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## DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

RMPS COUNCIL MEETING

Rockville, Maryland
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

Health Services and Mental Health Administration

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Parklawn Building,
Conference Room G/H,
Rockville, Maryland

Wednesday, August 4, 1971

# C O N T E N T S

P R O C E E D I N G S

DR. MARGULIES: In the interest of sticking to various time schedules and getting our Council meeting over with promptly, we will begin now without any further hesitation. We do know who has the earliest kinds of leaving schedules and so on, and I think we can adhere to that and not run into any difficulties.

I don't know when Dr. Brennan is coming. We assumed he would be here and we haven't had word to the contrary, so perhaps he'll come in a little later.

So we will start the program review now. We will take up those first which will make it convenient for those who have to leave earliest and I will turn that part of the meeting over to Dr. Pahl.

DR. PAHL: Dr. Millikan, Dr. Everist and Dr. DeBakey have somewhat earlier departures, so with your permission, I think we would like to rearrange the order of our reviews and start with California. Dr. Millikan.

May I also ask the appropriate staff to sit at the end of the table and add their comments as before, and the regional office representatives, following their meeting this morning, will be in to also participate on the individual applications as appropriate.

DR. MILLIKAN: On June 10th and 11th, 1971, there was a project visit to the California Regional Medical Program and

and you have, I believe, under the California tab, a green abbreviated or synopsis version of the project site visit report. There's a longer one also available that has been distributed.

In any event, there are several interesting kinds of problems that are symbolized by the California Regional Medical Program, and I suppose one of them has to do with the potential differences in opinion between project site visitors and between-- the total concept of the project site visitors, and that of the review committee. It also exemplifies the potential difficulties in the triennial review process when we're dealing with an altered budget structure from year to year, and that has inherent in it some difficulties in the judgment process with the rest of us because of some differences in quality in the subdivisions of the entire Regional Medical Program.

Now, if you look at the first page of the blue sheet, you'll see a series of recommendations and the first one addresses itself to a portion of the original application after the one kind of plan and the other to a second kind of plan; and ultimately you see there's a recommendation down here for $6.2 million per annum for the California Regional Medical Program.

Now, I disagree with this recommendation as a project site visitor and as a member of the Council, if that's where we're going to stop with our potential action, and in trying to interpret the summary represented by the blue sheets, it seems

likely that a portion of this judgment to make such a recommendation was arrived at because of the fact that a couple of these subdivisions, which in actuality are regions, are very poor. And if you look at the nine that make up California, one can see unequivocably that what's called Area 1, Area 4 and Area 5 are among the very, very best in the United States, consisting of San Francisco portion, the U.C.L.A. portion and the U.S.C. portion, the latter two having been the two that combined to initiate the action that has been consummated by the formation of the ninth area which is the one at Watts-Willowbrook or the Drew School and King Hospital area.

These are offset, as one looks at the total program, by a couple of areas that among the very poorest, and this is San Diego and Oberlinden(?), 6 and 7; and number 8 has one good program and that's the Irvine-Orange County area. It has one good program, the community stroke program, and that is about it in terms of what's actually gone on in that entire area, which, of course, is over several years. And, as one talks rather candidly to the personnel of that area medical program, they don't have much in the way of plans for anything more, if you recall, at the time of our project site visit.

So, I think that while the California concept seems to me continues to be working, that is having nine regions really amalgamated under and working through a central office, I think that phenomenon is working pretty satisfactorily. There

are certain disadvantages inherent in the situation where you put very, very poor quality area in combination with a very, very good one and ask people to assess a budgetary outlay on the basis of their total reaction to this. So this is one of the problems inherent in the California Regional Medical Program grant application.

Now, the next item that I have already mentioned has to do with the problem which might be a delightful problem which might be created if in a year or 18 months or two years we had a considerable change in the budget base from which we operate. In other words, suppose that our allocation and appropriations in Congress is actually released and is considerably increased by $30, $40, $50 million; and a program like this California one is locked in to its triennial review process to $6.2. Well, we would simply keep in mind that that would be the height of inequity, at least that's my opinion about it, and we would need to rereview the thing.

Now, there's one possibility that we could take an action at this point in time, because there are two plans actually in front of us, plan A and plan B, which could make some allowances for an altered budget structure if there was one at the end of the line.

Now, the review committee has a little bit of a dim view of plan B. Well, I think most of us on the project site visit seemed -- didn't see anything very materially wrong with

plan B at all. I don't know what the others' reaction is, but plan B sounded like an entirely equitable plan.

One of the points about the whole triennial review process and about the kind of internal guidelines that we approved yesterday unanimously at this table was that we are in essence giving what might be called a bloc grant. After careful and full review and inspection and deliberation, we are saying "For each of the three years we are going to give you 'x' amount of money and you become the decision-maker as to the precise way in which various portions of this money is spent."

And so what we're really talking about here in plan B is an increased total funding and it was the review team's opinion that these people are highly competent to make decisions about how to wisely -- it was the project site visitors' opinion that the California, the CCRMP and its subdivisions are highly competent to make decisions and good decisions about how to spend that quantity of money.

So I think that probably there would be a series of comments from staff and I don't want to belabor this issue any further, but I am summarizing my own reaction by saying that within the context of what I've been commenting about that I have some disagreement with these blue sheets. There's some people here in the room who were on that project site visit and studied this thing at great length.



DR. PAHL: Does staff have any comments to make

relative to the discussion?

MS. SALAZAR: I think that you can say that the blue sheets reflects the consensus of the reviewers, as Dr. Millikan has pointed out, with the recommendations stated on the first page. It's a rather large team, as you can tell from this report, and has received further information since returning.

DR. PAHL: Dr. Ochsner, have you any comments as the other reviewer?

DR. OCHSNER: No, I haven't.

MS. KYTTLE: Dr. Millikan, did I understand you correctly when I thought I heard you say that it was your interpretation that the blue sheet was recommending $6.2?

DR. MILLIKAN: Well, to go through this, they don't recommend $10.043.

MS. KYTTLE: No. I was of the opinion that the intent of the blue sheet was to recommend $8.3.

DR. MILLIKAN: Minus 121.

MS. KYTTLE: Well, the kidney panel had met later and restored the 121 which got it to $8.3.

DR. MILLIKAN: Correct. And what I'm trying to emphasize here is that I think we either ought to make dual recommendation or say that we will bring this back to the review process if and when there is more total money in the RMP kitty short of the three-year process.

DR. MARGULIES: Well, I think it's very important right now to emphasize the fact that we really need to make decisions. We are asking the Council to make decisions based on what they think that program merits without regard to any assumed budgetary restrictions or we're in bad difficulties. So I think it should be based on what you see is meritorious and then we will have to make a decision based on the funds available.

DR. MILLIKAN: Well, I could filibuster about this $10.2 million but I don't mean to get into that kind of a position. We heard a presentation yesterday concerning just one fragment of the California Regional Medical Program, and that's what is now called Area 9. This is the Watts-Willowbrook. This is one of the most exciting developments in the American health scene as far as I'm concerned. That's just one portion of this thing.

Now, generally meritorious -- if you look at the San Jose Valley project, the San Fernando Valley project, and a whole series of things in here where we have outstanding examples of innovative and initiative kinds of ideas. We have some of the best coordinators in the U.S.A., who are not even called RMP coordinators. They're local area coordinators. You look at Areas 1, 4 and 5, I think they're really outstanding people in the whole nation.

Then when you look at the concept of $10 million and

you can't help but quietly think about some of the other RMPs. This $10 million is relatively modest.

DR. PAHL: Is there further discussion by Council or staff?

DR. MILLIKAN: Well, my inclination at this point in time is -- Harold has made to me an extraordinarily important basic comment just now. He said that we should not consider these simultaneously with thinking in our minds eye about the budgetary constraints for our entire program. Well, in a sense, that's almost impossible to do, and I think you, having been through the grants game for years, understand that.

The review committee can't do that either. They really can't say, "All right, we're going to forget the budgetary restraints in our entire review process." I don't believe they'll work that way. We can't work that way around this Council.

Now, if I were to forget those restraints, I'd say unquestionably they should get the $10 million. Thisis what we should pass. Now, knowing in one's mind's eye the money is not available --

DR. MC PHEDRAN: I agree with you.

DR. MILLIKAN: Because on the basic item of whether they have put together an organization and have peopled their organization with individuals competent to go through the decision-making process and work with one another and come up

with a sound plan -- for instance, Area 5 has a whole new initiative planning process going on and has some very exciting things they're doing and it took us an hour and a half or two hours to look at that particular portion of the thing. This is the U.S.C. part of it. They're moving, moving, moving continually.

So they have demonstrated unquestionably they have the mechanisms and the personnel to wisely use that kind of money.

DR. HUNT: Total population of the area is what?

DR. MILLIKAN: 21 million.

DR. KOMAROFF: That raises a point I wanted to make, that with 10 percent of the nation's people, California is relatively underfunded. I don't mean underfunded in terms of merit, just in comparison with other Regional Medical Programs.

I haven't read recent grants or been on site visits recently, but I knew the program before and it seemed to me that it is an outstanding region, that we ought to at least approve a level consistent with our evaluation of its merit, taking per capita population considerations.

DR. PAHL: Mrs. Silsbee has a comment I believe.

MRS. SILSBEE: It's a question of Dr. Millikan. The last time California came up and you were looking at the whole program, there was a recommendation for about $8.3 and that they had some hard decisions to make and you wanted to get some notion of how they went about making those decisions. And in order to

have the record clear, I'd like to have some notion of the difference in the decisions between the $10 program and the $6.3. Is there some indication that they made some tough ones?

DR. MILLIKAN: I can't give you -- in their application are the details. There's some discussion of it in the project site visit. I can't give you the details of the difference between the $8.3 million program and the $10 million program.

Now, what has been accomplished out there -- for instance, there is an entirely new internal review committee which has been formed and is now active. We had the opportunity to meet the judge who has accepted the chairmanship of that committee, who is -- one of the purposes of founding this -- of having them actively internally reviewing the phenomenon going on in each of the areas, is some extra internal monitoring.

Now, the central office and the RAG of the CCRMP is fully aware of the problems of Areas 6, 7 and 8, and they are rather intensively trying by leadership example and by personnel from the central office going in to work with these folks to do something about the low level.

Incidentally, when you have a central office like this it's highly effective. I couldn't help but think about this in the Ohio State instance. When you have a central office they can take certain kinds of actions in a portion of the total region that we really can't take at the district level, and this is what Mr. Ward and his personnel are doing with Areas 6, 7 and

The decision-making process, Judy, about their own priorities, as far as I'm concerned, has been adequately solved, and they are now prepared to struggle with, argue about, and ultimately make decisions concerning their internal priorities.

DR. MARGULIES: I met with that committee recently when I was out there and there's no question about the fact that they're working hard to do exactly what you describe.

DR. MILLIKAN: What did you think of the leadership of that committee?

DR. MARGULIES: I think it's excellent. In fact, they are calling meetings on their own more frequently and with more determination than they had expected.

When I talked about considerations of funding level, I should have also said that the regions themselves are in a quandary over this kind of issue because they received at the time of the cut in funding levels was promulgated a very strong suggestion that during the next fiscal year they would be held to the same kind of funding level that they were in in the preceding year, or that they were in after the funding cut was imposed, and this makes it difficult for them to decide what they should aim for because they don't know whether they should restrict themselves to what they think they're going to get because of the letter they received or whether they should try to go for something that they really believe that they can achieve; and they're struggling with this kind of an issue and

it's a difficult thing for them; and if we then modify our judgments in addition to the judgments they've already imposed upon themselves, it's sort of a double hazard as far as they're concerned.

I know we can't ignore the total budget. At the same time, I don't know how we can anticipate our budget for this year because we don't know what it is, and in the absence of that kind of information, I think the most that you can do to look at the program on the basis of its merits is the closest to a fair judgment we can get.

DR. MILLIKAN: It's kind of interesting that one of the simple signs of overall quality of California in the Regional Medical Program is the very fact that they have already presented us with an alternate plan. They're so effectively working and planning that they have two down here.

DR. PAHL: Dr. Millikan, I'd like to ask you to comment on point 2 on page 22 of the site visit report which pints out that the $10 million plan of the region proposes activation of some previously approved activities and so forth. Have conditions changed?

DR. MILLIKAN: This is exactly the reason that I made the comment that I did about the relative similarity of the triennial concept and the bloc grant concept. You may not recall that yesterday I was the one that asked the question about whether this Council and the review committee are going

to review brand new projects that are brought into a region by its personnel during the triennial? The answer is no, we're not going to review them.

DR. PAHL: Not unless there's a request from one of the three parties.

DR. MILLIKAN: All right. But what we approved yesterday did not include reviewing new projects, only supplemental and so forth.

DR. MARGULIES: You do also have the flexibility of making a decision at this meeting and altering it at the next one if there are changes in funding levels which you have to respond to and which you cannot identify at the present moment.

DR. MILLIKAN: That's right. The only point I'm trying to make is that whether we're talking about the $8.3 million minus the 129, or whether we're talking about 9 or 10 or whatever, we are really talking about a sum of money that is going to be put there, that is in California, with them as the primary decision maker about the spending at year two and year three unless some big questions are raised or whatever. That's what I'm getting at.

DR. PAHL: That's correct.

DR. MILLIKAN: And this comment that actually relates to some activities or projects which might be conceived one or two years ago is from a timing standpoint irrelevant. My answer is it shows lack of practical recognition of the processes

that have been developed out there for decision making about this money.

DR. PAHL: Would you care to place a motion before the Council?

DR. MILLIKAN: In light of the comments and admonitions concerning our philosophy as we review these grant applications, that being that we should look at them on the basis of their merit and that the alterations in quantities of money be a portion of the staff's activities as it looks at our annual available budget, I move that we approve the amounts of money listed under plan B with the provision that alterations in that amount be the action of staff, such alterations dependent upon staff judgment of the availability of funds.

DR. PAHL: Would your motion, Dr. Millikan, be for that level of funding for the 05 and 06 years also?

DR. MILLIKAN: Yes.

DR. PAHL: Well, if I may just rephrase it, the motion then would be for level funding for three years at $10,043,175 with exact amounts to be determined on the basis of negotiation by staff during that period, and for the sum to include the kidney project.

DR. MILLIKAN: Right.

DR. KOMAROFF: Second.

DR. PAHL: The motion has been made and seconded. Is there further discussion?

(No Response)

DR. PAHL: If there's no further discussion, I would like to have all those in favor of the motion please respond by saying "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

If we may now turn to the application from Hawaii, with Dr. Millikan again, and Dr. Ochsner as backup reviewer.

DR. MILLIKAN: In December 1970, I believe there was a project site visit and there have been, as some of the Council members are aware, a number of problems in the Hawaii Regional Medical Program. One of them concerned with the quantity of time the program coordinator was able to devote to the program and have I heard correctly that since the application was submitted and since the most recent project site visit there has been appointed an assistant or an associate coordinator at a full-time level?

MR. MORALES: It was Mr. Livermore Tuncks(?) who was on core staff as a program planner has now been put into the position of executive administrator, and also, Dr. Hasegawa is seriously considering the possibility of coming on board at 100 percent kind of effort.

DR. MILLIKAN: In the application he's now listed as

100 percent in the application.

MR. MORALES: I understand he still hasn't.

DR. MILLIKAN: The reason I asked this question is a series of project site visitors over many, many months, over three years or so, have all recommended that the coordinator be full-time and/or have an associate or assistant or deputy coordinator who can devote a significant amount of time to this activity, and that had not taken place at the time of the last project site visit and was mentioned as a matter of great concern by the project site visitors. So that is now cleared up.

Another problem has to do with the allocation of money time and effort that are devoted to the Basin -- the Pacific Basin, and the Hawaii RMP is responsible for that activity. Now as I get the general scene, when discussion goes on in the Hawaii Regional Medical Program RAG there is a friendly feeling toward devoting activity and money to the Basin, but when it gets down to actually saying that "x" amount of money is going to be used for this purpose, why, the amount of money gets smallers so it almost dwindles away.

Now, there's some problems, of course. The transportation allocation must be pretty significant because it's costly to fly back and forth to the Pacific area, and I wonder if any thought has been given any place along the line to maybe in this instance helping, in a sense, the Hawaii RAG by putting

a little bit of earmarked, $30,000 or $40,000 or something like that, for the Basin? Would that be possible?

DR. MARGULIES: It could certainly come in the form of a strong recommendation which would produce about the same effect.

DR. MILLIKAN: I don't know how the others feel about it, but from what I've kind of heard, it would seem in this particular kind of situation this would assist the Hawaii RAG a little bit and Hasegawa if there was some very strong recommendation like that from this end of the line, just set that aside, so to speak, and use it that way and not get into this interminable discussion and when you finally get down to money matters about whether they're going to put any money out there in the Basin.

I don't know whether staff has any comments about this.

MR. MORALES: I think that this would be very helpful to the region because Dr. Hasegawa has a concern and has had for years now that funds that he receives for Hawaii can be easily depleted in the trust territory which is 3 million square miles of area which he's responsible for, and the budget that is reflect in the blue sheet is a recommendation by committee course is keeping really a tight rein on what funds Hasegawa will have for Hawaii itself, and if an additional $30,000 was awarded for the trust territory then he will know

what he will have to work with within Hawaii and, in addition, can continue on with activities and possibly expand his activities a little bit as far as core staff and planning in the trust territory with this $30,000.

