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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGIONAL MEDICAL PROGRAMS SERVICE

REVIEW COMMITTEE

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Wednesday, 12 January 1972

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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REGIONAL MEDICAL PROGRAMS SERVICE

REVIEW COMMITTEE

Conference Room E,
Parklawn Building,
Rockville, Maryland
Wednesday, January 12, 1972

The meeting was convened at 8:40 o'clock a. m.,
Dr. William Mayer presiding.

C O N T E N T S

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P R O C E E D I N G S

1
2 DR. MAYER: I think we might begin. Did everyone
3 get a copy of the agenda on the way in?

4 The first item on the agenda is the introduction
5 of Mr. Robert Toomey as the new member on the Committee.
6 Mr. Toomey isn't here yet, and we will introduce him when he
7 comes in.

8 As some of us were discussing at breakfast this
9 morning and last night, our hope is that the agenda by the
10 changes in the review process will have provided us a little
11 degree of freedom in terms of time as we move through things,
12 and it would be my hope that we would have some time to
13 discuss some issues that many of us have had some thoughts
14 about. Whether we will be able to get at some of that this
15 morning or might more appropriately hold on to it until the
16 end, I think we will just use our own judgment as we go
17 along.

18 With that I would like to turn it over to Harold
19 Margulies for the report of the Director. Hal.

20 Can you all hear back there? We are working without
21 sound.

22 DR. MARGULIES: I will depend upon my voice carrying
23 far enough, and then if the amplifier comes on I will de-
24 amplify myself.

25 As you can see from the agenda, there are a few

1 general items that I want to bring for your attention, and
2 I do know that, as Bill has indicated, you would like to have
3 some further discussion, and I see no reason why we shouldn't
4 get into whatever issues are of concern to you.

5 I think most of you are familiar with the fact
6 that we are going to have a meeting of the coordinators
7 in St. Louis. This is being set up in such a way that there
8 will not only be a coordinator present from each program
9 unless there is some major conflict in his planning, but two
10 other people, which means that there will be in many cases
11 a member of the Regional Advisory Group present as well.
12 And the conference was set up around the hope that we could
13 develop during the process of our deliberations a kind of
14 professional discussion rather than one which is dealing,
15 as they so often have, with fiscal issues or with procedural
16 issues or with general questions which have to do with
17 federal practices.

18 Now the latter will not be outside of the discussion
19 because we will have present for the meeting Dr. Duval, who
20 will be speaking on Tuesday night, Jerry Reeso, who is the
21 Deputy Administrator for the development part of the Health
22 Services and Mental Health Administration, and we will be
23 discussing some of the same things at that meeting that we
24 are going to talk about here, including such things as the
25 fiscal outlook for '72 and some of the major program

1 interests which have been evolving in RMP and in the Health
2 Services and Mental Health Administration.

3 We have only in the last few days finally received
4 the confirmation of our budget for the current fiscal year,
5 and we still have not completed our spending plan which has been
6 developed, is under discussion, and should be completed
7 within the next few days, God willing.

8 The total appropriation which was passed by Congress
9 has been released for RMP. That means a total of about 145
10 million dollars. Of that total about 135 million is available
11 for what are not considered direct operational costs, and there
12 have been placed on that total 135 million dollars certain
13 specific and designated uses for funds which I would like to
14 go through with you for a moment.

15 One of them is -- and these are fairly final at the
16 present time, some room for modification, but not much --
17 one of them is seven and a half million dollars for area
18 health education centers. Another is eight million dollars
19 for emergency medical services. A third is 16.2 million dollars
20 for health maintenance organizations. And the fourth is five
21 million dollars for the construction of a cancer facility which
22 was an earmarking out of the last appropriation process. This
23 leaves us something in the range of 97 million dollars, 97 to
24 98 million dollars, to which we will add in our planning for
25 the current fiscal year an estimate, which is difficult,

1 extremely difficult this fiscal year, of what funds will be
2 available, because they have not been expended during the
3 current fiscal year or during the past fiscal year. In other
4 words, what has been considered carryover money. So we are
5 talking about something in excess of 100 million dollars for
6 the grant process.

7 Now since that represents a very significant
8 increase over the last fiscal year it means that the general
9 environment for spending in the RMP has changed considerably,
10 and it means the fact that we are into mid January before we
11 get this confirmation of news raises some serious questions
12 which we will have to talk about during the next few minutes.

13 Now let me go back over some of those earmarkings
14 to get an idea of what the issues are involved in spending the
15 funds because they are being managed in a slightly different manner
16 from what we had expected in the past.

17 As you remember, the area health education center
18 concept has been a subject of uncertainty for some time because
19 there was introduced the administration bill which proposed that
20 the area health education centers be funded out of the Bureau
21 of Education and Manpower Training in the National Institutes
22 of Health, and so in the budgetary process there were funds
23 identified out of the Bureau's budget which are for AHEC.
24 There were also funds identified out of our budget for the same
25 purpose. There is now being developed and there should be

1 completed within the next 48 to 72 hours a process of managing
2 the area health education center out of both resources by a joint
3 review process. This will allow us to have a single place
4 to which applications for area health education centers will
5 go, a method of deciding whether or not they are reasonable for
6 joint funding or better designed for funding under RMPS
7 or under the Bureau. There will be a joint kind of site visit and
8 joint review process involved. It is not certain at this time
9 how much of this will be done by contract and how much by
10 grants, and that question is still under discussion.

11 There will also be developed joint agreement on a
12 set of guidelines describing specifically what is anticipated
13 in an area health education center, and those guidelines are also
14 somewhere near the point of completion at the present time.

15 There have been significant differences between the
16 position of RMPS and of the Bureau, in which the Veterans
17 Administration has been much closer to the position of RMPS.
18 Over time those differences have gradually disappeared, so we
19 appear to be talking in general about the same thing.

20 When that process has been completed and when we
21 get an agreement on guidelines and on joint process we can
22 begin to look specifically at funding for the area health
23 education center. And that process I will get back to in just a
24 moment.

1 of decision which has grown out of considerations in HEW and
2 the Office of Management and Budget. There is an agreement A
3 under section 910 RMPS can very easily get into the
4 emergency medical service activities. As you know, we have had
5 elements of EMS in various programs around the country for
6 some time. In order to manage that in an effective fashion
7 there was created in HSMHA, again in the Development Division
8 which Mr. Reeso manages, a committee to insure that EMS
9 activities would appropriately involve other programs in
10 HSMHA which are deeply concerned with emergency services.

11 There has been for some time an activity in HSMHA which
12 is confined to emergency services. There is the National
13 Institute of Mental Health which, of course, has some major
14 suicide prevention programs and related kind of crisis
15 intervention activities. Maternal and Child Health Services
16 is concerned, among other things, because of poison control.
17 And this combination and some other activities in HSMHA are
18 being combined in the form of a general steering committee in
19 which RMPS is active along with CHP.

20 The project responsibility for emergency medical
21 services in this arrangement will be in the Division of
22 Professional and Technical Development in RMPS, and there will
23 be again a decision made over a period of time regarding
24 how much of the activities initially to develop emergency
25 medical systems will be by contract and how much by grant.

1 Now very closely related with this is the mass
2 activity which we have never discussed that I can recall with
3 this committee. That is a program which has been a joint
4 activity of the Department of Defense, the Department of
5 Transportation, and HEW, in which RMPS staff has been involved
6 as the HEW part of it. And it has had a considerable amount
7 of publicity and I believe a considerable amount of effectiveness.

8 It depends in part upon the use of helicopters which
9 are available by the happy circumstance of having military
10 installations near enough to the area being served so that the
11 helicopters are available, in use, are required in any case
12 for training of military personnel, and can be fit in with
13 local requirements.

14 Now this has not created a system obviously, and
15 in most cases has been available as an adjunct to an occasional
16 emergency medical system rather than one which is well knit.

17 It is the purpose of the present activities which have
18 been under way only for about ten days to foster the
19 development of systematized emergency medical services which
20 cover major urban areas, smaller cities, combinations of cities
21 and rural areas, and some rural areas.

22 There has been set up a process through this
23 committee structure for considering various potentialities, and
24 there will be further action on it and expanding action very
25 likely in the next fiscal year to help develop stronger

1 emergency medical service systems. These, of course, will
2 include appropriate attention to special problems like those
3 of heart disease, stroke, other medical emergencies, as well
4 as the emergencies which grow out of accidents and other
5 forms of violence.

6 The Health Maintenance Organization activity again
7 takes a slightly different path because it is set up under
8 circumstances which require the HMO development to depend upon the
9 use of funds which are currently available rather than on
10 funds which have been appropriated for the specific purpose of
11 HMO.

12 Since we last met or discussed it, or at least in
13 the last few months, there has been established a specific
14 service for Health Maintenance Organizations which is
15 parallel to RMPS and which is part of the development group.
16 It will be their responsibility to develop the HMO's, to
17 identify those groups which are eligible for funding for
18 feasibility studies, for planning, and for development.
19 And RMP funds can be utilized for those kinds of purposes.

20 There will be a combination in this activity of grants
21 and contracts for their development, using some of the contract
22 money for demonstration purposes in HMO's. There will also
23 be contract funds available, we believe, for furthering the
24 development of methods for monitoring the quality of medical
25 care which will be used as a part of the monitoring strength

1 of RMPS and of the RMP's as the programs begin to move from
2 a development into an operational phase. That is the
3 Health Maintenance Organizations.

4 We anticipate that the RMP's will not be involved,
5 as they have not been, in such questions as the organizational
6 structure of an HMO, the reimbursement systems, actuarial
7 data, marketing, etc., but will have a major contribution
8 in the professional aspects of quality, quality monitoring,
9 continuing education, better uses of manpower; and again as we
10 look at such things as emergency medical services will be
11 in a position to develop special demonstration activities
12 as a part of HMO's to strengthen EMS.

13 The cancer facility which is being considered will
14 be reviewed by the next meeting of the Council. We have an
15 application which is in the area designated by Congress for
16 support from the northwest part of the United States in
17 Seattle. There is a site visit which is planned for later this
18 month which will be joined in by a number of programs in HSMHA,
19 by the National Cancer Institute, and by other groups which
20 have been looking at this particular activity; and I think
21 that that review process will probably take place without any great
22 difficulty.

23 Now this leaves us at the point where we can consider
24 a spending plan for the Regional Medical Programs and can con-
25 sider such specific items as the funds which will go into

1 kidney activities. We have proposed, and I believe that
2 we will gain acceptance of the idea, that the funding of
3 Regional Medical Programs in this expanded budgetary year
4 will be based upon the relative rating process which
5 the review committee has developed and will allow us to utilize
6 the funds in relationship with the capacity of the Regional
7 Medical Program to operate at a higher fiscal level and to
8 utilize the funds for effective program development. As a
9 consequence the ranking process which you have developed
10 and which you have been utilizing will be applied totally
11 throughout this process of increase in funding or of
12 restoration of funding where that has been in issue.

13 There are still some programs which are burdened
14 by the fact that their funds were cut during the last fiscal
15 year as a consequence of very limited funding. Wherever
16 appropriate-- and I think this will apply in many cases --
17 we anticipate that those funds will be restored.

18 This should allow us for kidney activities a total
19 of something in the range of eight, eight and a half million
20 dollars for kidney proposal funding which would be consistent
21 with the kinds of requests we have and which would be
22 consistent with the needs of other programs, and for general
23 RMP support.

24 Now this brings me to one final initial comment or
25 discussion, and that has to do with the potential need to set

1 up an additional process or a different time related process
2 for reviewing during this fiscal year. As we are now
3 scheduled there would be a meeting of this review committee in
4 April and a meeting of the Council in May. If we are to offer
5 the opportunity to RMP's to request supplementary funds, if we
6 are to consider new proposals for some of the new areas which
7 I have just brought to your attention, it may be necessary
8 for us to either consider another meeting or to set back the
9 meeting of Review Committee and Council by one month so that
10 we can include a larger number of proposals, so that we can
11 give programs a longer opportunity to develop activities which
12 they may have held in abeyance or which they may not have
13 considered because of the discouraging influence of the
14 reduced funding of the last fiscal year. We will have to have
15 some further consideration of that during the course of the
16 Review Committee meeting today or tomorrow.

17 We are also considering -- and this means that we
18 have a number of things to discuss -- the advisability of
19 using this time when we have additional funding in a relatively
20 short period of time in which to make wise use of it a
21 change from a four times a year to a three times a year review
22 cycle. Now this is, I must make as plan as possible, at the
23 point of exploratory consideration. It is based upon the
24 thought that from the point of view of the staff of RMPS,
25 particularly the Operational Division, if it can be worked

1 out in a feasible fashion -- and we haven't gone through all
2 of the dynamics involved in that "if" -- there would be real
3 advantages in being able to schedule application submissions,
4 site visits, and reviews with an interval of four months
5 between each of these activities rather than three.

6 At the present time with the reduction in staff in
7 all of the federal programs, including RMPS, and with the
8 clear evidence that our reduced staff requirements are going
9 to continue, the workload on the Operations Division is so
10 great that they are spending all of their time and overtime
11 on the process of preparing for review, carrying through
12 review, reporting back the results of review, and then beginning
13 with the next cycle. This means that the opportunities for
14 technical advice, for working with the regions in other
15 ways outside of this review process, are so limited that they
16 are quite plainly inadequate from our point of view and
17 inadequate from the point of view of the Regional Medical
18 Programs. It is a very great problem.

19 On the other hand, if we move from a four times a
20 year, a quadannual to a triannual program, it would mean that
21 we would have to very carefully adjust the workload on those
22 every four month schedules so that this committee, for example,
23 is not suddenly deluged with a large number of total triannual
24 reviews at one time, and can have some reasonable balance in
25 the amount of time and attention which it needs to give to the

1 kinds of program reviews coming before it. And that takes
2 considerable analysis and planning and a great amount of foot-
3 work. If it can be done, however, it provides this kind of
4 advantage for the current fiscal year, and that's why I bring it
5 up in connection with the review cycle.

6 If we were to decide that there is an advantage for
7 staff, for the RMP's, and for you, in waiting one month before
8 we get into the next review cycle it might also be the
9 opportune time if it appears to be worth while to move from
10 the four to the three times a year cycle because this would be
11 the initial stage in doing it. It would provide us some kind
12 of funding flexibility because some of the fiscal years of
13 Regional Medical Programs would have to be changed to
14 accomodate a three times a year cycle rather than a four, and
15 it would allow us to be more flexible in the ways in which
16 we fund them from one fiscal year to the next -- that is our
17 fiscal year -- and would maintain a more even utilization of
18 RMPS funds in this and in the next fiscal year.

19 That last consideration is not an essential one, but
20 in the final management of our grant awards it might be
21 an extremely useful tool. I would not suggest, however, that
22 that be the basis for the decision about whether this change
23 in cycle is worth while. So we really have two considerations
24 in talking about changing the review cycle. One of them is
25 only a partial change, which would be to delay the meeting this

1 year for the next review cycle. The other would be to move
2 at that point to a triannual review -- not triennial, but
3 triannual.

4 These are some of the major considerations that I
5 think are worth considering at this particular point, and I
6 would suspect that you may have some questions to raise about
7 them.

8 DR. MAYER: I only comment, Harold, that as I sat
9 here I was getting warmer and warmer, and I didn't know whether
10 it was the heat of the room or the fact of my anxiety about
11 the magnitude of what you were just saying or of really having
12 a total feel for what you are saying.

13 Let me go back and pick up what I think must be a
14 key issue out of what you have said to this group, and that
15 is the issue of the talk about the expansion of the programmatic
16 efforts of RMPS, you know, striped away from kidney, area
17 health education centers, et cetera, et cetera. What is the
18 magnitude of that component in your best judgment, and what
19 are your thoughts about commitments towards those dollars on
20 a time span?

21 DR. MARGULIES: We considered a number of
22 possibilities, and what seemed to be the best -- and I have
23 to get affirmation of this -- would be to begin with the base
24 of restoration of funds to all RMP's where they have been
25 cut entirely on the basis of budget reduction because this

1 was not last year a programmatic consideration, it was a
2 fiscal consideration. We would then propose that there be an
3 increase in funding for those programs which the Review
4 Committee has rated--we will call them A, B, C, A being
5 highest -- rated at the A level, with the decision being made
6 on the basis of the Council approved level, the present funding
7 level of the program, and what appears to be its capacity to
8 utilize increased funds in an effective fashion. In most
9 cases this would be in the range of about 20 percent, more
10 or less, in that range, for A programs.

11 We would also consider those programs which were
12 rated at the B level, but which in general had a relatively
13 strong review and which in time have appeared to be strengthen-
14 ing their activities, so that they could be given
15 supplementary funding this fiscal year -- immediately, that
16 is -- on the basis of the strengths which have been identified
17 and which appear to justify it.

18 Those programs which are rated C we would not be
19 able to award simply because we have increased funding
20 because there is no intention of using this money in any way
21 excepting to maintain prudent growth of Regional Medical
22 Programs. If we should get to the point, Bill, where we
23 couldn't use the funds effectively without giving them to
24 programs which don't rate it we would prefer to return the money to
25 the Treasury, which is something that no program likes to

1 think it is going to do. But we would be consistent.

2 DR. MAYER: We did in '66, you know.

3 DR. MARGULIES: Yes. It has only been done once.

4 DR. MAYER: Let me ask two additional questions.

5 One is how much money are we talking about, and two is who
6 is going to make the decisions and by what process.

7 DR. MARGULIES: We are talking about for the money
8 which is used to maintain the Regional Medical Programs a
9 total grant level of approximately 100 million.

10 The decisions on how much money goes to the
11 program will be carried out the same as they have been and
12 will be. These are administrative decisions. They represent
13 essentially the decision of the Secretary, which means the
14 decision of HSHMA in this particular case, based upon the
15 level, the relative ranking of the programs which have been
16 developed through the Review Committee.

17 DR. MAYER: Well, I think in terms of increments.
18 I need to have the base off of which 100 million compares
19 with.

20 DR. MARGULIES: It compares with last year.

21 DR. MAYER: Which was--

22 DR. MARGULIES: Approximately 70 million.

23 DR. MAYER: And you are speaking --let me see if I
24 am clear then. What you are saying is you are thinking about
25 incrementing commitments towards RMP's of approximately 30

1 million dollars then over a time span that presumably is
2 before June 30, 1972, is that correct?

3 DR. MARGULIES: No, what we would propose to do is
4 to first restore funding, add funding to programs. We can
5 manage to do that and still have available approximately
6 something in the range of nine million dollars, according to
7 our best estimates, which then can be identified for other
8 special purposes which we may find desirable, and this gives
9 us a wide range of potentialities.

10 For example, we may find at that particular time --
11 and this depends upon our being able to complete the analysis --
12 that it would be desirable to expand area health education
13 centers, to develop some major activities for rural health
14 care delivery systems, to do more in the emergency medical
15 service system, to develop some contracts to strengthen our
16 quality monitoring activities. We can identify under these
17 circumstances special activities such as a strengthening
18 of our support for the Pacific Basin through the Hawaii RMP,
19 and so on. And there is also the possibility in
20 those circumstances of some strengthening of kidney activities
21 if this appears to be appropriate.

22 We felt that it would be better not to utilize the
23 entire sum of money in the first go-round. But part of this
24 decision of what one would do with those nine million dollars
25 which are still not committed would depend upon whether we

1 went from a quadrannual to a triannual review cycle, because if
2 we were to do so and we were to take advantage of being in
3 two fiscal years at one time a significant amount of the money
4 could be expended for that purpose. This would lead to a
5 smoother level of funding from this fiscal year to the next.

6 DR. MAYER: So what you are saying then is in all
7 probability there will be an increment of about 21 million
8 dollars into RMP's, with nine million dollars of that gap
9 between 70 and 100 still hanging in terms of possibility of
10 flowing into those other activities. Is that--

11 DR. MARGULIES: Right.

12 DR. MAYER: With decisions to be made administrative-
13 ly on the basis of, one, those that were administratively
14 reduced, fiscally reduced; secondly, those A programs and
15 possibly B programs on the basis of rankings of this committee,
16 and those decisions to be made by when?

17 DR. MARGULIES: Well, they should have been made
18 already. But we have proposed this spending plan, we should
19 have a decision about whether this proposal is final, and
20 generally speaking I think it will be affirmed probably this
21 week.

22 DR. MAYER: Okay. Questions?

23 DR. WHITE: Is that nine million dollars sort of an
24 RMPS developmental component?

DR. MARGULIES: Part of it--

1 DR. MAYER: Did you all hear the question?

2 DR. MARGULIES: He wanted to know whether that
3 represents an RMPS developmental component.

4 DR. MAYER: That is ten percent.

5 DR. MARGULIES: It really represents more than
6 anything else the potential utilization of it for changing from
7 one type of cycle to the next because that could easily
8 consume six to seven million dollars of it. Since we
9 anticipate -- of course, we don't know what fiscal '73 will
10 bring us, we will see what the President's message is within
11 the month, but I have no reason to believe that it will not
12 be fairly consistent with what we have at the present time,
13 but likely at a lower level.

14 DR. MAYER: Leonard.

15 DR. SCHERLIS: I don't know how the others voted,
16 but when I voted for some of the groups it wasn't with the
17 idea that they were able to utilize any more funds than
18 what we were giving them. Very often a specific RMP would be
19 rated A, at least by my judgment, on the basis of their
20 having all the qualities that go into a good program, but
21 still cutting what they had asked because there was no
22 possibility of them utilizing these funds in a manner which
23 would justify their being granted.

24 In other words, while you stated that some of the
25 reasons were purely fiscal, I question in my own mind how

1 you could utilize the large increment that you have stated
2 in a manner which would justify their being utilized
3 merely because these were rated as A's. And also you stated
4 this would be purely an administrative decision, is that
5 correct?

6 DR. MARGULIES: (Nods.)

7 DR. SCHERLIS: I have some questions as far as being
8 able to really spend these funds in a way which would justify
9 that large increment being used.

10 I have several other questions. Can you answer
11 that one?

12 DR. MARGULIES: Yes, I think the answer to your
13 first question is relatively simple. The level of funding
14 which you have approved for programs and which was approved
15 by the Council is always way above what they are actually
16 given in a grant award. There is, generally speaking,
17 for A programs -- and there are variations in this -- a level
18 of grant award which is not higher than 65 percent of what
19 Council and you have approved. So you have approved for them
20 levels well above what they are now receiving. There is little
21 reason to doubt that they could utilize the funds which you
22 have agreed they could use.

23 DR. SCHERLIS: In other words, as far as the Review
24 Committee recommendations are concerned your feeling is
25 that when we ask for a full funding only 65 percent on the

1 average has been given after the final granting mechanism,
2 is that right?

3 DR. MARGULIES: That's right. There are variations
4 of that, and that is simply because we haven't had the funds
5 to do it.

6 DR. SCHERLIS: Of the total, which was 70 million,
7 about how much of that is going in now under direct or
8 indirect support of development of HMO's? You have earmarked
9 16.2.

10 DR. MARGULIES: The HMO is separate from this.

11 DR. SCHERLIS: Is it really? I am talking about how
12 in some of the regions a great deal of developmental work is
13 toward HMO's. What percentage of that, not the earmarked
14 funds.

15 DR. MARGULIES: I don't know the answer to that.
16 But the amount of money which the RMP's are now currently in-
17 vesting in HMO's is not very great. But we don't have a
18 figure on it at this point. It is not a large sum at this
19 time.

20 DR. SCHERLIS: What sort of review mechanism are
21 you thinking of for AHEC and EMS, and so on? Would that be
22 part of the total review mechanism in a region or would
23 they be separate review mechanisms?

24 DR. MARGULIES: We haven't settled that issue yet.
25 My own preference on this one is for us to go through the

1 review process for area health education centers in a manner
2 similar to what we would do for regular RMP review, and we
3 have gotten close enough to the completion of guidelines
4 so that I think we will be able to bring them to the national
5 coordinators' conference next week in a final form, or at least
6 give them to them within a few days after that meeting. But
7 whether we will be free to go through the regular grant
8 process in this limited period of time or not is a question
9 that hasn't been settled, and it has to be settled at the
10 level of the administrator of HSHMA.

11 MR. PARKS: I would like to get some information as
12 to the actual volume of funds. As I understand it,
13 approximately one-half of the fiscal year has expired at this
14 point. And you are talking in terms of roughly the 30 million
15 dollar increment that would be allocated and applied to
16 the various programs. Isn't this in fact by virtue of the
17 shrunken year a double impact for programmatic absorption?
18 By that I mean 30 million with half a year expired would
19 have the impact of roughly 60 million if you are talking about
20 utilizing it between now and expiration of the fiscal year.
21 Or do you anticipate in this that there would be rather
22 substantial carryover balances that would go to extend
23 programs? That is one question.

24 The next question is this: that shouldn't there be
25 some review identification of the total problems that you

1 have within RMP's, and I am talking now about the programs
2 throughout the country, and shouldn't this money be earmarked
3 so that there is some specific onus or burden, if you will,
4 upon these programs to achieve those things that you are
5 trying to get done either nationally or those things which
6 regionally you feel to be desirable?

7 DR. MARGULIES: Let me answer the first question,
8 which is less complex than it would appear. I am glad you
9 asked it. What we did after the last review cycle for those
10 programs which -- you see, our fiscal year is not the same
11 as their fiscal year, which is a saving factor in this.
12 The review cycle which was completed in August was for
13 programs which had a fiscal year, their own fiscal year
14 beginning in the fall, in September and in October. At that
15 time we decided to run the risk, or rather I decided to
16 run the risk of anticipating a higher level of funding, and
17 so those programs have already been given a significant
18 increase in their funding to begin their fiscal year. So that
19 they have started at a higher level, at a level which is
20 fairly consistent with what I am now proposing. That is the
21 A programs and to some extent the B programs.

22 Now the last review cycle which you completed when
23 you were here last time is for programs for the fiscal year
24 which began January 1, so that they have a full fiscal year
25 coming up, and if we supplement the grant awards which were

1 initially made before we got the release of funds for them
2 they will have lost no more than one month out of the fiscal year
3 by the time they get to them.

4 The remaining funding which is in this review
5 cycle and in the next one is for fiscal expenditures which
6 have yet to be started in their fiscal year. So that in fact
7 we will be dealing with new fiscal years for the Regional
8 Medical Programs, and it isn't as though they were all half
9 way through their year.

10 We have accomodated for it in the first group, and
11 the other three-fourths of the programs have just started
12 or have yet to begin their fiscal years.

13 DR. MAYER: Does that answer that particular
14 question, Mr. Parks?

15 MR. PARKS: Well, I assume then administratively
16 you can handle the allocation of these funds.

17 DR. MARGULIES: I think we can.

18 DR. MAYER: Without a significant build up in
19 carryover obligation. I think that is the question.

20 DR. MARGULIES: I think we can, and, of course, that
21 has always been a problem when you get this late in the
22 fiscal year. It is distressing because in fact the
23 appropriation process was completed in August and there is a
24 determination in Congress right now to get this year's
25 appropriation process finished before July. If we had this

1 kind of allocation early in our fiscal year it would obviously
2 be much easier.

