what the possible alternatives are so far as their funding is concerned.

For example, they say, in their narrative, that if this program cannot be funded in toto, they would suggest that each state develop its free standing emergency medical services, which is one alternative for us to follow in trying to figure out how to get out of this dilemma. They also go on to say, in their narrative, that if no funding is available elsewhere, the state will be self-supporting within a three-year period, which is very encouraging at least, for them to say that they will mount this amount of money at the end of three years; both of which I think are very reasonable and mature statements to make.

So far as the other two programs are concerned, the central coordination of training and the planning and evaluation both of them, I think, are meritorious. The planning and evaluation, I think, is particularly so. They speak of evaluation as a function of tri-state regional medical program, including a rather sophisticated view of evaluation and evaluating the process and monitoring the process, itself, in evaluating

project achievement as a separate look, and then finally, doing what they call, impact evaluation.

I think that this is meritorious enough as a methodology for looking at emergency medical care systems that if they can do what they say they will do in some detail, that it will provide a very nice model nationally.

DR. MC PHEDRAN: Except they say about the impact, they do not "think they can manage it." This last part, which sounds like the thing that they have over everybody else, they say they do not "think they can do it with their pre-machinery," so it would have to come outside of this application.

DR. BESSON: I would at least encourage them by fully funding that portion of it, and I suppose -- I do not know how to reach a number with this, it is a difficult question to grapple with. If there is any merit to the notion that we ought to develop as large a deficit as we can by funding as many as we can, maybe we can turn off funds elsewhere in the federal establishment, and put them in here so we might as well buy the whole thing.

DR. SCHERLIS: Yes.

MR. STOLOV: Staff had an interesting observation when we were reviewing the community plan power development application from the tri-state region, and its ambitious budget, also. And we said, look to the program staff, which was called "core." The core staff activities, and they do

have a sophisticated evaluator on this. And maybe this is where staff could aid.

But, we looked also to the staff out in the Rhode Island area, the core staff out in the New Hampshire area, and we felt maybe, since they did assist, there could be some fine lines drawn. However, not being the technical budgetary person on this, I just threw this out as a methodology of how we were looking at the community base, manpower thing too; knowing the ambitious budget here.

DR. BESSON: They are really approaching the both from the point of view of encouraging each locale to do their own thing, and yet saying to themselves, well we are going to coordinate the entire effort and at the end of a year or so, they all should have enough maturity, so that we can look to the development of a tri-state-wide coordinated system, which, I think, is very nice.

What did you recommend?

DR. MC PHEDRAN: I find it impossible to recommend reduced funding in any intelligent way. I would go along with certainly, fully supporting the evaluation parts. I am inclined to recommend funding. I am sure they would not get full funding because there is not going to be that kind of money, and I think we can recommend whatever kind of funding can be allotted to this.

DR. SCHERLIS: What rating are you giving this?

DR. MC PHEDRAN: A four to five. I think it is very good.

DR. SCHERLIS: Mr. Besson?

DR. BESSON: I am going to give it, maybe a four. I am going to reserve "five" for Alabama.

DR. SCHERLIS: The rating is four. I think it is unrealistic to think in terms of full funding for this.

We might jeopardize a great deal by doing that. What is your feeling on this, Dr. Rose?

DR. ROSE: Dr. Hinman might speak to this.

DR. SCHERLIS: Yes.

MR. STOLOV: I know we do not use a formula funding as other HEW programs have used, but as a yardstick, I would like to throw out a factor, Dr. Besson, who has always looked at things in a quantitative manner. Tri-state regional medical program ranks 31 out of 56 regions in terms of funding, per capita funding, per that three-state region.

This is just a fact to supplement -- that may or may not help you with something.

DR. SCHERLIS: That further obfuscates our entire problem.

DR. BESSON: What do you mean by that remark?

MR. STOLOV: I did not know whether or not you wanted some other fact to help you with your decision, and this is one. I do not know if it is out of place.

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DR. HINMAN: I have a concern. If you look at the breakdown of the budget as per year one, the very beginning of the application --

DR. SCHERLIS: Opposite page ten.