DR. MILLIKAN: The review committee has recommended, as you see on the blue sheet, awards for the 04, 05 and 06 years $1.6, $1.4 and $1.3, and since this principal issue of the leadership appears at least to be temporarily solved, I favor or would move the recommendations of the review committee with the conditions as stipulated by the committee at the bottom of the first page of the blue sheet.

DR. OCHSNER: I second that.

DR. PAHL: Dr. Millikan, in order to clarify the motion, would the funds which you wish to have for the Basin be in addition to --

DR. MILLIKAN: I recommend $30,000 addition to be -- with a strong recommendation or however one wishes to phrase that that this money be allocated for use only in activities in the Pacific Basin.

DR. PAHL: The motion, then, is for approval of the Hawaii application for one year funding at $1,072,000 plus an additional $30,000 with the strong recommendation that that money be utilized for support of activities in the trust region and with the additional advice as specified on page 1 of the committee's report?

DR. MILLIKAN: Correct.

DR. PAHL: The motion has been made. Is there a second?

DR. OCHSNER: I second it.

DR. PAHL: Is there further discussion?

(No Response)

DR. PAHL: If not, all in favor of the motion please signify by saying "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

If we may now turn to Dr. Millikan's last application, Northern New England.

DR. MILLIKAN: Herb, I'm in a considerable quandary about this. I have never been on a project site visit here. I've heard discussions of it since the original visits of the TRW contract which was discussed and reviewed a number of years ago, and perhaps Mike DeBakey can help out if real precise recall is necessary. I've seen the application itself and the only portion of that application that I can see that makes any impact on people is the kidney portion, and this is one -- off the record --

(Discussion off the record)

DR. MARGULIES: Clark, one event has occurred and I

don't know how familiar you are with it, which has been the award to that area of funds for an experimental health delivery system, and this has brought together potentially the kind of data base which they have developed with the combination of other potentialities for an experimental system with CHP combination and so forth, which may make the activities they have been carrying out a little more meaningful in terms of actual project development.

How you can judge that at this early point, I don't know, but I think it's a point of information which is significant.

DR. MILLIKAN: Right. What I'm really saying is I don't feel competent because of my biases to make any particular recommendation about this one. This looks to me like a region that as many of us conceive of RMP has been essentially unproductive, and this data base business -- I thought the other day when I was reading through the full application, this is a little bit like a registry. Their data base situation is a little bit like a registry that is not a part of some plan. It is just collecting figures like crazy and apparently in this data base they have almost every kind of a number that you could ever want but what's ever been done with them or really going to be done with them, I don't have the foggiest notion; and I found no evidence in the application that there's any reason to think that any kind of care of people has been

influenced in any fashion by all the years of existence of this RMP. To me, it's just amazing. I think somebody has been on a site visit -- you've been up there --

DR. KOMAROFF: Yes.

DR. MILLIKAN: Well, you may have an entirely different look at it and I think somebody else ought to talk about it.

DR. PAHL: Dr. Komaroff, would you care to make a comment?

DR. KOMAROFF: I felt the same frustration, that this was a very excellent data collecting operation that was stymied more for reasons of personality than philosophy, from actually utilizing or even planning for the utilization of the data, and I think that was the consensus of the site visitors last December.

Frankly, the problem, as it did in several occasions yesterday, seems to rest with the leadership of one man who has a lot of strengths, but whose problem is in making connections with people that really count, and that means in this case the medical society, the medical school and even the school of public health which lies a block away.

At that time, in December, there were really very poor relationships and the RMP staff, extremely competent and imaginative in many ways, was operating or appeared to be operating in a vacuum; and the question was where they were

going to go from there and how adequately they were going to serve the broker role that they seemed to feel was their appropriate one.

DR. PAHL: Dr. Roth, do you have any comments as backup reviewer?

DR. ROTH: No. The only attention that I have really paid to it is its eventual gearing in with the New England Regional Kidney Program, that part of it, but I think Dr. Millikan sort of excluded that and talked about that separately.

DR. MILLIKAN: That is the plan it looks to me like is going to have real impact on people, a cooperative arrangement for the bettering of the care of people of this region, in this instance, with reference to kidney disease.

DR. PAHL: Is there further discussion from Council or staff on the basic proposal or the site visit? Mr. Colburn and Miss Houseal are here. Do you have any comments?

MISS HOUSEAL: In answer to what's happened since the site visit, I believe the region has been working with the medical society in developing a peer review mechanism. I don't know who will be funding this, but they are getting together with more of the statewide organizations than they did I believe at the time of the site visit.

MR. COLBURN: I think since the site visit, the data base has had somewhat of an impact on health planning in the region. They're getting a $460,000 award R&D for this data

base and this peer review, which is going to be monitored by the medical societies. So there has been a strengthening and it has status.

DR. MILLIKAN: From what I hear is they're sort of getting other grants to do the things that ordinarily RMP might do.

MR. COLBURN: They have had an impact also on formulating B agencies in the state. They just got planning awards for two B agencies.

DR. KOMAROFF: One interesting thing that they were doing, a private general practitioner, Gene Bont, had opened up his practice to both quality audit and financial cost benefit studies in a rural general practice situation, using paramedical personnel for a certain group of patients and not for others, using the problem oriented record, and this was just an inspiration at the time we were there but hadn't gotten off the ground. Do you know what's going on with that?

MR. COLBURN: I really don't. Dr. Shyer I think was coordinating that and he's left and I haven't seen the progress reports.

DR. PAHL: Mrs. Silsbee informs me that the regional office representative, Mr. William McKenna, knows a great deal of this and is at a meeting for a few more minutes and will be returning. Perhaps we could either defer the application or go on to the kidney aspect.

MR. MILLIKAN: Well, I'll make the motion that -- because I don't think we can phase this out or anything like that -- I would move the adoption or move that we approve the recommendations of the review committee, including recording the six items of their critique, under critique, with these items being kept very strongly in mind as we address ourselves ultimately to the acceptance of the triennial review application from them when it comes sooner or later, and that hopefullywe're able via the appropriate administrative leadership to see to it that some of the real concepts of RMP are gotten into their program.

DR. PAHL: All right. The motion has been made to accept the recommendations of the review committee, including the points made under the critique in the blue summary sheet and with the further advice as stated by Dr. Millikan.

Is there a second to the motion?

DR. SCHREINER: Second.

DR. PAHL: The motion has been made and seconded. Is there further discussion?

DR. MILLIKAN: I think the problem here is exemplified if one reads those points, that here is a region which has been active from early on in the history of this division with the absence of a good set of goals, objectives and priorites. They could simply sit down and write those out from 40 other regions if you don't have any ideas of your own. That's pretty close to

unacceptable, you see, to be in existence for five years and not have any good goals or objectives. I think that's the review committee's statement. If you look at number 5, the lack of a data collection strategy, and all they've been doing is collecting data for five years and they don't have any strategy for the use of any of it, according to the review.

DR. PAHL: I'm glad you didn't say the goals and plans of 55 other regions. Perhaps 40 or so. Is there further discussion?

(No Response)

DR. PAHL: If not, all those in favor of the motion please signify by saying "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

I would like now to turn to the application from Texas, with Dr. Everist as principal reviewer.

DR. EVERIST: For those Council members who remember the early history of Texas TMP, this review will be refreshing. For newer members, it will be a revelation.

By using the most euphemistic recordable descriptions of the first three years of the Texas Regional Medical Program, one could say that they were disharmonious, disgruntled, disbelieving and distressful.

There were a variety of organizations competing for whatever it was they felt RMP could deliver. By some strange alchemy, the current coordinator, Dr. Charles McCall, has enticed a phoenix out of the ashes. Texas is still not a showplace for RMP, but it certainly has seen the light of the 1970s on the horizon.

Texas has about five percent of the nation's population scattered over an area of 267,000 square miles and they have recently rediscovered subregionalization. In the past, Texas has had difficulty measuring its goals and priorities with the national goals and priorities. The fault was probably bilateral, but that was the past and the future looks better.

The grantee institution is now the University of Texas system with offices in Austin, and is also now the fiscal agent, and they are requesting triennial review with a total of a three-year funding of $5,632,416. This would include a ten percent developmental component for three years, core, and three new projects; one approved unfunded, plus eight continuation projects for one year; two for two years; and two renewal projects for one year.

They are also requesting earmarked kidney disease funds on a non-competing basis for a period of three years.

The project orientation which currently entraps a fair amount of the substance of the Texas RMP has not been signally successful with perhaps two exceptions. The newer programmatic

approach seems to have a regional concept well in hand and shows a true concern for the deficiencies in the health delivery system, especially for cannulas and blocks. Examples of this are an attempt to improve the quality of care given by black physicians, the high priority placed on a project called GRO, to provide in-service training in small rural hospitals and the employment of a regional staff, now three, potentially ten, and selecting these employees from local, knowledgeable, effective people.

The managerial hierarchy of the program would seem to be most adequate and the new coordinator almost beyond reproach.

The review committee has solved the very sticky problem of how to react to the past and a good future is garnered from their site visit and a written proposal.

They recommended $1,590,000 a year for two years to improve the developmental component. They are not placed on triennial review but a site visit will be made at the end of one year. This is only $125,000 less than they requested for the first year and a little than $300,000 under their request for the third year.

The committee has expressed their faith by allowing the developmental component while at the same time they have adopted a "wait and see" attitude.

I, therefore, recommend approval for two years at a

funding level of $1,590,000 including the developmental funding.

DR. PAHL: Thank you. Before we place the motion before the Council, perhaps we might ask Mr. Friedlander if there are any comments he would like to make.

MR. FRIEDLANDER: After years of listening to Dr. Everist do such a magnificent and incisive job of reviewing the review committee's recommendations, I couldn't possibly add anything.

DR. PAHL: The motion has been made for acceptance of the committee's funding recommendations. Is there a second to the motion?

DR. FRIEDLANDER: Second.

DR. PAHL: Is there further discussion? Mr. Posta, do you have anything?

MR. POSTA: That suits us fine.

DR. PAHL: If there's no further discussion, all those in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

DR. MARGULIES: I wonder if I could just make one comment at this point. The review of this region with its past history and present status which came through with the kind of enthusiastic summary in review committee as it has in Council,

again illustrates what we keep talking about with the RMPs from one moment to the next, and that is what kind of leadership is present and what that leadership can achieve, and this is an ideal example of what a difference it makes and we have some other examples of what a difference it makes which are less pleasing.

DR. PAHL: If we may now go to the application from Virginia, Dr. DeBakey.

DR. DE BAKEY: Well, the only thing to go by is the recommendation of the review committee on the blue sheet, and I would be inclined to go along with their recommended funding. I must say that I had some feeling that this may be inadequate. Is there someone here that has better information than is available in these sheets about the reason why they have cut back on some of the support, particularly in relation to supplies and equipment?

DR. EVERIST: It's two centers.

DR. DE BAKEY: I know that, but I'm talking about the --

DR. PAHL: Mr. Spear, could you perhaps comment on the funding recommendations?

MR. SPEAR: The Virginia RMP has had a great potential for activities in renal disease and the application that was received reflected at least some very good things that needed to be done, but the panel was unsatisfied with the kinds of

descriptions that were given about the activities. Their goals were not well described in some respects. There was some clear duplication of effort described, and the central difficulty was one, not unusual in many regions, that there was a need for further cooperation and coordination among the activities involved in renal disease.

The activities related particularly to a dialysis activity, the panel was willing to act on with some specificity and the review reflects that. The knowledge of the panel about the four possibilities in the region led them to desire that there be some conversation to see what are the base needs that can be met within the application that was submitted.

They were just unwilling to make some decisions on some parts of the application without further discussion face to face.

DR. DE BAKEY: Well, the reason I questioned this is because I get the impression that they felt that this was in good hands, and certainly Dr. Hume is able to give good leadership for this, there's no question about that.

MR. SPEAR: Yes.

DR. DE BAKEY: And it seems to me that cutting back on some of the funding that this is going to jeopardize their ability to do the job well, particularly when you have as good leadership as you have in the renal disease area as exists there.

MR. SPEAR: I think the key statement there is that

those funds be used as a base for discussion. This much could clearly be approved with no difficulties; that there might be a need for more was well recognized, but it needs to be clarified.

DR. EVERIST: There's a site visit coming up next month in Virginia and there could well be a kidney man put on the site visit team and recommendations given.

DR. DE BAKEY: Well, I certainly would go along with that. That's a good suggestion in my opinion.

I certainly would be willing to approve this, but I think we ought to take into consideration that there is a possibility, perhaps after the site visit in another month, and we have an opportunity to review this again and bring it back to the Council, if the site visit demonstrates there is a need for the additional funding, I think we ought to be open to provide it.

I just am a little concerned about cutting back on the funding of a group of peole that I have great confidence in and admiration for in terms of what they're able to do in this area.

DR. MARGULIES: I got the impression when we discussed this earlier after they had been down there, Mike, that the people were there but they really hadn't gotten together. There were some terrible gaffes in which an application was in with somebody's name on it and he discovered his name on there for

the first time when the application was in. It's that kind of disjointed effort. It's there but it hasn't been pulled together.

DR. DE BAKEY: I was on a project site visit in Virginia well over a year ago, and at that time I got the distinct impression that there were some polarizations as well in certain parts of the state, but it seemed to me that much of this has improved, that they were getting together and were trying to work it out, and particularly the renal program is one which was receiving the support of everybody. So I was particularly anxious to see if maybe this would be a good mechanism to demonstrate how they could work together to help all the people and particularly people that are in need -- the patients that need this type of management.

DR. SCHREINER: May I ask what the status of project 12, procurement, what the status of the funds was?

MR. SPEAR: Yes. I wanted to comment on that. We have been providing funds for the organ procurement development in that area and, in fact, that's the key point for the whole southeast area of the country, and we have just provided a third year of funding for organ procurement development activity which is expected probably to be the final funding, but we wanted to look at it again at the end of the third year.

DR. SCHREINER: I think, just to back up what Mike is saying, that at least in that particular program it's functioning

pretty well. If that goes down the drain, that's the hub of the whole 12 or 13 university network that's getting the typing and kidney --

DR. PAHL: Dr. Merrill, did you have a comment to make?

DR. MERRILL: I just wondered, this is labeled Virginia Regional Medical Program and I would assume, as Dr. Schreiner just mentioned, that it deals with patients from areas other than Virginia, and I gather that's perfectly appropriate for this program; is that correct?

DR. PAHL: Yes.

DR. MERRILL: I notice also that there is a salary for a physician part-time in here. Does this represent a departure from the policy which we discussed yesterday?

MR. SPEAR: You're looking at the figures here?

DR. MERRILL: Yes.

MR. SPEAR: The proposal, among the other things it talked about, was the development of two satellite dialysis units and the key to these units was that one was to be for paying patients and one was to be for indigent patients. One was to be relatively fancy and one was to be relatively plain; and the panel couldn't accept that philosophy. So this represents their judgement of faults that would be encountered were a single dialysis satellite were to pick up both the paying and the indigent people.

DR. MERRILL: But the services of physicians who would be essentially rendering service to patients is included in that?

MR. SPEAR: Yes.

DR. PAHL: Dr. DeBakey, was that in the form of a specific motion for concurrence with the committee's recommendation but that should be subsequent should the site visit indicate a need for additional funds that this request will be brought back before the Council?

DR. DE BAKEY: Yes.

DR. PAHL: Is there a second?

DR. EVERIST: Second.

DR. PAHL: Is there further discussion?

(No Response)

DR. PAHL: If not, all in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

DR. DE BAKEY: I think Dr. Everist's suggestion to have someone from the kidney disease panel on the project site visit would be desirable.

DR. PAH: Yes, we will have appropriate representation from the staff and the kidney disease panel on the site

Now, we're hoping for Dr. Brennan still perhaps to make it to the meeting so with your permission I would like to take up the Bi-State application with Dr. Ochsner as principal reviewer, and we'll hold the New York applications pending the arrival of Dr. Brennan or at your pleasure.

DR. OCHSNER: I haven't made a site visit there and I don't know when the last site visit to Bi-State was made. I think you're all aware of the fact that this is one of those hodge-podge regions in which it involves a large metropolitan area, St. Louis, and two fine medical schools and then a very large rural area in southern Illinois.

Apparently they have a strong coordinator. They have difficulties because of the type of arrangement with the many diversified interests, but apparently they're doing a fairly good job.

I would recommend what the review committee recommended, that there be an additional year instead of the three years requested, and this be in the amount of$924,113.

DR. PAHL: And your recommendation includes the concurrence with the committee's disapproval of the developmental component and the other funding relative to the projects?

DR. OCHSNER: Yes.

DR. PAHL: Dr. DeBakey, you were backup reviewer. Do you have any special comments?

DR. DE BAKEY: No. I would agree with that.

DR. SCHREINER: I wanted to ask, what's the status of the proposal that they were preparing on a multi-regional renal training program? Does anyone know?

DR. OCHSNER: I don't know what the status is about that. All I know is what they've got here.

MR. JEWELL: We do know there is an application in the mill. They have not yet formally submitted it to us but they are awaiting word as to when the doors open for 910 consideration.

DR. SCHREINER: I knew that they were working on a very comprehensive proposal.

DR.MARGULIES: Yes. That was Missouri, Bi-State and Kansas. They have been working on it. I get the impression from talking with the coordinators separately that they're finding this more difficult to do this together than they had anticipated and I have the feeling that they will come in more separately with their applications and try to join in some way, but that's not necessarily true. I think that, again, this might be affected considerably by level of funding in the way in which we come back to them because the idea of combining over that area is very sensible.

DR. SCHREINER: It had some very exciting aspects in one place where I thought we could exert a little leverage maybe.