3 And the answer to your other question is yes, there
4 is a desire to emphasize some of the major movements which
5 HEW and the administration have been supporting in the health
6 field, and one of the reasons for designing the coordinators
7 conference around the issues that we have, access to medical
8 care, emergency medical services, area health education
9 centers, improved forms of health delivery, is to emphasize
10 movement in that direction. That is also why I think such
11 things as emergency medical services and area health education
12 centers have been identified as special kinds of activities
13 for increased emphasis.

14 DR. MAYER: Jerry.

15 DR. BESSON: I have a somewhat complex question.
16 We have a new stated mission for RMPS articulated in the past
17 year, and as a review committee we have been asked to
18 emphasize in our assessment of individual regions the compliance
19 of program regionally with new mission. As I will come to
20 when I discuss the regions which I have been assigned, the
21 staff opinion and the director's opinion about the
22 appropriateness of a particular program has to be in light of
23 new mission of RMPS. But yet as I add up these figures I
24 find that we have some 37 million dollars allocated to area
25 health education centers, HMO's, and emergency medical

1 services, and construction of cancer facility, all of which
2 is consistent with new program. Implicit in this then is that
3 the 100 million dollars should be allocated to the old
4 program, if you will, and yet we fault individual regions for
5 not being in line with new RMPS directions. Specially when
6 I come to my region I will note that staff has allocated
7 only maybe 20 percent of the requested amount because the
8 program was not in line with new mission.

9 I am not sure that I really understand how this
10 review committee should function, whether we should view
11 the entire 140 million as being available only for new
12 mission, whether we should view that money as having to be
13 spent because if it is not spent it may not be again allocated
14 next year no matter what the program is, whether we should
15 be selective in viewing an area as being A, B, or C
16 depending upon how adequately it is in line with new directions.
17 And I think we really as a review committee have to have
18 a little bit more clearly articulated modus operandi in
19 light of your statements this morning, and perhaps you can do
20 that for us generally, although most of us have done our
21 homework before we came here.

22 DR. MARGULIES: Well, now that is not a complex
23 question. You can do better. There is no question but
24 that there is no implication in the 100 million dollars which
25 is not earmarked for anything other than the new directions

1 which are part of the mission statement. One year ago today the
2 new obligational authority which had been recommended for RMP
3 was 52.5 million dollars. We are now operating at the level
4 which I have just described. The reason for the change
5 in the level of support of Regional Medical Programs is
6 essentially because it has designed a new direction which has
7 support in Congress and in the administration, and if we
8 should utilize these funds for anything other than to
9 strengthen these new directions I think we would be doing a
10 disservice to the intentions of those who have appropriated
11 the funds.

12 There is no suggestion so far as I am concerned that
13 we should utilize these funds merely to be utilizing them. As
14 I indicated earlier, if there is not an effective way to
15 use them in a manner consistent with the mission statement
16 and with the total directions in which we would like to see
17 the RMP's go then we certainly shouldn't spend the funds.

18 In other words, I think that it would be inappropriate
19 for this review committee within the limits of what people
20 can humanly do to review these Regional Medical Programs now
21 on any other basis than what they have done in the past.
22 We have asked you, and you have, I think, reviewed them not
23 on the basis of what kind of money might be available, but
24 rather on what they are merited in terms of support. We
25 have tried to keep separate limited funding from the quality

1 of the program. We should also keep separate more generous
2 funding from the quality of the program. It should be review
3 on the basis of the merits of the RMP and the way in which it
4 is consistent with the review process, with the mission
5 statement and the directions in which RMP's are now going.

6 DR. BESSON: Again the legislation says something a
7 little different than that statement of a year ago, and I am not
8 sure how this 140 million dollars jives with these two
9 statements which seem to be somewhat inconsistent. The
10 legislation asks for support of programs that are in line
11 with improvement in the care of heart disease, cancer and
12 stroke first, and also not as an afterthought necessarily,
13 but maybe as a political statement, include something which
14 has been expanded to be the new mission.

15 I am still not sure then as I review a program
16 whether any programs that are not in line with the objectives that
17 were articulated a year ago, whether those programs should
18 be funded.

19 Now eight months ago this came to a head in this
20 committee when as a matter of testing the waters I was
21 reviewing the Iowa program -- excuse me, Miss Kerr, but we
22 will get this out in the open -- I was reviewing the Iowa
23 program and asked that the Iowa program be denied completely
24 because it was inconsistent with the new mission of RMP even though
25 each of the new programs were meritorious. The Review Committee

1 upheld that position and passed it up to Council. Council
2 reversed the Review Committee decision, and the message that
3 I got from Council at that time was that this was an
4 inappropriate action of the Review Committee. Maybe in the
5 intervening eight months the entire emphasis of RMPS has
6 changed. Were that action to be taken today I would be
7 very curious as to how Council would react. And I am not
8 sure that I clearly understand how I should review a program
9 in light of this statement.

10 DR. MAYER: Let me just emphasize that one, Harold,
11 because I just blew all of last Sunday going through that
12 exercise myself in another frame of reference, Jerry, in
13 terms of legislation, and what I assume you are calling our
14 RMPS mission statement was that rather lengthy letter that
15 tends to confuse frankly mission, goals, objectives back
16 and forth, and it is hard to get a fix on what it is that
17 is really being specifically stated, and then take a
18 look at other information that has been provided by RMPS
19 in various devices and it does get a little fuzzy in terms
20 of what really is being said. And the thing that got to me
21 was the very point you are asking.

22 In an attempt to try to get some clarification of
23 this I went back to the new law, and all that did was serve
24 to confuse me even further in terms of where we are. And
25 I think we really do need some clarification here on this

1 one and what are you intents also about a more explicit
2 statement than the one that has already been produced.

3 DR. MARGULIES: Well, I suppose the best thing I
4 can do on this is to paraphrase what the Secretary said and
5 which I think is a valid statement, and that is that you can
6 read the RMP legislation and make out of it anything you want.

7 When I went before the Appropriation Committee last
8 year I described the kinds of directions for RMP which we have
9 been supporting here, and these were acceptable to the extent
10 of the kind of support which you have witnessed. I don't
11 think that we are at the present time trying to be non-
12 categorical, but we are trying to eschew the narrowly
13 categorical, the kind of thing that picks out one part of one
14 phase of one disease and concentrates on it because that
15 appears to be a nice thing to do.

16 I don't believe that I can settle for you the line
17 of distinction between an effective program which is
18 concentrating on one aspect of the system and an effective
19 program which is taking a broader base. I think there are
20 ranges of distinction, and I am not convinced, although I
21 would like to hear more from other members of the Review
22 Committee, that this is as difficult a distinction to make as
23 it appears to be. Unless you are talking about whether
24 it should be a program as it was three years ago rather than
25 as it is at the present time, because there has been a

1 significant change in what the RMP's are doing; there is a
2 movement in the Regional Medical Programs toward the creation
3 of a more effective kind of goal, and I think the review
4 process has identified that. But there has not been produced
5 in this process of review evidence that each RMP is like every
6 other RMP, and I think that those kind of differences can
7 continue.

8 So far as the Iowa program is concerned, Jerry, that
9 was not overruled on the basis of your interpretation. That
10 was a difference in your interpretation. They did not agree
11 with your analysis of the program, which is fair game.

12 DR. BESSON: Say that again.

13 DR. MARGULIES: The change from the Review Committee
14 to Council was a change in perception of what the program
15 represented.

16 DR. BESSON: I thought our decision here represented
17 a statement of principle, namely that, at least as I phrased
18 that resolution, we were testing the Council's intent to
19 fund only programs that were in line with new mission. Seems
20 to me that that particular program, the kinds of things that
21 they were asking for were still on the old model, and that
22 this might have been a good test. But maybe we chose the
23 wrong test.

24 DR. MARGULIES: That was just a matter of professional
25 disagreement.

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DT. MAYER: Dr. Brindley.

DR. BRINDLEY: I would like to ask a question and make a comment if I might. I have a disagreement with Jerry about the point he was just mentioning. I really question the -- I would like for us to say that we would review each region having been proposed to us, what their needs were, how they could best meet those needs and how they would utilize money to improve health care. The question would be who determines what national goals, objectives and priorities are. If the regions, like Jerry mentioned, all have to conform to national goals and priorities what input do they have to comment on what they need and how it will apply to them? We don't seem to determine it. Does the Council determine it? Who does determine that?

DR. MARGULIES: National goals and priorities are always the prerogative of the administration. That is true year in and year out. The legislation for this, like every other program, says that the National Advisory Council will review programs and it will make recommendations to the Secretary. The decision about grant awards -- the decisions are made by the Secretary. That is always an administrative decision. And consequently so also is the definition from one period of time to another of what represents the major goals and objectives of the government in the development of budgets and in expenditure of funds

1 of its programs, and that is a part of the general political
2 process. Now whether that is right or wrong is something
3 that I don't believe I am competent to judge.

4 DR. BRINDLEY: Let me ask you one question concerning
5 the HMO's and area health education centers and things of
6 that nature. That might be the very best way to use our
7 money in some areas, it might be in some areas that is not
8 the most effective way of delivering health care. Now
9 according to Jerry, we would be critical of that area that
10 doesn't wish to go about it in that way because for them
11 another method is better.

12 DR. MARGULIES: No, I think that is a perfectly clear
13 point. Let's be specific about something like the Health
14 Maintenance Organization which is something that the
15 administration is keenly interested in. There is no constraint
16 upon a Regional Medical Program to get itself deeply involved
17 with HMO's. If they say that they think we can serve the
18 broad purposes of our region and be consistent with national
19 goals by restricting our activities to a certain phase of
20 the health delivery system -- a good example that we reviewed
21 last time is the Ohio Valley RMP which you are familiar with.
22 Their concern has always been concerned with the improvement
23 of ambulatory medical care and with an emphasis on better
24 uses of health manpower, and they have not covered a lot of
25 other activities, that they say for our part of the country

1 that is the best thing. If you measure that against the
2 broad statements which the administration has been emphasizing
3 of increased access to care, of improved product of the
4 system, greater efficiencies, cost containment, etc.,
5 there is no inconsistency.

6 On the other hand, if the purposes of an RMP were
7 to provide transplant facilities in as many hospitals as
8 possible over a short period of time, to pick an absurdity,
9 I think this would be unacceptable.

10 Now it is the range in between which causes great
11 difficulty, and it is why we have a review committee upon
12 whom I don't think we can impose a very strict kind of set of
13 rules, but one which is broad enough to allow you to use your
14 judgment.

15 DR. BRINDLEY: If Ohio Valley says they can do
16 the best job in this manner that is all right?

17 DR. MARGULIES: That is the main purpose of the
18 program.

19 DR. MAYER: Mr. Hilton.

20 MR. HILTON: I just wanted to say prior to what
21 has just been said the suggestion perhaps that there needs
22 to be better communication between the Executive Branch that
23 articulates national goals and the local regions. Part
24 of the reason that my recent site visit was agonizing was
25 because we ran into the situation the Jerry and others have

1 identified where people were in effect quite frustrated,
2 wanting to know from us what it is that they should do so
3 we could evaluate them so they could get money. We talked
4 as best we could about program management and kinds of
5 things to keep in mind, but I think we all had a flashing
6 around there of the real issue, and that is we cannot perhaps
7 effectively evaluate unless it is quite clear to us what it is
8 that needs to be evaluated, and give ratings and what have
9 you. And the issue of money always gets in the way. People
10 always want to do whatever it is they are going to get money
11 for.

12 So I think that needs to be made clear in our
13 minds as we look at the program precisely what it is we are
14 evaluating for, and I just echo his point.

15 DR. MARGULIES: Well, I think that is a very
16 valid criticism. I think we have been inadequate in our
17 capacity to get to the regions and to do more than simply
18 send them pieces of paper. We need to have a better capacity
19 to work directly with the regions; and at the present time
20 with the staff strength we have and with the demands that I
21 have described in the review cycle this is being done very
22 inadequately, and I see little kind of relief from it unless
23 we are able to lessen the demands of the review cycle, which
24 is one of the reasons for going on a three time a year basis.

25 The people in the Operations Division, people in

1 the Professional and Technical Division, are so heavily involved
2 with the activities which are now consuming their time that
3 that aspect of it which is -- really the way to communicate
4 is to be with people and talk with them and to examine what
5 they wish or what they think needs to be done against what
6 their understanding is of what should be done, is essential.
7 And yet we do have a real limitation on how much we can do
8 about that.

9 MR. HILTON: Once that kind of communication and
10 dialogue is under way then will staff be communicating these
11 local needs and concerns to the appropriate people?

12 DR. MARGULIES: That is our intent, and, of course,
13 that is one of the reasons that we worked so hard, and we almost
14 were unable to do it, to get Dr. Duval and to get Reeso to
15 the national coordinators meeting, because this will give
16 them the first opportunity to not only lay out for that group
17 what it is they expect of Regional Medical Programs, but also
18 to answer the kinds of questions which the Review Committee
19 is raising.

20 But there is a long chain of events from Pennsylvania
21 Avenue to Independence Avenue to the Parklawn Building to
22 the regional offices to the RMP's, and in the absence of close
23 working relationship it is extremely difficult. I am not
24 satisfied with it. I would be most dishonest if I said that
25 I was.

1 DR. MAYER: Harold, one of the questions which I
2 asked which got lost which I would like to reiterate is is
3 there going to be an attempt to develop a more explicit
4 statement and perhaps a more organized statement than the one
5 that has been developed as of now relative to RMPS mission,
6 goals, objectives?

7 DR. MARGULIES: Yes. I must tell you that the
8 production of the one that you are talking about was in itself
9 an extremely complicated task. Interestingly enough, even
10 that one, when we have met with coordinators and staff, has
11 been looked at by very few people. We had a meeting of
12 several coordinators in here not long ago and 65 percent of
13 them had not even looked at that mission statement. So, you
14 know, we can do it and we will do it, but it is going to
15 require a great deal more than that.

16 DR. MAYER: It is very, very important for us that
17 have read it five times and still don't have a clear picture.
18 I think, you know, you gear your educational program to the
19 bright ones in the class as well as those that are moving
20 along slowly.

21 DR. MARGULIES: Well, I can say this about it. I
22 like the way it was written in the original form.

23 DR. MAYER: All I was commenting was that there are
24 some of us who didn't, and we would appreciate some--

25 DR. MARGULIES: No, I don't mean that form; I mean

1 the original form.

2 DR. MAYER: Jerry.

3 DR. BESSON: Well, I think that is critical for the
4 entire program, and the whole way in which the Review Committee
5 operates has been very elusive. The way the Council reaches
6 its decisions -- I have used the term capricious before, and
7 I will use it again, because we seem to be operating under
8 directive guidelines. Now that is because the administrative
9 staff of RMPS under the Director is somewhat chary about
10 ordaining how RMP should be run and would like to remand to
11 the periphery making decisions, and, of course, the anniversary
12 review process implied that this is the way it should be
13 done. But in so doing the periphery and the Review Committee
14 are left in a double bind.

15 On the one hand we are told that the center will not
16 ordain how the periphery will run its affairs, and the
17 periphery will organize itself to do its own program priority
18 determination and we will either say yea or nay depending on
19 whether they did it right or not. But on the other hand,
20 as I review programs now I see that staff does ordain
21 because they say these particular projects don't seem to be
22 in line with new mission, therefore we will cut funding from
23 X to X minus 100 K, or whatever. That leaves the region
24 in a double bind, and they grasp the straws that emanate from
25 this center when they see the mission statement, and I see

1 it quoted very widely, because there is very little guidance
2 they have from the center.

3 The Review Committee I think is left in the same
4 position. Even after having served on this Review Committee now
5 for close to three years I am not sure that I understand what
6 I am doing and how I am supposed to be doing it; and in that
7 candid statement I think I must say that others on the
8 Review Committee and Council, let alone the coordinators,
9 must feel in the same position of trying to grasp at clouds
10 and not quite sure whether what they are doing is appropriate.

11 So I again make a plea for some frequent articulation
12 of what it is that we should be up to, or telling them what
13 we are going to do and how to go about it within broad
14 guidelines and let the area choose its own modus operandi
15 within those broad guidelines. But these guidelines are
16 necessary again and again.

17 MISS KERR: I think what we are generally saying,
18 we are floundering somewhere, and Jerry just said let alone
19 the coordinators -- and while my information came to me
20 very informally, I think it is the appropriate time to bring it
21 out, I think the coordinators are floundering. Some visits
22 I have made and have heard others have made, there were
23 comments "when you Feds make up your mind," actually from
24 the group as we visit them. So they, too, are feeling
25 anxious about this.

1 My understanding is that the coordinators have
2 employed an attorney. The source of the funds I don't know.
3 One wonders. But for what reason, I would ask the question.
4 Is their level of anxiety so high that they feel they need
5 legal advice, or is my information incorrect?

6 DR. MARGULIES: The only one that I am acquainted
7 with is the fellow who serves as a secretary to the Southeast
8 area coordinator group. Presumably the fact that he is an
9 attorney is incidental to his general organizing and
10 secretarial responsibilities. I have the impression, however,
11 that he extends his efforts in many other directions, and
12 I am not very keen about it. But it is being paid for,
13 I believe, by a combination of Regional Medical Programs.
14 What he does is help convene meetings and help develop common
15 programmatic concepts among the Regional Medical Programs in
16 the Southeast area.

17 DR. MAYER: Leonard.

18 DR. SCHERLIS: I would suggest that they could better
19 put these funds into getting a psychiatrist.

20 (Laughter.)

21 I didn't want Dr. Besson's comments to go further
22 uncommented upon because I share a great many of his doubts
23 and anxieties. I confess I always feel better after the
24 morning session than I do after the end of the second day at
25 these Review Committees because I am reminded of "Of Mice and

1 Men," there are two characters, George and Lennie, and
2 since my first name is Leonard I have some feeling for it.
3 Lennie is rather simple-minded. In fact, he has some cerebral
4 impairment.

5 DR. MARGULIES: Bigger than you, though.

6 DR. SCHERLIS: Much bigger than I. But for assurance
7 he always asked Gorege to tell him about the rabbits and then
8 he feels better; and it is always nice to have Hal tell us
9 about how the review mechanism might work.

10 I do have a great deal of concern because frankly
11 when I go to some of the regions for site visits -- we are
12 there very much on a very important basis obviously, their
13 longevity and their very existence can depend on our
14 decision, and I find it very difficult to really be in a
15 position, except very often have a good guts reaction to
16 what goes on. I have a feeling abdominally that is good
17 or bad, and then I translate this, as I will today, into
18 specific funding recommendations in terms of dollar value,
19 and I can put a color value on it, it is pink or blue, but
20 it is hard to really put a dollar value on it.

21 I am getting increasingly impressed with the
22 similarity of goals and objectives in the regions, and I
23 could be naive and assume that they all openly define the
24 ultimate truth simultaneously which doesn't really seem to be
25 realistic. Or else the realistic thing is that they know what

1 the goals and objectives are, because if I put out my hand
2 frequently enough with the wrong bottle I am sure I will get
3 it slapped, eventually I will know that other bottle is the
4 right one. I am sure they get the message. The rewards
5 are obvious enough. And I think that what we discern as
6 the regions are beginning to really decide what their real needs
7 and objectives are, the question whether it isn't really a
8 cyclic mechanism, if they know that if they define the goals
9 and objectives a certain way the funds will not be forthcoming.
10 And I am impressed when we talk about some regions having
11 turned the corner that it is merely that the smoke signals
12 have become denser and denser from the spot from where they
13 emanate.

14 I do have concern now that we again are talking about
15 defining goals and objectives and now that we are adding
16 what are really tremendous challenges -- ANEC's, as I view
17 them, are tremendous challenges to regions, and the potentials
18 of duplication, of confusion, of overutilization and few
19 resource people, the attempts to define needs on the basis
20 of groups as set up in that document are horrendous. It was
21 a document which I went to bed last night and I awakened not
22 any clearer in my own mind, though very often sleep does
23 have benefit. I am increasingly confused about the goals and
24 missions of RMP, particularly how they get translated into
25 the field, how we can sit here and decide how these funds

1 can best be expended.

2 I hope that as the morning goes on we will have
3 further discussion because I think that as you determine
4 the dilemma many of us face it isn't quite as clear when we
5 are out there in the field working and trying to reach an
6 important decision how we can put into clear focus some
7 of the priorities that are obviously required.

8 DR. MAYER: Let me raise two quick points, Harold,
9 and it relates to AHEC's because I think that gives us an
10 example of two issues. You talk about a combined effort with
11 the Bureau. You commented that 7.5 million would be set
12 aside, and possibly more if there is some left over of the
13 nine for that activity. How much is the Bureau putting in?

14 DR. MARGULIES: At the present time approximately
15 11 million.

16 DR. MAYER: Then the second question, which gets back
17 to Dr. Brindley's point in terms of who sets national goals
18 and priorities, I think it would be helpful to us if we had
19 some feeling of how your document of December 23rd on the
20 relationship of area health education centers, how the
21 RMPS position paper was evolved and who developed it,
22 because I think that does in fact have an impact on policy
23 very clearly as people think about that kind of effort.

24 DR. MARGULIES: The area health education center
document which will emerge, and as I indicated earlier in

1 the morning, is just being completed as a set of guidelines
2 is being developed commonly -- and by that I mean by staff
3 work within review and approval by those under whom they
4 operate, with the Veterans Administration, the Bureau of
5 Education and Manpower Training, the Regional Medical
6 Program Service. And the process that will be followed so
7 far as HEW is concerned is to create a set of guidelines
8 which are accepted both in the National Institutes of Health
9 and the Health Services and Mental Health Administration;
10 this when it is in a form which is acceptable to Dr. Wilson
11 and Dr. Marston will be signed by them, sent to the
12 Assistant Secretary, to Monty Duval, and if it is acceptable
13 in that form will then be used as the guidelines for the
14 development of area health education centers governing the
15 activities of both Bureau and RMPS.

16 We will continue to operate together under those
17 guidelines in the process of review and support of area health
18 education centers as the proposals come in and as they go
19 through a joint review process.

20 DR. MAYER: Let me just pursue this one step further.
21 You indicated that in that joint review process there would
22 be the possibility that it may be funded totally by NIH,
23 totally by HSHMA, or combinations thereto, which sort of
24 implied to me that there were different kind of labels to
25 justify the reason for that. And if we are talking about joint

1 guidelines then I don't understand why there isn't a joint
2 pool of money.

3 DR. MARGULIES: Simply because the funds have been
4 appropriated by different processes for different organizations,
5 and the best that we can do with them is to work out
6 arrangements in which there is a reason for both of us to be
7 involved in the funding of one activity.

8 But you are quite right in suspecting that there is
9 still some difference in perception in the Bureau and in RMPS,
10 and I don't think those differences have been completely
11 resolved, and I agree that that is an unsatisfactory state of
12 affairs. That could be resolved in the office of the
13 Secretary, and up to the present time has not been.

14 MR. PARKS: I raised some questions about certain
15 things of national emphasis and how the money was going to
16 be used and this kind of thing. I am going to raise it a
17 little more specifically for two reasons. One, I think it
18 was oversimplified when it was originally put out. And
19 secondly, it would require me, I think, to compromise a bit
20 with intellectual honesty.

21 For example, I am concerned about the overall civil
22 rights compliance, the whole process of RMP's, their existence,
23 their operation, and the mechanisms by which they carry out
24 whatever it is that they are doing. Do we really know about
25 it? In terms of our evaluation sheet, which is fairly

1 specific, we have minority interests here which is rated 7,
2 I guess, in terms of weight. Yet in terms of the status, the
3 articulation of the law -- this is a law and order matter --
4 by both the Executive Branch, the President, and your
5 Secretary, there are certain specific things that I have
6 question about whether there is in fact compliance with the
7 law.

8 The question I put to you is whether additional
9 money should be put into a process that further extends this
10 kind of aberration is a fact that needs to be addressed
11 here honestly and openly.

12 I am not sure, for example, from my review of these
13 papers and from the one site visit that I have been on, which was
14 not terribly helpful, that there is an equal employment
15 opportunity, that there is an opportunity for equal
16 participation of the black professionals, that there is an
17 equal opportunity for access to the granting process, that
18 is to participate as applications for grants or for programs
19 from the Regional Medical Programs themselves. I am not
20 sure what it is in terms of so-called staff administration,
21 what instruction do they have. Are the instructions of
22 the Secretary of HEW in fact being carried out?

23 And let me give you an example. I have here a letter
24 from the Secretary, and it is a letter addressed to me, and
25 this will give you the kind of example that really creates a

1 tremendous problem. And we are talking about money. Money
2 is it. Health, everything else revolves around money. This
3 is a money system. We are talking now about the
4 dispensation, if you will, of 100 million dollars cash or
5 in favors, whatever it might be.

6 This is a letter dated August 9, 1971. It is
7 addressed to me. It is from Elliot Richardson. It says:

8 "Dear Sir:

9 "It has been the policy of the federal government
10 to encourage and promote the development of minority owned
11 enterprises. In conjunction with this policy the government
12 has intensified its efforts to increase the deposit
13 of funds in minority banks. These institutions are themselves
14 small minority enterprises with most of their commercial
15 accounts being other minority business heads. We should like
16 to encourage your organization to deposit a portion of the
17 funds received from this department and other sources into
18 minority banks located in your vicinity. Stimulation of minority
19 banking communities will enable these banks" --

20 He goes into this, he has attached to it a list
21 of the banks. Has this in fact been dispensed to the
22 RMP's? Is it a part of the process that you go through in
23 reviewing these RMP's?

24 I take this as a specific kind of example. I just
25 happen to have this in connection with something else.

1 There are a number of other kinds of directives that
2 have come down that pertain directly to the dispensation of
3 federal funds, and I am not so sure here with the guidelines
4 what role these things should play, whether we should continue
5 to participate in the further extension of these kinds of
6 law and order aberrations -- by that I mean in terms of
7 compliance. Should we compromise, as I have seen in some
8 of these things where we say that the fact that the minority
9 involvement is not present in either the delivery or in the
10 RAG and that kind of thing, that it is oversight of nice
11 people and that we pass on?

12 I mention it here, and I think it ought to be out
13 openly and honestly.

14 DR. MARGULIES: Let me answer the specific issue
15 which you raised, the Secretary's letter. That information
16 was transmitted to every grantee and every coordinator
17 in the Regional Medical Programs with strong emphasis that it
18 be followed. That is not enough. We have, as I indicated
19 in the last several sessions, placed great emphasis on
20 equal employment opportunity in Regional Medical Programs
21 as we have in RMPS. We have not -- and you are quite right --
22 raised this issue in my judgment to the proper level of
23 consideration in determining grant awards.