DR. HINMAN: -- opposite page ten, you will see in the first year, $251 thousand for planning and organization, and almost $600 is allotted for things that might be considered partially implementation. I just wondered if we have a mixture here and are dealing with an attempt -- they have 119 thousand for data collection, and agencies; 251 thousand for planning and organization, and they are immediately going into education, some equipment --

DR. BESSON: Excuse me, Ed. They are dealing with such a mixed bag here, they do not go from that to education. It is that they are allowing each region to submit their own budget for their particular needs, and I think what they have done is gotten everybody stimulated so that eight regions here -- there are not eight -- six, plus New Hampshire, and Rhode Island, are submitting a separate budget.

It happens to add up to 251,000, but that includes -- you know, they are accepting everyone's budget, and then on top of that, for coordinated training, and coordination, it is, they are submitting a separate budget.

DR. HINMAN: My question, though, is are they in the one budget saying we are going to plan, and implement from

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year one?

DR. BESSON: Yes.

DR. GIMBLE: The most encouraging part of the application is the small amount that has been allocated to equipment purchases, so it looks like they said, we are going to plan a lot and buy very little the first year, and it looks like they are doing it.

DR. SCHERLIS: I just wonder if they asked for $10 million, if our support of $10 million would be realistic, and I question whether our recommending $850 thousand or $847 thousand is realistic.

I think I would like to have a motion made for a sum, and if the recommendation includes that, if additional funds are available, they should be funded up to so and so, at a high priority.

DR. ROSE: It might be easier for the committee to make a recommendation and let the amount of funds be handleed administratively, the judgment in terms of how much funds they are going to be able to get.

DR. SCHERLIS: We never do that.

DR. ROSE: Assuming the whole thing is meritorious.

DR. SCHERLIS: Can I ask for a recommendation for a motion at this point?

DR. BESSON: Let us just rate it and leave the funding go open.

DR. MC PHEDRAN: I feel so foolish recommending an arbitrary figure based on nothing. I have no way of basing it. All I can do is say, it is a meritorious program and maybe these things -- maybe they can consolidate some of this planning, organizational activity. Maybe, it would not have to be so costly.

DR. SCHERLIS: Are you recommending full support as requested? With a rating of four?

DR. MC PHEDRAN: I am rating it as four and realizing that full support is just not going to happen, could not possibly happen.

DR. SCHERLIS: Dr. Besson?

DR. BESSON: I have a different view of this. I do not view this -- it happens to be tri-state, but it would be like saying, well, what is the eastern operations branch, what kind of a program do they have? They do not have a single program, they have 27 programs.

We do not have single program here, we have ten programs, so that the number that I would use would be predicated on that as an underlying assumption. I think that the project is meritorious, the whole thing is meritorious, and if I were to be forced to give a figure, I would have to say the full thing and let the chips fall where they may.

DR. SCHERLIS: I just wanted you to -- this is with full knowledge and intent then, we are recommending that sum,

it is quite apparent.

Any further discussion from members of the Review Group?

All those in favor, say "aye."

(Chorus of ayes.)

DR. SCHERLIS: Opposed?

DR. BESSON: I would also remind the Chairman that --

DR. SCHERLIS: I do not believe you recommended the whole thing.

DR. BESSON: It is only one wing on a B52.

DR. HINMAN: Unfortunately, we do not even have a motor on a B52, an engine.

end #12

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DR. SCHERLIS: All right. Virginia.

DR. ROTH: That one is mine.

DR. SCHERLIS: Dr. Roth on Virginia.

DR. ROTH: I think the important thing to point out to begin with about Virginia is that we're talking about a total request of $30,250. It is a highly hypothetical application, on behalf of a council which says that it is in the early phases of initiating the organization of a community emergency medical services council. And in the makings, it has covered that whole planning problem, if approved and funded, would be turned over to this council.

It has not been approved by the RAG, and although we have only a request for this $30,250, it rates a substantial operating grant of $244,415.90, for a total 3 year amount.

It is distinctly a matter of building upon existing services. It is pretty sophisticated in the use of, for example, helicopter service is available in the area. But it is my feeling that it is such a relatively small amount that if the only matter before us now is the approval of the $30,250, I would give the program a 3 - 1/2 to 4, because it has built on a base of accomplishment, and recommend full funding.

DR. HINMAN: I would like to add one point, Dr. Roth. The planning portions of this have been reviewed by CHP and the RAG, and have been approved.