DR. MARGULIES: Yes.

DR. PAHL: The motion has been made. Is there a second to the motion?

DR. DE BAKEY: I second it.

DR. PAHL: Any further discussion? Does the staff have further discussion on this application?

(No Response)

DR. PAHL: If not, all in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

We may now turn to the Georgia application with Dr. Cannon as principal reviewer and Dr. Schreiner as backup reviewer.

DR. CANNON: The Georgia application has been studied both by the site visitors and the review committee and they turned in almost identical recommendations to approve the number of people approved in the recommendations that are before you and we've had a significant study.

Now, there is one question concerning policy that we might take a minute to discuss. Both the site visitors and the review committee were anxious that some way be worked out to fund a program to stimulate underprivileged students in high school into the health care system. This received a gold star

both by the site visitors and by the review committee. However, it's been the policy of this Council not to fund programs in career oriented programs.

In other words, sometime ago when we were discussing applications referable to different stratas in the personnel training of health care workers, we put a limit on the funding of the schools. Isn't that correct?

DR. MARGULIES: That's right and, of course, that issue came up during the discussion of that particular activity but the people who looked at it were so impressed by its potential that they felt that this was one time when it could be described in different manners or one in which you took advantage of the fact that you make your own rules and have the opportunity to make exceptions to them if you find it wise.

DR. CANNON: It's a very small amount of money, $23,000, in comparison to an application which is asking for $3.7 million per year at least, but it would require some change of policy. I would like to have the staff that recommended the Council reconsider it express their opinion.

DR. KOMAROFF: Is this something that could be accomplished out of core without calling it a separate project?

DR. CANNON: It could be.

DR. KOMAROFF: Thus without violating policy.

DR. MARGULIES: Well, you can, but I don't think we need -- it's our policy and I think that we deal with it as our

DR. EVERIST: We don't need to change our policy.

DR. MARGULIES: Miss Nelson, do you want to comment on this?

MISS NELSON: I was going to comment that on our policy, the last sentence, we do state that RMP funds may also be used in planning health careers recruitment activities. This is in spite of the fact that we said we didn't fund operational programs. It may be used in planning health career recruitment activities as a part of and coordinated with the overall manpower strategy for the region, and do you see this as a part of that endeavor in Georgia?

DR. EVERIST: It's a moot question.

DR. PAHL: We can waive it.

DR. EVERIST: Sure. We can waive our own policy and just make an exception.

DR. CANNON: Well, I believe that we're making a mountain out of a molehill because I think we could very well work out the funding on this. I think we'd sort of want to make an issue on it to see if there was going to be a policy change by the Council.

My feeling is that we ought to express our interest but tell them that our policy is unchanged at the present time. I think he's well aware of it. I kind of have a feeling that we're kind of making an issue about whether we're going to change our policy or not.

DR. MARGULIES: I think we can describe it as something which Council regarded as a good thing to do so long as it was done in a manner consistent with our policy, and he'll understand what he then needs to do.

DR. CANNON: All right. Now, as to the overall program, you will note that both the site visitors and the review committee have recommended funding of $2.8 million per year instead of the requested $3.9, $4.3, and $3.9, and very clearly set out the reasons for deletion of this amount of money from that requested, and they were on the basis of programs in which they withheld funds or thought they had little or no relationship to the overall program and not likely to remain viable without future support from RMP, and that they could be incorporated in other projects.

For instance, they have two respiratory projects that deal with respiratory disease, one in pediatrics and one in adult respiratory diseases; and the fourth reason, it would be more appropriately funded from other sources of support.

There is one question when you're tabulating the funds how both the site visitors and the review committee come up with $2.8 million. There is a questionable item and that's under project 6, communications network, a request for $160,000 and I presume that the recommendation is that this not be funded. Now, I could not tell from what was given to me either on the blue sheet or the site team report whether the recommendation

was for deletion of this amount.

DR. PAHL: Mr. Nash, can you help us out on that?

MR. NASH: Yes. The recommendation was not including funds for that project.

DR. CANNON: Then, if you turn on the yellow sheet, to run down the projects that funding was changed, the statewide cancer program with a cut of about 60 percent of the funds, and then the respiratory center and the facilities for respiratory diseases were merged and that funding was cut. There was another merger of patient and family education with the learning resources and that funding was cut. Then the kidney disease program was dropped or cut.

DR. MARGULIES: Bland, could I -- I just got a letter yesterday and was waiting to get to this kidney one. This is one letter from Albert Tuttle and the other from Gordan Barrow about the kidney proposal. They feel that this had an inadequate review and they feel very strongly about it. There was not a site visit, and they felt that to look at it from our point of view was out of context to the rest of the activities which are going on down there. And I indicated that we would be happy to withdraw that particular proposal from consideration at this time until we could have a site visit to satisfy their requirements.

DR. CANNON: Well, what about the ad hoc panel on renal disease?

DR. MARGULIES: Well, the ad hoc panel did not make a site visit and they felt that they had based their judgment on incomplete information and they would like to have them look at it more fully, and I thought their objection was valid as I went over it with the kidney division. So they prefer not to have any consideration of it at this time.

DR. SCHREINER: While you on it, I had planned to make some comments on that area. One of the problems and I think we commented on this in the orientation sessions -- it's a minor problem. The ad hoc kidney review committee is very good, however it is pretty heavily loaded with four transplant surgeons and sometimes their decisions reflect the surgical prejudices.

Now, they just sort of took a sort of black or white approach to the fact that there wasn't a surgeon there, and at the time they considered it there wasn't. They were in the process of recruiting a new chairman in the department of surgery.

DR. DE BAKEY: They've got one there now.

DR. SCHREINER: And they got a very fine one who has also committed himself to a transplant program, and he's very cooperative and very academic surgeon, and I would think that that was probably a kind of hasty comment that was made.

The other problem was that all our negotiations were with the young fellow who ran the dialysis unit who is a very

dynamic person who is leaving for personal reasons, and they sort of took that as a comment that the whole thing was going to collapse, whereas the fact is that the dialysis center at Greeley(?) is the closest of any unit in the whole South to fulfill the criteria that the NIH study group set up on the ideal nephrology center, and it was partly set up with RMP funds. I think it would be a little unfair to pull the rug out from under it.

DR. CANNON: This gives some insight as to the strength of our representation in the kidney -- very logical objections -- and I'll be discussing this further on another report that I have.

Well, let's delete that from our consideration and say that such projects as physiology for nursing and nursing instructors and projects for dietitions and so forth, there were no other projects in question or programs in question except one, and both the review committee and site visit team said that a plan for a health maintenance program at Stephens County, which is a county of about 20,000 people, will not be considered for funding on the basis that we no longer are funding new multiphasic screening testing.

For those of you who are not aware, this is a small rural county and has an ongoing program such as this, you should look to Iuca, Mississippi. If you go down to Iuka, Mississippi, they have a program similar to the one that was recommended here

in Stephens County. It is the key to bringing those people who haven't had health care into a health care system. It's a gimmick and it works very well with a followup of health care. And we can't really analyze that on paper, as Clemmons' committee did, as to the value of multiphasic screening because it's the byproduct of the technique that accomplishes something that we in RMP want to accomplish.

So I would suggest that some further consideration be given to the Stephens County health maintenance program so that it could be placed in a different context of its primary purpose, and I do not believe that we should exclude funding for that program; but, as I say, site visitors and reviewers have suggested that we do so.

DR. KOMAROFF: Are adequate provisions for referral and continuing care provided in this?

DR. CANNON: As near as I can tell from the material sent to me from Georgia -- Georgia has a very unique way of getting their information with forms and things, so that we may not have all the information you want from them. Relying on the site group, maybe they could tell us. Did you look into that program?

MR. NASH: No. We didn't really look at any of the projects there from a technical aspect. They do have followup built in the program. I think the reason the site visitors recommended no funds for this project was based upon the

policy or recommendation of Council that no further multiphasic screening be approved and be supported.

DR. CANNON: Well, I would recommend that some way we would not change our policy for multiphasic screening, new programs, but that we would support an activity such as this which accomplished the goal that's more important than finding out whether multiphasic screening is a wise program to support financially.

You see, if we pass this, the way I look at it, we've already acted against the recommendations of the Brennan report, which we accepted.

DR. MARGULIES: Well, those recommendations were saying -- and I think this may be at least part of the resolution of the issue that you raised -- they said that these should be suspended until there can be a more adequate evaluation of the usefulness of these kinds of screening activities, and I think that if you want to take action on that pending that evaluation, and we can then spend more time with them to see whether this fits in with the other kinds of issues or not, it gives us at least a way of responding.

We don't know how long the evaluation will take, of course, and what the nature of it will be, but there is an intensive effort going on all through HSMHA to take a look at this multiphasic screening issue because it's all over the place and we may have some kind of basis in the near future of being

able to lift our kind of prohibition on it.

DR. MILLIKAN: Could we then amend the motion to include such a phrase as continued support for this activity you mentioned pending evaluation and appropriate further judgment concerning it?

DR. CANNON: I would accept that.

DR. DE BAKEY: Bland, you have some personal experience with this?

DR. CANNON: Only in Iuka. I went down about a month ago, a little more than a month ago, to Iuka, Mississippi, because I had heard so much about Iuka, Mississippi and its program.

DR. DE BAKEY: How did you happen to hear about it, because I never heard about it?

DR. MILLIKAN: Haven't you, really?

DR. DE BAKEY: No. That's why I'm interested.

DR. CANNON: Well, it's a community on the periphery of the Regional Medical Programs in Memphis, and if there's anything that speaks well for working in outlying regions, I think this is the one place I would point to. And I wondered if the staff of RMPS has this impression. Would you speak to it?

MR. RUSSELL: Yes. I think you'd have to know Dr. Cosby who heads up the mobile multiphasic screening unit in Iuka. This was about ayear ago that, Dr. Cannon, it actually

got started and underway, a year or a year and a half ago. As a result of the mobile unit and the interest of the general practitioners in the area, they have stimulated a tremendous amount of interest, not only in the mobile unit but they are bringing in other programs. They got the local mayors involved. It's really delightful.

DR. CANNON: The main thing is bringing people in for health care that's never seen a physician.

DR. EVERIST: I'm not sure it's appropriate to be discussing this because we are going to be discussing this in the Memphis region in just a little bit, and I personally have some different ideas about Iuka County.

DR. MARGULIES: Dr. Everist, in his quiet way, is saying that this part of the discussion is out of order because we're going to get to that next.

DR. CANNON: Well, I'm not discussing Memphis. I'm telling you the value of a program which uses multiphasic screening, that we call multiphasic screening programs really ought not to be called that. They're using multiphasic screening to effect a program in getting started, a health care system for people that otherwise don't get in the system, and I say it's wrong to exclude funding of those programs on the basis of the Brennan's Committee rpeort.

DR. DE BAKEY: You're making a generalization, it seems to me, and I'm not sure that that's correct. Multiphasic

screening has been around for a long time. It doesn't always do what you say it does. So it depends on who does it and how it's done.

DR. MILLIKAN: I thought he was not making a generalization. I thought he was making it specific.

DR. CANNON: I wasn't generalizing, because it's Dr. Cosby that makes it work down there.

DR. DE BAKEY: Is this Stephens County you're talking about?

DR. CANNON: Yes.

DR. DE BAKEY: And Iuka is in Stephens County?

DR. CANNON: No. Stephens County is in Georgia. Iuka is in Mississippi.

DR. DE BAKEY: What do we know about Stephens County?

DR. CANNON: What I know is only there is a multi-specialty group that is prepared to take over this health program for the community of which 25 percent of the population is below poverty level. Now, if the 25 percent below poverty level are brought in for the first two years, no charge, for their screening and positives will be referred to physicians if they don't have a physician, with no charge health care will rendered for those two years.

DR. DE BAKEY: Fine. That's a good objective.

DR. CANNON: And then, after that, it's supposed to generate it's own support. But to call it a multiphasic

screening program isn't -- because multiphasic screening is done in a lot of different ways. It doesn't always have to have a big computer. It can be done with a small laboratory and one doctor.

Well, again, I would recommend that we fund it and not call it a multiphasic screening program .

DR. MILLIKAN: With this amendment?

DR. CANNON: Yes, with the amendment that when this is finally decided it would be reviewed. So, if we now sum this up, there's a recommendation for $2.8 million without a decision on the program 36, which is kidney disease, which is requesting a quarter of a million dollars, because that's still in limbo; but adding a sufficient amount which is $107,000 to take care of the beginning of the Stephens County program which would bring it to about $2.9 million.

If you will accept that, I will move that the $2.9 million would be the appropriate funding.

DR. MILLIKAN: Second the motion.

DR. CANNON: Per year.

DR. PAHL: Is there discussion by the Concil? Dr. Cannon, the requested amount for that project 39 in the third year drops precipitously to $16,000, and I didn't know whether your motion basically was to $2.9 million for each of the three years or to reflect the requested amounts.

DR. CANNON: In the absence of my portable computer,

I tried with my pen to tabulate the amounts that were deleted by both groups and I couldn't come up with $2.8 million. It wouldn't work out correctly. And I got within $100,000 and I thought that was pretty good, and so I thought if they went $100,000 more than what they recommended it wouldn't be too bad. Now, if you can figure out a closer figure on that --

DR. PAHL: I'll take your portable computer.

DR. SCHREINER: The point you were making is that the third year recommendation would drop off by roughly --

DR. CANNON: $16,000.

DR. SCHREINER: $84,000.

DR. PAHL: The recommendation would be for $2.9 million for each of the first two years and the $1.9 million plus the requested amount for project 39 for the third year.

DR. CANNON: I think the staff could figure out these amounts and I think they know the intent of Council.

DR. PAHL: All right. The motion has been made and seconded. Is there any further discussion?

MR. NASH: I have a question. Does your motion include the recommendations made by the site visitors and review committee regarding the other projects and the no funding recommended?

DR. CANNON: Yes. That's what I went through.

MR. NASH: With the exception of kidney.

DR. CANNON: With the exception of kidney and the

exception of the Stephens County project.

DR. PAHL: All in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

DR. MARGULIES: I want to remind us all that because we're still in the transitional period that these comments in the form of recommendations and advice and so forth are advice rather than requirements. I think we all understand that but I have to keep reminding us of that from time to time.

DR. PAHL: Perhaps we could have our coffee break now and reconvene.

DR. MARGULIES: One thing we do want to get done before anybody is ready to leave is have any further consideration of the review criteria which we discussed yesterday, so we may interrupt the review if necessary for that purpose to make sure that the majority of the people are here or as many people are here as there are now.

(Recess)

DR. PAHL: If we may come to order, I believe what we would like to do is return to our original agenda and take up the three New York applications starting with Albany. Dr. Brennan is not with us and we will call on Mrs. Wyckoff for the principal review.

MRS. WYCKOFF: Albany seems to be in trouble. It had a review committee report sad. They seemed to be pretty irritated with Albany and there's quite a management problem there. Both the review committee and the site visitors seem to feel that they desperately need the help of a deputy coordinator who is someone who can bring administrative ability into this situation.

This is atriennial application but the critique here seems to be centered around the fact that it's nothing but the renewal of ongoing projects with 75 percent of its activities within the core budget and most of its operational project money eaten up by the continuation of its two-way radio project which is something they seem to set score by that has 60 hospitals now equipped with this two-way radio system and a lot of money is used to keep up this equipment and continue operation of this program. The hospitals are not yet willing they say, to absorb this and need three more years of time to do this.

The review committee recommends that this Albany RMP be funded at $900,000 for one additional year, with a followup site visit in a year to check the region's progress with regard to numerous and specific recommended changes. Now, they have been very adamant about these changes and I think perhaps it would help if we put them into our recommendations so they have this leverage to work with.

The necessary changes are: (A) mechanisms for the phase-out of RMP support to be developed for this two-way radio and coronary training activity with the understanding that RMP funds will not be forthcoming for longer than 12 months and no more than one-year terminal support for coronary training; that the RAG and its executive committee must become a policy-making body which actively review and evaluate ongoing proposed activities and they need education as to their responsibilities. They suggest that a conference seminar might be a way of doing this. That the planning and review sub-committee of the executive committee be composed of only executive committee members, now rather fuzzy being composed of staff and a lot of extraneous people that should not be voting on it, and that all deliberations of the executive committee must be reviewed and considered by the Regional Advisory Committee.

They feel that the functional review procedure needs to be straightened out. They have a situation where the present consulting groups have been established to serve both technical review and program development, so that there has to be a means of separating these functions so that technical review people -- review is not performed by the same group that develops the activity. This is a plain conflict of interest situation.

They also recommend that efforts be made to include

in the technical review process qualified people from outside the Albany and Albany Medical College area. Now, this area evidently has some of the same excellent data base collection which has been going on in the neighboring region but it hasn't been applied -- the same problem.

They feel that strenuous efforts must be made to fill the core position of the nurse coordinator and they need a set of operating objectives which are quantified and measurable, time dependent, and ranked in priority order.

They also have some suggested considerations here which I think don't need to go into the recommendation, but which could be worked out by the staff.

So, in view of this situation which I think ought to be discussed along with the other New York regions to see whether or not there is a possibility of combination, I would like to move approval of the review committee's recommendation that this project be funded for only one year more for $900,000.

DR. FRIEDLANDER: Second.

DR. PAHL: Is there other discussion from staff or Council?

MS. FAATZ. Well, I think what was important about Albany is that there is hope that the recommendations of the site team which the review committee adopted are specific enough that in a year's time when the site team goes back there's really not much question about what has to have been done as

there as there has been in the past.

DR. PAHL: Thank you.