24 I would be completely sympathetic to making it a
25 stronger issue and identifying it as one of the reasons for

1 funding or not funding a Regional Medical Program. We have
2 seen improvement. Improvement isn't enough. And this
3 is true in the range of areas in which grant funds are expended.
4 It is true in membership of Regional Advisory Groups, and
5 it is true of staff employment, both professional and
6 nonprofessional.

7 The figures that we put together recently -- and I
8 would like to have you see them -- indicate a level of
9 employment which was quite striking the last time we had a
10 review of minority employment. And I think we probably have
11 those data available, and I would like to distribute them and
12 get your comments on them.

13 But this is an issue which I think has to not only
14 be looked at, but has to be given greater emphasis or we
15 are mismanaging our affairs.

16 Now the other aspect of it, of where the funds go
17 and what opportunities minorities and underserved groups have
18 to gain benefit from a Regional Medical Program, get us into
19 the question of how one is able to utilize RMP funds and
20 what should be the mechanisms involved. I have been talking
21 to Dr. Duval, and I will be seeing him again later this
22 week, about this kind of a question as it relates to
23 comprehensive health plans. Under good circumstances
24 comprehensive health planning activities should be so
25 developed that there is a true minority representation, so

1 that there is a selection of priorities for the community,
2 an identification of what that community wants to get with
3 what it is investing and what is being invested in its name
4 by federal, state and local government. And the Regional
5 Medical Programs should be totally responsive to those
6 identified needs. CHP has not been able to produce yet that
7 kind of a structure. I think it should.

8 My own feeling, which is not generally shared,
9 however, is that not only should that be developed in such a
10 way that the total community interests are represented with
11 strong emphasis on minority interests, but Regional Medical
12 Programs and other federal agencies should be bound by it.
13 Not just review and comment; I would favor a much greater
14 authority for CHP, because I do not believe that what we are
15 aiming for is going to be produced by the Regional Medical
16 Program operating as an independent agency. It is too much
17 provider dominated, which is the nature of it, and it is not
18 going to spontaneously seek out, and even though it may try
19 it may not do it effectively, those kinds of investments for
20 RMP which affect the principle that you have been stating.

21 I would be happy to see this Review Committee pay
22 a much higher level of attention to those issues.

23 MR. PARKS: Well, in terms of what we are really
24 addressing, and this is in terms of focus and the kinds of
25 emphasis, what roles and fate this plays in the evaluation

1 of the programs and this kind of thing, it is a particularly
2 hazy area, fuzzy, if you will, because I think in terms of
3 utilizing the things within the Department of HEW that are
4 identified for some of these purposes we need that kind of
5 advice really before another cent is dispensed. We need
6 the advice of the civil rights compliance unit within HEW
7 as to whether in fact -- not whether they have signed the
8 forms, but whether in fact these programs are doing what they
9 should be doing under HEW guidelines, under guidelines of
10 various statutes, under the guidelines of the various
11 executive orders which date back now as long as the Eisenhower
12 administration. We do not know. And these are things about
13 which there certainly is neither obfuscation or question. We
14 need not search for these, and the mechanism for providing
15 us with that advice is present and is a part of the establish-
16 ment.

17 What I am suggesting to you is that I think there
18 are some things that we could do with it.

19 DR. MAYER: Further comments?

20 Yes, Jerry.

21 DR. BESSON: I think Mr. Parks introduces a new
22 notion in the review process, one I think we should pursue
23 perhaps a little more vigorously. If these morning sessions
24 are going to be more than psychotherapeutic catharsis I
25 think they really have to be translated into direct action.

1 I think it is not sufficient for us to platitudinously
2 say that we need greater emphasis on this, and if I read
3 Mr. Parks' comments and the Director's acquiescence to his
4 comments correctly I would like to suggest to the Review
5 Committee that we do take the step that is implicit in his
6 comments and make -- and I would like to make this in the
7 form of a motion, Mr. Chairman, for Council's consideration
8 and decision -- that no RMPS program be funded without
9 prior indication of compliance of that program with the civil
10 rights unit of the Department, and that a sine qua non be
11 established. And I would like to put that in the form of a
12 motion for Council's consideration with decision at its
13 next meeting.

14 DR. MAYER: You are making a recommendation of
15 this Review Committee to Council?

16 DR. BESSON: Yes.

17 DR. MAYER: I need to have clarification, Jerry.
18 Well, is there a second before discussion?

19 MR. PARKS: I will second it.

20 DR. MAYER: I need to have clarification from staff.
21 I frankly have been assuming that that in fact was happening.
22 If it is not, then I think the motion is in order.

23 DR. MARGULIES: Jerry, do you want to comment on it?

24 MR. ARDELL: The only thing I can say is to the best
25 of my knowledge what we are doing here I think kind of goes

1 back to your comment. I don't know the extent to which the
2 desires of the administration are carried out by this
3 Department. And the only notice we have gotten to date is
4 the continuation of what Mr. Parks has just mentioned from
5 the administrator, and we in turn gave that to the programs.

6 I don't know if we move in this direction -- I
7 think what you suggested, Dr. Margulies, is that we are
8 independent, we are one show doing this. I don't know who
9 else would go to this extent at this particular time. I
10 think we need to pursue this before we--

11 DR. MAYER: Let me be explicit. I need to have
12 the question in order to answer -- you know, because if the
13 answer to the question is one way then the motion is in fact
14 appropriate. If it is not needed then we need to know that.

15 DR. BESSON: Mr. Chairman, in the review of the
16 program that I have had for this session I have had no indication
17 that there has been compliance by a reviewing unit with
18 civil rights legislation as far as HEW programs are concerned.
19 I would like that to be an incorporated part of the materials
20 that are presented to me for Review Committee decision.

21 DR. MAYER: Well, that is a different motion, Jerry.
22 Then I wouldn't have had any trouble with it. Your
23 recommendation to Council was that they take the necessary
24 steps to insure that funding does not occur. Now what I have
25 just heard you say is that you would like to move that this

1 Review Committee request that that compliance be provided to
2 them before they go through the review process. Have you
3 changed your motion?

4 DR. BESSON: No, I haven't at all. I just added
5 the teeth that such compliance be a sine qua non to funding.

6 DR. MAYER: Well, I am still unclear. Do you or
7 do you not want to have that information before you go through
8 the review process?

9 DR. BESSON: Yes.

10 DR. MAYER: Or do you or do you not want the
11 assurance that it is there before funding occurs?

12 DR. BESSON: Yes.

13 DR. MAYER: So there are two different levels and
14 two different issues.

15 DR. BESSON: I would like to have the information,
16 but if the information doesn't represent compliance I
17 don't even want to look at the program. I would consider that
18 it is a sine qua non of program approval, and without it
19 that program not even be bothered to be reviewed. Does
20 that make it clear, Mr. Chairman?

21 DR. MAYER: Yes, you are going to have to modify
22 the motion that you made then, because what you in effect
23 from an administrative standpoint have just said is that you
24 want to have that compliance before the review process is
25 initiated.

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DR. BESSON: Right.

DR. MAYER: That is a different statement than the statement you made earlier. That's all I am saying, and I need to be clear what it is you want.

DR. BESSON: That's what I would like. I would like Council's decision on that point.

MR. PARKS: He said the compliance report, and that a certification of compliance be a sine qua non, without which condition--

DR. MAYER: Somehow I am not coming through.

DR. BESSON: Perhaps you can state my motion, Mr. Chairman.

DR. MAYER: What I heard, Jerry, without writing it down, was your request for certification of compliance and adequate review to insure the compliance occurred was a recommendation you were making to Council so that that had been accomplished prior to any funding.

DR. BESSON: And add the additional clause that no funding be considered without such compliance.

DR. MAYER: All right, but that still doesn't get at what I then heard you say, is you don't even want it to go through the review process until it is there, because that's a different frame of reference.

MR. PARKS: Well, let's write it down.

DR. MAYER: You see the point I am making. The

1 point I am making--

2 MR. PARKS: We will take care of that. Let's
3 try to write it down. The first point is -- again I don't
4 want to usurp your motion because I am only the seconder
5 of it.

6 DR. BESSON: Well, I would add the third clause
7 that you just stated, that the program not even be
8 reviewed unless such compliance is part of the information.

9 DR. MAYER: All right, fine. I just need to have
10 it clear because those are two different issues.

11 DR. SCHERLIS: Is there a specific written directive
12 which is a checklist as far as what is or is not compliance?
13 I ask this from a sense of naivety of instruction. You
14 have talked about compliance. Is this a written checklist
15 document. Dr. Margulies, do you have such a listing. What
16 would the certification of compliance indicate?

17 DR. MARGULIES: No, all grants and contracts
18 of the federal government require civil rights compliance,
19 but I am not acquainted with any kind of checklist which
20 would determine whether or not that compliance has occurred.

21 For example, every university which receives
22 federal funds has to have civil rights compliance which would
23 cover a wide range of legislative acts. It is separate
24 from -- what Mr. Parks was also talking about was
25 executive order, which is another kind of, but related, question

1 And I am not familiar -- my own ignorance -- with what
2 kinds of check-off lists might exist and what kind of
3 measures have been carried out to confirm that compliance has
4 in fact occurred or prove that it has not occurred.

5 DR. SCHERLIS: Another point of information, how
6 would passage of this motion affect your operation?

7 DR. MARGULIES: Herb says we would go out of
8 business.

9 DR. PAHL: So would every university in this
10 country.

11 DR. SCHERLIS: Could you amplify that, because that
12 is a very interesting response which I didn't anticipate.

13 DR. PAHL: Let me not comment as Deputy Director
14 of the program, but as an individual. I think all of us are
15 aware of civil rights acts and what has happened and what
16 has not happened in the country. I have only been in the
17 federal government for ten years, and I am not sure I know
18 what does and does not go on in compliance with all the
19 rules and regulations for awarding grants and contracts.

20 I think what it is we wish to do and what we do
21 accomplish in the country are two different things. It is
22 my personal opinion that if this resolution were adopted
23 and implemented our program would not be able to operate at
24 all, because I daresay that I don't know a single community
25 in the country that fully complies with the civil acts and

1 regulations, civil rights legislation of the country. I am
2 sure such communities exist, but I don't know of them.

3 This doesn't say we shouldn't strive to meet those
4 goals. But if one sets an ultimatum for the next
5 review cycle that no funds would be awarded unless full
6 compliance were achieved it is my personal opinion, not
7 that of a program official, that this program and no other
8 program in the federal government probably would be able to
9 function. The highway program I am sure couldn't. The
10 Department of Defense couldn't. HEW can't. That is not to
11 say that we shouldn't strive toward it. But if it is an
12 ultimatum, I have been in several universities and at
13 least from my personal observations those universities would
14 not be able to receive another penny either if full compliance
15 with all the legislative requirements had to be met by the
16 time the next disbursement of funds occurred. So I will
17 be very interested to see what occurs.

18 What I think we do have is civil rights legislation
19 with appeal mechanisms, etc., built in. But as we all know,
20 even in the case of Virginia and its integration of schools
21 in the newspapers, it has taken many, many years, and we are
22 still not at that point. I don't see how it is possible for
23 RMPS in the next three months to achieve national compliance
24 with civil irghts legislation.

I am not in disagreement with the goal. I am trying

1 to look at it from a very practical point of view. I think
2 the subject should be explored, more should be done, but it has
3 to be done in the practical sense if we are to achieve
4 anything.

5 MR. PARKS: May I get a point of clarification?
6 Are you saying the law should not be complied with? Is that
7 your position?

8 DR. PAHL: Indeed not. I want to make that
9 perfectly clear.

10 DR. BESSON: But, Dr. Pahl, perhaps some of us
11 neither share your diffidence nor your semantic choice of
12 words when you use the term ultimatum, implying we are in no
13 position to use that kind of approach, implying further that
14 it is going to take some tooling up. I think that if we
15 hold the purse strings -- and I suppose we do as a review
16 committee, as we really are a policymaking body in advising
17 the Council -- then we would be negligent in our leadership
18 role if we didn't do what we thought appropriate, if the
19 authority is truly vested in us rather than yourself and
20 Dr. Margulies, which I think the law asks us for, then I
21 think it is our choice and the staff really must comply with
22 the policymaking body.

23 If I am incorrect in that assumption, Dr. Pahl,
24 perhaps I should stop right here and perhaps you can either
25 reassure me--

1 DR. MARGULIES: May I respond to that, because the
2 Review Committee is not a policymaking body. The Review
3 Committee is created as an administrative device to support
4 the activities of the Council. The Council is a policymaking
5 body and is advisory to the Secretary. This is a review
6 committee.

7 DR. BESSON: I accept that. We are advisory to
8 the Council, and we would request Council determination on
9 this as a policy matter. But I think initiation of policy
10 change may occur here for Council concurrence.

11 DR. MARGULIES: Certainly, but that is not the same
12 as being a policymaking body.

13 DR. BESSON: No, no.

14 DR. MAYER: Sister Ann.

15 SISTER ANN JOSEPHINE: Yes, I would like to ask
16 Dr. Pahl what steps are taken to review compliance. I mean
17 is there any supervision of this as appropriations are made,
18 the degree of compliance? What steps are taken to review the
19 degree of compliance?

20 DR. PAHL: In our program to the best of my
21 knowledge none are being taken. Perhaps staff can modify that
22 comment. Jerry.

23 DR. ARDELL: Except to the point that there is a
24 published list of those organizations that are in compliance,
25 and if they are not in compliance we are informed and we do

1 not make grants to them until they are in compliance.

2 DR. MARGULIES: I think one must recognize that
3 the whole process of reviewing civil rights compliance
4 involves a very large segment of the government which I think
5 most people would recognize has not been able to do all that
6 it would like to do and all that should be done. But I
7 doubt that you could read the newspapers for a week without
8 finding evidence of a challenge to civil rights compliance
9 in schools, in hospitals, in construction work. But it is
10 a part of HEW, it is a part of DOD, and the civil rights review
11 and enforcement activities are of tremendous political
12 prominence, so it could hardly escape one's attention. But
13 we are a part of the HEW civil rights compliance activities.

14 SISTER ANN JOSEPHINE: I raise this question because
15 I know that we have many, many fine -- just as in any kind
16 of business, we have many, many very fine policies, but unless
17 there is surveillance of the implementation of the policies
18 their formulation may simply be a political move. And I
19 think that as we are looking at Regional Medical Program
20 services we need to ask whether we feel at this point in
21 time that we are looking at one of the weaknesses of the
22 program when we say we have a policy that applies not only
23 to this program, but to every federal program that is being
24 funded, and yet we are not exerting good management
25 supervisory control to see that the policy is implemented.

1 This is as I interpret the question.

2 DR. PAHL: I would like to agree that we are not
3 exercising the degree of management surveillance and
4 control that we would like. This also holds true with other
5 areas, and that is in the management of grant funds. It also
6 holds true with copyright laws. Again it comes down to a
7 question primarily of not what one would like to do, but what
8 one is able to do.

9 There are other sections of HEW that are large and
10 have the responsibilities for carrying out surveillance, appeals.
11 We must in all good conscience depend upon some other unit
12 of the government than ourselves in a very practical sense
13 because society is interrelated and we can't do everything.

14 Again that is not to say that one is in disagreement
15 with the goals. But I think Mr. Ardell would agree that
16 every grant and contract that emanates from RMPS has many
17 conditions attached, and in all honesty I don't think any
18 of us in this room can say that we provide surveillance over
19 most of the conditions under which we make the grant and
20 contract awards. There is a mechanism by which if matters
21 come to our attention that there is noncompliance in this
22 and other areas then there are routes, mechanisms, etc.

23 I do not see us in practical terms having the
24 wherewithal to carry out what the Review Committee is
25 suggesting, however desirable it may be.

1 DR. MAYER: Dr. White.

2 DR. WHITE: I think this kind of resolution clouds
3 our role. I think we are mixing up what our purpose in life
4 is and what the purpose of other people might be in
5 reference to this particular point. And it puts me in the
6 position of having to choose between the consequences
7 of being a bigot or the man from Lamanchia. I don't believe
8 this is an inappropriate concern by any means. I don't
9 want to be classified as a bigot. On the other hand, I
10 think it is totally inappropriate for us to be acting
11 as a policeman, which is what we are trying to do.

12 DR. MAYER: John.

13 DR. KRAWLEWSKI: Let me just carry on with that
14 comment a bit because it is along the lines of something I
15 wanted to say before. I think one of our real problems is
16 trying to determine the role of this committee here. If
17 we see Council as a policymaking body and then we see the
18 RMPS staff carrying out that policy and implementing it
19 throughout the regions, it seems to me then our role is
20 one to look at the structure of these regions to try to
21 assess their ability to formulate and carry out programs and
22 advise in that capacity.

23 Now it is disturbing to me in a way that we find
24 the funding levels are only about 65 percent of what we
25 recommend, because we look at the capacity of a region, we

1 recommend the level of funding that we believe they can
2 handle. In many cases I guess Council may alter that a bit,
3 but essentially establishes a level along those lines, and
4 then sometime later when the real decision is made apparently
5 when the money is parceled out and you determine who should
6 get what, and the decision at that point I think is the
7 crucial one, and the factors that are taken into consideration
8 at that point are the factors I think that are the important
9 ones, whether they concern compliance with certain laws,
10 whether they concern whether or not the region has developed
11 goals and objectives that are in line with national
12 priorities. I would like to have you comment on the kinds of
13 things that you take into consideration when you give that money
14 out.

15 If in fact you are acting in a capacity where you
16 believe that these regional offices should be very closely
17 aligned with your central staff here and that you have specific
18 things that you would like to have them do, and if they do that
19 you are going to give them money for it, then I think
20 probably this Review Committee is inappropriate and that
21 what you need is a body of individuals that might site visit
22 programs and give you a written report on it as to what their
23 capacity might be or their estimation of their capacity, and
24 then you use that when you make your decision, but disregard it
25 if you wish, and parcel out the money on the basis of

1 specific things that you would like to have accomplished and
2 whether that management team is accomplishing it or not.

3 DR. MARGULIES: Well, that statement I think is
4 the crux of what we have been talking about.

5 Let me go first to the question of why we don't
6 fund at the level that has been approved. It is pretty
7 simple. We did this, we took a look at what would happen
8 if we awarded grants to all programs at the levels which have
9 been approved by Review Committee and approved by Council,
10 it would far exceed our budget. So it is simply a matter
11 of making adjustments on the basis of what funds are
12 available.

13 The question of how we make that decision -- the
14 answer to that is determined by what kind of relative ranking
15 and what kind of input is made by this Review Committee,
16 which in fact is the most critical, formalized, careful review
17 process that we have available.

18 Now the next point that you raised, of having some
19 kind of a process by which we determine conformity versus
20 something which determines whether or not this program
21 represents an effective institution for the region, is one
22 that represents the range of differences which we see here
23 present. Len was saying that he sees programs coming up
24 with the right words, they parrot the kind of sounds which are
25 being made at the national level. It is my belief that if you

1 then follow the general statements which are made at the
2 national level with a specific guideline as to what each
3 RMP should do, that that is exactly what each RMP should do,
4 and we would be deciding in the Parklawn Building what should
5 be done in every Regional Medical Program. I don't think we
6 have that ability. I think it would be a sad mistake, and
7 I guess the real difference lies in how general our description
8 of goals should be and how within those generalities the
9 review process should be carried out.

10 I understand your anxiety over it. For what it is
11 worth, I think this review process, considering the fact
12 that we are trying to describe a new institution in
13 shifting times and with heavy demands being placed upon us,
14 works remarkably well. I think if you were to set up a
15 different kind of system which is analytical and careful it
16 would come out very close to the kinds of determinations
17 which this review committee is making. If we get very explicit
18 about it then we might just as well switch to some kind
19 of formula grant and see if the program is doing exactly what
20 we told them they ought to do, in which case I can't see
21 much point in having a Regional Medical Program.

22 On the other hand, if we want to go to a series of
23 projects scattered around the country there is also no need
24 for a Regional Medical Program. We can simply make the
25 grant awards to the project directors and carry it out in a

1 scattered fashion.

2 Somewhere in between is a structure which manages
3 to elicit a sense of coordination and of general direction
4 and determination for the providers of medical care in the
5 region. They base their actions on a series of analyses and
6 judgments which lead to a finite program. They do this with
7 varying degrees of skill. They are hampered at the present
8 time by the need to move from old patterns to new ones.

9 But in general I think the process is representing
10 region by region the emergency of an understanding of what
11 they should be.

12 For example, just to add one more comment to it,
13 if it is true that comprehensive health planning plays a
14 significant role or should play a significant role in what
15 an RMP does or what other federally supported activities do,
16 then to have a strict kind of description of what RMP is
17 based upon that as a theory, when the fact is that B
18 agencies and A agencies are highly variable, would be a sad
19 mistake. I can point out areas for you, and you know them,
20 too, where there is a powerful B agency in an RMP. And I
21 can show you the reverse. And the circumstances which
22 prevail in those communities are totally different. And they
23 need to be measured by the kind of specific site visit and
24 review mechanism which is carried out here.

25 It is not a program like a university which admits

1 so many people, graduates so many people. It doesn't have
2 this kind of a finite function. But I think its purposes are
3 becoming clearer and clearer.

4 I think this Review Committee from my point of
5 view is an essential part of the activity. If the Review
6 Committee decided that it didn't need to do what it has been
7 doing we would have to go to the trouble of forming another
8 one, because it adds tremendously to this review process,
9 and at this point I can't feature a way in which we could
10 operate intelligently and honestly without that input,
11 including all of the differences which we have this morning.

12 DR. MAYER: We have a motion that is on the floor.
13 Let me see if I can recapture at least, if not the precise
14 wording, the intent of the motion -- that the motion
15 recommends to the Council of the Regional Medical Program
16 that the Council consider the adoption of a policy which
17 would insure that before funds are awarded to an individual
18 Regional Medical Program that that individual RMP was in
19 compliance with the Civil Rights Act, and that furthermore,
20 that they further consider the establishment of a policy
21 which would insure that regions not be reviewed through the
22 existing review process until such clarification of compliance
23 were there.

24 Now does that catch it or not?

25 DR. BESSON: Yes.

1 DR. MAYER: Okay. Further discussion of the motion?

2 DR. WHITE: I wonder if the originater of the motion
3 would define compliance for us.

4 DR. MAYER: The question was what is meant by
5 compliance.

6 DR. BESSON: Is there a body in HEW that is charged
7 with the authroty of definition?

8 DR. MARGULIES: Yes, the whole structure which
9 enforces the Civil Rights Act has measurement of compliance.

10 DR. BESSON: Is there a division that is assigned
11 the responsibility of doing so for HEW?

12 DR. MARGULIES: Broadly in HEW, yes, for all of HEW.
13 There is in education, there is in health, there is in
14 welfare.

15 DR. BESSON: Then I would ask that the application
16 be presented to the Review Committee with the definition
17 outlined by that group.

18 MISS KERR: Maybe I am getting to a simplified
19 version of this, but a ball park figure -- and as I have
20 been reviewing regional medical programs, making site visits,
21 etc., I tend to come to the conclusion that they are complying
22 if there is an equal representation percentage in the
23 people involved and in the staff as we find in that particular
24 region. That is the only measuring stick I have had to go on.

25 MISS ANDERSON: Includes females, too.

1 MISS KERR: Well, I can't argue that. You know, I
2 don't have much -- but, for example, there are Regional
3 Medical Programs in which there are ethnic groups, quite
4 sizeable ethnic groups, for which I have seen no
5 representation. There are others I have seen them very well
6 represented. So this is the way I have been measuring.

7 DR. MARGULIES: Well, you realize that this would
8 have to include compliance on the part of the grantee agency,
9 which means that every university, every medical school, every
10 state society which is responsible as a grantee agency
11 would have to show compliance with civil rights in all of its
12 contracts, in its construction, in its employment, in its
13 staffing, in the way it handles its faculty, and at the
14 present time this also includes proper identification and
15 advancement for women in employment or on faculties, which,
16 as you know, is quite an issue in itself.

17 DR. BESSON: I don't care about the details. It
18 is the principle.

19 DR. MAYER: Joe.

20 DR. HESS: I wanted to ask, Jerry, if you had
21 any time deadline in mind in making this motion, and if so,
22 the administrative mechanism for dealing with that deadline
23 in terms of ability of the arm of the federal government that
24 deals with this question to get in and participate in a
25 meaningful way in this process so that proper certification

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could be done in keeping the review cycle and process--

DR. BESSON: Well, Dr. Hess, I am sure that we could discuss for another week the reasons why it is impossible to accomplish or implement this motion. But if the Council decides this, then it is for staff to have the problem of implementation. I am interested in the principle involved, and I am interested in assuring ourselves as a review committee that this question is considered by Council; and maybe the details make it impractical, but this is a question that we are discussing, whether the weights that are assigned here for judgment of the ranking of an individual region could not have minority interests changed from the weight of 7 to a weight of 16 as a sine qua non. That is all. Now that may be impossible to implement. But if that is the case then staff will have to decide that with Council.

But I am not being coy when I say that is not my problem. It really isn't. I am interested in laying out the philosophical basis for this principle.

DR. MAYER: Further discussion of the motion?

MR. ARDELL: I would like to say I wonder if there isn't a little different area of concern here, and that is as it relates specifically to the RMP, because really there is no application that can be processed in this Department that does not comply with Title VI as one of the

1 assurances. It is in the boilerplate in every application
 2 that we review. And I think you are really concerning
 3 yourself more with do we take a hard look at what the RMP
 4 is saying it is doing in the way of providing for minority
 5 involvement, minority support, et cetera.

6 Now if that is not so, then I think what you are
 7 asking us to do is to really go behind the assurance that the
 8 Department has already received from every applicant to make
 9 sure in fact that this is true.

10 DR. BESSON: Well, I am not satisfied that that
 11 is enough. I think as regions read the tea leaves daily --
 12 and I am sure they do try to decipher the vibrations that
 13 are emanating from this august body and its counterpart,
 14 Council and administration, I am interested in sending them
 15 a message, and even if we gain no more than 10 percent or 5
 16 percent or 2 percent, 1 percent enhancement of this effort
 17 by means of this message, I think it is in the right
 18 direction. If we gain a hundred percent that would be fine,
 19 too.

20 DR. MAYER: Further discussion of the motion?

21 DR. SCHERLIS: Dr. Besson, you stated you are
 22 interested in principle, yet as I read your motion it is one
 23 of exactly logistics, because you are saying either they
 24 are in compliance or not, and if they aren't then that's it
 25 as far as funding or even consideration of review. And I

1 would wonder whether or not you could redefine your motion,
2 perhaps after a coffee break, to bespeak more to the principle
3 than the logistics.