DR. SCHERLIS: The logging sheet has a check mark

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"yes." Is that correct?

DR. HINMAN: The earlier ones didn't. The first logging sheet didn't.

DR. SCHERLIS: But that is a subsequent change in the operating data that we received. The present log sheets state that they have been reviewed by RAG.

DR. SILSBEE: It is the planning portion only.

DR. SCHERLIS: That is all we are talking about, planning, at this time. I am secondary reviewer on this and I also review it as essentially a planning phase, since they state they want to evaluate, categorize, and coordinate their existing 'emergency' services, and I think in view of the fact that this is a planning phase, and they have devoted considerable thought on how to go about it, I would concur with the feeling of the primary reviewer on this and would also recommend support for the sum requested which is for one year, a total of $30,250.

I would concur with that recommendation.

DR. ROTH: This I would assume makes no commitments on our part for anything but those operations.

DR. SCHERLIS: This is purely for one year.

Any other comments on Virginia?

I thought it was 3.

DR. ROTH: 3. That's good.

DR. SCHERLIS: Any other comments?

All those in favor say aye.

(chorus of ayes)

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(Chorus of ayes.)

All right. Next is West Virginia, Dr. Roth. That is a series of 3 projects.

DR. ROTH: West Virginia is a series of 3 very sketchy requests, the first for a rural, multi-county -- and it is actually 4 counties -- in Northern West Virginia, and the second one is for actually a single county building within a single hospital, primarily, have access to taking care of emergency cases. And the final third one is a state wide program, or it would have state wide application ability, to train emergency medical technicians.

The problem here, it isn't fair to poke fun at a grant request, but I would say that the grantsmanship illustrated here was unsophisticated in the extreme. Dr. Besson pointed out that he had a series of letters which were like filling in blanks, and that has clearly been the operation here in West Virginia.

Somebody, a coordinator, wrote a letter and said "I think it would be nice if you all sent back something along this line," so they all copied the letter, and just changed the signatures and put in the names.

DR. SCHERLIS: A lot of these are from voluntary fire departments, too.

DR. ROTH: Yes. This is almost pathetic.

There are 20 -- I haven't tallied them -- 21 letters

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from individual members of a newly formed Dodridge County emergency squad. The letters go something like this:

"We have this emergency squad formed, and it would be nice if we just had a radio that we could find out where it is we are supposed to be going, and if we could see that we could have a doctor or somebody in the hospital when we got back."

There is one delightful one where the young lad says, "We hope to finish our class soon on heart de-fibulation, in the care of heart patients. And as a member of the class, I realize the great need for communications."

This is the heart of this request. So you are given a situation in which you have virtually no medical personnel to provide the care, and once you can herd it in, you have practically nothing except hearses available to be the mechanisms of transportation. You have bad roads, you have a relatively small population -- I'm sure you don't have an awful lot of transient travel, so you're not worring so much about automobile accidents and so on as you may be about myocardial infractions and industrial accidents, and things of that sort.

But it is a testimony to abject need in an area which lacks resources of all kinds, and the request, even though modest, translates into a fairly high ratio in terms of dollars to population. But if need is one of the qualifications for eligibility, I would say this ranges 4 plus in need, and very low

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in terms of the resources to work with which tempers your enthusiasm, or at least your predictions, about how much will come of it. But I think for an application with a strongly Appalachian flabor, that it deserves our consideration.

The 3 are somewhat complimentary. The one for a single county, Jackson County, and a single hospital, really, to my way of thinking, there is scant use in correcting all these emergencies unless you have somewhere to take them with some kind of care to give.

And they certainly need the instruction of the emergency medical technicians. So I would lump them all together as being, to a degree, somewhere related, tending towards systematisation.

By taking a figure of practically zero for the state of the art but a figure of 4 for the degree of the need I would come out averaging that off with about a 2 and recommend funding.

DR. SCHERLIS: For all 3?

DR. ROTH: For all 3.

DR. SCHERLIS: I am secondary reviewer. I also arrived at a grade of 2. I was very concerned about the initial 2 requests for funding first of all in terms of who is to do the training. The first one, for example, was to be done by, as I interpret it, a local staff in the hospital of Stonewall Jackson.