DR. MARGULIES: I'd like to just add to that that these recommendations really should be supported by a good bit of interim effort on the part of the staff; and quite frankly, we are always in the uncomfortable situation regarding a coordinator and the kind of leadership he provides because we have a relatively laissez-faire attitude, but there seems to be no question about what's needed in Albany, as there will be in some of these other programs, and I think we might be able to supply a little more firmness to our concern over that recommendation than a deputy coordinator. I think there are other alternatives which we could suggest.

MRS. WYCKOFF: Well, if they could unfreeze all the money they've got tied up in that two-way radio thing --

DR. PAHL: The motion has been made to accept the committee's recommendations on the Albany application. Is there a second to the motion?

MR. MILLIKAN: Second.

DR. PAHL: Any further discussion?

DR. MILLIKAN: Did you want to hear discussion of the others before the vote?

MRS. WYCKOFF: Do you think it would help matters to discuss the Rochester one before a final vote?

DR. MARGULIES: I rather doubt it. I think there's

not much that we can do now except look at each one separately.

DR. PAHL: All those in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

We will now turn to the Central New York application with Mr. Friedlander as principal reviewer and Dr. Cannon as backup.

MR. FRIEDLANDER: Well, Central New York at Syracuse has essentially the same problems it seems as Albany has for a different set of reasons. I think while Albany has regressed, we might say, I think Syracuse has sort of just treaded water and done more of the same, but it's not really much of a surprise.

It seems to me that the review committee's critique which really reflects the observations of the site visit team really summarize what you find in reading the application. It might be well to run through a few of these because they are all reflected in the conditions under which the funding is recommended.

The fact that the objectives are described in terms of activities rather than anticipated accomplishments, this is sort -- you get the vague feeling that they're talking about

activities but there's no connection with accomplishments. They refer to the Regional Advisory Group as a viable entity with fairly good leadership. I guess we get into some more of this middle-level kind of quality. Suffers from a lack of allied personnel, consumer representation, particularly inner-city and rural community, model cities, etc.

The review committee believes that the Regional Advisory Group -- and I think this is also substantiated when you read the application -- needs to assume a greater role in giving leadership to the planning and operational activities of the program. They seem to be set aside from the program. It all seems to be project oriented and that the Regional Advisory Group has not assume responsibility for developing a regional plan.

The executive committee of the Regional Advisory Group, too, needs to expand its membership to include broader representation from low economic consumer groups, rural physicians young activist physicians, allied health personnel, etc. The same problem exists here.

And then the concern expressed over the membership of the Regional Medical Program's committees, which consists primarily of physicians and little interrelationship existing between those committees and indeed -- between the committees themselves and between the committees and the health related groups in the community. They constantly refer in their summary

of their activities of having working relationships with various of the community health related groups but nothing seems to happen.

The review committee also -- and I think with faint praise -- the present core staff is good but small in number. Then they have the same problem here that Albany reflects, is this recommendation that someone needs to be there to help the coordinator who's been there for quite a while but he's a nice fellow and if he got some help maybe they could move. It's a very similar kind of thing.

Then the other criticism which seems appropriate -- this, again, is reflected in the recommendation -- the activities previously funded by the Regional Medical Program have not been absorbed into the local health system with the exception of the home health aid program.

Now, in Syracuse, I guess the thing that's comparable to the two-way radio in Albany is the nurse education program, but this one seems to be an extremely good program but seems to be operating in a kind of vacuum for its own purposes and has no relationship to the -- or very little to the other allied health activities in the area.

The question of evaluation, you get this from reading the application as well, but you wonder about this. They have three evaluators and there's no relationship among them. There doesn't seem to be any interrelationship between the evaluating

group and the core staff. They all seem to operate separate from each other; and also the fact that there are three part-time evaluators, three physicians who obviously have other interests in the community. But the region does express an interest in evaluation but doesn't seem to be doing much about it.

On the basis of these kinds of observations, it seems that the ten conditions under which the recommendation is made seem to be appropriate. The funding recommendation is that there be a $200,000 addition to the current funding and that this $200,000 be utilized to develop activities that will help to improve delivery of health services to the urban and rural poor which appear to be two real priorities for the region.

On the basis of this, I would move that the recommendation for one year funding of $850,000 with the listed conditions be approved, and also that the contingent on, as recommended by the review committee, a staff followup visit six months following the award of this application to evaluate the progress that's been made in meeting the conditions.

DR. PAHL: Thank. Dr. Cannon?

DR. CANNON: I support the comments given.

DR. PAHL: The motion has been made. Is there a second?

MRS. WYCKOFF: Second.

DR. PAHL: Is there further discussion from Council or staff?

(No Response)

DR. PAHL: If not, all those in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

We now turn to the Rochester application, Dr. McPhedran the principal reviewer.

DR. MC PHEDRAN: The Rochester Regional Medical Program was site visited June 24-25, and the recommendations of the site visitors were agreed upon by the subsequent review committee.

Specifically, the recommendation was for this upcoming 04 year $800,000, with this year only, and a followup site visit after that year.

For comparison, the third year was $895,000 for a 12-month period. It actually had been an 18-month period with a funding of $1.45 million.

The same problems of essentially no program but rather a collection of projects continues in this region. That is, it's a problem that has been identified before. A site visit team in April 1970 -- and I think a subsequent management assessment visit, although I can't find that at the moment -- made the peculiar recommendation that a deputy coordinator be

appointed to give the program direction and strength. It is hard to view this as other than a poor substitute for an entirely new direction. Some progress has been made, however, and even the conditions suggested in the critique on the blue sheet I think reflect the progress that was seen in the last year. For example, the second condition particularly, was that the region would have in this 04 year flexibility in budget rearrangment to build its core staff, develop a revised form of regional leadership, etc., and this condition was thought reasonable by the review committee because of changes in the region; for example, diversification of the Regional Advisory Group and improvement of that, and creation of an active executive committee of the Regional Advisory Group which appeared to provide increased strength for the program.

Also, other hopeful signs were some objectives and priorities had been set and listed which wasn't the case before, and another asset was that the program had a good reputation with physicians and nurses in the area; but one wonders whether this wasn't to some extent because the program could be bent to almost anybody's purposes, at least according to the critique here.

Developmental component was requested but specifically denied in the critique.

I move acceptance of the review committee's recommendations of $800,000 -- I'm sorry, I left out one thing. The

condition in the recommendation is that the kidney project is excluded from funding within the $800,000 level, but it's stated that if earmarked funds become available there is no objection to increased award of funding for this activity. This project, however, did receive an unfavorable review from the ad hoc kidney panel and I wonder whether that is a wise recommendation. If the review was unfavorable and if the program is in difficulty, I'm asking for advice here, wouldn't it be better to suggest that that be left out unless -- and they be discouraged from putting this into operation -- unless it would cripple the whole regional kidney program. I'd like to have some advice and help from staff and others about that.

DR. MERRILL: Is that kidney program in this yellow sheet here somewhere, a summary of it?

DR. PAHL: Mr. Spear, would you be able to give us any information on the Rochester kidney proposal as it was reviewed by the ad hoc panel?

MR. SPEAR: I don't think it is, Dr. Merrill.

DR. PAHL: Mrs. Silsbee has a comment while you're looking.

MRS. SILSBEE: Dr. Merrill, that application had come in the cycle before this one and the kidney panel reviewed it several months ago before this application came in. The region at the time they submitted this application didn't know the fate of the kidney project so it was not included in this.

yellow sheet.

DR. SCHREINER: I don't understand that.

DR. PAHL: The description of the kidney project is not included in the materials before you at this time because it was reviewed earlier. I think the question that Dr. McPhedran had was why did the ad hoc panel find this proposal unsatisfactory, an d then is this a wise thing to include it in the present recommendation.

DR. MC PHEDRAN: Not exactly. I'm taking it as given that the ad hoc panel found it unsatisfactory, and I'm wondering why, if that was the case, why the review committee felt that if earmarked funds became availble there's no objection to an increased award to permit funding of this activity.

MS. FAATZ: The site team didn't feel very strongly about this one way or the other. They had the recommendations of the ad hoc kidney panel and the ad hoc kidney panel objected to this proposal primarily because it seemed to be a number of years behind the times. The site team, as I say, did not feel strongly about it.

I think the thinking was that perhaps if earmarked funds became available and there was nowhere else to put them -- it was a very wishy-washy kind of recommendation.

DR. MC PHEDRAN: Well, that's the way it seemed to me and that's why I wonder if we shouldn't -- I think we should exclude it. We should go along with the recommendations of the

ad hoc kidney panel probably.

DR. SCHREINER: One of the comments that I've been making lately is this whole ad hoc kidney panel mechanism serves to really cut us off from the kind of information we got from the very simplified decision making. We have very little opportunity to look over their shoulder. You know, somebody left the program so somebody says the whole program was out, a $300,000 program and one man left the program and they thought it would collapse.

I'm not sure that we're getting the input to review the kinds of things that we do want, a lot of things based on outside experience and the other people, because there's enough information here. I'm totally in the dark. They've got a good dialysis program up there if we could develop that in some way. They probably don't have transplantation and this probably influenced the recommendation of the committee.

DR. MARGULIES: I think your criticism is absolutely valid. We have not supplied Council or the review people at all adequately with the reports of the ad hoc panel as to the basis upon which they made their decision or what their criticisms were, and I think this has been part of the ad hoc arrangement itself.

That's easily corrected, particularly now that we have that level of interest on the Council. I think we won't have any further difficulty with it.

DR. MC PHEDRAN: Well, I'll just say that I'm in the dark about it and I just need somebody else to help me decide.

MRS. SILSBEE: Dr. McPhedran, I think the reason why the committee was so wishy-washy about this is that if the kidney redevelopment was an agency by which the broader program could be brought together, then they would feel that that could proceed. But they didn't know on the basis of the ad hoc panel's considerations.

MR. SPEAR: Mr. Stolof is at the mike and he was involved in the review of that project.

MR. STOLOF: I can speak only as was told to us by the reviews. The emphasis of the Rochester project which was a part of an overall plan to seek to strongly stress sharing and rather than procuring more organs they were sharing -- they were setting their mechanisms programmed around the international sharing of organs rather than stressing procuring more organs to be used. I think this is why the panel met with disfavor on the project and it felt that due to the state of the art of the tissue typing they questioned the Rochester proposal because it was basing the majority of its sharing on tissue typing findings.

DR. PAHL: Dr. McPhedran, do you wish to --

DR. MC PHEDRAN: Well, I just think I'll have to move adoption of the review committee's report, perhaps leaving in the third wishy-washy conditions, being unable to come to grips

with it any better than this.

DR. MARGULIES: I think that since this is so unsatisfactory, what we really should do is provide at least some members of the Council, perhaps Dr. Merrill and Dr. Schreiner, with enough information so that we can come back and take another look at this particular activity at the next meeting of the Council because I think it's all out of phase and it's vague and generally unsatisfactory.

DR. MILLIKAN: Would you accept that as an amendment?

DR. MC PHEDRAN: Yes, I would.

DR. MILLIKAN: I amend your motion.

DR. MC PHEDRAN: You're amending my motion. I accept.

MR. MILLIKEN: Second the amendment.

DR. PAHL: The motion has been amended and seconded to approve the committee's recommendations and defer any action until next Council meeting on the kidney project. Is there further discussion on this motion?

(No Response)

DR. PAHL: If not, all in favor please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

Because Dr. Everist will have to be leaving before too long, I wonder if we might skip to the Memphis application with

Mrs. Wyckoff as the principal reviewer and Dr. Everist as backup reviewer.

MRS. WYCKOFF: This is a request for $2,754,000 for the fourth year of operation. They want $2.5 million for the fifth year and $2.3 million for the sixth year, making a total of $7.7 for the three-year period. The current level of support is now $1,512,795.

1. They want authority for a developmental component in the event new funds become available.

2. They request continuation of 5 projects within the currently approved period, amounting to a total of $461,046.

3. They ask for $799,548 for core and $524,283 for continuation of 7 projects beyond the approved period. They want $969,356 for 12 new projects for each of three years. They will phase out three previously supported programs.

There is a difference of opinion between the site visitors and the review committee on the amount recommended to the Memphis RMP. The site visitors recommended $2 million for each year, making a total of $6 million over the three years. The review committee recommended a cut to $1,627,000 for each of the three years, a total of $4,950,000. The review committee cut core funds from $799,548 to $600,000. Then they cut all projects, continuation, new and renewal, from $1,954,685 down to $1,027,000. The review committee's total recommendation, low

as it is, is still above the current direct cost level of $1,512,795.

For those of you who do not know the Memphis region, it is important to understand the extraordinary character of its composition. The RMP geographical boundaries cover portions of 75 counties in five states: Tennessee, Arkansas, Mississippi, Kentucky and Missouri. The area is a medical marketing natural watershed. It is served by the University of Tennessee Medical School.

As you may remember, the original idea of RMP was that it would operate largely outside of the political subdivisions of government and be designed to serve the natural groupings of providers, educational institutions, and voluntary health agencies. Now things have changed and RMP must cooperate with Comprehensive Health Planning and other government agencies that are structured along the lines of political subdivisions. Memphis RMP has had a heroic task in trying to work out these relationships. Therefore, when site visitors and review committee and staff say that the organizational structure of Memphis RMP is "complex," "cumbersome," and "complicated," it must be understood that they are struggling with an anormously difficult problem. When, for example, HSMHA issues a seemingly simply requirement that RMPs must submit their proposed projects to CHP for comment and review and receive at least an acknowledgement from them, in

Memphis, this means getting answers from five state CHP "A" agencies, and innumerable "B" agencies, and then going to three HEW regional offices.

On top of this there is the elaborate structure of the Mid-South Medical Center Council which is designated as the RAG for the MRMP. It covers 75 counties, has 156 members, 51 percent consumers. It is the grantee agency for the new Experimental Health Planning and Delivery System Contract with the National Center for Health Services Research and Development for $728,000. However, this body meets only once a year and if you will look at the chart at the back of the site visit report, you will get some idea of this unusual arrangement. I think you have that chart which may help you because this gets very complicated.

The site visitors tried to find out exactly where the decisions were made and this was not easy. On paper, the Medical Center Board of Directors, consisting of 45 members elected at the annual meeting of the Mid-South Medical Center Council appears as the final authority for the RMP. It consists of 18 providers, 27 consumers, and is the CHP agency for 14 counties. This Board, which represents only 14 counties, meets ten times a year and puts its stamp of approval on the RMP proposals, which it receives from the new RMP Policy and Review Committee, a 36 member body of 28 providers and 8 consumers which meets monthly, and is appointed by the RMP coordinator.

This body, on the other hand, represents 75 counties in five states and is a standing committee of the Mid-South Medical Center Council. Its chairman sits on the Mid-South Medical Center Council Executive Committee which is the policy making body for the CHP "B" agency among other things. The site visitors questioned the legality of the RAG decision making process. I understand that that is now being put into a study committee and that our recommendation that they go to the regional general council at ATlanta if found to be necessary.

As it happens on a site visit when everybody's hair was let down, it developed that the real decision making seems to be performed by a small, very hard-working Planning Board which isn't even on the chart, but which is established to advise the coordinator. It not only screens all proposed projects for applicability, but advises the coordinator which applicants should be given core staff assistance in developing a proposal. This Board also meets monthly with the Policy and Review Committee. It has limited representation from the categorical committees.

The core staff seems to have independent decision-making power almost equal to the Planning Board, judging by the large number of activities stimulated and conducted by them with little or no relation to the goals and objectives of RMP. They simply report directly to the coordinator.

Actually, the coordinator is trying to fill two

positions, himself and a much needed administrator. Both he and the core staff have been a little too eager to please too many groups all at once. Core has put in a vast amount of time helping other health organizations to apply for funds only generally related to the broad goals of the Mid-South Medical Center Council and the RMP. There is a question whether the cost of this is justifiable.

Unfortunately, the coordinator seems to feel he can fill this large administrative void by recruiting an assistant for program development who is now coming aboard. The review committee and the site visitors felt that much more is needed, and that the coordinator should hire a full time executive officer with broad administrative experience to carry on the day-to-day operations of the MRMP.

One of the problems that concerned us is the obvious and documented need of the black population and yet the staff contains almost no black professionals. One example of this problem shows up in a beautifully designed physician continuing education program based on community hospitals. Practicing specialists from the private sector are invited by general practitioners to participate in advanced clinical conferences in which the patients of the inviting physicians are the subject of discussion. This plan is designed to serve a network of small and medium sized hospitals in the region, and has met with much success. But when I asked how many black physicians it

reached, the reply was "None." When I asked why, the reply was "Because the black physicians do not have the educational qualifications to practice in these hospitals." So the dilemma was complete.

In another situation staff pointed out that they had achieved a big step forward by arranging for black physicians to be allowed to visit their own patients in a Memphis hospital even though they could not care for them. Review commitee and site visitors agreed that an increased effort is warranted.

The goals and objectives and priorities of the region are stated, but the policy of accepting spontaneously appearing projects to please special groups has prevented the development of activities based upon the clearly identified needs of the region. A nural sequel to this desire to please so many groups is the not unusual tendency to pass on to the RMPS and the Council the unpleasant task of saying "No." The region has not been able to phase out its support of seven projects after three years of operation. The decision to continue support is made without adequate evaluation of the effectiveness of the activities to date. The region is only now proposing to set up an evaluation orocess but in the meantime wants as much as 28 percent of the requested project funding for extending the life of these seven projects for more than three years.