4 DR. BESSON: No, I think the principle has no
5 meaning unless it has the teeth of funding. I think that
6 is the only weapon--

7 DR. SCHERLIS: I was just using your definition of
8 your motion, and you recognize it has having teeth in principle.

9 DR. BESSON: I do indeed. Our only leverage
10 is funding, and unless we can speak with funding we have no
11 voice.

12 DR. MAYER: Further comments?

13 MR. PARKS: Well, I will make one other comment.
14 The total responsibility for monitoring this does not rest
15 with the officer in the Secretary's office that is charged
16 with -- or the civil rights compliance unit -- but there
17 are some very specific federal agencies that not only oversee
18 this, but will help you implement, and that is their
19 specific charge. The Civil Rights Commission is one. The
20 Equal Employment Opportunity Commission is another. And
21 there are various state and other agencies that would impact
22 upon your universities and various other kinds of operations,
23 and that is a matter that I would leave to some extent to
24 their expertise; and certainly in terms of burden it should
25 represent only a mythical burden in terms of what this staff

1 would have to absorb.

2 I would think in terms of notice that they have
3 had notice about a law that has been passed or an executive
4 order that has been published ever since it has been uttered
5 either by the Congress or by the President, and certainly
6 presumably all factions of society, both donors and donees,
7 public and private, have had notice that the law is there
8 and understand that the law is to be complied with.

9 All we are asking here is that we come out with a
10 policy position which clarifies what is or what should not
11 be done, and I think this is not just a thing that we are
12 going through here in terms of something nice in principle.
13 It is indeed an obligation. And I think most of the people
14 here, certainly every one of your public officials, including
15 you, Dr. Margulies, and your staff people, took an oath
16 when they embarked upon employment as a federal employee.
17 I think this motion that is here, it simply calls upon them to
18 live up to that oath, calls upon the Council to take a
19 policy which would encourage that.

20 DR. MAYER: Dr. White.

21 DR. WHITE: I think the passing of a resolution of this
22 sort simply strengthens the concept of tokenism. I think
23 our responsibility along these lines is to make sure the
24 program the Regional Medical Program proposes attends to the
25 needs of these people.

1 DR. MAYER: Dr. Hess.

2 DR. HESS: I have some real trouble with the wording
3 of the motion as it now stands. I think if this were accepted
4 literally the way it was stated that it would be much more
5 destructive than it would be constructive. And I am totally
6 in sympathy with the principle which you are trying to get
7 across, but to say that there would be no funding would
8 be destructive, it seems to me, of many of the good things
9 which are going on in RMP's which are indeed reaching and
10 helping many of the very people that your motion is saying
11 they are going to help. So I will have to say the wording
12 of the motion as it now stands is one I cannot support even
13 though I am in favor of what I think is the principle.

14 Now if you want to modify that and say further
15 increments, without an absolute cut off -- the implication
16 of your statement is that there would be absolute cut off of
17 funds and the dissolution of Regional Medical Programs,
18 and I do not think that would be constructive action. But
19 the message that you are trying to get across it seems to me
20 would get there by some further emphasis on this as part of the
21 review criteria and a modification of the rate at which
22 new funding is granted based upon heavier emphasis on this
23 particular criteria. I think you get the behavior that you
24 are looking for, but without destroying what is already there.

DR. BESSON: How would you modify it? I will

1 accept a modification if it is in line with support of the
2 principle.

3 DR. HESS: Something to the effect that consideration
4 for further increments of future funding will not be
5 considered until there is assurance that the region is in
6 compliance with the Civil Rights Act, or however that might
7 be worded, putting the emphasis on the further increments
8 rather than all funding, which is the way I interpreted your
9 motion.

10 MR. ARDELL: You see, that statement can be
11 questioned because we wouldn't make a grant unless -- so I
12 think what you are really asking us is to go behind that
13 compliance and see really if it has been implemented.

14 DR. MAYER: We will take two more comments and then
15 we are going to vote on the motion.

16 DR. SCHERLIS: Are you telling us that every region
17 states that it is in compliance?

18 MR. ARDELL: Every grant program must be, before it
19 can be funded, in compliance with Title VI of the Act.

20 DR. SCHERLIS: Then what we are being asked to vote on is
21 a modification of this. Do we investigate to see if they
22 are indeed in compliance? Because on the one hand we have
23 written statements testified to by responsible--

24 DR. LEWIS: I think I share the problem with
25 Dr. White or that Dr. White articulated very nicely, insofar

1 I think if you vote against any such resolution you are at
2 risk of at least upsetting your own emotional feeling towards
3 bigotry, and I feel personally that the obstruction that
4 we have been discussing right here is virtually impossible for
5 me to interpret since I really don't know what any two people
6 around this table have meant when they talk about compliance
7 and what kind of details that really means, and I don't
8 know whether this intent at abolishing one form of prejudice
9 might not actually allow for the exercise of other forms
10 of prejudice if we become highly detailed as to whether a
11 region get all of the money due to it or not. And what I
12 would really rather see is a test case; that is if a region
13 that is up for its triennium is one that Mr. Parks or
14 anyone else at this table is questioning in terms of having
15 such a low score in this particular category as to whether
16 it actually is in compliance with the Civil Rights Act, then
17 I would like to bring that up to task.

18 But to make this across the board a motion is
19 to me a difficult thing to fathom because I really don't know
20 how I can vote for it, but I don't know how I can vote
21 against it.

22 DR. MAYER: Dr. Thurman.

23 DR. THURMAN: I think that many of us share the
24 concern of being labeled bigots, and for that reason I would
25 to propose a substitute motion, and this would be to go back

1 to what Jerry said initially, to propose that we ask the
2 Council for permission to let us as reviewers consider this
3 in our site visits over the next three to four months, about
4 how compliance can be adjudged, because we have the
5 prerogative as site viewers to come back and say that
6 piece of paper that you signed is a piece of garbage and we
7 want some officer to investigate. This would be a much
8 more meaningful approach than for us to get hamstrung at
9 the present point in time with a motion that some of us
10 find we have to vote against, but yet we don't want to be
11 labeled bigots.

12 This would give us a point of four months -- and
13 I think Mr. Parks could live with four months, having lived
14 with it for X number of years -- to let the reviewers as
15 they go to a place say "what does your statement of compliance
16 really mean, you signed it, what does it really mean,"
17 because we still have the obligation as site reviewers to
18 request a compliance visit be made. That is our prerogative as
19 the site reviewer.

20 So I would offer that as a substitute motion, not
21 as a delaying action, but rather than keep from being labeled
22 as a bigot, as Dr. White and others said, because I have to
23 vote against your motion as it stands. So I offer that as a
24 substitute motion.

DR. BESSON: Well, I would be willing to accept

1 that as a substitute motion if we do have some indication on
2 the review form that compliance is indeed more than just
3 pro forma. That is really what I am interested in. I think
4 we have a responsibility to determine the accountability of
5 a region for compliance. I don't know that this is being
6 done. I don't see it on the portion of the documents that
7 I reviewed at any time. And if such a statement could be
8 incorporated then I would be perfectly satisfied.

9 MR. ARDELL: There is an assurance in every
10 application.

11 DR. MAYER: Let me see if I have caught the
12 substitute motion then. It is up to both the initiator of
13 the motion and the seconder of the motion as to whether they
14 will accept the substitute motion or whether they will
15 not, and we will vote on the original motion. So I gather
16 the intent of Dr. Thurman's motion would be that we would
17 recommend to the Council that the Review Committee as it
18 participates in the review process be encouraged by Council
19 as a matter of Council policy and as an indication of
20 Council policy to give particular attention in their review of
21 the program, both in site visits and in this committee, to
22 the issue of compliance with the Civil Rights Act, and --
23 well, I think that is essentially it.

24 DR. THURMAN: And if question arose we could ask
for a compliance officer to visit.

1 DR. MAYER: And you heard that -- if question arose
2 that we would have the right to ask for a compliance visit.

3 DR. BESSON: Could we after that have some
4 documentation that this has taken place as part of the
5 material presented to us without accepting it tacitly?

6 DR. MAYER: The implication being, Jerry, that
7 each site review process -- the intent of the motion would
8 be that each site review process would carry out the motion
9 and document that they have in fact carried it out.

10 DR. BESSON: Yes.

11 DR. MAYER: Is that clear? Is that an acceptable
12 substitute motion?

13 DR. BESSON: Yes.

14 DR. MAYER: Is it acceptable to you, Mr. Parks?

15 MR. PARKS: Well, with this exception. I take
16 it that it does not mean that we should really dicker with
17 whether they complied with what the law is or not. I gather
18 that is not at all the intent of this motion, because there
19 is a requirement that there be affirmative action, plans,
20 various other kinds of things which are very specific. Is
21 that--

22 DR. THURMAN: That is correct.

23 MR. PARKS: I will go along with it.

24 DR. MAYER: Does everyone understand the substitute
25 motion?

1 DR. SCHERLIS: Could you please repeat it?

2 DR. MAYER: Well, let me try it again. That
3 this Review Committee is recommending to Council that
4 Council establish a policy in which they instruct those
5 participating in the review process, whether that be site
6 visits or this review activity, that a special interest be
7 given to, and attention to, the issue of compliance of
8 the individual regions with the Civil Rights Act, and that
9 as a part of the review that documentation occur in each
10 and every instance that that has in fact occurred in the
11 review process.)

12 MISS KERR: There was also an added stipulation,
13 wasn't there, that if the reviewer felt--

14 DR. MAYER: Oh, yes. And if in fact the reviewers
15 felt that there was some question of compliance that they
16 would have the right and responsibility to request that
17 appropriate review of that issue occur.)

18 Does that catch it?

19 DR. THURMAN: Very good. Fine.

20 DR. MAYER: Leonard, does that clarify it for you?

21 DR. SCHERLIS: (Nods.)

22 DR. MAYER: All right, further comments?

23 MISS KERR: Question.

24 DR. MAYER: All those in favor of the substitute
25 motion?

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(Chorus of "ayes.")

Opposed?

(No response.)

All right, let me say that I would like to now welcome Mr. Robert Toomey on board. I hope that you weren't holding back because of newness. I can assure you that that will wear off very rapidly as we go along.

Let's take a 20 minute break or so for coffee that Leonard asked for a half hour ago.

(A recess was taken.)

DR. MAYER: I think we have gotten the audio back on across the table. We haven't been able to do anything yet about the heat situation. We have left the two doors open. Does anyone have any concern about that?

I would like to move on to the kidney disease program.

MR. HILTON: Mr. Chairman, if I may, could I just interject one thing before--

DR. MAYER: Yes.

MR. HILTON: I would just like to make a motion. I think in our capacity as being advisory to the RMPS staff it might be appropriate for me to make this motion, and by way of doing so just to briefly for a couple of moments revisit the topic of discussion earlier with regard to minority interest. Someone had raised the question of

1 compliance and what it meant and whether or not there was in
2 existence a checklist. To my knowledge there isn't. There
3 is usually a glowing statement somewhere that suggests
4 really a spirit document, the spirit of the law being such and
5 such; and I suspect that you can trust under the motion that
6 was passed just before we broke that some reasonable
7 efforts will be made to insure enforcement on that.

8 I would like to approach that angle from a different
9 point of view, something that we can do locally on the staff
10 if we are so inclined. We found in my state of Illinois
11 that we talk about the spirit of the law and the spirit of
12 compliance, people are best able to respond to that
13 effectively if they have the self-interest, the personal
14 self-interest, the determination, and creativity to look around
15 and see what it is they need to do to comply. It is often
16 a situation, as someone mentioned earlier, nice people who
17 simply haven't thought of this or overlooked some things
18 that they could do.

19 In response to that problem locally in our own area
20 we pulled together what really might be considered a kind
21 of brain trust, of people who have the interest, the
22 determination, the creativity to put special attention on this
23 particular problem area. They advise us as to how we might
24 best go about complying as a free consultant kind of service
25 to the organizations and the various publics we serve, and I

1 think that might help the problem, if there are people who want
2 to comply with the civil rights legislation but quite honestly
3 don't know how, and what for very understandable reasons
4 wouldn't know how. It doesn't necessarily affect them; as
5 our society runs right now most of the people who comprise
6 the establishment are not the people this compliance was
7 designed to benefit.

8 I wonder if it might not be appropriate for RMPS
9 to consider the possibility of incorporating in its overall
10 operations a kind of brain trust, an advisory kind of group
11 of this sort, subgroup, that relates specifically to this
12 issue; not an enforcement body -- I would stress that -- but
13 really an agency that reviews or looks at the various programs
14 and their needs and makes suggestions to those coordinators
15 and RAG groups as to what might be done in their particular
16 locale to make them relate more better to the Indians or
17 chicanos or whoever happens to comprise a good bit of
18 their constituency.

19 DR. MAYER: Leonard.

20 DR. SCHERLIS: If I could respond by asking a
21 question. Are you impressed with the good results of the
22 brain trust in Illinois? And I don't want you to go on record
23 as answering it, because the RAG of Illinois has 4 of 47
24 who represent minority groups, and looking at just the sheer
25 data, having shared the site visit in Illinois, I would not

1 suggest that this would be the route that might be the most
2 successful to contemplate for the rest of the RMP's.

3 MR. HILTON: I might suggest I wasn't talking about
4 the RAG of Illinois. No, I was talking about our own
5 educational concerns in Illinois. I am quite impressed in a
6 negative kind of way with our own -- no, we would like to
7 do this with the RAG of Illinois.

8 DR. SCHERLIS: I was just wondering how we were de-
9 fining success.

10 MR. HILTON: Right.

11 DR. MAYER: I think this is a very appropriate
12 suggestion. What we have done from time to time over the
13 last umpteen years now, we have made suggestions to the
14 staff relative to those kinds of things that they could do
15 that would be helpful in the process, and staff has consistently
16 been responsive, I think, to those needs. I think the
17 message has been heard very clearly as a suggestion in relation-
18 ship to how you go about implenting if the Council accepts
19 our proposal.

20 Now I would like to move on then to the kidney
21 proposal. Dr. Hinman.

22 DR. HINMAN: Thank you. I will follow the order on
23 the agenda, although it is not necessarily the order of
24 development of activities in the kidney program in the
25 Regional Medical Programs Service.

1 At your last meeting you posed four questions to
2 Council, by resolution, and I will report back their answers.

3 The first question was whether the Council recommends
4 that money apportioned for renal disease be considered in a
5 proportional ratio to the total amount of money of the RMPS
6 budget. And the Council answer was no.

7 The second question was whether the total amount
8 of money--

9 DR. MAYER: Wait a minute. Slow. Maybe we better
10 make sure we have got that one. Let's take them one at a
11 time.

12 DR. HINMAN: Well, the first two are really almost
13 one question. That's why I was going to it.

14 DR. MAYER: All right.

15 DR. SCHERLIS: Can we turn off that clicking sound?
16 We have enough static as it is.

17 DR. MAYER: Why don't we go on, and we will try to
18 get at that.

19 DR. HINMAN: The second question was whether the
20 total amount of money spent in a given region for renal
21 disease should be in proportion to the total amount of dollars
22 being spent in that region. Now the answer from Council
23 to that was also no. The philosophy -- well, principle here
24 being that we are not a categorical program nor is money
25 allocated by Congress or apportioned in a totally categorical

1 fashion, nor is it our desire to become a categorical program
2 again in the narrow sense of the word. And this was what
3 lay behind the answers to those two questions.

4 DR. MAYER: Are those two clear? You all have
5 a copy of the questions now. Comments on those two?

6 SISTER ANN JOSEPHINE: Are we running into a
7 problem -- I know if they say no the answer is no, but I would
8 like to raise a question. On number two it would be possible
9 if there were a group who could really push through proposals
10 for renal projects in an area where maybe the amount of money
11 allocated to the program would not represent an allocation
12 commensurate with the needs in the area, and that would be
13 the thing that concerns me.

14 DR. HINMAN: We are very concerned about this, and
15 when I talk about our new proposal for the review mechanism
16 for kidney disease, which is item number five on my list
17 assigned, it will come to that. But we are concerned that
18 kidney not be necessarily the dominating part of any one
19 program.

20 However, the point was made that the treatment of
21 in stage renal disease requires a coordinated, cooperative
22 effort of various providers throughout a region, and if
23 agreement or cooperation can be secured among these providers
24 in the area of in stage renal disease this might be a
25 mechanism of bringing the region into a regionalized approach

1 to the treatment of other patients and the handling of other
2 health care issues. And I think that that is a valid point,
3 that there are regions in which the nephrologists and
4 transplant surgeons may be further along and they are being
5 willing to cooperate between institutions than other types
6 of providers.

7 So that Council discussed the very issue that you
8 have raised, Sister, and because of the tremendous cost of the
9 resources in in stage renal disease, but felt that we should
10 not take an arbitrary position either way, but handle it on
11 the merits of the individual region and their total program;
12 not projects, but their total program.

13 DR. MAYER: Okay, third question.

14 DR. HINMAN: The third question was whether renal
15 programs funded by the regions will come out of their total
16 budget or out of a separate budget. The review and funding
17 will be done on a semi-separate basis, but it will be their
18 total budget dollars when it goes back to them in the advice
19 letter. Confusing?

20 In other words, if region X has a kidney program
21 approved for \$50,000 and their total budget is two million
22 dollars -- their total budget is two million dollars, then
23 the fifty thousand has to come out of it. In other words,
24 the total award includes the kidney dollars.

25 DR. MAYER: Do they have the same degrees of freedom

1 with it after they get it that they have with the other?

2 DR. HINMAN: You mean in the anniversary triennium
3 sequence?

4 DR. MAYER: Let me give you a for instance. This
5 group decides that it approves a million and a half for
6 a region, and it also has a half million dollar kidney
7 proposal which the ad hoc review group reviews and think is
8 fine and we think is fine and Council thinks is fine, and it
9 has an award of two million dollars. All right. What I
10 am saying is can they, if their original proposal had four millic
11 dollars in it and we only approved half, can they take
12 that half million dollars of renal money and pump it into
13 something else, or have they got to pump it into kidneys?
14 If you excuse the pun.

15 DR. HINMAN: I really don't know the answer to
16 that question.

17 DR. MAYER: Well, it is an important question.

18 DR. HINMAN: The question that was asked, Herb,
19 was can a region take kidney money out and pump it into
20 other programs. In other words, if there was a total award
21 to a region of two million dollars of which \$500,000 was
22 kidney money, could that RAG then pull 100,000 out of that
23 back into other program areas.

24 DR. PAHL: I think we would want to have a request
25 for approval come in to RMPS for a major change like that.

1 DR. HINMAN: Is that any different from any other
2 major program change?

3 DR. MAYER: Now let me -- it is different. Maybe
4 I don't understand the ground rules. All the question I
5 am asking, Herb, is when we send back an award we send it
6 back with some advice and then we delete some projects, but
7 in essence we usually approve most of the projects, et cetera,
8 that they have in it, and if that is four million dollars
9 worth of stuff and we gave them two million dollars, it is
10 my assumption that what the regions are now doing is coming
11 back in to you with a proposal that says okay, this is how
12 we are going to spend the two million dollars and you
13 allocate it. And you say okay, sign off.

14 Now what I am saying is if that goes back and a
15 half a mil of that two mil is kidney disease and they come
16 back in with no kidney disease in that project, or only
17 200 thou of kidney disease in that project, do you treat that
18 any differently than anything else.

19 DR. PAHL: Jerry is shaking his head. He may have
20 some personal experience.

21 MR. ARDELL: Not really personal. I was thinking
22 that again it boils down to what is considered a significant
23 change in the scope of the program as it was determined to be
24 funded, and if reducing a sizeable amount of money going
25 to kidney into something else I would think that our review

1 process should at least get the blessings of the director of
2 the service for moving in this direction. I think that is
3 probably open for discussion. But that is the intent of the
4 whole system as I have interpreted it myself, that significant
5 changes really, we ought to be informed in advance rather
6 than after the fact. If they are less significant then I
7 think that they do have the prerogative to move ahead and
8 just inform us after the fact.

9 DR. PAHL: Well, I think what Jerry is saying is
10 what I thought I was saying, that we are not treating it
11 differently than any other major change, but we will consider
12 that, I would believe, to be a major change.

13 DR. MAYER: Ed.

14 DR. LEWIS: I'm reassured that the word categorical
15 is considered a vulgarity in these chambers, because it saves
16 me using a lot of other words. The thing that tickled me
17 about the answer from Council was that we had a real problem here
18 the last time and we asked them a question which amounts
19 to "is this pen black or white," and they came back with
20 the answer "yes," which is absolutely right. But I take it
21 from Dr. Margulies that kidney activities will account
22 for 8 to 8 and a half million dollars of this 135 million
23 dollar budget for this fiscal year, that there is some
24 categorical consideration to the way in which kidney projects
25 are funded, and I would like to have clarification of that

1 specific point.

2 I just wonder if there was someone who was at the
3 Council meeting who is aware of whether they really took it up
4 as that specific point or whether they indeed took it up as
5 is this pen black or white because this we knew already.

6 DR. HINMAN: Well, Ed, as you know, there are
7 certain constraints upon the allocated dollar that come to
8 RMPS even though they are noncategorical, specifically the
9 AHEC and the HMO types of constraints. The kidney is not
10 a constraint in that same context, but it is a level that
11 appears to be in the context of the total RMPS program
12 and the total request coming in from the regions, a figure that
13 is a fundable figure that is discussed between RMPS and the
14 office of the administrator and the various other parts of
15 the budget cycle.

16 That is a vague answer, but the process is not as clean
17 and crisp as is the pen black or white. At the end of this
18 fiscal year it is our anticipation that the total dollars
19 that could be identified as going into kidney will be
20 in the order of magnitude of eight to eight and a half million.
21 That does not mean that we are setting out to spend eight and
22 a half million dollars.

23 Maybe it would be appropriate to talk about how
24 we intend to handle the review process of kidney at this
25 stage instead of later.

1 As was stated I think at the last review committee
2 meeting, if not, it had occurred or was occurring by the
3 time of the Council meeting, the ad hoc renal panel is not
4 meeting any more. It had its last meeting early in September.
5 The idea that was behind this was Dr. Margulies' desire to
6 include kidney as well as the other programs in the total
7 regional development activities of a particular region.
8 However, because of some of the peculiarities of the renal
9 disease funding necessities, some of the gaps between the
10 state of technology and the delivery in many areas, it will
11 still continue for a period -- I don't know whether that is
12 one year, six months, or two years -- to be handled in
13 a semi-separate fashion.

14 We are working on the guidelines at this time, and
15 they will go something like this. When the renal group in
16 a particular region has an idea and begins to discuss with the
17 local RMP that they would like to submit an application
18 or proposal for support of their program the RMP is to refer
19 them for consultative assistance to RMPS. Someone on my
20 staff will assist them in explaining the guidelines that are
21 appropriate at that time, and new guidelines are being written
22 to update the November, 1970 ones, and advise them as to
23 whether the idea they have would seem to be at least in the
24 realm of activities that are appropriate for the limited
25 dollar that RMP has at this time.

1 If they continue -- they can at that point decide to
2 continue and submit a proposal or not. It is their decision.
3 If they do submit the proposal to the local RMP, the local
4 RMP will be instructed to have a local technical review,
5 it will be recommended that they include experts from outside
6 their region, but that will not be mandatory, and we will
7 be maintaining a list if they ask for assistance here to
8 give them names of people that could assist on this local
9 technical review.

10 Following the local technical review it will go
11 to the Regional Advisory Group the same as any other element of
12 the RMP program. It will then be submitted to the Regional
13 Medical Program Service, at which point my staff will be
14 asked -- Bob Chambliss's staff will be asked for two
15 certifications that will go with it to the Review Committee,
16 i.e., you. The first certification is as to the adequacy
17 of the local technical review. In other words, whether in
18 our judgment it was an adequate review on the basis of the
19 documentation furnished by them, that the people that
20 reviewed it were indeed competent -- or I shouldn't say
21 competent, but at least should have been included in a
22 review committee and whether they did review it, and that
23 this was considered by the RAG, the recommendations from
24 this committee.

25 The second certification would be as to the adequacy

1 of that RMP to administer the program that is requested.
2 And that gets to the question that I think was behind
3 Sister Ann's question, and that is whether this would be so
4 skewing to the local region's program that they could not
5 effectively carry out their total program activity and
6 administer the kidney one.

7 This certification or absence of certification would
8 be before you as part of the packet that you would have for
9 the review of that particular region, and it would then
10 stay in the cycle.

11 DR. LEWIS: Can I respond to that?

12 DR. MAYER: Yes.

13 DR. LEWIS: I have to articulate my response in the
14 knowledge that I am assuming an attitude of general
15 belligerence and will probably upset a very longstanding
16 happy relationship with Dr. Hinman. But I really must
17 look upon -- Dr. Scherlis wants to turn my microphone off --
18 I must look upon what you have just said as a very naive
19 approach to spending a limited amount of funds in a field
20 that requires a lot of money, because it is very clear
21 that the ad hoc review panel was originally formed because
22 of the requirement of technical assistance, but also because
23 it appeared that there needed to be a body that was able to
24 determine more than local activities. That is, there had
25 to be an overview as to how much kidney activity was going on

1 around the country or in the areas surrounding a given region.

2 Now it seems to me that what we have done is this.
3 I honestly believe in view of the fact that RMPS has
4 articulated decentralization that something like a central
5 ad hoc review committee is an embarrassing thing, politically
6 embarrassing particularly. But I think that what has been
7 done is this -- that we are now asking the regions to
8 construct their own programs which they are doing anyway.
9 In order for them to even construct the program they have
10 to include virtually every element of expertise in the renal
11 field in the region, otherwise it wouldn't be a regional
12 program. So obviously the region's program will reflect
13 the special interests of all of the expertise within that
14 region.

15 Then we supply them with a list of people from the
16 outside who are consultants, but they are only consultants.
17 They cannot tell the region -- they can pass some judgment on
18 whether the technical capability is there, but they cannot
19 pass on judgment as to whether the region is asking for
20 a Cadillac, a Buick, or Chevrolet, because they have no
21 authority to do that. So a region can very well come
22 through with a proposal for \$750,000 when it only needs one
23 for \$250,000, not because they are trying to cheat anyone,
24 but because they would honestly like their patients with
25 kidney disease to be in a Cadillac rather than a Chevrolet.

1 And I think that this really puts renal programs into the
2 area of political interests rather than into the area of
3 technical interests where it should be.

4 And I might add that I think that this renal area
5 and the way in which it has been approached is a very good
6 example of the way in which the Review Committee has been
7 emasculated in terms of having an input into RMP activities,
8 because all of this has gone on without any indication to
9 myself, or as far as I know, any other member of the
10 Review Committee in terms of how this thing would be organized,
11 how things would go forward from here or not.

12 When you said, Ed, that these programs would come
13 through and be passed on to you on the Review Committee
14 I can guarantee you that you were looking straight at me
15 because the renal programs are being passed down to this
16 end of the table, the reason being that most people who do
17 not have nephrology expertise are not willing to pass
18 judgment on these very expensive and highly technical things.
19 And I can tell you that all that I am is a rubber stamp, and
20 if the other members of the committee will permit me, I will
21 tell you that I am not about to be the in-house nephrologist.
22 I think that this is a very poor way in which to approach
23 the role of the Review Committee in such a technical and
24 expensive field.