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I agree, some training should be done. I felt more and more as I read it that they should have one training center, that was the Davis and Elkins College, for a sum of $28,000, rather than dispersing this in 3 different areas with different levels of ability and I would concur with 2, but I thought the total funding should be about $30,000, because I didn't have some concern about dispersing the training into the other areas.

What was your reaction about the action of Stonewall Jackson Hospital as far as being able to carry out the program?

DR. ROTH: It was apparent to me throughout the thing that they're going to have to import talent to do -- they just don't have the capacity there. And this Davis Elkins College thing seemed to me to be by far the best.

DR. SCHERLIS: I was concerned -- for example, in the first one under training, they stated -- the 4 physicians in Louis County, the lone physician in Dodridge County, and the national health corps physician in Gilmer County, which is the total medical compliment, have agreed to conduct training courses for these men.

They're going to deliver the 82 hour course. This requires, I think more ability than they can muster for that sort of a training effort.

DR. BESSON: I wonder whether it might not be worthwhile in the advice to this region to work jointly with the state of Maine on their problem which is very similar, and their

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solution, which is perhaps ideal for this kind of area. If they are production video tapes, there is no reason why the video tapes can't be used in West Virginia in these rural counties. just as well as they're used in Maine.

DR. SCHERLIS: The second one, they say "Upon funding of this application the hospital will recruit and immediately train 80 emergency technicians" and again I question their ability, without the sort of help that you referred to.

My suggestion would be that we go along with the third regional training center, which is the Davison-Elkins Group, and maybe expand their program somewhat so they can incorporate training the others. I have a certain reluctance as far as the amount of funds they have requested for the first 2 hospitals, concerning what might come out of it when they are done.

DR. ROTH: I'll agree with this, completely.

It has always been a problem to me to -- I think Jerry Besson spoke about our issuing the seedlings, or watering them. There isn't even a seedling here to nourish, you have to start doing some planting.

DR. SCHERLIS: Is anyone here from the West Virginia area who could comment?

Dr. Henderson, do you want to comment on the problems of this project?

DR. HENDERSON: I think the generations that have been made are accurate. I have been scanning this application

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here for a few minutes. The fact that they have submitted 3 proposals that are very similar in nature and have essentially all the same working necessities brings me again to Dr. Roth's consideration of the need.

Now actually, the heart of all this is employment of former military types to function as emergency medical service technicians. This may give this thing a bit more rooting than if they were to be starting at scratch and wandering around looking for people to train. In the light of that and in view of the need, would it be practical to fund just one of the 3 proposals?

Number 18, the first one, goes in the direction of trying to provide priority health care services for rural communities that have none, or counties. The price tag on this one is said to be $6,000. And even though there is spotty support for doing it, if they can in fact apply it, previous military corpsman, and if they can find a physician who will work at running the project, to me it would be worth doing. Because then it might provide the impetus to energize activities in the regions of the other proposals.

MR. TOOMEY: The thing that bothers me, and it is not on my list to read and I haven't read it -- the thing that bothers me is that knowing that West Virginia has a state wide health planning organization funded under the Appalachian Regional Development Act, and from what I hear, it seems quite apparent

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that there has been, as I would read it, little contact between this project and the Appalachia Project, or the Applachian program. And with the fifth or sixth years of expenses under the Appalachian Health Program, which is a specific section of the Appalachina Region National Development Act, it seems that they should have been farther down the road than what apparently has come out from this RMP.

My point is that I think that they ought to look at each other.

DR. SCHERLIS: Any comment from staff on that?

Yes?

VOICE: The application as it is does not reflect the true working relationship that exists between RMPs and the Appalachian TCHPA Agency. The application does reflect the cooperation between the RMP and the local B Agency, which is the -- the liaison man working with the advisory group to the B Agency in determining the local needs and priorities.

Someone made a comment about why do we have 3 similar proposals from 3 separate areas. Well, when West Virginia uses field staff very effectively, and there is a field man assigned to these areas, he has quite a bit of knowledge in EMS.

So therefore this is one reason these particular proposals come from that particular area. And one other thing, too. The West Virginia regional medical program has just recently restated their objectives, and one of their proposed area object-

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ives is the emergency medical service.

DR. HINMAN: Norm, are you saying that there are accountive working relationships between the Applachian Health Program Planning Council and the West Virginia RMP?