Both review committee and site visitors recommend that if Memphis RMP in light of its reduced budget still wishes

to continue these seven projects, it should not be for more than one year.

Among the new projects proposed is a request for $438,000 for Neighborhood Health Centers, Project No. 36. In it, Memphis RMP expects to act as a broker to put together a complete comprehensive health care package for four existing public health department facilities, expanding preventive services by implementing primary care. Their search for other federal funds has already been successful to the extent of $120,000 from NCHRD for the pediatric nurse practitioner training program which is a part of the package, therefore it is recommended that the Memphis RMP not invest more than $318,710 in this project.

Both the site visit team and the review committee felt that funds should not be provided for project no. 39 "Continuing Education for Physicians in Tennessee," a continuing education activity of the Tennessee Medical Association. It was felt that this could easily be financed through dues of members.

In the final analysis and in spite of some of the negative aspects noted, the Memphis RMP has made progress in moving away from a medical school oriented staff and has good working relationships with medical societies, hospital associations, health departments, CHP and other regions of RMP. It is decentralizing and reaching out to broaden its base.

If it can put its administrative house in order, it

has the potential of becoming one of the better RMPs in terms of addressing the broad issues in the provision of health care.

However, I do not believe it is ready yet to be given authority for a developmental component . I share the site visit team and the review committee's recommendation against it.

I move approval of the review committee recommendation for a funding level of $1,627,000 for each of three years, or a total of $4,950,000, and I recommend the approval of suggestions that are listed in the site visit report -- I mean, in the blue sheet.

DR. PAHL: Thank you, Mrs. Wyckoff. Dr. Everist, do you have anything.

DR. EVERIST: Mrs. Wyckoff has enunciated all of my concerns excepting one. I think the region has begun a series of efforts toward delivering health services, just as Stephens County is attempting to do in the program in Georgia. These are all very good and they can't be faulted for their humanitarianism and so on. But we just got over this in the 314(e) problem and we're going down that same path in some other areas, and I think we ought to be aware of this, and this very laudable group in Iuca County, Mississippi is an example of this. You can't fault it. It would be against sin or the flag. It's just delivering health services and nothing else.

And the other thing is I think we ought to be

concerned about this one of two or three multistate RMPs and whether or not they are really viable in light of the other programs that go along political lines. I think we just ought to be aware of it anyway; whether or not we make any policy changes now is not important, but I think we ought to be aware of this.

This is a very difficult region to administer I'm sure, with the kinds of difficulties -- it's amazing that they get along so well with the contiguous RMPs, and they do apparently. They were all there represented from each of the four RMPs that impinge upon them. That's all I have.

DR. DE BAKEY: I don't want to prolong this discussion because maybe this isn't the time to bring it up, but I think it's awfully important for us to continue to keep in mind and maybe to review from time to time what the main thrust of the Regional Medical Program is, and why is it necessary to establish enabling legislation to do this job.

I think it's important to go back and in a sense recognize the history of its development and recognize the intent of Congress in developing enabling legislation and the amendments that have since been added to it.

In the final analysis, if this objective is being achieved by the funds which the enabling legislation provides, then I think it would be wrong for us to set up regulations that would in a sense contradict that development. So I just

want to give you a word of caution about this because it's awfully easy to get set up in a set of regulations that really handicaps you from getting to your objective in order to standardize a method of doing things.

This is the only thing I'm concerned about in our discussions of these various regulations or policies that we set up.

Now, I know we have this policy on multiphasic screening and I think in general it's a good policy and I think, in other words, what we've done is desirable; but I think at the same time, if we find that there is a means to achieve an objective that is a sort of congruent with the objectives of the Congress in setting this up, then I think it's important for us to keep that in mind and not allow ourselves to get entangled with regulations or policies that prevent that from being achieved because there's always more than one way to achieve an objective.

So, I'm very much impressed, for example, with a statement here that says that in the three-month period, January-March 1971, they had 1832 adults screened, leading to the detection of 1386 abnormalities. Now, here's a population that two-thirds of the adults there have abnormalities; one-third of which required referral to their family physician. Now, if you can tell me any other way by which this could have been picked up, some other means by which this could have been

done, then I think we ought to try and do it. But in the final analysis, this is one of the objectives of the program.

So I think, despite the fact that this may not fall within, let's say, the methods by which we want to achieve the objective, if it is achieving the objective we ought to do so.

The second thing is that I realize that the future of this type of entity as a regional medical program may fall afoul of the political realities of the programs that may be developed in the future for funding, for interfacing with other programs, the fact remains that they do have something going right now that is reasonably effective, and I think that, again, we must be a little cautious about trying to change something that in a sense would jeopardize the efficacy of their achieving the objectives they're trying to achieve.

Where we can help them, I think we should do so, and I think there are a number of areas here and recommendations being made that could help them, and the site visitors group has pointed these out, and I think with good will they could do it.

DR. ROTH: I had one very small comment or question on a very minor point in Mrs. Wyckoff's report. There was one project in which it was recommended that it not be funded because -- and I think I quote fairly closely -- that it could easily be funded by the medical society from members' dues.

MRS. WYCKOFF: Yes.

DR. ROTH: I wondered what medical society had to say about this, recognizing that members dues in medical societies are quite a problem these days with all levels increasing and I don't know what the situation is in Tennessee, but a recent dues increase has had the effect of 9,000 members of the New York State Medical Society dropping their membership and I don't think that RMP wants to take, in effect, a project which alienates physicians from cooperation in good programs.

It's a very minor item but I wonder if we're exceeding our prerogatives in RMP in telling medical societies what they ought to spend their dues money for.

MRS. WYCKOFF: Well, I think perhaps they felt that the relationships were very good and solid with the medical society there and that if they pride this program very much they might be willing to put up -- they were willing to risk it anyway.

DR. ROTH: Normally medical societies, as I'm sure this Council understands, are not funding agencies of projects of the type that RMP deals with.

DR. EVERIST: I have just a brief comment on that, Dr. Roth. This was supplying an extra person on the staff of the medical society which I think is justified, but I think you're perfectly right that we ought to delete our comment.

DR. ROTH: It would be fine if it was the other way around, if the medical society said that it could cheerfully

absorb the project.

DR. EVERIST: I think it's an inappropriate comment.

MRS. WYCKOFF: Do you need a motion to delete that comment?

DR. PAHL: We'll accept that as consensus of the Council as an amendment to the motion.

Dr. Hunt, did you have a point?

DR. HUNT: Yes. I'd like to endorse Dr. DeBakey's statement relative to the screening process. I heartily endorse screening facilities and screening processes as long as they're productive, but it's my understanding that the objection was that we were a little tired of the "DUDAD"(?) development stage to the point that we were spending millions of dollars to develop something that a couple hands, eyes and ears could do very easily, and that this was the part that we were a little bit discouraged about and that if the phasing screening process could get away from the multiphasic screening -- get that word out of there, and just call it screening process, that if it's productive and it's bringing medical care to a group of the community that hasn't got it and needs it, then we're for it, and we'll fund it.

DR. DE BAKEY: Another example, for example, in the Georgia group, where, of course, they've had a longstanding interest in hypertension and there's been several studies which have clearly demonstrated that a great majority of hypertensives

in the United States, and there are some 20-odd or more million people in the United States with hypertension, go unrecognized. And they pointed out in the study that they did just the simple screening city that they did that -- it wasn't multiphasic screening -- 28 percent were undetected requiring treatment. Now, I think this is important.

Here's a disease in which there's no better example of the objectives of the heart disease, cancer, stroke program than hypertension, because here's a disease in which there is sufficient knowledge available at the present time to be able to effect a significant impact upon its control and upon mortality and morbidity. There's no question about that. This has all been very well demonstrated and just recently in the studies that came out from Frieze clearly demonstrated even moderate hypertension requires management control if you're going to affect mortality and morbidity, and there's no question about the fact that you can do it and there's no question about the fact that drugs are available for this purpose. So all we need to do is to bring this to the people who have it.

This is really what the whole program is about. This is the basis for it. So if you develop a screening program that can pick up hypertensives in an effective way and really bring them in and provide good management control for them, then we have accomplished a significant thing so far as this program is concerned. This is what we want to do. Now, the mechanisms by

which we do it seems to me is important only in determining the efficacy. That's all.

DR. MARGULIES: Well, the question of screening is one thing, of course. The question of multiphasic screening is noather one.

DR. EVERIST: And the delivery of health services is another.

DR. MARGULIES: Yes. If you look over the document on which you made a decision last time, you'll find that we have millions of dollars invested in multiphasic screening around this country just in the RMPS activities and there are many more in others. Whether or not they are serving an effective function for screening purposes is open to doubt and for the most part I'd say they haven't been.

Now, if you want to screen hypertensives for the cost of one multiphasic activity you could screen hundreds of thousands of hypertensives, set up programs, and do something about it. And if the Council wants to change the policy in the direction of multiphasic screening because this is the only way in which you get screening, it, of course, is free to do so; but I understand that that is not what you're talking about, Mike, at all.

DR. DE BAKEY: That is not what we're talking about.

DR. MARGULIES: What we need is simplicity in screening effectiveness in it related to continuity of care and related

to the high risk populations. And the hypertensive is a very good example.

But the multiphasic effort, almost in every instance, is associated with some enchantment with a gadgetry which is involved, and a tremendous diversion of effort into something which produces relatively little in the way of patient detection and care. I think we need to differentiate carefully between one and the other. It would be interesting to know what they could have done in that county without a complicated mechanism with an effective screening process. Perhaps it couldn't have been done.

But if we're going to get good screening activities, I think we have to lean away from the multiphasic and look more in the direction of simple screening of the kind that you're talking about.

DR. DE BAKEY: I think another factor to keep in mind is that it depends -- that one of the important factors in all of the screening processes, whether it's multiphasic or more specific and simple forms of screening, it's related to some extent in terms of the population that's being screened. Now, obviously, in this area, we're dealing with a population in which there has been little or no medical care over a long period of time and, therefore, no matter what you screen in that area, you're going to screen a lot of abnormalities because they haven't had the care they should have.

So if you do multiphasic screening in which the people there had good -- you know, beginning with prenatal care and have had good care all long, then the percentage of results is going to be extremely small in terms of abnormalities; and perhaps the whole process will become less efficient and, of course, economical. But any kind of screening in a population in which the medical care has been bad over a long period of time is going to be worthwhile.

DR. SCHREINER: There's another side of the coin now. I think we've gotten ourselves into semantic difficulties because what you're really talking about is a detection program for hypertension which is a very, very valid thing; but if a region has put together -- to bring people to a storefront or bring a van to some people -- then it may be very much more efficient actually to try to detect many multiple things rather than just try to detect one thing.

In other words, the added cost to obtain something on that model might be relatively small, and even though the yield for those other detection programs might not stand up in their own right, they might stand up very well as a supplement to a hypertension detection program.

I think, at least what I thought I was voting for when I voted against the computer thing, was whether these were random data collections by questionable methods of very, very high cost. The Public Health Service is spending almost a

million dollars locally here to develop a computer program for writing admission notes on patients. The way it works out, you go through a questionnaire, you return the questionnaire to a clerk and the clerks puts it on a key sorter card and the key sorter card computerizes the chart. That's a half a million dollar pen.

DR. DE BAKEY: I agree with you. I think though, there's one other thing to keep in mind and it's difficult for us to keep it in mind because we're not accustomed to having this reponsibility, but you will recall that the heart disease control and other disease control programs that used to be in an entirely separate agency were transferred to us and they're supposed to have transferred the money. Of course, that's just a real shell game because what it meant was that the money had disappeared but we have the responsibility.

So there is no other control program, virtually, except that which resides, in a sense, in this agency for these areas. The National Institutes of Health don't have them either.

DR. MARGULIES: Well, I think the decision which was made last time really said only one thing; that we think that there is potential merit in what we're doing but we don't know what the merit is and what the best way is and under what circumstances, and let's not spend more money until we can get a few answers. I don't see any readiness to change that.

Of course, Dr. Everist's point still remains valid and

it's a troublesome one. We've dealt with it many times in this Council. That is the responsibility for delivery of health care is something which could absorb all of our funds and get us into no end of difficulty, particularly is that true when what you're supplying is desperately needed and you can't back out of it, and we're eating up most of the national budget in trying to meet exactly those kinds of demands to pay for services.

DR. DE BAKEY: Well, of course, again, if you go back to the law, you will see that we are discouraged from doing that, very definitely. So that I'm not sure that we would be on very good legal grounds spending money for just delivery of health care.

Now, this has to be in the form of demonstration and that sort of thing, and that's what I think we're trying to do.

DR. PAHL: The motion has been made and amended. Is there a second to the motion, which primarily is to accept the recommendations of the review committee together with the specific points relative to the individual projects and deletion of the reference to the medical association dues for project 39.

MR. MILLIKEN: Second.

DR. PAHL: The motion has been seconded by Mr. Milliken. Further discussion?

(No Response)

DR. PAHL: All in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

MRS. WYCKOFF: This does not knock out the multiphasic project you understand. That is, it's up to the RAG to decide how they're going to redeploy these funds.

DR. PAHL: Before turning to the next application, I think we would like to request your attention to the sheet of paper that we handed out to you yesterday relative to the review committee's overall ratings and rankings of the applications which we've been reviewing, and although we haven't gone through the entire listing because there will be some additional departures as a result of other plans, I believe it's important to us to have a sense of the Council relative to this new procedure.

Please understand this is still on a trial basis. We do intend, unless you feel it's completely inappropriate, to improve and utilize it again for the next round and we believe we will be able to bring better information to both the review committee and to the Council in terms of the rating system. But we would like to have whatever comments you would wish to make at this time relative to your feeling as to how well the committee reflects your thinking on the applications or any other comments that you might have relative to the presentation

yesterday and further thoughts.

DR. ROTH: I assume that in the further modifications that this will be taken into consideration, but it appears to me that we have done an awful lot of talking about the competence of leadership, the impact of an individual on a program, and another thing that this roughly manifests is that where you have strong leadership you have good programs which get up into the "A" group; and yet, as I recall the mathematical model, there was no real way that you could directly put that consideration in.

DR. PAHL: That has already undergone modification in the sense that the organizational viability and effectiveness criterion has now been separated into separate items for the coordinator, core staff, regional advisory group, and grantee institutions; so that there will be separate ratings for those four items and I think that will provide the committee and the Council with greater opportunity to express preferences in this area.

DR. HUNT: My feeling, relative to this, is that as a rating system does where you're trying to transfer opinions to numbers, I think it's a pretty good one. But I certainly would feel that in the future I would interpret the number you give to a program with the feeling that I have right now, that it's an almost impossible task to transfer the various ideas that we have relative to a program to a single number; and I

think these numbers as you show that they're weighted -- really, I would rather rely upon the English language to describe a program rather than a number because I think it's going to bring back to me something that I -- the interpretation that's given here, for instance, by the site review and by the review committee.

I guess what I'm saying is I don't understand why we have to transfer the English language to a number. What is it to be used for and what's the motivation for it? It appears to me we spend an awful lot of time and money trying to do this and I commend the effort, but I just wonder if we're trying to do something that high school teachers have found almost impossible for the last 50 years, and that's trying to get a different grading system for students.

DR. PAHL: Before responding, maybe we can have additional comments which bear or extend that observation and then we will try to respond.

DR. WATKINS: On the same topic, it would seem to me, looking at the chart "C", it puts New York, Albany, Central New York and Rochester on the lowest level of the totem pole. I wonder if it has a significance. To me, it doesn't seem to qualify New York to any place in the program when you put it at such a level and in New York we feel very proud of the job that we are doing in New York.

DR. KOMAROFF: I'm impressed that the numbers really

do nothing more than substantiate or tend to substantiate the accuracy of what we think are intuitions, but I think to spare ourselves some outside observers feeling that decisions are arbitrary that it's easier to defend, particularly in the time of fiscal stringencies, easier to defend the allocation of funds when you attach numbers, granting the artificiality of it. NIH does it and most health funding agencies do it and I support it as a generality.

DR. MERRILL: I think my experience with this kind of system would lead me to believe that both things are possible; that what you're doing with the numbers here is simply giving something to your opinion to weight it and give people a brief summary idea of it.

If, for instance, goals, objectives and priorities has a score of two, that will ring a bell and someone can ask you why. At that point your English comes into play and you can say it has a low priority. Otherwise, you have to write 28 pages, each one of which describes a figure. If you have five reviewers and they all give it 12, then I think most people would agree with it. If one gives it 2 and the other 12, at that point you have your discussion and bring out your difference.

I think this is simply a shorthand method of doing that and I approve of it.

MR. MILLIKEN: I would add to what Dr. Merrill has indicated here, that I think the rating system is not an end in

itself. It cannot be. On the other hand, I think it's exceedingly helpful to this Council to have worked out a rating system which shows where the weak points are, where the other kind of judgments must come in in terms of dealing with each individual application.

So, in that sense -- and I felt yesterday the comments generally from other Council members supported the fact that this should not be an end in itself; that the total ratings of these scores are only for further judgment by this Council. That end, I think, is very worthwhile.

DR. PAHL: Thank you.

DR. SCHREINER: I'd strongly recommend the reading of the editorial in the current weekly edition of Time Magazine, which is entitled, "Imaginary Numbers," and it points out the psychological traps for numbers, for example, that are accepted widely in publications and in Congressional hearings and on other official data, and how difficult it is to unnumber a number once it is established.

For example, everybody will quote the dollar value of goods stolen by heroin addicts in New York City and I've heard it on three TV programs, and then somebody took the trouble to investigate how it was arrived at and it turns out that it's in excess of all thefts that occur in New York City; and, of course, it couldn't be reall to arrive at that. But it got embedded because it was a number and it now has become a fact

or mistaken for a fact.