DR. HINMAN: Let me respond. There are several

1 points that you raised. First, my concern is that there be
2 Chevrolets for all the patients throughout the country,
3 not Cadillacs.

4 Secondly, there are other very technical projects
5 that are submitted for review by this committee, and to my
6 knowledge none of them are shunted to a particular specialist
7 or individual because of a particular area of expertise.
8 I am not sure that kidney should be treated any differently from
9 anything else in that respect.

10 Third, this could all become a very major problem
11 if there were no guidelines to the regions as to the types
12 of activities that we are concerned with or feel that would
13 be appropriate for the RMP dollars to go into. As long
14 as there is going to be any special handling of money for a
15 particular area that has to be some sort of guidelines so the
16 regions and the applicants can know what it is we are talking
17 about. This was one of the issues you all spent a little
18 time on earlier, about communication from this office to the
19 regions.

20 We are concerned -- and that's the topic on the
21 agenda called life plan -- with whether a region has developed
22 a plan whereby any patient who is identified as being an
23 irreversible chronic renal disease and in impending
24 difficulties, i.e., unable to manage his own self and
25 needing assistance, should have available to him access to

1 care. This care includes medical management as well as the
2 adjuncts of hemodialysis and transplantation when it becomes
3 indicated. However, the costs of this, as Dr. Lewis pointed out,
4 are extremely high. The only way in which society --
5 well, that's getting awfully grandiose -- but the only way
6 in which we can begin to meet these costs is for it to be
7 on a planned basis in which there are adequate facilities, but
8 not duplicative facilities, in which the most cost effective
9 method of treating the patient is the treatment of choice
10 whenever possible.

11 So that we are developing a guide that we hope will
12 become accepted by the Council and accepted by the regions
13 as a method of going about it which will require that the
14 region have such a plan for care of their patients, that
15 the RMP dollars would be used for selected portions of
16 helping them develop the resource, the pieces of this plan;
17 so that with the assumption that the reimbursement mechanisms
18 as they are developing in most areas will continue to
19 develop to support the cost of the patient. This would
20 include an emphasis that early decision be made as to whether
21 the patient is or is not a candidate for transplantation, and
22 if not, whether the patient is a candidate for home hemo-
23 dialysis, and if not, whether a candidate for ambulatory center
24 which is a lower cost hemodialysis, and as a last resort
25 institutional dialysis when they reach that point.

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Dr. Scherlis.

DR. SCHERLIS: I admit to being a little further confused than I was even earlier, because if I am in the position of being a member of the site visit group or being a member of a local RAG and if I have before me several projects to choose from -- let me put myself in the position of being a member of RAG, with well defined goals and objectives, and if I see that we have X number of projects, one of which happens to be renal, and by the very nature extremely expensive, and by the very nature giving service to a relatively small group of the population, I would have to evaluate this service in terms of goals and objectives, and I would suggest to you that I would not support, looking at a priority system, any renal project on a local RAG priority basis if I am to look at the problem of the total delivery of health care services.

It is not that I don't recognize the fact of its importance, but I would suggest to you that when a site visit group goes out they will be faced with the same quandary, namely, unless there are fairly firmly designated funds that you will not see eight and a half million dollars spent, but you will see only a small proportion of this spent in terms of the total health needs, particularly as we look at the overall expanded efforts of RMP.

Now if I am alone in this point of view then that

1 would be an interesting finding that I would be led to believe
2 would not really exist.

3 I don't think the renal programs would really
4 get the support or the priority rating unless they are given this
5 by point of view of specifically designated funds. And I
6 would like to have some reaction from other members of the
7 Review Committee. It isn't that I am opposed to renal
8 projects, but you do jeopardize them by putting them in with
9 the general fund as far as seeking levels of support. I
10 would suggest that those that receive several hundred
11 thousands of dollars now would be cut drastically and
12 that funds be used by core for what are higher priority items
13 in that region at this particular time. This could very well
14 be what would happen, I predict.

15 DR. HINMAN: This is the justification for the
16 continuance of a semi-marking of funds.

17 DR. SCHERLIS: I wanted to ask you what you meant
18 by semi-separate. That was the best answer I ever heard to
19 an either/or response. Referring to question three, I
20 expected you to say yes, given that choice; but you said
21 semi-separate, and that confounded me further.

22 DR. HINMAN: This is the only program in which
23 there would be a partial earmarking of funds. Now the
24 word earmarking or separate funds is a very dangerous
25 phrase. If we start earmarking that a particular category

1 for one reason or another should be handled by eight million
2 dollars out of 135 or such thing, then the answers to
3 questions one and two are automatically going to start becoming
4 percentages and yes. And then the people that are interested
5 in other parts of the health care delivery system will be
6 seeking and pushing to get an earmarking of funds and we
7 are back to purely categorical project review.

8 We are attempting to resist this as much as possible,
9 recognizing that the gap here in renal disease is an
10 unusually great one, recognizing that there has been unusual
11 interest in the legislative arm of government to see to it
12 that there are dollars going into this program and trying to
13 juggle between the two. That's why I say semi-separate.

14 DR. SCHERLIS: Let's put this on the following
15 basis. We go to a region and they have asked for 2.9
16 million dollars, and we decide looking at the region that
17 their request of that funds includes \$750,000 for renal, and
18 we feel that the needs in that region are so great in other
19 areas that the renal program really does not deserve support,
20 particularly since we feel that the total request is out
21 of line. Therefore funding level is suggested which
22 specifically excludes renal.

23 Now what impact does your semi-separate funding
24 have on that decision, because the way that I would suggest
25 we might go would be back to a national group which is

1 specifically charged with the renal funding and attempts to
2 get some distribution and some sharing of these facilities
3 on a large regional basis, and I mean the joining of several
4 states together.

5 Could you first answer the first part of the
6 question, how would you counteract that?

7 DR. HINMAN: The first part, I cannot conceive of
8 enough funds becoming available for kidney that a \$750,000
9 project from a particular region would stand up unless it were
10 a nine-ten interregional project, and the review mechanism
11 for that has not been established.

12 DR. MAYER: Let's make it \$300,000, \$250,000.

13 DR. SCHERLIS: I'll settle for that, \$300,000.
14 Whatever it is we put a red line through.

15 DR. MAYER: The principle is absolutely critical.

16 DR. SCHERLIS: This is what happens when you go out
17 to a region--

18 DR. MAYER: This is what we asked the Council, and
19 what we are getting back is mush.

20 DR. HINMAN: I have the 20 pages of Council minutes
21 here, the stenotype of them.

22 DR. SCHERLIS: We asked that they answer yes or no,
23 and we can't say semi-separate.

24 DR. MAYER: Do you understand the question that
25 he has asked? That is a very important question he has

1 asked, Dr. Hinman. The question is what happens then by
2 semi-separate funding. Let's say we implement your review
3 process, and it turns out that you staff feels that that's
4 a good renal program, but that review group has gone out there
5 and said that's a good renal program but that's not what they
6 ought to be doing in that region at this point in time.

7 Where are we?

8 DR. HINMAN: Somewhere along the line what the
9 region needs has to be taken into consideration by either
10 you or by the Advisory Council, doesn't it?

11 DR. MAYER: That's the question we are asking.

12 DR. WHITE: May I make a comment?

13 DR. MAYER: Well, let me just pursue it, because
14 I have the feeling that if in fact the answer to his question
15 is that no further consideration is then given to that
16 renal project because in fact it is in fact within the
17 total region's activities that's being considered, then
18 what Leonard has originally suggested is that you are not
19 going to get out of this review committee anything that
20 even comes close to approximating eight million dollars worth
21 of recommendations for kidney disease, you will be lucky
22 if you get a half a mil. Now that's my guess. Now that's
23 a fact -- I suspect it's a fact. I see a lot of nods
24 going along, just as I saw them when Leonard made the
25 statement, and how are we going to deal with that?

1 DR. WHITE: Seems to me this is inconsistent with
2 what we are supposed to be doing these days. We are
3 determining, I thought, the quality of the region and its
4 ability to assess its own needs and the way in which it will
5 meet these needs, rather than our going out and saying to
6 them these are your needs. And if we make that decision
7 about kidney problems then we are usurping what they presumably
8 should be doing.

9 DR. SCHERLIS: In those regions when a renal project
10 gets to the local RAG it comes in differently. It really
11 doesn't compete for what else you are asking for. I know
12 that many RAGS approve renal projects because it is a
13 different way of presenting it to RAG. It's a different
14 priority because you are told don't worry about this funding,
15 that's a separate vehicle, it really doesn't come out of the
16 total support that we will be given. It's a completely
17 different type of support that has been discussed.

18 Now if a region knows that it is asking for X
19 dollars and they are asking for it with a renal project standing
20 side by side with what it feels are higher priority items--

21 DR. MAYER: And if they know this Review Committee
22 is going to look at it the same way.

23 DR. SCHERLIS: We are changing the whole way in
24 which it is presented. It won't get out of the regions to
25 get to us is what I am suggesting. I may be wrong in my guess.

1 DR. HINMAN: At the present time, though the Regional
2 Advisory Groups are not attempting to relate the magnitude
3 of the renal program to the total needs of the region either.
4 I mean you are caught between the rock and the hard place
5 here, because it should be taken into consideration.

6 I think Dr. Pahl was just -- do you want to make
7 the comment that you made to me?

8 DR. PAHL: I don't think it will clarify it except
9 to say what the present procedure is, and one that we have
10 no alternative at the moment but to follow, is that we are
11 requesting both the region and the site visitors review
12 committee to consider the kidney proposals as a separate
13 consideration from point of view of merit and involvement in
14 regional activities and in funding, and that these dual
15 recommendations, if there is a kidney proposal and
16 the regular regional medical program proposal, go to the
17 Council where in fact it has been up to this point also
18 handled in separate fashion.

19 We are identifying -- coming back to the budget
20 matter, we are identifying funds to the tune of eight and a
21 half million out of this fiscal year, but there is not
22 a hard line item in the budget. And I think this is where
23 some of the semantic difficulties come in about separate and
24 not separate. We have been required to identify for HSHMA
25 what our level of spending is anticipated to be for kidney

1 projects, and we hope to identify kidney activities at
2 that level by the end of this fiscal year. There is no item
3 within the Congressional appropriation which says that we
4 will spend that much money for kidney.

5 DR. MAYER: What you have just said then, Herb,
6 that it is separate--

7 DR. PAHL: Yes.

8 DR. MAYER: And we should consider it separate?

9 DR. PAHL: We are requesting that it be considered
10 separate and transmitted to the Council in that sense,
11 where they in fact up to this point, including the last
12 Council meeting, are also looking at the kidney proposal
13 in any RMP proposal as a separate issue, and at the last
14 Council meeting in fact have made separate motions relative
15 to the RMP level of support and the kidney.

16 Now I am afraid I can't clarify further, and I
17 would suggest that if further discussion is to occur that
18 we have Dr. Margulies here, because I don't think Dr. Hinman
19 and I can say anything except over and over again what we
20 have been telling you.

21 DR. MAYER: We went through this at the last
22 meeting and spent a lot of time on it, sent it up to Council
23 for a good reason, because this committee didn't know how to
24 act -- you know, they just didn't know how to deal with the
25 issue. Now, you know, if we are going to wait another three

1 months to find out how to deal with the issue, fine, tell
2 us. But my assumption was we were going to get this
3 resolved at this meeting so we knew how to deal with this.
4 And if you want us to deal with it separately then let's
5 talk about a review process that deals with it separately,
6 and I'm with Ed -- I think the review process you have
7 established doesn't provide me with what I need as a review
8 member. If we are going to deal with it together, then
9 we will deal with it together, and you will have a limited
10 number of kidney proposals approved by this, but the review
11 process is adequate. And I have to have an answer to that
12 one way or other.

13 MISS KERR: And we have to go one step further,
14 too. And that is if the regional program level is separate,
15 lest we have happen what we were discussing a while ago,
16 that they take the renal funds and use for another priority,
17 unless it is a separate priority.

18 DR. MAYER: Ed.

19 DR. LEWIS: Just in answer to your initial comment,
20 I really would not be so pretentious as to insult the other
21 members of this committee by suggesting that renal projects
22 or their scope are any more technical than any other project
23 or philosophically are different in any way. I think that's
24 absurd, and I have never suggested that. But what I would
25 suggest is that both historically in terms of Congressional

1 hearings and in terms of the spirit of why money was initially
2 given to kidney disease, and on the basis of there being
3 relatively few people involved, and however you want to look at
4 all subjects being equal, I can tell you that the budgets of
5 these kidney programs are a hell of a lot more than I have
6 ever seen pass through this committee, that the thing is a
7 separate topic. And I cannot sit in judgment of every one
8 of these things, and I would doubt very much that Doctors
9 Merrill or Shriner sitting on the Advisory Council would
10 want to. And I really think that what you have done is
11 essentially emasculated what was not a bad way of reviewing
12 things in the interest of decentralization, the politics
13 of noncategorical approach, and so forth. And right now I
14 am left in a situation where I don't know how to consider kidney
15 project, and boy, they are coming in in droves, I can tell you.

16 DR. SCHERLIS: Would the Chair entertain a motion?

17 DR. MAYER: Well, Dr. Pahl was getting ready to
18 comment.

19 DR. PAHL: Well, in Dr. Margulies' absence I would
20 suggest that within RMPS conceptually we are treating kidney
21 as a separate activity from the review process and the funding
22 level in the manner in which we have tried to state. There
23 is a real separation at the staff level, at the review level, and
24 at the Council level. And if it is appropriate to have
25 staff reconsider its proposed review process I think that's

1 most legitimate.

2 The best advice I can give you is that we are
3 requesting that you consider the kidney proposals separately
4 because we are into this semi-earmarking of funds and this
5 does require us to look at it in a separate fashion. So
6 the conceptual framework is, I think, quite clear, and we
7 must ask you for specific advice on the kidney proposals.

8 I think also it is fair again to have you look at,
9 consider, and advise us as to whether you think we now have an
10 appropriate process to do this or not. But I don't want to
11 leave you in doubt as to how we are reviewing kidney--

12 DR. SCHERLIS: I just want to ask one question.
13 What do we do when we go into a region and they say part of
14 our budget is a renal project. Do we say we don't want to
15 look at it because that has a separate mechanism, or do you
16 want us to say we recommend zero funding, in which case what
17 do you do in RMPS? This is the logistical bind that we are
18 in. I don't think I had an answer to that. I don't mean
19 to be difficult, but this is exactly what we face when we go
20 into a region now. What do you recommend we do, look at it
21 or not look at it, and what level do we look at it?

22 DR. HINMAN: We recommend you look at it as you
23 look at the rest of the program, but we hope to be able to
24 supply you with specific questions, concerns or comments from
25 their review to guide you in looking at it.

1 There were two site visits held during the December
2 cycle of site visits in which there were specific questions
3 posed that needed to be answered so that recommendations
4 could come to you today. We hope to be able to provide this
5 type of support for the site visit teams.

6 DR. MAYER: Let me try to get at the same question in a
7 different way. As I listened to your original report,
8 Dr. Hinman, I implied that the answer to question three, which
9 was whether renal programs funded by the regions will come
10 out of their total budget or out of a separate budget, my
11 initial reaction was to write down comes out of their total
12 budget; and when I got to question four from your comments
13 I implied -- whether renal programs should be considered outside
14 the total regional activity or not -- I wrote down not
15 outside.

16 Now what I heard Dr. Pahl say to me suggests that
17 what I answer to number three is it comes out of a separate
18 budget, not the total budget, and what I have also implied
19 is that it comes outside the activities.

20 Now we have just literally got to have an answer
21 to those questions or we can't function in the renal area in
22 the manner in which I think we have an obligation to function,
23 and that's why we sent the questions up to Council four
24 months ago. And I can't be more explicit -- I'm not trying
25 to be obstinate, I'm just trying to -- tell me what to do, and

1 by George, I'll go ahead and do it, but don't give me something
2 that I can't do or I object strenuously.

3 DR. HESS: I would like to ask for perhaps some
4 historical clarification at least as to why we are in this
5 dilemma with regard to renal disease. How come this is
6 treated in such a special way as opposed to coronary care
7 units or cancer treatment centers or any other kind of
8 categorical type activity? Is it a matter of political
9 wisdom that some people in Congress or somewhere else have
10 a real thing about renal disease programs and this is the
11 price that we pay in order to get favorable activity on other
12 funding for the Regional Medical Programs as a whole, or is
13 this something at the Council level, or where did this all
14 come from?

15 I think if we know the reason why we are at this
16 point in history it may be able to help us see our way out
17 of the current dilemma.

18 DR. PAHL: Let me preface my going off the record
19 by saying I will give you the best answer I am capable of.
20 Now I would like to go off the record.

21 (Discussion off the record.)

22 DR. MAYER: If that is the case I need to know then
23 what is the answer to question three and question four that
24 this committee asked of the Council.

25 DR. PAHL: Let me try once again. The Council

1 provides a budget to the region which specifies whether or
2 not the kidney activity has been approved in whole or in
3 part and specifies the dollar level for the approved portion
4 of the requested kidney activity. The applicant receives
5 one grant award statement together with the information
6 about the specifications. So trying to get away from the
7 semantics, there is one budget figure for the region which
8 is shown on all records, but which involves a number of
9 dollars specifically earmarked for whatever has been approved
10 by the Council for the kidney activity. In that sense
11 the region has one single total budget of which a portion
12 is earmarked by the Council.

13 From our point of view one grant award is given
14 out of RMPS funds, but we identify for the office of the
15 administrator and other units of government that a certain
16 number of these dollars are for kidney activities, the
17 sum total of which we anticipate will approximate eight
18 and a half million by the end of fiscal '72.

19 I hope that identifies total budget and separate
20 budget.

21 DR. MAYER: Now question four.

22 DR. PAHL: Well, let me first try to answer
23 point four, and perhaps Dr. Hinman can read you an appropriate
24 statement from Council.

25 We in RMPS believe that the kidney activities from

1 a program point of view should be reviewed at all levels
2 within the total context of the Regional Medical Program for
3 that area. So forgetting funding aside, we are interested
4 in having our own staff, site visitors, review committee,
5 and Council consider whether the program in kidney activity
6 proposed by the region makes sense for what the region is
7 proposing to do, and whether it has the capability to carry
8 out its total program, including its kidney activity.

9 We are not trying to keep it separate from a
10 conceptual or programmatic sense. Yet we must identify at all
11 stages that it is separate up to and including the funding in
12 the manner in which I have tried to explain to you.

13 DR. MAYER: But that's where we are on the horns of
14 a dilemma, because you can't do that. In other words,
15 if you go into a region and you take it within the total
16 context -- you know, what I indicated and Ed has suggested or
17 Leonard suggested might occur, will be that there will
18 really be that there will really be nonapproval of kidney
19 project after kidney project after kidney project, and therefore
20 the political decision that has been made -- and I am not
21 saying that that was an inappropriate decision, you know -- is
22 not going to be adhered to. So you can't unlink program
23 and dollars, and anybody who tries to unlink them is going to
24 end up with chaos. And that's where this committee is, and
25 we have to know whether you want us to review that as a part

1 of the total program, and including their funding, or whether
2 you do not. And if you do, you know, then are are going to take
3 one approach to it, and if you do not then there's another
4 approach to take to it, and it's really as simple as that.
5 It's not that complicated a question.

6 DR. PAHL: Well, I would have to state that since
7 we have spent several meetings and seemed all to be acting in
8 good faith and toward the interest that it would seem to be
9 that complex. We have requirements on us which we must
10 discharge which are complicated by the history, the political
11 context, and the funding. And yet we are attempting within
12 the concept of a Regional Medical Program to look at the
13 capability of their carrying out what they propose to do
14 and the manner in which they propose to utilize their own
15 staff and funds. And it is a dilemman, it's not the only one
16 we have. I really can't clarify what it is further that
17 we are attempting to do. I recognize the dilemma. I do not
18 have the answer for you. I believe that unless Dr. Hinman has
19 it from Council, which is a transcript which we will be
20 happy to place before you in xerox form, let you read and discuss
21 further, or read it to you, which is somewhat lengthy, or have
22 Dr. Margulies give you the clearcut answer, I cannot be of
23 further assistance in resolving the dilemma for you.

24 DR. MAYER: Then we have to resolve it ourselves. Is
25 that what you are saying? We will be glad to do that because,

1 you know, we have got to have some resolution. If Council
2 can't do it and staff can't do it, then we have to do it
3 ourselves. And we are glad to do that, I suspect.

4 DR. PAHL: Well, let me throw it open to staff,
5 because I really feel I have failed the Review Committee in
6 trying to do something which which Dr. Margulies apparently
7 to this date has not also been able to do either. Is there
8 anyone in the room that feels that they can state better than
9 I what we are attempting to accomplish or say it in such
10 terms that we can get off the horn, because we all are trying
11 to act in good faith, but I am unable to do more than what
12 I have just attempted. So I would have to say if it comes
13 to one or the other acting, you act and we will respond.

14 I would suggest before the committee takes the
15 action that you permit Dr. Hinman to read what he thinks are
16 appropriate sections which I think we can condense from the
17 Council transcript, because part of our difficulty is that
18 we are intermediaries and it wasn't that much clearer at
19 Council meeting. So if you would like to have it perhaps it
20 would be helpful.

21 DR. HINMAN: After the lengthy discussion about
22 kidney at Council Dr. Margulies summarized what he took to be
23 their sense of discussion, and they passed it.

24 "It is the sense of the Council that you wish to
25 continue to review on the basis of the merit of the proposal,

1 that you are not in the position to determine year by year
2 budgetary allocations; that you would like to be in a
3 position, however, to criticize the budgetary decisions which
4 are made and have some accounting of how those budgetary
5 decisions were made; and what you mean by regionalization of
6 being associated with regionalization of kidney activities, that
7 this can be either through an RMP or through a section 910,
8 but that it should be designed in such a way that it
9 services the broadest possible public interest."

10 DR. MAYER: That doesn't deal with the issue.

11 DR. HINMAN: I have a practical suggestion for
12 today, which is what you were getting to, Dr. Mayer. It would
13 seem -- and the thing that will allow something to be
14 transmitted to Council for them to have the dilemma would be
15 a three level thing. One, to approve or disapprove the
16 kidney projects that are in the particular regions you are
17 reviewing today, to establish a dollar level for the region
18 without the kidney project in it, and to suggest a dollar level
19 for the kidney keeping the total regional needs in mind.
20 Is that clear? Or possible, I should say.

21 DR. MAYER: Well, without having the individual
22 proposals before us -- you know, I was very fortunate in the
23 one I had which had a kidney proposal because I wasn't
24 presented with the dilemma because it did have ad hoc kidney
25 group report on it, and they voted against it, all three parts

1 of it, and so it solved my problem. I didn't have to face
2 the issue. But I suspect there may be one that is meritorious,
3 and then I don't know with the ground rules we now have how I
4 am going to make a decision relative to that, and I guess we
5 just have to wait until we get to that or we establish a
6 principle now in terms of how we are going to deal with it,
7 because it really relates to your proposed review process,
8 because depending upon the answer to that question I either
9 accept or reject, you know, the kind of assistance you are
10 going to try to provide us in the review process.

11 Yes, Ed.

12 DR. LEWIS: I would just like to add to the chaos
13 that exists by saying that these proposals by virtue of the
14 fact that the signals keep changing are not being reviewed
15 in a uniform way; ergo, I was on the site visit team to
16 Florida, the Florida program was reviewed by me, the budget
17 was reviewed on Monday here in Washington with the people
18 from Florida and with the people from the kidney program, by
19 myself, and it has now passed up to the review committee.
20 On the other hand, other renal programs have come other
21 ways. Some have come straight up in the manner in which
22 Dr. Hinman is suggesting it should be done in the future,
23 others have come through the ad hoc review panel. And I
24 think that this is really highly unfair to people who are
25 applying, and I don't know what the answer to this is, because

1 there is a definite need, the money is there, and we have to
2 do something. But I think that this must change.

3 DR. MAYER: What is the sense of the committee in
4 terms of how we want to approach this? Do do want to wait
5 until they get to the test case, or do you want to arrive at
6 some other kind of approach?

7 DR. SCHERLIS: I would suggest that we might best
8 defer all renal projects until we can consider them in a uniform
9 way, because I am sure that practically every renal project
10 which we present to this committee will have cleared RAG
11 on a totally different priority system. And I'm not opposed
12 to renal projects by any means. Having two kidneys myself,
13 I cherish them. But I think that on a priority basis looking
14 at the overall needs of a health region, I think there are other
15 things that a RAG might act on, and unless we have uniform
16 instructions to RAGS and to this Review Committee and to all
17 members of site visits we are going to be measuring renal
18 programs on a changing yardstick, and I don't think this is
19 fair to those that are turned down for reasons outside of
20 consideration that we impose on other regions.

21 I know your confusion, and that is you were not
22 given any clarification at Council. That's quite apparent
23 from what has been said. But I think in all fairness to
24 having to answer yes or no to regions which have spent
25 literally years evolving well coordinated projects, I don't

1 see how we in fairness can compare one region to another,
2 one having a program, the other not.

3 DR. MAYER: What is your suggestion then? Could
4 we then move on to some other parts of the kidney activity
5 and assume that we will get at this head on when we are faced
6 with reality testing.

7 DR. HINMAN: There were two other points that I
8 wanted to bring to your attention unrelated to review
9 mechanisms.

10 One is that there are a number of federal programs
11 that are involved in various aspects of funding in stage renal
12 disease, and to date the level of cooperation and
13 coordination between them has not been at its highest. We
14 feel that in certain key areas, three specifically, that there
15 should be a central protocol or some central agreement as to
16 how funding and support of these areas goes on so that at
17 some point in time information will be available to providers
18 as to what will be the best thing to do for patients.

19 The three areas are antilymphocyte globulin
20 preparation, HLA typing and its value and necessity, and
21 registry information of both dialysis and transplantation.

22 To this end we have initiated discussions with the
23 agencies involved to attempt to come out with some sort of
24 common protocol, the most crucial one being antilymphocyte
25 globulin, because if it does turn out that this is of value

1 in transplantation patients the necessity for the Food and
2 Drug Administration to license it so that there can be
3 commercial production becomes an overriding issue at some point
4 in time. So we are trying to get the FDA, three Institutes
5 from NIH, the Division of Biological Sciences, Arthritis
6 and Metabolic Diseases, and Allergy and Infectious Diseases,
7 the V.A., and our group together, and possibly including some of
8 the Department of Defense activities, because we are all
9 involved at some level in funding. So we hope that from this
10 something can come forward that will be of assistance
11 in the field of kidney disease.