VOICE: Have definitely.

DR. ROTH: Beyond how much virtue it is, but that first project , the 4 county project, serving a population of 103,000 people, working out at about 73 center per capita in an area where, as far as I know, there is very little overall support given.

The second one works out somewhere inbetween $3 and $4 per capita and I would be willing to drop that one out completely. But somehow or other I would like to do something to get those radio sets into these pseudo ambulances, to get something into that 4 couty area of West Virginia.

DR. SCHERLIS: I really think in terms of the 4 county area, that is as far as there being adequate information or they're really having paid attention to the good lines in having at the time all system care, there are serious shortcomings.

And yet, perhaps they should have enough funds to at least make a start of this. They're talking about 6 full time patchers, 2 paramedics. It is a budget which, while it adds up to $76,000, I question whether or not they might better spend some of those funds for planning.

DR. ROTH: They could do a great deal with less than

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half of that.

DR. SCHERLIS: This what I feel and I think if we could talk in terms of putting more into planning and getting a small course started, than perhaps a reasonable sum instead of $76,000 might be something like $35,000. But for quality of training I still think that Davison Elkins looks good.

DR. ROTH: Yes.

DR. SCHERLIS: And the first one would be for $35,000, and the second is zero, the third for $28,000 and crossing out the second. I'll put that on as a motion. $35,000 for the first one, zero for the second phase, the third phase, $28,000 as requested and that rating was 2, 2 for each of those.

Any further suggestions?

(No response.)

All right, all in favor --

(Chorus of ayes.)

Opposed?

We now move out of the eastern branch regions into the south central branch region, and the irrepressible Dr. Besson.

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MR. TOOMEY: We are still in south central, Wisconsin?

DR. SCHERLIS: Wisconsin, Mr. Toomey.

MR. TOOMEY: This proposal is submitted by Wisconsin Regional Medical Program, Inc. It has a funding requested of approximately $648 thousand the first year, $756 thousand the second year, and $765 thousand the third year.

I have rather an extensive review. Do you want me to go into it? Because actually, I will jump to the conclusion that it is the best program that I have read. The application is excellent, well prepared, describes all elements of an

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emergency medical services system. It is factual, has clearly defined objectives and methods for evaluating the effectiveness of a total, comprehensive operating system.

It includes in its formulation -- it includes efforts by the people in the Highway Safety Program, Comprehensive Health Planning Agency, the Hospital Association, Medical Society, Governor's task force, a health program and policy council, greater Milwaukee agencies and Milwaukee County Medical Society.

The applicant represents the -- the application represents the efforts of key groups of health providers in the development of this program over the past five years. I think it is the best one I have read. I give it a rating of five and would recommend full funding.

DR. SCHERLIS: Dr. McPhedran?

DR. MC PHEDRAN: I concur. It is one of the two best that I read.

DR. SCHERLIS: What was the other one?

DR. MC PHEDRAN: I thought tri-state was very, very good. This is terribly good, too, and it has been long in preparation. And it shows it.

I cannot remember what rating I gave tri-state. I am afraid I would be inconsistent. I do not think I gave it a five. I would give this at least a four. Maybe it is a little bit better than tri-state. I do remember the body of the-

application, where the argument is built up about how the thing is to be time-phased, and what the methods are, what are the assumptions on which each step is based, and how these assumptions can be validated.

It is really very good.

MR. TOOMEY: It provides for an organizational structure to carry it out from the start to the finish.

DR. SCHERLIS: What about the money recommendation?

MR. TOOMEY: I concur with the funding. It seems for the project, in relationship to some of the requests for other funding, this is quite reasonable.

DR. SCHERLIS: All right. The record should show that they will be funded as requested, for three years?

MR. TOOMEY: Yes, sir.

DR. SCHERLIS: All right.

DR. HINMAN: What is the rating?

MR. TOOMEY: Did we submit it?

DR. SCHERLIS: Between four and five.

DR. MC PHEDRAN: I would say 4.5, and you are going to say five, right?

DR. SCHERLIS: let us make that five, then.

DR. HINMAN: Five?

DR. SCHERLIS: The staff has suggest we use the number five, since they provided us -- we have been given a quota system. We have a certain number of fives.

Have we used up all of our twos and threes?

DR. ROSE: Right, several times over.