It seems to me there are three things to analyze: How you arrive at a number; whether the number has any validity and usefulness; and then how you interpret the number. I think it was a very useful exercise to go through this to see whether or not a weighting system could be developed that appears to agree, at least in one instance, with the overall general approach in the English language. In that sense, it leaves me reasonably comfortable; that at least there hasn't been any bizarre weights put on the value. As an experiment, that's good.

I also see the shorthand value of it, as John has pointed out. What I'm really worried about is the interpretation of it. Once you get something down into a number, then the more simplistic people are, the more they will approach that imaginary number as a fact; and if we're concerned with -- instead of trying to help Congressional relations, we'd be worsening it by giving it some artifacts really which can be seized on and which are going to be given a kind of permanence that they really don't deserve.

So I'm really more concerned not with how we arrived at it, which I'm happy about; but what's going to happen to it.

MR. FRIEDLANDER: Following up on what's going to happen to it, I think it all depends on who's interpreting it. If the ratings given here are to be used by the Council, I think

this is probably not the most effective way to effect its purpose. But I think this kind of rating system will serve the purpose to dispell a misconception that's gone on about RMPs for a long time, namely, that Regional Medical Programs are either succeeding or not succeeding; they are good or they are bad; and the "they" is really a collective singular noun. This has never been true. This is one of the hardest things in terms of interpreting Regional Medical Programs, that we've had.

Now, in all honesty, if the Regional Medical Program Services acknowledges the fact that there are variations in the quality of programs and publicly acknowledges this, --public including the Congress -- I think this is really facing the reality and I think it's going to help the Regional Medical Programs collectively and separately to know this.

Now, it's going to be a sensitive point, no question, in each of the various regions, particularly those that wind up in the "C" category; but, again, it may be the motivation to move upward.

DR. MARGULIES: Well, I think the thing which concerns you mostly, as I understand it, is what use will be made of this kind of a numerical system. And for practical purposes within the context of our usual function, they will be used for defensive purposes. They will be used so that we can, when we are asked to give evidence that we have made an analysis, have

something which someone can look at very quickly, as you have indicated. Now, if they want to know more about why there is a difference between Albany and California, then there will be ample evidence which can be all the way from this Council meeting on back to the life history of both of the Regional Medical Programs.

You may recall that in April of this year when there was a funding cut, the only kind of decision which seemed to be tenable -- and this was a political decision; it was not a programmatic one -- was an across-the-board cut which affected everybody, which means that it did not affect everybody equally; it affected them very unequally. For example, there were programs which had unexpended funds, which ended up as a result of the cut, with having slightly less unexpended funds. Others which had budgeted well, managed well, which were severely damaged. Now, what appeared to be a very even act was a very uneven one.

We are dedicated to the concept that we should invest public funds where public funds will benefit the public, and when there is a disparity in the ways in which programs can meet public needs, that should be reflected in the way in which we expend our money.

I don't believe that this numerical system is going to help this Council per se. I think it will help greatly, however,

when we make the decisions which will flow out of this meeting and every other meeting on grant awards, and we can then use this as a method for describing to people who object how we made the decision, how it came out. As I have indicated on other occasions, every state has two Senators and several representatives, and when you make a change they are heard from, along with a lot of other people.

I think that we all understand that these are judgments we are making. You may feel uncomfortable with the grading system but, in fact, you're exercising not only a grading system all the time but you're spending millions of dollars one way or the other in the process. And it is primarily for that purpose that we need this kind of a mechanism. In fact, in the absence of it, we'll have great difficulty in doing anything other than what Chairman Flood described as the "meat axe" approach to reduction in funds or to elevation of them.

DR. HUNT: But the application of a number to a poorer program is not going to negate the necessity for giving an explanation to an irate Senator.

DR. MARGULIES: No, you're quite right, but it's interesting how effectively we can negotiate with people in the political arena if we stand on a professional base. When we start trying to deal with them politically, then we are in great difficulty. We're in their game, and you may be expert at it--

I'm sure you are -- but I don't feel that I am. But if we say that this has had a professional review by the best kind of talent available and this is how it came out, we stand in a fairly unchallengable position, and if we can provide evidence numerically and from that meeting back to a very careful analysis with the kinds of data which comes into this review system, I think we stand in a pretty good position.

We have these kinds of discussions all the time. For example, there was very recently -- and I can't use the names -- a call from the Secretary's office to me from -- reflecting the interest of a very prominent chairman of a prominent committee, saying he was interested in program "x" in his home state. Well, the response was -- and it was a very comfortable one -- that they had a priority list of six and this was sixth on the list, and this was a complete professional judgment. It appeared to be good but too expensive. Now, this leaves us in a very understandable relationship. He can exert what political influence he wants but there was never any suggestion that I do anything about changing that priority. It's understood that that is a professional judgment and what these numbers do is simply sharpen or crystallize the professional judgment process which I think we need for our own security.

I think that you're quite right, though, that it would be madness to get deluded into thinking that the numbers per se are meaningful. They are simply another way, as you say, a

shorthand way, of saying what we've had to do otherwise with a lot of words and a lot of papers.

DR. SCHREINER: Well, this is the whole point, though. I was reassured by your statement that it was going to be used defensively because, like Mike has commented a couple of times, we have keep reminding ourselves of the psychological trap. The trap is that we are all our sense of individual analysis of a region in relationship to its needs and unique features and so forth, and all our English, as Dr. Everist says, can be very perceptive and precise in its evaluation.

For example, the Defense Department said it was necessary for every commander in Vietnam to report body counts weekly. Well, the net effect of that -- and it may not be a coincidence -- that the most measured war in our history has been the least successful; and the net effect was that the military decisions were based on faulty data which we now know, and this has gone on for eight or nine years.

Now, the danger of it was not that they were forced to put in counts. The danger was that they thought they were real, and it was the psychological effect on the people who had to make decisions based on this data which was much more harmful than the fact that these numbers were used to defend the defense budget with Senators and with Congressmen and used very effectively.



DR. MARGULIES: But the thing that we have had to do

in the past in defending the RMP is exactly what you're describing. We've had to produce body counts. We've had to go before Congress and say we treated so many people; we saved so many lives; we produced so many digits in service and activity; none of which was reflective of what RMP was all about. And by talking about institutions called Regional Medical Programs, as elements providing a kind of action and comparing them, we can draw attention to what we really are. I think Ed's point on that is quite valid.

Now, the numbers business I know is distressing and perhaps we could find some other way, but it is concrete and it's easy to look at; it's understandable.

DR. KOMAROFF: Can I take one specific issue with the numbers, and that is that I have a feeling that the direction of Regional Medical Programs toward minority groups or populations of particular need is buried in these criteria in several different locations, and I would prefer that it be separated out and be more heavily weighted.

DR. PAHL: We have to apologize. That point, again, has already been done. This is such an evolving system -- Mr. Peterson presented yesterday the point -- that there is now an additional criterion which has to do with minority representation on RAG, core staff, and the kinds of projects and activities, and that's a separate criterion which is now number 19 or something, and we will be sending to you a slightly modified sheets

which will show you that, as well as the breakout of management and evaluation into two parts and coordinator, core staff, and other items that we covered this morning.

DR. MARGULIES: You realize we could have made this much more impressive by making it 2.87 to 3.27. At least we used large numbers.

DR. PAHL: We would hope to use this system, I think, in the same sense that NIH has -- that is, the better side of NIH -- where it is a tool. It is helpful to study sections, and as a tool to management, but it certinaly is not to be all and end all. I think if we can kind of keep that example in mind, which has served the country well for some quarter of a century, we will have achieved in less than that time perhaps some comparable understanding around the country.

Is there further discussion or comments? Please don't limit it to this opportunity. As you have a chance to think about this further, if you feel you wish to get in touch with us about specific points or general matters, we would appreciate continued discussion on this basis. But we do intend to go ahead with the improvement and modification of it. We will try it again in the October session and we will be displaying information to the review committee at that time and to you, in a way which I think will make some of this not only better accepted, but also really much more useful in terms of common discussion across all regions.

MR. MILLIKEN: At that time could we have a little more fill-in on the weighting that went into determining the performance was 40 percent, process was 35 and program was 25?

DR. PAHL: May I just answer that at this point in time because I don't think I'll have any further information by October. This was an arbitrary, well-considered, but nontheless arbitrary, decision by the staff committeee, presented to the review committee, and with the request that they accept this until they finished reviewing the applications and then discuss it. They found no difficulty themselves in accepting these weights. That's not to say that as individuals they might not have varied it. It was completely and remains completely arbitrary and at this point we have no feeling that we know just what the absolute answers are on this and we would appreciate some comments from you.

DR. MARGULIES: I think one of the better tests of it is as we gain experience with it will be at the time of the site visit when you get a real sense of how effective it is, but anywhere along the way this is open to criticism and alteration; although we have to have some measure of consistency or we run into real difficulties on that, too.

DR. PAHL: The only last statement I would make is it would seem that the performance of a region is something you can hang your hat on. It's really what they've done. With regard to the program proposal applications, particularly in

their present form, leave much to be desired in terms of providing the kinds of information which, unless you happen to site visit the region, would give you sufficient information to base intelligent decision on these criteria, so we will be trying to extend through questionnaires and other activities the information available to the review committee. And it was felt that the program proposal is what they propose in the future, and that should be given somewhat less weight than the actual performance.

Then, the organization and the processes that they engage in are so very important. We keep coming back to that again and again in our discussion. So it fell out of a common sense approach and a reflection upon what both the review committees and site visitors and Council have been discussing within the memories of those on the staff who participated in the formulation of the system. But it is arbitrary when you come down to the last analysis.

Well, thank you for your comments. I think that we have and will benefit from these and we'll be bringing you a slightly revised system which incorporates the points you have brought up and we'll keep the other matters well in mind as we continue with it.

Perhaps we should look at our logistics for a moment. My count is we have seven or eight items to go through -- seven specific actions to go through, and it is now noontime. We

have promised Dr. McPhedran to release him from the Michigan one before about 12:30 so that he may catch a plane. Is it your wish to go beyond the Michigan one which I think we should take up now, or hold up and then --

DR. ROTH: Can't we go on through?

DR. PAHL: We can go on through if that's your pleasure.

All right. Let's proceed with the Michigan application if we might, with Dr. McPhedran as principal reviewer.

DR. MC PHEDRAN: Michigan was site visited June 9th and 10th and I was on that team. This is an outstanding REgional Medical Program. It is so because of its thoroughly professional program staff or core staff, and also because of its regional advisory group.

The professional advice in the regional advisory group -- that is, the technical review panel -- the cooperation between groups of, for example, the alopathic and osteopathic physicians; their ability to set priorities; and for another instance, money management -- these were all a few aspects out of many which were outstanding.

The site visit team agreed that goals and objectives -- that is, for short-term objectives -- were not well-stated, but this criticism viewed against the backdrop of the whole program seems almost quibbling.



Their problems with evaluation and how to measure are

shared by all of us and it was clear at the time of the site visit that the advisory group and the program staff were actively considering this matter before the site visit and, in fact, it was to be a subject of major discussion in a planned retreat, a program staff and advisory group retreat, which I think was to be held in August.

The program coordinator, up until now, Dr. Heustis, is resigning for personal reasons, and this will be a significant loss but certainly not crippling.

All of the site visitors felt that the regional advisory group and the staff would be able to keep up the high standards of this program during any transition and that they would be able to find and be able to attract an excellent successor.

Our recommendation, which was concurred in by the review committee, was for level funding at $2.1 million for the fourth, fifth and sixth years for each year, and that would include the requested and approved developmental component. For your interest, this compares with the current 03 year figure of $1.9 million and compares with the requested 4, 5 and 6 year figures of about $3.3 million each year.

We also felt that some projects which had undoubtedly been useful in the past, for example, some of the stroke projects appear to have engendered very satisfactory cooperative arrangements, but some of them might really in deference to the

priorities of the region might be discontinued in favor of other parts of the program to which the region really had given a higher priority. We agreed, and last night in the small hours I showed myself to be an easy grader, which everybody knows anyway about me, and I gave it a grade of 358 against the highest grade in group "A" of 327. I was really dazzled by the program I guess, but I think that it was an outstanding program.

I move acceptance of the review committee's recommendation.

DR. PAHL: Is there a second to the motion?

DR. KOMAROFF: SEcond.

DR. PAHL: Further discussion?

(No Response)

DR. PAHL: All in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

May we take up the Wisconsin application with Dr. Roth as principal reviewer and Dr. McPhedran as backup reviewer.

DR. ROTH: Wisconsin is another one of the outstanding programs I think. I have been particularly struck by the fact that having participated in a site visit in Wisconsin and finding things in generally very good, the site visit team made

recommendations in some detail with respect to ways in which it might be even better and stronger, and in a very short space of time there is evidence that the region has responded to those suggestions and implemented most of them and started implementation of the rest.

I see no reason to disagree in any respect with the recommendations which are before you on the blue sheet and I would move that the recommendation which is for a slightly reduced funding be approved.

DR. PAHL: Thank you. Dr. McPhedran?

DR. MC PHEDRAN: I second that.

DR. PAHL: It has been moved and seconded to accept the recommendations of the review committee for the Wisconsin application. Is there further discussion?

(No Response)

DR. PAHL: If not, all in favor please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

May we now turn to the Maine application, Dr. Hunt.

DR. HUNT: This program -- of course, Mike was the original reviewer, and in the absence of Mike, I'm impressed by the inquiries that I have made since I arrived at this meeting relative to the Maine program. Everybody seems to be

enthusiastic about it and especially about its director, and that I therefore feel that we should recommend, and I so move to recommend the funding as recommended by the review committee of $1,100,000 for the first year, $1,200,000 for the second, and $1,300,000 for the third. This is a moderate reduction from the request which was $1.5, $1.6 and $1.8 million. The review committee is impressed with the program and it seems to be doing well and, therefore, I move its adoption.

DR. PAHL: Dr. Hunt, I assume that your motion for approval also includes the committee's recommendation for including development funding within those levels?

DR. HUNT: Yes.

DR. OCHSNER: Second it.

DR. PAHL: The motion has been made and seconded to accept the committee's recommendation on the Maine application. Is there discussion?

MR. COLBURN: I'd like to make a comment if I could. The present level of fuding in Maine is about $850,000. The requested level is $1.5 million. This requested level, except for an increase in core, of about $138,000, is based on all that's presently approved activities; and in view of the discussion this morning on California, I wonder if there's any-- if Council has any concern about this recommended level of funding? I think the reduced level, as I recall from committee, was not -- was based in light of the fiscal constraints of RMPS

nationally present and not on the merit of the program.

DR. PAHL: Thank you.

MR. FRIEDLANDER: It might be of some interest to the Council to know that the Veterans Administration, when we selected eight sites of Veterans Administration hospitals which we thought might be -- these are all unaffiliated -- that is unaffiliated with any medical school -- might be good sites to consider for area health educational centers within at least the concept as we saw it, one of the reasons Trocus Maine, which is the only Veterans Administration hospital in the State of Maine, was a good possibility was because of the Regional Medical Program there.

I was at the site visit there three weeks ago and I must say that the program, both the hospital and the Regional Medical Program, even exceeded our expectations both separately and in their relationship.

I only say this in terms of supporting the kinds of things you're saying, that Maine is doing this kind of a job.

Incidentally, parenthetically, it might be interesting to note that this kind of an attitude about the Regional Medical Programs is borne out in most other places we've been for this very purpose. Buffalo certainly demonstrated its capacity when we were in Erie. North Carolina certainly demonstrated its activity and its promise . And it's this kind of thing that's being borne out, but Maine is one of the classic examples of

this kind of cooperation.

DR. PAHL: Is there further discussion?

DR. HUNT: I was the secondary reviewer for Maine and one time had occasion to review the application. I haven't done so this time, but certainly the strength of the program as I remember it then and from other sources would make me wonder whether Mr. Colburn's suggestion perhaps that we should adhere more closely to the requested amount, maybe that would be correct.But I have no way of knowing from going through this firsthand but the review committee might have.

DR. MARGULIES: I think your point, Spence, wasyou feel the reduced figure was not based upon programmatic considerations but rather on fiscal restraints that were presumes necessary for them to consider. Is that right?

MR. COLBURN: Right.

DR. HUNT: I would have no objection to that as the backup reviewer and I amend my motion that the advisory council feels that the amount could be increased to the requested amount with the fiscal funds being available.

MR. MILLIKEN: Could we hear a little more about what the items of difference are here? What will not be done?

MRS. SILSBEE: I believe that the review committee also was concerned about the lack of specification in the second and third year in terms of the -- and they felt by giving them a gearing up time to see how they would switch from

this project to program thrust that by providing graduated funding it might be an opportunity to study that a little more carefully.

DR. HUNT: I think that's a valid observation because there is a lack of specificity.

DR. PAHL: The Chair understands that you wish to withdraw the amended motion and return to your original motion endorsing committee's action?

DR. HUNT: I will stand on my original motion.

DR. PAHL: The original motion which was made and seconded is that the recommendations of the review committee be accepted. Is there further discussion?

DR. MC PHEDRAN: Would it be reasonable to accept their original request with provision that we need to have more specification for the second and third year? I don't know whether this can be done under the triennial system.

DR. MARGULIES: You certainly can and you have the opportunity with the second year to alter the recommended funding.

DR. HUNT: I accept that.