12 The second point is in light of this, and because
13 of some of the other controversy and problems in the area,
14 it is recommended that any project that requests funds to
15 produce antilymphocyte globulin, that review or approval
16 of this be deferred until there is a coordinated strategy.
17 This recommendation was accepted by Dr. Margulies.

18 DR. MAYER: Is that here for our information or for
19 our--

20 DR. HINMAN: For your information.

21 DR. MAYER: All right. Do you want to comment, Ed,
22 anyway?

23 DR. LEWIS: Yes, I would like to comment anyway
24 that I think it's unfortunate that one of the few things
25 that RMPS can do, and that is fund at least local use of

1 antilymphocyte globulin, which I would put out to you is
2 effective, because I think a panel of experts will argue
3 from now til the cows come home about whether it is or not,
4 but at least it is as effective as coronary ... in the care
5 of the patient with the MI, and I think this is the one area
6 where people could have gotten some help and now it's an
7 area that has been cut off. And I would also put to you
8 that I personally believe that FDA will never, never pass
9 antilymphocyte globulin for interstate commerce. Never.

10 DR. MAYER: Any comments from staff about that?

11 Okay, we have got a prediction on the record then.

12 Dr. Hinman, any other items?

13 DR. HINMAN: That's enough headaches for today.

14 DR. MAYER: All right, I would like to turn now to
15 report from Mrs. Kyttle. She has a couple of issues she needs
16 to point out to you. Lorraine.

17 MRS. KYTTLE: Should some of the items that
18 Dr. Margulies discussed earlier today require a movement of
19 the Council -- and I would ask you to turn to the calendar in
20 your books -- if we were to move Council from May back to
21 April, and therefore move committee back from April to
22 March, would the dates--

23 DR. MAYER: The other way around.

24 DR. PAHL: Move committee from April to May.

25 MRS. MYTTLE: Right. Excuse me, I'm going in the

1 wrong direction. I'm sorry. Would the dates -- asking you
2 still to keep April 12 and 13 logged for the standing meeting,
3 would the dates of 10th and 11th of May be agreeable for a
4 meeting that could be put on the books, and when the thing
5 finalizes we can say whether we will be meeting in April
6 or May?

7 DR. MAYER: Not for me, for one.

8 MRS. KYTTLE: All right.

9 DR. MAYER: I have seen three. Any others? Four.

10 MRS. KYTTLE: To move it up or back in that week,
11 would that help?

12 DR. MAYER: 8th or 9th, 12th or 13th. No. No.
13 10th and 11th.

14 MISS KERR: There is a regional conference that
15 has been long scheduled.

16 MRS. KYTTLE: The whole week. May 8 or 9, or
17 9 or 10, some time in that week of the 8th through the 12th
18 of May, two days.

19 DR. MAYER: How many cannot be there on 8 or 9?

20 (Show of hands.)

21 DR. MAYER: 9 or 10?

22 (Show of hands.)

23 DR. MAYER: 10 or 11?

24 (Show of hands.)

25 MRS. KYTTLE: At the risk of pushing it into

1 Council, is the week the 15th through the 19th better?

2 DR. MAYER: It is not for me since we have
3 graduation and that's one thing a dean doesn't miss.

4 MRS. KYTTLE: The latter part of the week of the
5 4th or 5th? And that will put staff on its ear.

6 DR. MAYER: That's better. All right, how many can't
7 be here the 4th or 5th? There's one. Just one.

8 MRS. KYTTLE: Now thinking of your travel, it is
9 sometimes hard to get out of here on a Friday, which is the 5th,
10 is the 3rd and 4th--

11 DR. MAYER: How many can't be here the 3rd or 4th?

12 DR. PERRY: 3rd only.

13 DR. MAYER: So that's one and a half.

14 MRS. KYTTLE: 4th and 5th seems the best. Dr. Pahl,
15 do you think maybe it might wind up as a one day -- Friday
16 is darned hard--

17 DR. PAHL: I think we have to consider a two day
18 meeting, and please understand this is still predicated on
19 our receiving instructions as to whether we are going to
20 be bringing you additional grant applications in the area health
21 education center, and that one is trying to be decided by
22 the office of the Administrator. It may go contract route,
23 in which case we may not be compelled to hold the meeting
24 later than the currently scheduled one. So we are asking
25 really that you consider a two day meeting in May rather than

1 a two day meeting in April, but holding all dates open for
2 a few days until we can try to come back and cancel one
3 of the two proposed meetings.

4 DR. MAYER: Okay, then let's tentatively hold on
5 to May 4, 5, because even though Friday travel is abominable
6 out of here, if you have got a month's notice or two months'
7 notice you are in pretty good shape.

8 All right, other items.

9 MRS. KYTTLE: The green document that we passed
10 out, we have because we thought it might help you with some
11 of the deliberations that we were wrestling with this
12 morning.

13 The other document that I am passing out is showing
14 you how through the last review cycle your ratings
15 placed the region. The box in the middle shows the specific
16 ratings by the committee, and the items to the right show
17 the staff anniversary review panel's conclusions that came
18 out of the last review cycle as well.

19 DR. MAYER: Try me again.

20 MRS. KYTTLE: The box in the middle represents
21 the ratings and therefore the placement of the region in
22 an A, B, or C category on those regions that were site
23 visited and specifically reviewed by committee last time.
24 That's the box in the middle. The box to the right are the
25 ratings that came out of the staff anniversary review panel,

1 and you remember last time our procedures, we were just
2 beginning, and those regions that were anniversaries within
3 the triennium just went through, they are coming to you this
4 time as timely information rather than post information. But
5 this is how the regions that were anniversary applications on the
6 right fell out via staff anniversary review panel's rating.
7 That's how they fell into A, B and C. And, of course, the
8 information to the left is as it says, the July, August cycle.

9 DR. MAYER: And the adjusted raw, what--

10 MRS. KYTTLE: Well, the July, August cycle was the
11 experimental, and for openers some of these had to require
12 adjustments, because when October, November cycle came out you
13 could see the differences between the settled rating and the
14 for opener ratings, and that's the difference between raw
15 and adjusted.

16 MR. PETERSON: What we found, Bill, was as a result
17 of your initial trial the average rating in the July cycle
18 was around 260. When we looked at your next average it
19 was, if I remember the figures correctly, 301, and the first
20 staff panel was 303, which was, given a 500 scale, seemed about
21 right. So we took an adjusted mean and multiplied your
22 earlier scores to make them roughly equivalent to the two
23 succeeding actions which tended to cluster the mean right at
24 about 300.

25 MRS. KYTTLE: This places 27 regions, and next time

1 we will come to you with the chart that will add 12 to it from
2 this.

3 DR. MAYER: All right. Other comments? You were
4 going to comment on some discrepancies between Council and--

5 MRS. KYTTLE: Yes, from the last October, November
6 review cycle the recommendations of committee on Arkansas
7 were accepted by Council, the recommendations on Arizona,
8 and Colorado, Wyoming were accepted; the recommendations on
9 Connecticut were not accepted, and when we finish I will have
10 something before you on that. Iowa was accepted, Indiana
11 was accepted; and Ohio Valley had an adjustment, a modification.
12 Virginia was accepted.

13 The items going to Council from the staff anniversary
14 review panel generally were accepted with two slight
15 modifications; Tennessee Mid-South had a slight modification
16 and New York Metro had a slight modification.

17 The three standing kidney proposals that came to you
18 last time were accepted by Council. Georgia and Rochester
19 came out to be negotiated with budgets, and those budgets
20 have been negotiated.

21 In your book under the pink tab at the very back
22 under other business are three documents. Two of them concern
23 Connecticut, and one concerns Ohio Valley. And at the risk
24 of working from the back up, the difference in Ohio Valley
25 turned on Council's disapproval of the kidney project within

1 that proposal, and their rationale is there.

2 The rationale on the modification of the Connecticut
3 recommendation is more extensive. You recall that committee
4 came out with several suggestions, and there are two responses
5 there, one to the decision that the Council made on the
6 recommendation itself, and the second is Council's response
7 to several of the suggestions made by the committee. These
8 have not gotten to you before. You see them in your book
9 for the first time. And, Dr. Mayer, if you would rather take
10 a minute to read it or take it up again tomorrow, whichever
11 you wish.

12 DR. MAYER: No, I think it is very important that
13 this review committee do understand where it is running
14 counter to the wishes of Council because it is helpful to us,
15 because in a sense that's one way in which policy is established.
16 And I would simply suggest that we take this information
17 and review it and think about it, and set aside a little bit
18 of time tomorrow to discuss it rather than to try to do it
19 now.

20 MRS. KYTTLE: Attached to your agenda is the
21 statement about the confidentiality of the meeting and the
22 conflict of interest.

23 DR. MAYER: And I think I would only add to the
24 confidentiality a more even explicit feeling that the review
25 cycle rating sheet which you have is handled with extreme care,

1 because if in fact there are going to be dollars attached
2 to those, as was suggested at the outset of this meeting,
3 it takes on even more importance that they be handled with
4 exquisite and extra care.

5 MRS. KYTTLE: Dr. Pahl, would you want to mention
6 anything about the discussion of the rating and the criteria
7 with the steering committee?

8 DR. PAHL: Well, the only point is that as we had
9 informed you earlier, we would not fully implement the
10 rating and review criteria until the steering committee
11 representing the coordinators had had an opportunity to
12 comment upon this to us, and over the time period since we
13 last met we have again informed the steering committee of our
14 interest in formalizing this as a part of our total review
15 process and asked for comments again. And then we met with
16 them in Chicago the first week in December and they
17 uniformly endorsed that we proceed with it, and I believe, Pete,
18 a communication has gone out now.

19 MR. PETERSON: It is in the process of going out
20 now. The actual letters to the 56 coordinators are being
21 put in the mail now.

22 DR. PAHL: But it is clearly understood by the
23 steering committee, and thus all the coordinators, that the
24 review criteria and the ratings, weights, etc., that you have
25 before you are now part of the RMPS review process.

1 I should really say that this endorsement by the
2 steering committee was not given in a grudging way. Many
3 of them felt it was a marked improvement in communication
4 in the sense that they now for the first time did understand
5 some of the points on which they would be reviewed, and there
6 was a common basis that would be applied across all regions.
7 So there was some degree of enthusiasm voiced at least
8 by the steering committee members that we have this, and let's
9 stabilize on it and move ahead, subject to change after a
10 year or more of experience. But we have stabilized on what
11 you have before you.

12 DR. MAYER: Could I just ask one question while we
13 are on it? The figures that are there on the RMPS rating
14 sheet which you provided us, Lorraine -- and I am now
15 asking this because it is quite clear -- I'm talking about
16 the single sheet that had the box -- I need to know if those
17 figures are the sum of the weighted numbers or are they
18 represented as overall assessment numbers only?

19 MRS. KYTTLE: They are the range of the weighted
20 total score given by reviewers. Your middle block, for
21 instance, Arkansas and Iowa, ranging from 339 to 341, those
22 then represent the scores of all of the reviewers with the
23 weightings taken into consideration, divided by the
24 number of reviewers, and one of those attaches to Arkansas and
25 one attaches to Iowa.

1 Does that answer your question?

2 DR. MAYER: Yes, I guess it does. It causes me
3 some problems. How have you handled those in which someone
4 has failed to put a number down in one of those little
5 blocks?

6 MRS. KYTTLE: Frank.

7 MR. ICHNIOWSKI: We treated it as a blank and took
8 it out of the calculation.

9 DR. MAYER: That becomes important because what
10 we were doing, you recall, was circling those ones in which
11 we had some discomfiture with. How are you handling those?

12 MR. ICHNIOWSKI: We counted just as you scored,
13 even with the circles.

14 DR. MAYER: All right, because that has some
15 implications about whether I am going to circle or leave
16 it blank from now on.

17 MR. ICHNIOWSKI: The number of circled items last
18 time comprised only about 15 percent of all the scores, which
19 didn't have a major effect. We tested taking them out and
20 it didn't change it.

21 DR. MAYER: Is everyone clear on those questions?

22 All right, why don't we break for lunch, try to
23 be back by 1:30, and we will start in on the individual
24 projects. It would be my intent to go through them roughly
25 as they are outlined on the sheet.

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(Whereupon, at 12:50 p.m., the meeting recessed,
to reconvene at 1:30 p.m.)

AFTERNOON SESSION

(1:30 p.m.)

1
2
3 DR. MAYER: I thought we might before we started
4 in, in that Harold is here fortunately with us, we might
5 just comment briefly on the kidney issue that we were
6 discussing with him present. I think he understands the kind
7 of dilemma which we are faced with fairly clearly. And I
8 guess the feeling was in this morning's discussion, Harold,
9 that the answers we got back from Council and as staff then
10 interested it left us the same place we were four months
11 ago when we sent the request up to Council for clarification.
12 We are still on the horns of the same dilemma we had
13 previously.

14 DR. MARGULIES: Well, I think that the best way to
15 handle the kidney review and funding activities is to keep
16 them separate from the Regional Medical Program application
17 itself. I think it is quite clear that this has caused a
18 great amount of confusion. So what we will do is allow
19 regions to submit requests for support for kidney activity.
20 We will continue to identify a separate amount of funding
21 as we have indicated we would for this purpose.

22 We will ask the review committee, with the assistance of
23 outside technical review on each one of the kidney projects,
24 to review the proposal and to make its recommendations,
25 and we will keep that separate from the review of the

1 Regional Medical Program. This will mean that for each
2 renal project there will be outside consultation -- that is
3 consultation outside of that region, to make sure that there
4 is adequate technical review, and the committee will receive
5 the results of that kind of technical assessment as well as,
6 of course, the staff assessment of it.

7 DR. HESS: Any given renal project will be used
8 specifically for that then.

9 DR. MARGULIES: That's right. It will be regarded
10 as a separate category. We will continue in this process to
11 try to build it around a national network of completely
12 adequate facilities for dialysis and transplant and have
13 that kind of a design in mind, as we have had for well over
14 a year.

15 DR. SCHERLIS: And when we go to a region as a
16 member of a site review committee we should not make any
17 judgment or recommendations on that project, is that right?

18 DR. MARGULIES: Keep the kidney project separate.

19 DR. SCHERLIS: In other words, we make no
20 evaluation of that project.

21 DR. MAYER: Well, I suspect that the evaluation
22 ought to at least include now that Regional Advisory Group
23 and others themselves look upon that and what are that staff's
24 capabilities of administration. I think those kinds of issues
25 are probably appropriate.

1 DR. SCHERLIS: As far as funding we look on that
2 entirely separate, don't make any recommendations on the
3 funding of the renal project?

4 DR. MARGULIES: Not as a part of the site visit
5 or the RMP. The kidney activity would be considered
6 separately. If there is a request for a kidney proposal at
7 the time that the RMP is being reviewed and if the review is
8 carried out at that time then we will have people to look at
9 that particular activity separate from the rest, although
10 as Bill has indicated, where there is obvious need to look
11 at the two together that should be done.

12 DR. PERRY: This is probably the best part of
13 all. If you are fortunate enough to have Ed Lewis with
14 you on the review committee you can look at it in relation
15 to the total, but you can really look at its merits also at
16 that point.

17 MISS KERR: Then these kidney funds are earmarked
18 and are not interchangeable with the other funding or the
19 other program?

20 DR. MARGULIES: Tha'ts the way we will administer
21 them, yes.

22 DR. SCHERLIS: Has that decision been made on
23 the basis of the discussion we had earlier this morning
24 or is that the decision reached at Council?

25 DR. MARGULIES: That's pretty much the way it was

1 understood prior to the meeting of the Council and after
2 the meeting of the Council. As I have tried to say on many
3 occasions, there is just no question about the fact that the
4 kidney activity is categorical and that it in fact addresses
5 only a part of the kidney problem, in stage kidney disease,
6 and it's a purely categorical activity which needs to be
7 kept separate from the broader ranges of RMP activity. And
8 since it has been difficult to try to look at them in a common
9 context I think it is quite clear that we should apply the
10 separate categorical review process.

11 Now the only difference between this and what we
12 have done in the past is that we are attempting, and we hope
13 to get more effective in the course of time, to do this in
14 such a way that we do over time cover the nation's needs
15 with centers, so we are going to be looking at it here in
16 terms of locations for geographical access.

17 DR. THURMAN: I think one thing that makes that
18 exceedingly difficult -- to take a very specific example,
19 the Greater Delaware Valley -- if you had two hands and two
20 feet on which to count on the site visit at Delaware Valley,
21 it was obvious that they had no plan that really went to
22 regionalization of kidney disease. They are talking about
23 opening more when they don't have enough to run one. It's
24 very hard emotionally, mentally, fingers, toes, or any other
25 way to sit there and say these guys really know what they are

1 talking about in any category if they are that blind in kidney
2 disease. That's the real problem, and I think that's the
3 one that precipitated most of the discussion here this
4 morning. You cannot take any categorical disease and remove
5 it from the rationale of what RMP really stands for, because
6 that's where it started. That's where even though the
7 category has changed -- I mean even though the mission has
8 changed, it's still very difficult to look at a group of
9 people who are going to be spending a dollar and not say
10 can they really do it even though this process would be
11 categorical.

12 To give you a numbers game, they don't have a
13 hundred transplants a year and yet they are talking about
14 opening five centers. Well, that's just totally unrealistic,
15 and it certainly puts a bias in the reviewer's mind about
16 the rest of the program if they are not working together
17 well enough to do that.

18 DR. MARGULIES: I think your point is perfectly
19 valid. But one of the things we would anticipate would be
20 looked at in the process of carrying out technical review of
21 a kidney proposal is whether there is evidence of a capacity
22 to concentrate facilities and to produce a regionalization
23 of the program, and if it's evident either directly or
24 indirectly that that's not the case then this would not be a
25 fit project for support.

1 I think you will find if you keep them separate in the
2 review process that it will be possible at the time that
3 the review committee meets to raise the kind of question you
4 just raised more comfortably than if you tried to intertwine
5 them at the time of the review process. We are caught a little
6 bit one way or the other.

7 DR. THURMAN: I would just argue the reverse. When
8 you are sitting there talking to the guy who is doing all
9 the rest of it, it's very difficult when he says "I can't
10 count potatoes, but I can count oranges." You wonder how the
11 hell he's doing it. And that's really what it amounts to.
12 And that automatically puts a degree of bias in the rest of
13 your evaluation if we are doing to look at it that way and
14 yet still think of it entirely separately.

15 DR. MAYER: I guess, Bill, where I am, is that I
16 am far more comfortable with a decision having been made,
17 that if those recommendations come from that expert panel
18 and I have been into that region and looked at other issues
19 and look at what that region is doing about regionalization
20 in other issues, and that review panel on kidney disease comes
21 in, one of the key things that I am going to ask as a review
22 member here is not, you know, the quality of the people
23 involved because supposedly they have looked, but I can ask
24 them about regionalization because I think I know a little
25 bit about it. And if it's not there in it then that becomes

1 issue in my decision. So I think we will have at least at
2 review committee a chance to meld them together, whether or
3 not we meld them on site or not, on individual site visits.

4 Any further comments on that?

5 Harold, I have to say that's the most helpful,
6 succinct two minute statement that I have heard for some time
7 relative to this issue.

8 DR. MARGULIES: It's easy when it's categorical.
9 That's what is so attractive about it.

10 I would like to suggest that, if the committee is
11 agreeable, we might set up a period of time in the morning
12 for an executive session because it is quite apparent to me,
13 as I think it is to you, that you still have a sense of
14 discomfort over a lot of the things which we have attempted
15 to discuss today and the last time, and I think we might be
16 able to deal with them more effectively in an executive
17 session. We could do that first thing in the morning for
18 whatever period of time is appropriate to your time schedule.

19 DR. MAYER: I think that would be helpful and
20 appropriate, and probably first thing in the morning would
21 be a good time to do it. It would be an executive session
22 consisting of the Review Committee and Dr. Margulies and
23 whoever else he chooses to bring.

24 All right, are you ready, Leonard, for the great
25 state of Illinois?

1 DR. SCHERLIS: So that's why we are here, isn't it?

2 DR. MAYER: That's one of the reasons.

3 MR. HILTON: Should I, Dr. Mayer, excuse myself?

4 DR. MAYER: I suspect it would probably be appropriate.

5 I think the record ought to show that Mr. Hilton has left,
6 and also ought to show that Dr. Schmidt is not with us today.

7 DR. SCHERLIS: The Illinois site visit was
8 conducted on December 15 and 16, last year. Dr. Brindley was
9 with us at the time. The other members of the site visit
10 included Dr. Vaun, who is Director of Medical Education
11 in Jersey. This is of significance because some emphasis of
12 the Illinois program is on continuing education.

13 By the way, about how much time have you allowed for
14 each review?

15 DR. MAYER: I haven't divided it up.

16 DR. SCHERLIS: About an hour?

17 DR. MAYER: That for review and discussion would
18 be fine.

19 DR. SCHERLIS: About 15 or 20 minute review.

20 Other members from the staff included Mr. Nash,
21 Public Health Advisor, Mr. Piatek, Program Analyst, Miss
22 Hulburt, Dr. Gimbel, and Mr. Ryan.

23 The site visit I think was a very profitable one
24 in the sense that we met the evening before. I think we knew
25 what our problems were as far as what some of the difficult

1 areas were that we had to explore further. We tried to
2 put most of our emphasis on these areas.

3 You all have the report. I would like to emphasize
4 some of the things about it. The report is organized on the
5 basis of our rating system. When we do this I think you can
6 see it has some advantages, but at the same time it does
7 permit a certain amount of duplication.

8 We were impressed with the numbers of people who
9 attended the site visit representing Illinois. This was
10 not alone important as far as numbers, but as far as the
11 groups which were represented.

12 We were most favorably impressed with the executive
13 director, Dr. Creditor, who I think used the site visit
14 for many reasons, not alone to present the Illinois program,
15 but I think he was also manipulative in the sense that some
16 of the agencies which were represented -- he helped
17 utilize their presence to try to make some points with them,
18 and I think he did so in a sense of trying to get them to
19 recognize what some of the problems were which they posed for
20 RMP and how they might better cooperate.

21 The list is a most impressive one in terms of
22 not alone board members, but groups which were represented
23 from the entire community, many of whom had traveled a long
24 way. And I must say it was one of the better organized and
25 most fruitful site visits in terms of having good

1 representation and the information which we desired made
2 readily available.

3 Our site visit charge was in terms of the fact
4 that the Illinois group has requested support for a core,
5 for projects of developmental components of its triennium
6 application, and so our charge was to review the region's
7 overall progress, to examine the experience and achievements
8 of its ongoing program, determine how this would modify the
9 program goals, objectives and priorities, to review their
10 prospects for the next three years, and then to arrive at a
11 funding recommendation.. We attempted to meet all of these
12 scores as best we could.

13 The funds which were requested were as follows:
14 From the present base which for the 02 year is 1.5 million,
15 they had requested for the 03 year 2.8 million; 04 year, 3
16 million, for the 05 year 3.2 million, which, as you can
17 see, is a most ambitious increase. It should be stated,
18 however, that their 02 year did represent a drop in level of
19 funding from what had been a previous year of, I think, 2.0
20 or thereabout.

21 The background of this group is that they now have
22 a board, a relatively new Executive Director, Dr. Creditor,
23 and we will get into that as we review our general overall
24 impression.

25 I think our overall impression was it was good, and

1 then we tried to translate that into terms of documentation.

2 First of all, the region has made excellent progress
3 since its last site visit in December, 1970. They have
4 established goals and priorities which are certainly
5 congruent with national goals, and I think practically every
6 region in the country has a rather similar program for that.
7 And they have administratively a board which I will get into,
8 they have a Regional Advisory Group, and they have an
9 organization which I think is a most effective one.

10 Their RAG does represent key health interests in
11 the region, is a responsible group, been able to make
12 decisions on a logical and well founded basis, and was quite
13 effective in carrying out its responsibilities. It does
14 appear to us that RAG is the decisionmaking body of the
15 Illinois Regional Medical Program, with a heavy input from the
16 Executive Director, but the final decisionmaking appears to
17 lie within RAG itself.

18 Their chairman is a highly capable individual. RAG
19 membership is involved in all levels. They have orientation
20 sessions for RAG, and their members take part in site visits,
21 and this has, I think, been a very important strength.

22 You will notice in our site visit documents several
23 references to the fact that they need more representatives from
24 minority groups. This is why I made the aside to Mr. Hilton
25 that I did earlier as far as Illinois was concerned.

1 The Executive Director is an extremely knowledgeable
2 individual, knows what is going on with the RMP in Illinois.
3 One shouldn't have to say that, but as a member of site visits
4 to other regions you sometimes find coordinators who are not
5 aware of the details of the program, and certainly their
6 coordinator is very, very well aware of all of the details.
7 He has been heavily involved with them, yet at the same time
8 has involved the other groups.

9 Those of you who may -- and I will just spend a
10 moment on this -- there is a unique arrangement in Illinois,
11 the Executive Director, Morton C. Creditor, and the Grants
12 Manager, Mrs. Una Creditor, who happens to be his wife, and
13 this is indeed unusual; but as we spoke to other members
14 of the Illinois group and as we met with her I think she
15 should not be discredited by virtue of the fact that her
16 husband happens to be Executive Director. I think they are
17 fortunate in having both people working there, and they both oper-
18 ate, at least during the day, I think independently as far
19 as some of the objectives are concerned. So I don't think
20 this speaks of patronage. I think it speaks of the fact
21 that they happen to be married each to the other.

22 Well, in addition to the Executive Director, as far
23 as the core staff is concerned he has a capable and energetic
24 group. In addition they have Dr. George Miller of the
25 Illinois region, and the participates as the core project

1 director. I will get involved in this a little more later.
2 Dr. Miller has been involved almost more than anyone
3 else in the country with continuing education for physicians,
4 and his participation as a member of the core group is
5 very important.

6 We did suggest that they have somewhat better review
7 periodically of their own core projects. This may become an
8 issue that RMPS has to consider more and more, the fact
9 that there are such good technical reviews of individual
10 projects, since more and more of these are supported by core
11 there has to be technical review in addition of core, and
12 how this can best be done may be a question of logistics.
13 But this became apparent to us more and more during the
14 period of our site visit.

15 In Illinois the CHP agencies have been very slow
16 to develop, and Regional Medical Programs contribute markedly
17 particularly toward the development of B agencies. So a lot
18 of the subregionalization of Illinois has been through
19 the vehicle of the B agencies of Comprehensive Health Planning.

20 Now since their new coordinator took over he has, I
21 think, given the whole Illinois Regional Medical Program
22 a sense of enthusiasm and of movement which had not been
23 there previously.

24 And if I can now go into individual items, they
25 reformulated all their goals this summer, and RAG is very

1 strongly involved with the whole RMP program, and as a result
2 they printed a manual flyer, and I think this is important.
3 It has had wide distribution. And this specifically states
4 what the objectives and goals and the funding procedures
5 are. This has been of importance as far as everyone who
6 submits a project knowing what the ground rules are before
7 they submit the projects.