MR. ~~COLBURN~~ Mckenna: I agree with that. The closer control and taking a look at actually what they attempt to do -- I think at this point they are intending to take a look at the projects that have already been approved and perhaps invest in those and see how things go, and I would say that we should take

DR. MC PHEDRAN: How could that be done by recommending that 04 year be funded if the money is available at the requested level and then leaving a recommendation for 05 and 06 open depending on what specificaions come in and then Council could review it at a subsequent time?

DR. MARGULIES: To make it a complete triennial review you ought to make a recommendation for all three years, but you can indicate that you would like to have another look at this program prior to the next year's funding to reconsider the level of funding based upon how well they have been able to specify their plans for 05 and 06.

DR. DR. PAHL: Is there a second to that motion?

DR. KOMAROFF: Second.

DR. PAHL: The motion has been made and seconded to accept the requested levels for the three years and to bring the Maine application before the Council again prior to funding the 05 year for Council reconsideration. Any further discussion?

(No Response.)

DR. PAHL: If not, all in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

The next application is Metropolitan D.C. with Dr. Hunt as principal reviewer and Mr. Friedlander as backup reviewer.

DR. HUNT: This application is an application from the Metropolitan Area of D.C. for a comprehensive renal program. As you remember, this was submitted previously and the site visit committee rejected it and I think it was rejected also by the review committee. It is now being resubmitted as a comprehensive program, as a single program, where there were three overlapping programs submitted previously.

I'm somewhat confused as to what to recommend here because of probably the confusion that has gone on with the kidney programs to date, and this certainly applies here. There are problems to be noted that are somewhat local and sometimes somewhat personal, but I think the point brought out by the review committee and the ad hoc committee I think should be noted. The ad hoc panel unequivocably rejected this proposal completely and so did the review committee.

However, they did make some -- and their reason, by the way, is stated, "It's useless at this time to consider expansion of a dialysis program which is already being conducted on an active basis without resolution and an effective way to develop first an efficient transplantation site." What they're saying, as I see it here, is there is no point in going anyplace in Washington, D. C. until you develop some facilities

for transplantation.

The irony of this that I observed when I was reviewing this, is that here in this community that is striving strenuously to develop a kidney program and certainly a transplantation site, we already have three, in the Army, Navy and the Veterans Administration, on-going programs with typing and so forth; and now we're trying to set up one for the civilian population. And if we're trying to centralize this, maybe we ought to send a message across the street that they ought to centralize their own.

This program was criticized by the ad hoc committee relative to its typing program because this is already being done by some of the services. The panel noted that four tissue typing laboratories are already in the area and they felt that federal funds will not change the organ donor population which has heretofor been tapped at a rate of only 1.25 organs per transplanting medical school.

The region confronts a dialysis bottleneck because there is no transplantation.

Rather than reject this, I would like to have the panel certainly with advice from those who are more knowledgeable about this than I am consider what can be done to help this area develop a transplantation facility and consider possibly recommending a site visit by the ad hoc kidney panel, the local nephrologists and surgeons and representatives from medical

schools.

As a member of the site visit committee I can tell you that the impression I received -- whether it's still rampant, but it was then -- that there is an old school tie business going on here, and a little bit of "Cabot and Lodge" business and I think maybe with the ad hoc committee sitting down with the local representatives some sort of a program for this area which apparently needs a program of transplantation can be developed.

So if there's any recommendation other than that I don't know what -- I can't put a dollar value on anything because it appears that they already have this in a piecemeal way. There is a private facility, an on-going facility right now, for private medicine, but the program really doesn't tell you how much of a need there is for the indigent population. At least I couldn't find it in the application. It might be there.

DR. PAHL: Thank you, Dr. Hunt. Mr. Friedlander, perhaps with your permission, we might ask Mr. Spear for his comments relative to Dr. Hunt's presentation which may answer some questions you have and if not, we would appreciate your further comments. Matt, would you please tell us about the review panel?

MR. SPEAR: We have from the panel almost the same problems that Dr. Hunt has voiced and the cause is just as he

stated them, and apparently the panel didn't know what to do because -- I don't know whether it shows up in your comment -- we had a little further comment at an earlier stage, in which there was a doubt in the minds of the panel that wanting to go to Metropolitan D.C. and resolve the problems, to whom would you turn? So it was the hope, then, that all else having failed, perhaps the people from the institutions, the senior people from the institutions, if they can be pulled together, as you suggested, and discuss the problem frankly among themselves with a third party group present, perhaps a resolution could be made.

We are a little pessimistic about it with respect to the "old school ties," as you describe them, that maybe that can't be broken down.

An alternative has suggested itself that has not yet been pursued, and that would be to perhaps call in firms of -- incorporation of non-profit groups of some kind who would take it out of the realm of the individual institution and provide them a mechanism to come together at a super-level, and this might work and might be something that could be proposed to them.

As it stands, even though they admitted in their application that one of their great needs is transplantation, the application never got down proposed what would be done. It proposed more dialysis and typing.

DR. PAHL: Thank you. Mr. Friedlander?

MR. FRIEDLANDER: I don't profess to be able to comment on this in the professional aspect of it, but there seemed to be a couple of aspects that bothered me.

First off, what bothered me primarily was the distortion that could occur in such a program, regardless of how effective the proposal might be. When you wind up giving a Regional Medical Program $700,000 for one year in one categorical area, and its total operational funded level is $800,000, this to me is a distortion and it would be terribly difficult to defend in terms of a regionalized kind of general effort to help many people in terms of availibility of quality care across the board.

That would probably be my primary objection to this kind of a proposal within this kind of a program, but that's hardly a helpful thing in terms of meeting the need if, indeed, this is the need.

Then, of course, it occurred to me that as Dr. Hunt mentioned, there are other kidney transplantation, matching, etc., efforts within the Greater Washington Area, and one of them is at the Veterans Administration Hospital. Interestingly enough, if you look at Little Rock and Birmingham and Seattle and Denver, you'll find that this kind of sharing activity with the Veterans Administration and the university is working out very, very well. Of course, those four places have a peculiarity

that Washington doesn't have. They only have one medical school so they all wear the same tie. So I guess that makes it a lot easier. That possibility it seems to me should not be overlooked.

But those are the two primary things, one of them an objection and the other one an observation, that I would add for the consideration of Council.

MRS. WYCKOFF: Does the Veterans Administration have capacity that you could share with the rest of them?

MR. FRIEDLANDER: Well, you see, you don't necessarily have to operate within the given existing capacity as it stands at the moment. That capacity can be expanded if, indeed, there is a need in a community to provide this kind of service and it cannot be met otherwise. So, you see, you don't necessarily have to limit yourself to what capacity you may have at any given moment.

DR. ROTH: The answer to Mrs. Wyckoff's question, however, is yes.

MR. FRIEDLANDER: Thank you.

DR. HUNT: I think in this proposal I think the Veterans Administration has agreed to give them some space.

DR. MARGULIES: There are two issues here which collide with one another. One of them is the spectacular ability of the D.C. RMP to operate without being able to find anybody in need of medical care within the District of Columbia, which is

astonishing. They continue to come in with activities which would lead you to believe that they're operating in the heart of Montgomery County which doesn't happen to be the case. And since they have really been expressing parochial interests of medical schools with close ties there and a rather resistant medical society leadership -- not the medical society -- it creates a problem when you look at a kidney proposal in that environment.

Then the kidney proposal itself has reflected that kind of particulated attitude.

Now, one of the questions we asked ourselves about this, and I think this is really what Dr. Hunt was getting at, is there a way of using this device as a method of bringing together the RMP and at the same time providing a reasonably well-integrated effective kidney program, or will the two actually be in collision with one another and nullify the efforts of both? I think that until one makes the effort to bring the principals together and discuss the potentialities, it's like to remain at an impasse.

It might be a way of helping matters, or when you look at those figures which Ed has just laid out, it might be a way of simply diverting what energy there is in the RMP into a big proposal which is attractive.

DR. MERRILL: I think, speaking as perhaps the last remaining kidney expert here, one of the problems that's

represented by this proposal has already been touched on, the fact that we don't have the figures for someone who's spent a lot of time in transplantation and dialysis, and I can make nothing whatever of the summary, nor, unless I know the exact capability of the Veterans Administration, can I comment upon the feasibility of the Veterans Administration alone handling the need of the D. C. area in transplantation.

It's been mentioned, for instance, there are other areas in which they're doing transplantation. The Army and the Navy have been quoted. The head Army transplanter you saw on the photograph taken in Watts. He's now in Watts. And the Navy transplanter was in the Holiday Motel the day before yesterday on his way to Tulane.

So these are the kind of figures I think we need, along with the number of patients on dialysis who might be suitable for transplantation, and also the tissue typing facilities; there are some problems about that.

I would like to know, if I might, about the establishment of a community home dialysis training. Does this mean new bricks and mortar or does this mean new funding and operation and on-going operation within a hospital or several hospitals? This would be important.

I think that probably the Washington area does need a coordinated dialysis and transplant center and I think the suggestion that people get together on this is an excellent one,

and in spite of the fact that money tends to be a dirty word, there is no greater catalyst for cooperation than funding-- I can promise you -- in this or many other areas. And I would think that if it is within the scope of RMP to suggest this and implement it, it would be well worth doing.

DR. HUNT: If somebody will name the figures and get them together, I'm willing to recommend it, if that is the catalyst. I think, having been there, that's a very good point.

DR. KOMAROFF: Do we have to name a figure or just indicate our sympathies for a revised proposal along these lines?

DR. MARGULIES: Well, there is an interesting grapevine in the kidney area which I suppose must be associated with the number of tubulars which are available, but somehow, whatever action we take is well disseminated before it's even been typed out, so that they are aware in the District of Columbia of what attitude this Council has not yet expressed but will express before this discussion is over.

DR. HUNT: I might tell you that doesn't work in reverse, because as a site visitor I rejected an ambulance program that was recommended by a local Congressman and, by God, I heard about it, but after the fact.

DR. MARGULIES: Yes, I know about that, too. I think if this Council came to the conclusion that the proposal is one which requires an extraordinary kind of review from the technica

point of view, from the Regional Medical Program point of view, an effort to try to resolve differences, and was willing to reconsider it then after that kind of further discussion, it would be a good idea. I know that we've already had the review and I know there have been all sorts of actions, but they have been inadequate to this extraordinary circumstance I think. Matt, does this seem reasonable to you?

MR. SPEAR: I think that's very good.

DR. MARGULIES: Bill, I think what you were talking about in your presentation is the way to proceed and we don't have to attach any money to it, but rather let them realize that there is something which can be done if they'll make sense.

DR. HUNT: Well, if there's such a thing as planning funds, I think they should be made available.

MRS. SILSBEE: We did that before.

DR. HUNT: We did that in the screening process programs here I know.

DR. MARGULIES: I think what you can do, if you want to, is disapprove it but give them the opportunity to come back with a better plan.

DR. HUNT: I think that's a pretty harsh treatment here because they're really suffering down here. We did that to them pretty badly last year on their general program and I would rather hold their program in abeyance pending a rereview after the site visit of the ad hoc panel and local interested

individuals, so I would move that.

DR. PAHL: Is the motion for deferral and reconsideration after site visit and supplemental material becomes available?

DR. HUNT: Yes.

DR. ROTH: I'll second it.

DR. PAHL: The motion has been made and seconded.

DR. HUNT: Consultation and site visit by the ad hoc committee?

DR. PAHL: Yes, by staff and the ad hoc committee.

DR. MARGULIES: They come in for a full review in November so this will work out all right.

DR. MERRILL: Is there any real advantage to having this proposal renegotiated, or rather what really needs to be done, having a brand new proposal based on some sound advice from people who know what we want to do and submit it?

DR. HUNT: That should be part of the recommendation I think.

MR. SPEAR: You know, the panel wasn't terribly disappointed with the application if they had pursued the point of providing a out for their dialysis patients with transplantation. The comment was made, "If they would just do one center, give some egress from dialysis, we could approve any one of the dialysis projects. Without this egress, something to add on to the backlog, there was no merit, so the application

contents were not totally without some use.

DR. MERRILL: Would that require, then, simply revising the original proposal to add transplantation or would it -- it seems to me it would require considerable revision to it in terms of tissue typing, availability of centers, inter-unit and inter-hospital cooperation and a good many other things. I think these things would have to be spelled out pretty carefully.

MR. SPEAR: This might well be done. One of the concerns was who has had a hand in planning the project that came in, and this was one reason that it was specified that it was desired possibly that the chief surgeon, chief of medicine, and chief pathologist at each of the institutions be at such a meeting.

DR. HUNT: I would amend my motion to include that. That's a very important point because it speaks to a relatively important part of this problem.

MR. VAN WINKLE: I would like to point out that the planning goes back in the District to my knowledge at least five years, and we did meet with representatives of all of the medical schools, all of the interested parties, the district health department, and there was planning money made available by the City Health Commissioner at that time, I think some $40,000 or $50,000. They assigned a resident full time to develop the planning on this. They met with us repeatedly.

This has been going on on a continuous basis. This is the second proposal that came in. They did come back to us for advice again. I can say that advice was not followed. And the young physician who was in said, "I fully understand what you're speaking about; I understand the need; and I could so do if it wasn't for this 'tie' situation." He says, "I'm not permitted to do so." And I don't really think that just going back and replanning -- it's been planned to death.

They're going to have to recognize what their problem is, and the problem relates to the patient who needs the service, and I think that's what they're going to have to address themselves to.

Now, I'm not sure -- I have even suggested that perhaps it should be a directive effort and perhaps we should go in there and do it through the contract mechanism, Dr. Margulies, rather than through the grant, because at least you can be directive in terms of placing emphasis on what should be done.

DR. HUNT: I don't know whether this is the time. I was going to address myself to this later on. But this problem, in a different form, it seems to me, has come up on every kidney proposal that we've talked to in one way or another. It appears that we have set up rather strigent regulations and directives relative to a categorical disease that we're having a lot of trouble getting them implemented. We're having trouble

finding the people and it's expensive.

As much as I abhor authoritative medicine coming down from up above in the "Big Daddy" approach, I sometimes feel that maybe that this is what we ought to be doing here, because we're getting into a very, very expensive facility and we know that most of the 55 programs in RMP can't fund a thing like this and carry it on locally after we get it started; and therefore, I think -- and this is a facility that we're not providing in our health care picture throughout the country -- therefore, this is the time and place, I think, for public authority to step in and say, "We'll provide this." And I think if we do this, then we can fit the plan to suit our own regulations, and what we're trying to do right now is set up a bunch of strict regulations that are going to cost a lot of money and we can't find the people to do them.

So I wonder if we shouldn't give some thought to whether or not this isn't the type of health problem that is national in scope, and we have a capability, limited as it is, to handle, that we shouldn't use a more directive and authoritative -- what you call the contract approach -- to handle it. We can't establish transplantation centers in all 55 Regional Medical Program districts. There's no question about that. And I think our job is to provide the facilities and we have to get the patient to the facility.

I'm even concerned right here in discussing this, when

I learned that Virginia has their own transplantation facility and it's not too far to Virginia from here. So that I think we have to look at the geographical area and if it's logical for two or three RMP programs to joing together to solve a program I think it's logical for the advisory committee to recommend that in contiguous areas we will set up the facility but you're going to have to bring the patient to the facility.

I strongly encouarge the use of volunteer help and the help of the local RMP program to implement what is handed dwon from above.

DR. MARGULIES: I think probably what we need, if I may suggest it, is again -- and we haven't done this in quite a while, and not in quite the form that I'm going to suggest it -- is to use a portion of the next meeting of the Council to bring us a little more up to date on what are the problems interfering with the development of these kinds of facilities; because they are only partially those that you've identified.

Certainly, one of them is the availability of competent people in a field which has advanced very rapidly and in which the expectations have exceeded facilities, individuals, skills and so forth; and I think it would be most appropriate if the Council did have some time next time around on that issue. Because the ad hoc committee has been uniformly -- not uniformly, but very frequently and overwhelmingly disappointed with the kinds of proposals that it's been reviewing, and if

that's the case, then we have a responsibility of trying to decide when then do you do about it; and there are a variety of ways in which we could approach it.

DR. HUNT: I would just add one personal experience to this to get my point across. There has been -- one of the proposals that we had here from the Foundation is a dissemination of knowledge program. I can tell you that that can stimulate some pretty good problems.

I attended, as a public official, a meeting relative to the health problems in our county in Western Pennsylvania, and as a result of an advertising program and calling attention with scare mechanisms about the number of people that are dying because they don't get dialysis because we don't have something to take care of this person, we had a massive influx of people that wanted kidney transplantation and dialysis facilities in every hospital in Allegheny County.

This is the kind of misinformation and hysterical information that we can get out, and it's wrong for various agencies to carry on this kind of a promotional agency without knowing what they're doing. We can avoid that by taking the bull by the horns and deciding what should be done, as much as I abhor that type of approach in other cases.

DR. PAHL: I'm afraid that my blood sugar is low and I would like to have someone please rephrase what is the Council's motion. Is it for disapproval with staff assistance

and reconsideration at November Council meeting; is it for deferral with staff assistance and reconsideration at the November Council meeting; or is it some other statement which I haven't included in those two?

DR. HUNT: Well, I'll make a motion and you can correct it as I go. I move that the action on the application be deferred. I recommend that an ad hoc -- a site visit be held to be attended by the ad hoc committee on renal disease, and that the local participation among others should consider -- should include the chief of medicine, the chief surgeon, and the chief nephrologist of each of the applicant institutions. I think that's enough.

DR. PAHL: Thank you. Has the motion received a second? Is the motion seconded?

DR. OCHSNER: Second.

DR. PAHL: Is there further discussion on the motion?

DR. MERRILL: Could I ask of the gentlemen at the head of the table what they think would be the most effective mechanism to getting action? Would it be to turn it down completely and ask them to come in with a brand new program, or to defer it to consultation and site visit?

DR. MARGULIESS: I think it pretty much depends on what message we give them, and if we reflect to them the concerns of Council, we can achieve the purpose of a completely reestablished, rethought-out program, if they're capable of doing it.

If they're not able to do as we suggest we may have to come back and say it didn't work.

DR. MERRILL: Just one other question here. What is the grantee for the application? Who is the grantee here, the applicant institution?

DR. MARGULIES: It's the RMP, the District Regional Medical Program, so it would be in that setting that the discussion would take place.

MRS. WYCKOFF: Isn't it important who convenes this group, whether you get cooperation or not? Wouldn't it be a good idea to arrange that the convenor not be the one that was doing it before?

DR. MARGULIES: Well, I think that what we will have to do in this case is make it an RMPS issue, rather than a kidney division issue alone, and it would be the RMPS to the RMP with the kidney issue and the RMP involved, so it's going to be a major kind of discussion.

MRS. WYCKOFF: Yes.

DR. PAHL: Is there further discussion?

(No Response)

DR. PAHL: If not, all in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

The next application is New Mexico with Dr. Schreiner as principal reviewer and Mrs. Wyckoff as backup reviewer.

DR. SCHREINER: The New Mexico application and the review makes two excellent points; one is the value of a good site visit and the other is the power of the DeBakey principle, "Send me the money."

I went out on this site visit and I believe Tony did too, and he may have some additional comments which I would welcome. My own impression, having been on a lot of site visits, was that it was a rather unique response to the site visit in that the response started happening while we were there, and as the very early interplay came out between the site visit committee and the region they not only accepted some of the things but they began to do something about them right on the spot. I think this was also significant and borne out in the letters and literature which has come in subsequent to the site visit which shows I think some very constructive turn of events.

The power, the money, just to put in perspective, my computer here comes up with an imaginary number which that for Illinois we're spending something like 10¢ a person, and for Texas about 15¢ a person, and for the New York State Regions about 50¢ a person, and that we've been spending in New Mexico roughly about a dollar a head.

Now, this has more than that figure would imply in terms of its impact because unlike some of the other programs that we've talked about where there are heavy Medicaid programs and heavy insurer programs, there's almost nothing going on in New Mexico. I think it's got one of the highest percentages of uninsured populations in the country. There are whole areas where there simply are no facilities at all, so we're not talking about whether sophisticated medicine can be brought, but we're talking about who's going to pay for the pickup truck that they throw the body in out there.

Sandobel County, for example, has an area that is larger than Connecticut that has something like 60,000 people or less, and there are no emergency medical services and no installation, so that this is quite a different ballgame in terms of deciding whether you're going to use this sophisticated method or that sophisticated method. It's a question of whether there's going to be any method going on which is a much more basic kind of decision.

So we found I think some defects in the program as it has been operating. One of the paradoxes was the coordinator which we have stressed the importance of. The coordinator here was a paradox in that he had not moved along with some of the missions that have been expressed by the Regional Medical Program on the one hand; on the other hand, he did have a remarkable sort of personal rapport with a lot of the people involved

around the state. So this put us in sort of an awkward position. It turned out, however, during the site visit, the dean, who had kept hands off the program for a couple of years, realized that he would have to give it some support and get to work on the likelihood of Dr. Fitz' resignation which has subsequently happened, and started a search committee and they've already secured a Dr. Gay who is a neurosurgeon who no longer practices and is willing to go full time with this program, and at least all the reports I've been able to get on him are very, very favorable. I believe that he worked with Dr. Millikan at one time in his career so he should have learned something.

The other part of the program that we criticized has to do with the fact that they had a number of good projects but they didn't have them molded into very good programs, an excellent example of which was the fact that they had a pretty good cancer registry going which was covering something like 90 percent of the region beds, and the most talented scientist we met in the ones we came up close with was a hematologist who was getting very substantial NIH funding and going into a big lymphoma project and wasn't using the cancer registry. So you could only come to one of two conclusions, either he was not relating his project to the program or else the cancer registries don't have very much practical importance when it comes down to a point of that sort. I don't know which conclusion I'd be willing to come to, but I think that it certainly would have been

expected that he would have worked better with this inasmuch as he did have here in project 17 a proposal for a leukemia lymphoma treatment program.

We could go on like that. There were some very, very strong points in the program, one of which -- the best of which perhaps was the emergency medical care system which was very unique and being worked out by Dr. Hendrickson who was a very dynamic person and saw these problems. It's hard for an Easterner to appreciate these problems. For example, they can't even use radio controlled ambulances up in the Four Corner area without having -- the distances are so great and the mountains are -- the terrain is so rough, that they actually have to have relay stations to amplify the message just to get a plain old radio telephone call through from an ambulance to a nearby hospital. So they have all kinds of special technical problems and he seems to be very aware of this and I think the only question of the future -- there's no question about the quality of that program and the imagination of that program.

The only question about the future was whether he would be able to lean on the emergency medical care legislation, and some of the grants that are being made now by the Department of Transportation and Defense to implement emergency medical care facilities -- whether he would be able to get any help from this, and I would think that we ought to continue to look at this to see whether we might be putting more money into the

programming of his activities for the sake of enabling him to get the help elsewhere, as a means to an end rather than as to the end in itself of funding the program.

With all of this, I would feel that the site visit report here is very accurate and quite up to date. The kidney program was very disappointing to us and, as I have dug into it, it seems to me that what happened is that they have two different groups of nephrologists with some polarization and Dr. Fitz really didn't want to take the effort in his waning days to get them together, so there really wasn't a coordinated kidney proposal.

Subsequently to our site visit, they have come up with a couple of pretty good ideas, and they are in the book here and don't look bad. The result is, however, there's no money in the grant for this and if they are not given developmental component as the review committee recommended, then they would have no way really of moving into this area and I think we would be defeating our constructive purpose because they're well on the way to put together some fairly good proposals. They have some facilities there and I think to encourage them, what I would recommend, is the overall figure of the review committee but add $30,000 or $40,000 as a specific funding for the kidney programs which have come in subsequent to the site visit which I think would get them started in that particular area -- give them the incentive to get them started in that area.

The recommendations of the review committee and I think the conclusions of the site visit were that it would be a good idea to reduce their overall request significantly for a one-year period to act as a further stimulus as to how serious we are in having them mean business in their reorganization.

As I say, all the indices since we were there have been very, very positive and very, very constructive, and I feel that they will be able to come in with a very strong program in about a year. They simply weren't ready for a site visit and weren't ready for the review as they should have been, and this was partly the work of the coordinator.

I'm going to move that we accept the recommendations of the review committee for $850,000 funding for one year, but that we add a $30,000 to $40,000 component for the kidney which came in after the site visit.

MRS. WYCKOFF: Second the motion.

DR. CANNON: $30,000 or $40,000?

DR. SCHREINER: $40,000.

DR. PAHL: The motion has been made and seconded. Dr. Komaroff, you were on the site visit. Would you care to make any further comments?

DR. KOMAROFF: No. I haven't seen what's come in on the kidney proposals since then, so I'd have to defer to Dr. Schreiner.

DR. PAHL: General discussion, Council or staff?

MRS. SILSBEEN: Have we received anything -- request for kidney money? I've not seen it in grants review.

DR. SCHREINER: They were outlines of a plan but there was no budget enclosed with it.

DR. KOMAROFF: The only reservation I have about adding money is that the region has had a fairly significant unexpended balance in the last several years, that there was indication among the projects that they requested continuing support for that they could achieve some savings by just consolidating staffs and coordinating projects more closely, and they might be able to find that $30,000 or $40,000 out of the $850,000 because they have had unexpended funds in the past.

DR. PAHL: Mr. Chambliss, do you have a comment?

MR. CHAMBLISS: I have a comment. It's taking a different tack from what has already been expressed, but I have the feeling that the site visit team was not totally impressed with the way in which the region of New Mexico is getting at making available to more people basic health services. You note that in the blue sheet that there are approximately 24 percent of the state population of chicanos and Mexican-Americans and Indians, and the region really has not as yet turned its attention to the health needs of that segment of the population, and the site visit team did make comments in that regard.

During the visit, mention was made that there in New Mexico was a good amount of health restlessness, and we pointed

that out to the dean and he responded by saying, "We don't have unrest here. We're not a big city of the East. We don't have the complex problems that they have in other areas of the country," and I might add, before we could hardly leave the city, the unrest had broken out in Albequerque.

We were simply trying to say I think that there are different kinds and different dimensions of health problems that the region should begin to look at, and certainly we feel that under the new leadership they will give some attention to these areas.

MRS. WYCKOFF: Is there any Migrant Health Act money being spent in Four Corners?

MR. CHAMBLISS: Very little. As a matter of fact, we found a project that was being funded by the Indian Health Service just before we made the site visit. It was to provide Indian children with hearing aids. My comment was that, "Is there not a greater need for basic health services which would include hearing aids to those who need them?" But there are programs going in but there's no comprehensive planning in totality to meet the kinds of migrant health needs that you would consider.

DR. SCHREINER: I would certainly concur in Mr. Chambliss' remarks and I think this was really what was behind our recommending and what was behind the review committee recommending a one-year grant versus a three-year grant. In

other words, this clearly puts them on notice that there is to be some program coordination, and the fact that we lowered it by a quarter of a million dollars is a modest slap on the wrist of our evaluation of what has been going on.

But I think for a new coordinator faced with two groups that he's got to pull together and he's only got a year to do it, $30,000 or $40,000 planning money would be a little bait I think for this incentive.

MR. ROBERTSON: I believe the record will show now that it's true that in the past they've had a sizeable carryover of funds. I think it will also show that this current year that the figure would be one that we could all live with. It's certainly less than $30,000, and they have places where they could use that $30,000 if rebudgeting is completed within this current year. So it's entirely possible there will be no carryover of funds left at all at the end of this year.

They have recently run their figures on it and the only reason they have money left over is that they over-reacted a little bit to the budget cut. With the new coordinator, Dr. Jim Gay, his attitude is one of expanding the program to the peripheral areas, and there's no question in my mind about it.

MRS. WYCKOFF: Have they made any application to the National Health Service for personnel? Have they done anything about that?

DR. KOMAROFF: No, and they had an ideal opportunity in which to do it. They're thinking about in Rio County a rural health center which would use paramedical personnel and could very well have used these two-year men.

MRS. SALAZAR: We have just a feedback letter stating that the New Mexico RMP has not made any inquiry about the Health Services Act but the "B" agency has.

MRS. WYCKOFF: They ought to get in line right away.

DR. PAHL: The motion is for the acceptance of the review committee's recommendations plus an additional $40,000 with the recommendation that this be for the support of the newly proposed kidney activities. Is there any further discussion?

MR. MILLIKEN: I wonder if that extra $40,000 should be in the form of a site visit or a consultant to go and work with them.

DR. MARGULIES: I think you might want to consider whether any additional funds should be left unimpeded so that the new coordinator and the new group could have an opportunity to move in the other directions or in the kidney direction, whichever they prefer, because they have a lot to do there and obviously with the issues -- particularly which Bob Chambliss raised -- they may really prefer to move in that direction.

DR. CANNON: In other words, don't earmark the $40,000. Just give them an extra $40,000.

DR. SCHREINER: It's meant to be a developmental fund to make it possible.

DR. CANNON: I'd go along with an amendment to the motion if you'll accept it, and call for the question.

DR. SCHREINER: All right.

DR. PAHL: All in favor of the amended motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

We will now turn to the Tri-State application, with Dr. Roth as principal reviewer and Dr. Cannon as backup reviewer.

DR. ROTH: Well, I believe that the Tri-State supplementary grant application is relatively simple. This has been reviewed by the ad hoc committee. It has developed cooperative arrangements with Vermont and Northern New England, with Connecticut, and it's main unhappiness is it comes out with a name like NERCRO, which sounds like something indecent in Iclandic.

The Council has already approved the Northern New England application, therefore, as you will notice, that the recommendation on page 4, the blue sheet, of the site visit, is that, although there were some extravagances in some aspect of

the proposed budget, that they considered that the revised budget proposals should be approved; that if Vermont or Northern New England was approved, that there be certain additional deletions in the Tri-State proposal. On the final page 5 they have presented figures which reflect both these considerations, with the deletion for the Vermont positions; and I would therefore recommend approval of funding at the rate proposed on page 5 of the revised application.

DR. PAHL: Thank you. Dr. Cannon?

DR. CANNON: I second these recommendations.

DR. PAHL: It has been moved and seconded to accept the recommendations from the review committee. Is there further discussion by Council or staff?

DR. ROTH: I can only say, in addition, that this represents quite an accomplishment over a period of the past year and a half in doing the kind of thing that I think Bill Hunt wants done in the Metropolitan D.C. area.

When we site visited up there, there was a tendency of Rhode Island, for example, to go its own way with Brown University insisting on having a transplant-dialysis program totally independent of the very nearby Boston thing. So that I assume that this represents a meeting of the minds and some compromise on these issues. Perhaps staff can fill that in for me.

MR. MC KENNA: Well, I think you're right. There has

realizaation of the need for this.

DR. PAHL: Is there further discussion?

(No Response)

DR. PAHL: If not, all in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

We turn to the final action before us with Dr. Cannon as principal reviewer, Dr. Hunt as backup reviewer, this application from the National Kidney Foundation.

DR. CANNON: I'd like to ask before George leaves if he would briefly give the Council some information, specifically how does the National Kidney Foundation differ from other foundations, the National Foundation for Multiple Sclerosis -- and there are hundreds of them. Is there some difference that we should perceive?

DR. SCHREINER: One major difference is that it's regionally organized rather than by states, so it differs from Cancer and Heart in that respect. So it does get into some of the same distribution and personnel problems that the RMP does. Some of the discussions we have about the coordinators reminds me of the affiliates' relations committee because we can pick out Ohio and Susquehanna Valley and the same trouble

there has troubled the Regional Medical Program.

DR. CANNON: It is a professionally controlled group or lay controlled?

DR. SCHREINER: Well, it's jointly. I would say it's closer to the -- the organization is a little bit different than the Heart Association. There is a Scientific Advisory Board which is completely scientific and academic and non-geographical. There is a Medical Advisory Board which is representative, with one elected by the Medical Advisory Boards in each region -- in each affiliate. There are about 41 affiliates. And the Board of Trustees is a mixture of doctors and lay people. The power -- the corporate responsibility is in the Board of Trustees.

DR. CANNON: We have a request for a million dollars to spent over a three-year period of time. The request comes from the National Kidney Foundation. The objective is to have a national program to increase the number of cadaver kidneys for transplantation by seeking the active support of 50 million Americans and the medical community.

It has two projections. One is a national project, an expansion of the existing educational program within the National Kidney Foundation. The second is local projects at the state or major metropolitan areas designed for more controlle and intensive effort than is proposed at the national level. In essence, they would like to have this million dollars to spend

in a three-year period of time beefing up an educational program to enhance the donor organ -- voluntary organ donor program for kidneys and to educate the people.

This would be under the executive director who would, in turn, hire a full-time project director and other personnel to carry out the message. There's also a request for some equipment, like desks, chairs, filing cabinets, typewriters, etc.

It's my feeling that while this is a very worthwhile and needed projection, that the enhancement of cadaver kidneys must be forthcoming if you're going to get a program of transplantation around the country to be effective, I do not see how we can at the present put money into a foundation for this purpose, because there are so many foundations and so many purposes that it would continue on infinitum.

So I would recommend the disapproval of funding. There's two alternatives to frank disapproval. One is that, if you really want to do this, there was earmarked $15 million for kidney in the last legislative act. Is that true? What happened to that?

DR. MARGULIES: No. What it finally ended up being was no more than $15 million will be spent for kidney. There was no earmarking.

DR. CANNON: There wasn't any earmarked funds? Well, if there are no earmarked funds, then I don't think we can get

around the requests from other foundations. I thought that was a possibility.

The other possibility would be using Regional Medical Programs in an educational way, the existing Regional Medical Programs.

I have a lot of sympathy for the program but I just don't see how we could open the gate.

DR. ROTH: I'll second Dr. Cannon's motion to disapprove for a somewhat different reason. It seems to me that this Council should take a rather pragmatic attitude, that before we start concerning ourselves with building demand for transplantation and dialysis and compliance on the part of those who would provide kidneys, we should have somewhat more assurance that we've got that in-between step of the facilities and the people that can make use of it and provide the service. I think therefore, this is premature.

DR. PAHL: The motion has been made and seconded to concur with the recommendation for disapproval of this application. Is there further discussion by Council?

(No Response)

DR. PAHL: All in favor of the motion please say "Aye."

("Ayes")

DR. PAHL: Opposed?

(No Response)

DR. PAHL: The motion is carried.

Before we depart, I'd like to just take a moment and thank Dr. Kleiger and Mrs. Hicks who handled the logistics of the meeting. I'd like to commend our own staff for their effective participation, and I'd like to thank the Council members, both those who were here earlier this morning and those remaining, for fitting this into a very busy summer schedule.

I don't know whether there's any more business that the Council may have with us. I believe, Harold, we have no further business to bring before the Council.

DR. MARGULIES: I can assure you it will be coller in November and next August it will be just as hot. Thank you again very much.

DR. PAHL: Thank you all. The meeting is adjourned.

(Whereupon, at 1:20 p.m., the meeting was adjourned.)