8 These objectives include the following: "Improving
9 health care delivery by making existing systems as effective
10 as possible and catalyzing the development and evaluation
11 of potentially effective alternate systems."

12 As an aside, they have used core funds very
13 effectively to help catalyze developments. They have used
14 three or five thousand dollars as support projects which
15 have been able to utilize these funds to grow and project
16 the influence of these goals further than I think largely
17 projects have elsewhere.

18 Goals B is "increasing the availability, efficient
19 utilization, and capability of health care personnel throughout
20 the IRMP," and goal C, "controlling those major medical
21 problems which cause economic loss, social distress, physical
22 and emotional disability, morbidity and mortality."

23 They are pretty good goals, I think they are quite
24 inclusive, and I would find it hard to fault them as much
25 as I would try to fault motherhood.

1 They give priorities to all activities as best they
2 can on the basis of A, B and C, in that order, and they
3 try to look at these very carefully.

4 One suggestion we made is that they set up some sub-
5 goals on the broad general basis of these three. So we did
6 suggest that they have some subgoals and smaller objectives
7 listed.

8 They have shown that they can terminate some
9 projects, and they have terminated two of them on the basis,
10 I think, of good critical review; one on the basis they had
11 not set up adequate evaluation, had no data that would
12 indicate any success, and the second on the basis, too, that
13 no further funds be awarded because performance was
14 inadequate. So they have shown that they can criticize
15 their own programs even though they had been previously funded.

16 As far as specific accomplishments and implementation
17 are concerned, they supported projects of improving cancer
18 programs, a coordinated cancer program which has involved
19 throughout the region several hospitals. They are having
20 some problems with this because as other hospitals improve
21 their facilities some of them utilize the central one
22 less, but certainly this gives some hope as far as being
23 able to continue them.

24 They have set up a coordinated home health project
25 in northern Cook County, a comprehensive health program. They

1 have multiphasic screening programs in the Chicago area
2 industrial plants to detect coronary prone individuals,
3 have stroke rehabilitation services, and all of these read
4 as you might expect since this is a list of what they have
5 had in the past as their whole categorical view and
6 emphasis. But the ones that they have had have been well
7 surveyed. They have met with the review, which I will get
8 into, which appeared to be extremely effective.

9 New activities which they are proposing include
10 home health services, a system of planning care, computerized
11 hypertension treatment, Winnebago County comprehensive care,
12 continuing education for Mid-Southside. And all of these
13 are directed at delivery systems. They have set up
14 programs which help support ongoing community health and
15 medical care systems and to help evaluate them.

16 They are very concerned with the whole process of
17 evaluation and are looking in their area under the
18 continuing education program at the whole concept of having
19 a much better method of peer review, and to this they are
20 looking at program oriented charts as their standard. And
21 they regard this as an important decision because they hope
22 that by setting up method score evaluation, utilizing
23 specific problem oriented charts in the hospitals and HMO's,
24 that this would give them a way of looking at success or failure
25 and patient problems, and they do have the medical societies

1 interested in this as well as their own evaluation groups.

2 The core activities are extremely extensive, and
3 this is why I mentioned they have used small funds to try to
4 move in certain specific directions, including support of
5 their educational support resources. This is the general
6 area which is under Dr. George Miller. It has been very
7 effective, and the question we had about this was the need
8 for technical review from the outside.

9 They have the North Suburban Association for Health
10 Resources, Mid-Southside Health Planning Organization. They
11 have been involved with home planning on a very active basis.
12 Study of Physician Referral Services, Self-Audit of Family
13 Practitioners. They have been involved in a whole series
14 of surveys of health needs, and so on.

15 I mentioned their minority interest, but in passing
16 just to summarize it, on RAG 4 of 47, nine percent
17 minorities on committees, four percent core professional staff,
18 24 percent for secretarial staff, 43 percent project
19 professional staff -- the way it averages out it comes
20 to -- I don't have a final figure on that, but you can see
21 there is a wide scattering. There is less than proportional
22 minority population in the state. Twenty percent that
23 represent minorities, 13 percent black, 6 percent Spanish
24 surname.

25 As I said, Dr. Creditor is a very effective, dynamic

1 force in the Regional Medical Program, has changed it since
2 he took over, and that was only on June 1st, 1970. These
3 changes have really been done very rapidly.

4 Core staff -- they have 21 full time members, and
5 they do have some vacant positions which they are trying
6 awfully hard to fill; heavily involved, as I have indicated,
7 in continuing education through that center supported project,
8 some very heavy involvement with other objectives.

9 Administratively they have a board of directors
10 which has reorganized so that it now has only fiscal
11 management, specifically manages fiscal affairs of the
12 corporation. We looked into this because we were concerned
13 as to whether or not it became involved with policies. The
14 board does not. It is purely fiscal and personnel concerned.
15 It has nine members, six of whom represent the schools of
16 medicine or osteopathy. Two of them are teaching hospitals.
17 So all of this is very heavily oriented toward the medical
18 school, and is purely fiscal-personnel, and by every way we
19 could we did establish satisfaction that it is purely on that
20 basis.

21 I have already read the goals to you. I won't go
22 ahead with that.

23 Its organization, to move further with this, they
24 have six standing committees, all of which are chaired by
25 members of RAG. So there is a heavy involvement by RAG.

1 These are the usual, executive, nominating, review, health
2 care delivery, and so on. These are not categorical. In
3 addition they have committees which are categorical.

4 I think they are really fortunate in their leadership
5 and involvement in RAG.

6 The review process is an excellent one. As I have
7 said, they do have published criteria and published
8 priorities, so that when a letter of proposal comes in it
9 is easy for the proposer to determine whether or not it
10 fits into the priorities of IRMP. Staff works informally
11 with them putting together the original application. It
12 goes to a technical review committee before it goes to the
13 overall RAG group. And the review committee is one which
14 gives out excellent reports.

15 As far as ongoing project surveillance they have
16 adopted a project review which is excellent, and they
17 evaluate the projects anywhere from two to four times a year,
18 with at least four times a year looking at it from a budgetary
19 point of view. They carefully go over items of the budget
20 to see whether or not funds are being expended in the direction
21 in which the grant was originally made, and this has been
22 of help to them in rescuing significant amounts of funds of
23 core supported projects. In addition they have been able to
24 maintain a quality of control by these frequent reviews which
25 appears to be of a high level.

1 We were impressed with the degree of involvement of
2 local agencies. As we said, the A and B agencies in Illinois
3 leave a great deal to be desired. Dr. Creditor utilized the
4 format of the site visit to ask questions of the A and B
5 agency representatives, which I think will get them off the
6 center in many respects as far as knowing what their
7 involvement should more strongly be. The worst criticism
8 was made in terms of their not having developed overall health
9 plans.

10 There appeared to be some schism between the
11 IRMP and the CHP in the regard that Dr. Creditor repeatedly
12 stated that the planning had been minimal and he assumed
13 that this was the prime role of the comprehensive health
14 planning, but in reality privately he informed us that they
15 obviously were involved in planning as well, but were hoping
16 that the CHP would be more involved both with the planning
17 and evaluation. They have been of little help in
18 evaluating projects as well. They have often left a great
19 deal to be desired. I think the site visit group felt these
20 criticisms of the CHP were indeed justifiable.

21 They have been very, I think, effective as far as
22 their educational programs are concerned. They have
23 established strong relationships not only amongst the medical
24 centers, but certainly amongst the surrounding communities
25 in addition. They have set up what they referred to as

1 articulated systems of health care. These projects include
2 home health services, the Illinois kidney disease program,
3 radiation therapy program. They help to develop models
4 of HMO's. And this is not reflected in the amount of money
5 they have spent, but they have utilized their staff heavily
6 and small amounts of funds as catalysts in this regard.

7 They have functioned as the liaison amongst the
8 35 developing HMO's of the state. So if anyone is concerned
9 about how many there are in the country I think that the
10 amount of funds mentioned this morning don't really indicate
11 either the number or the level of support because so much
12 of core staff activity around the country I think is
13 going into this, and it does not get reflected in terms
14 of the funds which are actually listed.

15 They are anxious as far as developed advanced
16 technology in health care, computerized hypertension services
17 There was excellent representation from several of the
18 developing HMO's in this area, and these I think are very
19 heavily involved with the Illinois Regional Medical Program.

20 Some of the specific projects include a radiation
21 therapy treatment planning center which helps to serve several
22 medical centers; the Illinois kidney disease program,
23 which again is one that has many different areas involved
24 with it, appears to be a good overall program, but they, as
25 they have admitted, have had little influence on discouraging

1 sporadic renal transplant surgery in other centers, which
2 the three in Chicago appear to be developing quite well.

3 They are involved with a comprehensive family oriented
4 community health center to help a poverty area of some
5 10,000, and this is the so-called Valley project.

6 They are also involved with the Hyde Park-Kenwood
7 planning for care which will involved some 45,000 residents.

8 I won't continue describing some of the details
9 except to state that we were impressed that this was a
10 region which, given funding, would be able to utilize it
11 effectively. They have shown the ability as far as leadership
12 is concerned, as far as having a RAG which reaches
13 responsible decisions, as far as having budgetary controls so
14 that it can cut off programs which are not effective, as far as
15 rescuing funds from these projects and utilizing them I
16 think with good judgment. They have good technical review not
17 only for new projects, but for those which have been
18 continuing, and not hesitating to cut them off.

19 I think there is a heavy involvement with the problem
20 of delivery of health care services and with input from, I think,
21 many of the projects which are going on in the Illinois area.

22 I think that given X funds they would be able to
23 use these funds quite well. So our concern was not on their
24 ability to utilize funds.

25 We felt that we would approve them, and recommended

1 this -- number one, we approved their program of triennial
2 status; number two, that we approve the developmental component
3 request; that we approve the request for core and projects,
4 all of this in a somewhat reduced amount.

5 We felt that they had the capability and maturity
6 and program to justify the amount which we will recommend. So
7 we got together our ouija board, and we decided that the third
8 year they had requested 2.85 million and we recommended 2.65;
9 for the 04 year they requested 3 million and the fifth year
10 3.2 -- I will go over that again -- the third, fourth and fifth
11 years, they requested 2.84 million for the third year, the
12 fourth year 3.0, the fifth year 3.2. Our recommendations for
13 each of those years in order were 2.65 million, 2.8 million,
14 and 3.0 million.

15 We feel this is one of the better regions as far
16 as being able to utilize these funds, that there is the
17 adequate opportunity in the region to do this, and therefore
18 the site visitors so recommended.

19 DR. MAYER: Dr. Brindley.

20 -- DR. BRINDLEY: I agree with everything that has been
21 mentioned. I had the opportunity of reviewing the program
22 a year ago, and it was of some interest to compare the
23 changes of a year ago and the present condition of the
24 program.

25 Strong points to me were the coordinator -- he is

1 intelligent, aggressive, eager, and a good salesman. The
2 RAG is a very good one. It meets frequently. They are
3 enthusiastic. There is representation from all fields.

4 There is a very good relationship with the Governor's
5 office, and they do keep good rapport with all the other
6 agencies except the Comprehensive Health Planning. The
7 gentleman that was there representing Comprehensive Health
8 Planning was nervous, concerned, really wasn't able to
9 propose a very good program, and apparently they haven't done
10 their part too well. That is not directly the responsibility
11 of the RMP, but it does hinder their program that they
12 haven't had very good assistance from the CHP, particularly
13 in planning.

14 There was marked improvement in the program over the
15 past year. Last year they were just beginning to sit down,
16 change their program, change their bylaws, agree on what they
17 might try to do, and they have made a lot of progress
18 in the last year.

19 They have an excellent method of evaluation and of
20 developing projects and programs. They have a very good method
21 providing funding and shifting those funds to areas of need
22 and reducing funding from programs that are not very productive.

23 Points of concern to me, when we were there a year
24 ago we asked them at that time have you evaluated needs in your
25 state, your abilities to meet those needs and proposals to

1 accomplish these; and they said at that time well, they were
2 just about to do this, and Comprehensive Health Planning
3 was going to help them with it. We come back again this
4 year and no one still has done it. Comprehensive Health
5 Planning hasn't done it very well. And as far as I could
6 tell -- as a matter of fact, they make the statement that
7 they haven't done this because it was too late when they
8 got started and now the programs are going around it, and
9 so we just haven't gotten around to doing this, that these
10 objectives and programs we have are all good, they are
11 national programs, people are bound to need it, and so we are
12 just going to move right on into this.

13 Well, I'm old-fashioned enough to think it might
14 have been better if they would have looked at real needs and
15 abilities to accomplish those, and I don't believe they have
16 done that as well as they might.

17 DR. SCHERLIS: Let me just respond to that point.
18 We were concerned about this, and I think you left after the
19 first day, so we met specifically with their program
20 coordinator and said you actually put out a letter which
21 stated -- and the letter specifically stated -- let's see,
22 I have it right here -- "as a matter of fact, it should be
23 emphasized that the Illinois Regional Medical Program is not
24 the result of systematic collection, collation, analysis,
25 interpretation of data, et cetera." We said what data do

1 you have. He said "all the data we have are dirty." We
2 said we would like to see it anyway, and then he brings out
3 replete volume after volume after volume of really very good
4 data, and I don't know why they put that ploy in.

5 Who else was on the site visit?

6 This was a very peculiar ploy, because we asked them
7 for data and they had some of the best analyses of health
8 data that we have seen, and when you think about Illinois and
9 their Chicago health system, and Dr. Stan and others who collect-
10 ed down in that area, they hae some very good data.

11 I think what they are emphasizing is there are
12 certain obvious needs that you can't get very clear data
13 on, because we took them to task on it and they brought out
14 document after document, beautifully evolved.

15 Perhaps you can comment on that later as a member
16 of staff.

17 DR. BRINDLEY: The goals that they mentioned to us,
18 of course, are national goals. They are certainly excellent
19 ones, but they really didn't have very good subgoals or
20 intermediary points of achievement, even though they could
21 improve on that.

22 The program still is largely Chicago related. They
23 did take the pledge and promise that they are going to
24 develop some regional goals and are now going to get
25 with this and improve it. But they haven't done as much as they

1 might in that regard.

2 Relationships with the CHP still were not as good
3 as they could be.

4 And then I was still concerned some about the size
5 of the budget for core. I realize that core is essential,
6 and it is very important and does lots of things other than
7 administration. But it is about half of the total budget
8 for the area, and although will be increased will still be
9 at about half. They are going to double the size, they
10 need to increase it some. But I just wondered if that is
11 the best way for them to use their money. They are going
12 to add three more people for the problem oriented record,
13 which we think is probably funded higher than it should
14 be, and three more physicians are going to join core to look
15 into this.

16 So I did have those concerns. I don't mean to be
17 unkind. I think they have made great improvement, and it
18 is much better. It did seem to me there are some areas
19 where they could further improve.

20 DR. MAYER: The recommendation -- let me see if
21 I am clear. With their current funding budget at roughly
22 a million and a half, which is really on a 14 month base,
23 which translated back would be around a million two or so,
24 what you are essentially recommending is a doubling of
25 their operational activity. I just wanted to make sure that

1 we are all clear on that.

2 Okay, discussion.

3 Yes, John.

4 DR. KRALEWSKI: The question on that core staff,
5 I think that is a good one. Do you think they will be able
6 to recruit -- they are going to recruit 22 people, is that
7 their plan, to add to that staff?

8 DR. BRINDLEY: Yes, and they have listed the
9 categories they are going to try to fill. They didn't say they
10 had those men available or they could get them, but that
11 was their aspiration and they are budgeting for it.

12 MISS ANDERSON: Do they have job specs for them?

13 DR. BRINDLEY: Don't push me too far. I've got
14 the names down here. They do say they have those needs,
15 and they related primarily as getting into the subregionalization
16 effort. We are now going to go out and address regions and
17 have two more schools.

18 DR. SCHERLIS: Illinois has a very rapidly expanding
19 medical school system, and they are subregionalizing through
20 that area.

21 Let me make one point that I perhaps should have
22 mentioned. Council had originally recommended for the
23 second year two million dollars. They were funded at a
24 level of 1.5. As they pointed out, this is probably the best
25 thing that happened to Illinois because they just had to

1 constrict everything they had. It gave them the opportunity
2 for a total re-evaluation of all the system with which
3 they were involved at the time.

4 Much of the increase will be core. As I have
5 indicated, core is very peculiarly competent I think in the
6 Illinois program. They have some of the best people, I
7 think, around, both as far as evaluation in the field of
8 education, and I think the whole problem of evaluating
9 quality of care with HMO's can be greatly helped by the
10 sort of program they are discussing in Illinois.

11 I think that as you look at their core project it
12 is a very ambitious one. There's no question about it. But at
13 the same time they have, I think, the energy and the ability
14 and a RAG which will permit them to utilize these funds.

15 I am impressed that that state will have very
16 little waste because of their method of budgetary control
17 and review and the priority systems they have worked out.
18 I would not be as happy about giving these funds to many
19 other regions. I think this region can handle it very
20 effectively, and the health needs in Illinois -- you know,
21 this is a huge state, and you talk about increasing it
22 2.6 million, you think about the size of Illinois and they
23 are getting involved now with delivery of health systems,
24 this is a very, very expensive area.

DR. KRALEWSKI: Do they have any vacancies on core

1 right now?

2 DR. SCHERLIS: They have a few, but as I pointed
3 out, they have hesitated to fill them because they had no
4 idea how much attrition there would be this year. The
5 signals from Washington waxed from little support to a lot
6 of support. And they have been hesitant, for a lot of reasons,
7 to hire people knowing they might not get support after a
8 few months.

9 I am not concerned about their filling them. From
10 what I can see, the morale on the staff is so high they
11 should have no difficulty attracting desirable people to
12 work there.

13 The whole feeling you get about the IRMP is one
14 of organization and is moving along very effectively, and
15 not just stars in its eyes, but knows how to utilize the
16 health dollar.

17 DR. MAYER: How realistic do you think their
18 pledge that they took, Dr. Brindley, to get outside the
19 city of Chicago was? That's a big state.

20 DR. BRINDLEY: Well, in speaking to us they seemed
21 sincere and genuine that they were going to make a real
22 effort to go to the other areas, and they showed us a lot
23 of maps and where they planned to go and how they proposed
24 to go about it, and particularly with the new schools
25 and area health education centers as it related to those

1 schools, community clinics in those areas. They did show some
2 health plans, home health care plans that would involve
3 other areas out of the Chicago area. They sounded
4 encouraging.

5 DR. MAYER: I just wanted to make sure we had as a
6 matter of clear record so that next year we could look at
7 that issue and see how far they have come.

8 DR. SCHERLIS: There were three negative
9 recommendations. One, they had to have increased minority
10 representation on the RAG. We discussed this at some length
11 with them, and I think they are impressed with the fact that
12 this is a very high item of priority as far as we were
13 concerned.

14 Number two, more clearly defined subgoals and
15 objectives; objectives including ones for core activities and
16 educational support resource activity. I referred to that.
17 That's Dr. Miller's activity.

18 We also emphasized they had to be able to
19 evaluate core projects technically.

20 And three, increase planning activities directed
21 toward subregionalization of program.

22 The CHP agency was one which I think should work
23 more effectively, and I think part of their emphasis on
24 not having data is they want CHP to be more directly involved
25 with planning and helping to get some additional data.

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You are concerned about the sum of money we are recommending, I gather. I am not.

DR. MAYER: No, I just wanted to point out we were doubling the budget of a region, that's all.

DR. BRINDLEY: It is encouraging, I think, from the minority viewpoint that the man in charge of that is a member of a minority group. He is one of the professional members of core. It is his job to go out and recruit and to find these people. He is a very energetic, enthusiastic person, and said he was making a real effort to find these people both for involvement in the core and also in the RAG. I think they are trying their best to get good members.

DR. MAYER: Other comments? Questions of the two reviewers?

MISS ANDERSON: I was just wondering here on the core staff aspect where they are sort of contradicting themselves, where they are talking about regionalization and extending out to the rest of the state they ask for three part time staff, a specialist for Northwestern University, Western Presbyterian, Chicago Medical, and they are all in the Chicago downtown area and not spread out.

DR. SCHERLIS: Don't forget the very heavy population which centers in Chicago. They are attempting something which if they can carry it off it will indeed be excellent experience, and that is to get each of the medical

1 schools to take a portion of Chicago as its area of
2 responsibility for the delivery of health care. And in doing
3 this they had the temerity to actually put lines on a map,
4 and this takes an unbelievable amount of gall, I guess,
5 to try to convince deans of medical schools that this is the way
6 to do it. And part of their attempting to do this involves
7 having support of the schools.

8 We were impressed with the involvement of the
9 medical schools in their overall community outreach programs
10 in Illinois, and the fact that we always had at least two
11 deans in attendance throughout this time, though if you
12 look at where the money is going it is not going to the
13 medical schools.

14 DR. BRINDLEY: I think there was an improvement in
15 the rapport with the physicians and hospital administrators.
16 When we were there before, why, they weren't too happy
17 with each other, but that seemed better this time. I talked
18 with several of the physicians about it, and they were
19 more enthusiastic.

20 DR. THURMAN: You don't see any turf problems as
21 they refer to them?

22 DR. BRINDLEY: Oh, sure. But they are doing the
23 best they can with that.

24 DR. THURMAN: As long as they can breathe they are
25 okay.

1 DR. MAYER: Other questions? John.

2 DR. KRALEWSKI: I understand you think it is a good
3 program, and I am in agreement. I am sure they have some
4 good things going, but one question yet I have on that core.
5 If they are going to add that many people they are probably
6 going to have to phase them in over a period of time, and
7 if they are going to do that they are probably not going
8 to be able to spend that core budget, and did your
9 cutbacks reflect that -- that's where your cutbacks were?
10 So they will probably be able to phase this group in and
11 extend that budget out in that way?

12 DR. SCHERLIS: I really think so because many of
13 these projects in which they ask support are already
14 beginning to move along somewhat. I think they have people
15 in mind for many of them.

16 I think it should be emphasized, too, that their
17 coordinator has been there a very short period of time,
18 is just beginning to turn programs around, and he has already
19 fixed in his budget for heavy amounts. If he is going to
20 have any impact it has to be by way of funding and new
21 directions, and we put a lot of our faith in his ability to
22 do this on the basis of what he has done by rescuing small
23 amounts of money by stopping projects, and taking that money
24 they weren't going to use. With RAG and technical review they
25 have phased out projects on the basis of not measuring up to

1 standards, not having adequate review, or not putting funds
2 where they should go. They haven't hesitated to do this.

3 MISS KERR: I got that the first time, but did
4 I miss anywhere along the line where you referred at all to
5 their turning over of projects or activities for outside
6 planning? Are they phasing out any support from the outside?

7 DR. SCHERLIS: This is a very heavy criterion as far
8 as their review process is concern. This is one of the
9 very strong points.

10 MR. TOOMEY: As they have divided up the city of
11 Chicago have they kind of adopted on a satellite basis
12 hospitals within the area to relate to one of the medical
13 schools or the hospitals have a multiplicity of--

14 DR. SCHERLIS: I should emphasize even if they draw
15 lines on the map these are real thick, heavy, fuzzy lines
16 because some hospitals here work with community hospitals
17 out here, and they are just beginning to move in that
18 direction, but as I said, it looks like they are doing it,
19 and they do have satellite facilities with hospitals
20 as part of this program. All of this is just beginning to
21 evolve at this point.

22 MR. TOOMEY: Is the relationship just medical
23 between -- in the hospitals is it the medical school or is it
24 relating to administrative as well?

25 DR. SCHERLIS: Their allied health professions are

1 involved very heavily. They have administratively -- I
2 can't speak to this. We had specific items that related to that.

3 DR. MAYER: Further comments?

4 MR. NASH: Dr. Scherlis, you seem to be so concerned
5 about the size of core. This includes, of course, Dr. Miller's
6 project.

7 DR. SCHERLIS: I think that is an important point,
8 that when they talk about core a lot of our curiosity centered
9 around the fact that within core they had some areas of
10 activity that might be funded as projects elsewhere. This
11 is particularly true of their educational resource center
12 under Dr. George Miller. And so a good part of that core
13 funding is through Dr. Miller. We suggested that they look
14 at this administratively as well in order to not just let
15 this be an ongoing project through core. One reason they set
16 it up is because they had it funded three years in a row
17 and it is a continuing resource for the state, will now
18 become heavily involved with their own problem oriented type
19 history.

20 But I appreciate that addition. This is one reason
21 why core is so--

22 DR. KRAWLEWSKI: Are they going to phase out that
23 project or do they plan to stay in it forever?

24 DR. SCHERLIS: I think if you look, they will be
25 in it a while longer. We did as one of our suggestions

1 emphasize they look at that whole administrative structure
2 and set up some ongoing technical review of it periodically.
3 So this won't be free swinging. It is a wonderful resource to
4 have in the state and should be there. The question
5 obviously is how long should it continue to be supported by
6 RMP. It should be added that this is not a major part of
7 the support by any means. He has a great deal of support
8 ongoing. I guess from the whole manpower and other agencies.

9 DR. PERRY: The Kellogg Foundation has just
10 funded a half million dollar project.

11 DR. SCHERLIS: This isn't something he needs only
12 for this. These funds are specifically related to RMP
13 activities.

14 DR. MAYER: Other comments?

15 Then your recommendation is two million 650,
16 two million eight, three million respectively.

17 DR. SCHERLIS: Yes, I make that in the form of a
18 motion.

19 DR. BRINDLEY: Second.

20 DR. MAYER: Discussion?

21 All those in favor?

22 (Chorus of "ayes.")

23 Opposed?

24 (No response.)

25 Well, let's take a minute to fill in the blanks

1 while we have a chance, remembering that 5 is the highest, 1
2 is the lowest, and circling those that you have some guilt
3 about.

4 DR. SCHERLIS: You are not requesting members of the
5 site visit to do that, are you, because ours is already a
6 matter of record, and I don't want to be caught in any
7 inconsistencies.

8 DR. MAYER: Can it be recaptured?

9 MR. NASH: I have one from Dr. Scherlis. I don't
10 believe I got one from Dr. Brindley.

11 DR. MAYER: Leonard, it sounds like you are
12 excused and Dr. Brindley is not.

13 DR. SCHERLIS: I am safe. He has mine.

14 DR. MAYER: I think we might move on then, Sister
15 Ann, to Maryland.

16 SISTER ANN JOSEPHINE: All right. The Maryland
17 site visit--

18 DR. MAYER: The record will show that Dr. Scherlis
19 has left the room.

20 SISTER ANN JOSEPHINE: The Maryland site visit was
21 made on December 8 and 9, and members of the site visit
22 team were Dr. Alexander McPhedran, Emory University Clinic,
23 and Dr. William McBeath, who is the Director of the Ohio
24 Valley Regional Medical Program. Staff present at the site
25 visit were Dr. John Farrell of the Health Maintenance

1 Organizations Division-- we were very happy to have him with
2 us because a substantial portion of the grant request from
3 Maryland is for health maintenance organization related
4 projects -- Mr. Harold O'Flaherty, from the Planning and
5 Evaluation Division, who prepared a very provocative list of
6 questions that we used the first evening prior to the site
7 visit to kind of get on the same wave length so that we
8 could evaluate the type of inquiry that we were going to conduct
9 as the site visit progressed; Mr. Clyde Couchman, the
10 regional office representative from Region III; and Mr. George
11 Hinkle from the Eastern Operations Branch. And we had
12 requested Mr. Hinkle to prepare a document that indicated the
13 questions that the previous site visitors had had, and then
14 to also indicate what corrections had been made so that this
15 would also serve as the basis of discussion.

16 Following the discussion evening prior to the meeting
17 we decided that it might be of advantage if the chairman
18 of the site visit team were to meet with the coordinator
19 of the program at breakfast so that possibly a good rapport
20 could be established between the site visit chairman and the
21 coordinator which would facilitate the site visit. And I
22 think that we had not done this on previous site visits I
23 have attended, and I personally found this very helpful.

24 The Maryland Regional Medical Program will have
25 completed its first three years as an operational program on

1 February 29, 1972. And the present application was for a
2 triennial award, and they also requested a developmental
3 component of \$100,000.

4 The purpose of the site visit was to assess the
5 region's overall progress, the quality of the current
6 program, and its prospects for the next three years and
7 its ability to handle the developmental component.

8 One of the points that was obvious the evening
9 before the site visit began was that the Maryland Regional
10 Medical Program has responded to the directives from the
11 national program in such a way that the program represents
12 almost a 180 degree shift in goals and priorities and
13 emphasis. And it should also be noted that this is a program
14 that has experienced a high turnover rate in coordinators.
15 In the five years of the program there have been five
16 coordinators.

17 Dr. Davens, the present coordinator, has had some
18 involvement and has been interested in HMO's, which is also
19 reflected in the proposals that have been made.

20 Johns Hopkins University is the grantee organization
21 for the Regional Medical Program. And in the state are the
22 two medical schools, Johns Hopkins and the University of
23 Maryland.

24 On the prior site visit the site visitors were
25 disturbed by the fact that it appeared that the Regional

1 Medical Program was heavily dominated by the two medical
2 schools.

3 The site visitors found that the Maryland
4 Regional Advisory Group has been expanded from 27 to 35 members,
5 and this in response to a criticism on the last site visit,
6 and the total committee structure has been changed. Five
7 of the twelve committees which have been established to
8 assist the coordinator and the RAG are of categorical
9 nature. Three have been recently established following
10 successful core supporting feasibility and planning studies.
11 Two are structured; they are the health care delivery
12 Maryland health data, and patient health education steering
13 committees. Two are structured to relate to the core staff
14 administrative organization; and one, the Western Maryland
15 Regional Advisory Group, has been recently established to
16 provide greater peripheral representation.

17 In each instance the committees have a written
18 charge developed in part by the discussions among the
19 committee members, and the advisory committee which has been
20 set up advises the coordinator on the general matters of
21 policy and procedures.

22 The coordinator is supported by a staff consisting
23 of 18 professionals and 14 secretarial-clerical personnel,
24 of which five positions are part time.

25 The core staff organizationally consists of the

1 coordinator, business manager, an associate coordinator
2 for project development, members of the Epidemiological
3 and Statistical Center, and the Division of Health
4 Manpower Development and Continuing Communication.

5 The core staff has been strengthened considerably
6 since the last site visit, and the site visitors were very
7 impressed with the chairman of the Health Manpower
8 Development and Continuing Communication Division.

9 Organizational changes have been made in an attempt
10 to provide a broader base for management and also to try to
11 eliminate the domination of the two medical schools in the
12 area.

13 The Epidemiology and Statistics Center, which is
14 associated with Johns Hopkins Medical Center, has been more
15 closely tied to the central core unit, and is now functioning
16 as the principal health intelligence and evaluation arm
17 of the Maryland Regional Medical Program. Previously there
18 was some concern that this center was funded as a unit within
19 the core structure, however it was functioning independent
20 of it.

21 In the guidelines that were developed and published in
22 August of 1971 for the Maryland Regional Medical Program a
23 very fine evaluation procedure is described. However, during
24 the course of the visit as we questioned the individuals who
25 were presenting the programs at some points it wasn't too

1 clear exactly how the E and S Center has been providing an
2 ongoing evaluation service.

3 In response to change in direction expressed in
4 the RMPS new mission statements, Dr. Davrens reported that
5 the medical school involvement in Regional Medical Program
6 activities has been redirected from continuing education
7 to planning and development of health maintenance organizations
8 and training of health professionals and new types of health
9 personnel.

10 The director of the Epidemiology and Statistical
11 Center, Dr. Leon Gordis, is moving to direct the efforts of his
12 staff toward the new mission of Regional Medical Program,
13 especially in the areas of collection and analysis of data
14 with specific reference to defined areas where there is interest
15 in and need for the development of a health maintenance
16 organization and area health education centers..

17 Dr. Davrens reported that since the last site
18 visit one of the criticisms that was made was that there
19 was no evidence of cooperative efforts with Comprehensive
20 Health Planning, and this could be documented at the
21 present time.

22 There is increased minority group representation.

23 There has been a discontinuance of the University of
24 Maryland tissue typing project, and Dr. Davrens repeatedly
25 reassured the site visitors that although the medical schools

1 support the Regional Medical Program they do not interfere
2 or attempt to control the program.

3 In view of the recent changing emphasis in the
4 strategy of Regional Medical Programs, the site visit team
5 elected to evaluate the Maryland Regional Medical Program
6 goals, objectives and priorities with respect to the proposed
7 new as well as past activity.

8 The goals, objectives and priorities are clearly
9 and explicitly stated, and the site visit team was
10 impressed with the fact that the objectives proposed for
11 the triennial period clearly reflect the objectives, goals
12 and priorities that are stated in their application.

13 DR. MAYER: Excuse me, Sister, did you say are
14 explicitly stated or inexplicitly?

15 SISTER ANN JOSEPHINE: No, they are explicitly
16 stated. However, the goals are in response to the recent
17 direction given to Regional Medical Programs.

18 DR. MAYER: It looked like a perfect rewrite to me.

19 SISTER ANN JOSEPHINE: That's right. That's right.
20 This is one of the disturbing things, I think, as we evaluated

21 The emphasis during the discussion and in the
22 submission of the projects, the emphasis on health maintenance
23 organizations, area health education centers, again was
24 stated in such a way that it was a direct restatement of the
25 directives from the national program.

1 The Maryland Regional Medical Program has made
2 substantial change in program direction, and one of the things
3 that disturbed the site visitors was that some of the
4 projects that had been implemented in previous years seemed
5 to be dropped without any planning or any phasing out
6 and new ones added, and it appeared to us that probably this
7 was done in an attempt to meet the newly established objectives
8 rather than following careful evaluation and in response
9 to the needs in the area.

10 The two projects for HMO's were passed by RAG, but
11 were not subjected to the evaluation and the technical
12 review process that are very well described in the guidelines,
13 and the same is true of two other projects that were
14 submitted under new projects.

15 The RAG -- although the membership of RAG has been
16 increased, the site visitors were disturbed that the majority
17 of the members of RAG come from the Baltimore area, and
18 there does not seem to be the type of representation needed
19 to better understand and respond to the needs of areas
20 peripheral to Baltimore.

21 The coordinator appears to be giving leadership to
22 the program. He appears to be relating well to the
23 representatives from the two medical schools, and he appears to
24 be communicating with RAG. However, as we had an opportunity
25 to discuss the activities of RAG with the members who were

1 invited to the meeting, it was our impression that RAG took
2 their direction from the coordinator, and although they were
3 information of day to day operations, that possibly RAG
4 was not as strong as it needed to be in order to fulfill its
5 role. Also RAG meets once a month, and does not have an
6 executive committee; and in discussing the reasons why
7 they chose to go this way in their organization it became
8 apparent that because most of the representatives are from
9 Baltimore that it is easy for them to meet this way, and
10 because there doesn't seem to be a well developed program they
11 have not really experienced a need for an executive committee.

12 Approximately two-thirds of the core staff are full
13 time, and there are only three vacancies, and Dr. Davrens
14 assured us that these three vacancies could be filled.

15 Many of the concerns raised about the core staff in
16 the past were predicated upon the fact that essentially they
17 were part time, and Dr. Davrens has gone a long way in
18 terms of changing this situation.

19 The site visitors are still unclear as to whether
20 in reality Dr. Davrens and his support staff are providing
21 leadership to the medical schools in terms of the Regional
22 Medical Program mission or if the medical schools are
23 dictating the direction to the Maryland Regional Medical
24 Program.

25 The grantee organization, as I mentioned before,

1 is Johns Hopkins University School of Medicine, and it
2 appears to have a very positive relationship with the Maryland
3 Regional Medical Program and would seem to be providing
4 them with the type of support help that they need.

5 Dr. Ancrum is going to continue with the report..

6 DR. MAYER: Gladys.

7 DR. ANCRUM: As far as participation in the
8 Maryland Regional Medical Program, they do seem to have quite
9 a variety of organizations and other professions in the
10 Baltimore area especially participating in that program.
11 They had some of the visitors there from some of the projects
12 that were going on, also other interested citizens around
13 the Baltimore area. Also they were very helpful in helping
14 to get the Maryland Health Maintenance Committee started,
15 which is a group that is currently operating--

16 DR. MAYER: Gladys, is that one wired down there
17 for sound? You were coming through fine, Gladys, until
18 we got the additional noise.

19 DR. ANCRUM: They did play an active role in
20 helping to establish the Maryland Health Maintenance Committee,
21 which is currently operating a health center in one of the
22 underprivileged areas in Baltimore. They do utilize some
23 of the community practitioners and also other community aides
24 for operating this facility.

25 Also Sister said earlier most of the planning for

1 the area has been locally and throughout the Baltimore area.

2 The one way they seem to be moving away from
3 Baltimore is through the Manpower Development and Continuing
4 Communication under Dr. Herbert's leadership.

5 Also they do have plans for correcting some of
6 this and becoming more active in subregionalization by
7 involving the comprehensive health planning B agency.

8 There was a question among the site visitors about
9 how they were using the assessment of regional resources.
10 The Epidemiological and Statistical Center did collect a
11 large amount of data, but we weren't able to determine as to
12 how did they utilize this data in determining needs, and also
13 using this as a baseline for developing some of their
14 programs.

15 In the management they seem to be emphasizing quite
16 a bit of strategy for developing health maintenance
17 organization. Both schools that are connected with the
18 program are doing further work in getting the health
19 maintenance organization established.

20 Also during the course of the site visit it was
21 learned about community activities that are being carried
22 out through the Division of Health Manpower and Continuing
23 Communication, and which they referred back to community
24 activities that went on with their second Monday series
25 several times throughout their presentation.

1 Also the way that these are monitored, they do
2 have quarterly reports which include a summary of their
3 overall accomplishments and their fiscal situation.

4 As also stated earlier, the main center for
5 conducting the evaluation of all the projects funded by
6 the Regional Medical Program for this area is the
7 Epidemiological and Statistical Center. In addition to look-
8 ing at the project for ongoing evaluation they also have a
9 committee that reviews the proposals and helps with being
10 sure that they do have quantitative ... that can measure
11 evaluation in the regional proposal.

12 Dr. Davens did state that this would be the main
13 intelligence center for the Maryland Regional Medical
14 Program, and that was also now a part of the core staff
15 rather than being a separate entity. However, we were not
16 clear as to how much direction for the center came from
17 Dr. Davens or they were still operating more or less as a
18 separate entity.

19 They have also worked out a conceptual strategy
20 for evaluating all the programs, and they do have five
21 steps that they follow. These are determine the project
22 goals, determine the project objectives, determine the
23 measurement of objectives attained, and also establish
24 standards, and collection of the data on performance, and
25 comparison of actual performance with standards previously set

1 Also there was a request for budget for the
2 Epidemiological and Statistical Center in which they asked for
3 additional funding for carrying out these activities and
4 evaluating the project. I won't go into detail on that
5 now because Sister will go back and give you a summary of the
6 budget outline.

7 The program proposals that the program have, as
8 Sister pointed out, they do seem to be leaning quite
9 heavily on the national goals that were sent out in the new
10 mission statement.

11 In view of the major thrust in the new areas of
12 the health maintenance organization it is believe that the
13 proposed efforts would strengthen the service in the
14 underprivileged areas.

15 I did mention about the one point that they have
16 going with the health maintenance organization. They also
17 had another in Columbia, I believe it is, the Johns Hopkins
18 school.

19 Under the area of continuing education, here is where
20 they are doing quite a bit of work in trying to get into
21 other regions other than Baltimore, and one of the reasons
22 that was given for this was with schools there and with the
23 ease that people get into Baltimore they felt they should
24 put their effort in the other area.

25 Also they have a home care program which is

1 designed to give comprehensive home care to families. And
2 also with the school of nursing at the University of
3 Maryland they are currently starting preparation for family
4 nurse practitioners.

5 The site visit team felt that the activities that
6 the program had projected for the coming year were realistic.
7 However, one thing that they felt could have been improved
8 was that the medical schools could have made a substantial
9 contribution to areas other than just in the Health
10 Maintenance Organization.

11 In dissemination of knowledge we were assured that
12 wider groups and institutions would receive immediate
13 benefits from the activities that were planned and also
14 those ongoing. However, it was difficult to pinpoint what
15 available benefit the information would provide groups in the
16 outer area.

17 One of the other projects, too, is they are
18 starting an information center in which the Regional Medical
19 Program will be employing some of the core staff, and it
20 will be more of a survey type of questionnaire in which
21 they will be getting information from insurance companies
22 and others about people who come in for the treatment
23 of drugs.

24 Do you want to add anything?

25 SISTER ANN JOSEPHINE: The questions that weren't

1 answered to the site visitors' satisfaction really were the
2 following: we couldn't seem to find out through what
3 mechanisms the goals, objectives and priorities were
4 developed and approved other than that they were a response
5 to the new direction from the Regional Medical Program.
6 Also there was some concern that most of the proposed
7 activities to be carried out over the next three years will
8 be geographically located in Baltimore, and that roughly
9 25 percent of the requested budget is going for HMO activities,
10 and it was unclear again on what basis this decision
11 was made other than again in response to legislation and
12 existing activity that had been going on.

13 We were unsure about the nature of the region's
14 planning process and at what point in the development of
15 a project evaluation is built in.

16 Also we were not clear about the nature of the
17 strategy and methodology used for carrying out project
18 evaluation, nor was it entirely clear who carries out project
19 evaluation, project staff or center staff. There was
20 indication that this is presently being worked out, but that
21 in many instances it was not applied to the projects in the
22 proposal that were submitted for triennial support. Also
23 we were not clear as to how the results of evaluation
24 activities affect the region's decisionmaking process.

25 And for these reasons we thought it wise to

1 recommend that the triennial application not be approved
2 as the triennial application, but rather approved for two
3 years at a direct cost support level of \$1,294,960. And
4 originally the proposal was to approve it at a level of
5 \$1,325,000, but in the recent mail a communication came from
6 Washington stating that the recommendations of the
7 Mini-Sarp review on the anti-lymphocyte globulin for renal
8 allograft project number 43 be deferred pending national
9 RMP policy on funding ALG production.

10 We are recommending that the developmental component
11 not be supported, and we are recommending that the project
12 level of \$861,313 be reduced to \$714,004. And the areas
13 in which we are making reduction are in the areas of the
14 Health Maintenance Organization proposal submitted by the
15 University of Maryland Medical School contract for \$172,309.

16 Dr. Farrell -- is Dr. Farrell here? Dr. Farrell
17 was present on the site visit team, and it was his
18 recommendation, and the group concurred, that since the other
19 organization that is supporting HMO activities will provide
20 \$25,000 for a feasibility study, and he felt that since the
21 description of this project made it fall essentially into
22 the category of a feasibility study that to fund this
23 project at a \$25,000 level would be appropriate.

24 Also it was the decision of the site visit team
25 that mini-contracts which had been used by this Regional

1 Medical Program and were funded at a level of \$95,270 be
2 reduced to two and a half percent of the total funding, which
3 would bring this to \$32,335. That two and a half percent
4 was arrived at after some discussion in the group. As
5 Dr. Daven explained the use of mini-contracts they really
6 were used somewhat like developmental component money would
7 be used. If a person came and had an idea for a project
8 that would be short term or needed some matching funds then
9 mini-contracts were sublet. And he pointed out that these had
10 been attracting many people to the Regional Medical Program,
11 but it was also pointed out that many people would be
12 attracted to any program that had money to give out. So that
13 possibly this might become a slush fund unless it were
14 controlled in a different way.

15 On page 19 of the Maryland Regional Medical
16 Program site visit that is included in your folder are the
17 site visit team recommendations, and members of the staff and
18 Dr. Ancrum and I would be glad to answer any questions on
19 these that you have to ask.

20 DR. MAYER: That final figure instead of
21 a million 325 was what, Sister?

22 SISTER ANN JOSEPHINE: A million 294, 960 for two
23 years, at the end of which time they could resubmit their
24 triennial application. And the reason that we asked for two
25 years rather than one, we felt that it would make it possible

1 for them to develop an application that could show that they
2 were able to evaluate the new direction which they had
3 suddenly taken with their program.

4 DR. MAYER: If what I interpreted was correct they
5 are currently operating at a million 672 level.

6 SISTER ANN JOSEPHINE: Yes.

7 DR. MAYER: This in effect then is a reduction
8 of almost 300,000, \$280,000 over their current operating
9 level. The interesting thing to me was it still provides
10 them with about -- if I am reading the yellow sheets correctly,
11 with a little over 550,000 more than they have in carryover,
12 which means that they must be phasing out a tremendous amount
13 of effort, \$900,000 worth of effort this year, if I am
14 reading those yellow sheets correctly. Is that correct? Are
15 they phasing that much out?

16 On one hand it says that the activity this year
17 is at a million 672 in the 03 year, and then on the other
18 hand it shows for the 04 program continuation with approved
19 period of support, and continuation beyond shows only
20 741,000, which suggests to me that they phased out about
21 \$600,000 somewhere.

22 DR. ANCRUM: I think they phased it out during
23 the time there was a reduction in the funds, they had a
24 25 percent cut and they phased out some of the program. They
25 used the amount that was in the ongoing program.

1 DR. MAYER: I guess the point is that they have got
2 a million six now in operation, and it only shows -- well, 741
3 of continuation of current activities of the 03 year into
4 the 04 year even in their request, unless I am missing
5 something.

6 VOICE: You are right, Dr. Mayer. They have about
7 eight or nine projects that come into the end of the 03
8 year support period. The sheet you are looking at, the
9 only activity they have ongoing in their request is number
10 19 and number 27 and project number 35 which are in this
11 summary which all of you have a copy of. Anything else, all
12 their work in the area of stroke, coronary care units, are
13 all coming to an end. That's what Sister Ann referred to
14 a minute ago when she said they had done a 180 degree turn--
15 around in the program.

16 DR. MAYER: So that on the one hand although it's
17 a reduction of current operating activity it's an increase
18 in terms of dollars to go into new program. That's the only
19 point I am trying to make.

20 All right, other comments?

21 Yes, Jerry.

22 DR. BESSON: Sister, I'm not sure that I understand
23 the relationship between the proposed mini-contracts where
24 they request \$95,000 and how they expect to use this money
25 other than their developmental component. As I read the

1 application I gather that they want to be able to respond
2 quickly to changes in RMP mission and evolving new thrusts
3 in national health programs, and this is really a description
4 of what the development component is. And yet you suggest
5 that the developmental component not be funded, but that
6 the mini-contract be funded in part.

7 SISTER ANN JOSEPHINE: Well, I agree with you on
8 that. The mini-contracts as we heard them described -- and
9 we asked several times -- were described in such a way that
10 they could be describing the developmental component. It
11 was the thinking of the group that rather than eliminate that
12 entire amount we would reduce it this time, with the
13 recommendation that it not be supported at a future date.
14 But there really wasn't other rationale behind it.

15 DR. BESSON: And the other question I have relates
16 to the \$25,000 that is recommended for project number 37,
17 the HMO health care study. Again as I read this University
18 of Maryland HMO proposal I wonder whether the admonition
19 that Dr. Margulies mentioned this morning about RMP's role in
20 HMO's being eliminated to follow the assessment of
21 manpower utilization and emergency medical services, whether
22 what they propose to do with this HMO health care study doesn't
23 lie beyond the scope of that. They are really asking for
24 funds to develop an HMO for a particular area, and that would
clearly lie beyond the purview of RMP's purposes, and so I

1 am wondering why even this 25,000 is--

2 SISTER ANN JOSEPHINE: Dr. Besson, there were
3 members of the site visit team who raised the same question
4 you are raising, and at that point we turned to Dr. Farrell
5 who was there representing the HMO operation and asked him
6 if he would talk to this point. And he, as I remember --
7 and other members of the staff may want to comment on this --
8 he indicated that he felt this was within the purview of the
9 Regional Medical Program support. And I know at the time
10 this discussion went on there were those who raised the
11 question whether at a future date, since we do not have any
12 guidelines that enable us to make these kinds of distinctions
13 at the present time except consultation we get from staff,
14 whether at a future date we are not going to have real
15 problems since the HMO effort is being funded from two
16 separate pots, and say, you know, how much of the RMP money
17 should go into this. This question was raised, and
18 probably someone else from staff wants to comment on this.

19 I would also share your concern.

20 MR. TOOMEY: Sister, I am confused, because on
21 page 21 of the yellow sheets you have got the HMO information
22 system which is with Johns Hopkins, and then you have a
23 contract with the HMO health care system at the University of
24 Maryland, and I understood you to say that the one at
25 the University of Maryland you disallowed.

1 SISTER ANN JOSEPHINE: This would be reduced from
2 172 thousand to 25.

3 MR. TOOMEY: How about the one at Johns Hopkins?

4 SISTER ANN JOSEPHINE: Well, the one at Johns
5 Hopkins -- and again we relied on Dr. Farrell as we were
6 making this decision -- the one at Johns Hopkins was allowed
7 for the amount that they requested. Apparently the
8 center at Johns Hopkins University is already participating
9 or providing data for the national effort in evaluating
10 Health Maintenance Organizations--

11 MR. TOOMEY: Is that the East Baltimore--

12 SISTER ANN JOSEPHINE: I think Dr. Farrell felt
13 that if this were disallowed that it might interfere with
14 this other effort, and I think this whole thing -- I'm glad
15 this came up because I think this whole HMO discussion needs
16 whatever clarification can possibly be given here from staff.

17 MR. TOOMEY: And then you have another University
18 of Maryland, the Bon Secours Comprehensive Health Center
19 is involved with the home care program.

20 SISTER ANN JOSEPHINE: Yes, and that home care
21 program is under this health education.

22 MR. TOOMEY: It just would seem to me that what they
23 were doing is trying in a way to split the derivation of
24 information between the single efforts of the two
25 universities to provide health services through these HMO's.

1 SISTER ANN JOSEPHINE: Yes, we shared your concern.

2 MR. TOOMEY: Actually one of them could probably
3 have taken the whole ball of wax.

4 DR. THURMAN: Could we carry that just one step
5 further because on the top of 23 there is another \$84,000
6 for HMO's which looks like it's really the E&S center.
7 The two on 21 that Dr. Toomey has referred to and on the
8 top of 23 is another \$84,000 for HMO's, and how much of core
9 really goes to E&S? I guess that's the real question,
10 because it really does look like all three of these contracts,
11 and the fourth one, too, would go back to E&S, which is going
12 to make it a pretty expensive operation.

13 MR. TOOMEY: May I ask is this Maryland Health
14 Maintenance Committee incorporated? Is that the Columbia,
15 Maryland--

16 SISTER ANN JOSEPHINE: No.. No..

17 MR. TOOMEY: Well, did you mention that they were
18 involved in that?

19 SISTER ANN JOSEPHINE: No, I didn't. This
20 corporation is one that Dr. Daven has been working with and
21 has been interested in.

22 DR. THURMAN: They also have another contract from
23 another--

24 SISTER ANN JOSEPHINE: That's right. The whole
25 HMO area here is very muddy, and this was the reason I think

1 Dr. Farrell was provided from staff. This never was really
2 made clear, and then today after Dr. Margulies' remarks
3 I felt a little more unsure about this because I was prepared
4 to come in and say that I felt that since there was another
5 organization that was providing support for the development
6 of HMO concepts the question I would raise is how much
7 money should be supplied from Regional Medical Programs. But
8 if I heard the discussion this morning I think that this is
9 not a part of the consideration. Is that right? Which is
10 a little confusing to me.

11 MR. CHAMBLISS: I would think so, if I might just
12 answer a bit here. It is my understanding that the limited
13 amount, not to exceed \$25,000, might be used for planning
14 and development for the feasibility aspects of the HMO,
15 that the larger amounts have to do directly with the
16 actuarial side, the marketing, the packaging, the establishment
17 of an HMO and the funding of it, the front funds required
18 to get it going. And that is not within the province of
19 RMPS. But certainly as it relates to planning of the
20 initial feasibility and the monitoring of the quality of
21 service rendered therein those are two aspects which
22 Regional Medical Programs could be involved with its funds.

23 DR. MAYER: Would you like to comment?

24 MR. HINKLE: Yes, Dr. Thurman made reference to
25 the EMS. They are supported by total budget of 179 or 189

1 thousand dollars. Now with reference to the HMO part of
2 \$84,700, that is in conjunction with a contract the HMO
3 office has made with Maryland Health Maintenance Committee
4 in Maryland, and the RMP of Maryland decided -- they
5 obligated themselves to take on the responsibility of setting
6 up an evaluation mechanism for this Maryland Health
7 Maintenance Organization committee up there, and that is
8 to set up an HMO other than the one they have ongoing now.
9 They have one through Johns Hopkins and this other one. And
10 they are going to try to set up an evaluation mechanism for
11 this Maryland Health Maintenance Committee HMO activity
12 which is supported about \$250,000, and they are going to set
13 up a system within Baltimore that can be later on expanded
14 throughout the state of Maryland.

15 And repeatedly -- and I think it was mentioned
16 before here -- we asked the same question, why can't the
17 EMS center set up this mechanism, and they repeatedly
18 advised us that they are overworked now, they don't have
19 sufficient staff to take on this additional responsibility.

20 So that's the reason they have a separate project
21 in here to go out and get outside assistance in this
22 evaluation.

23 DR. THURMAN: It says will also be part of the new
24 activity of the E&S center core staff. So that's not
25 outside.

1 MR. HINKLE: I was speaking about the \$84,700.

2 DR. THURMAN: So was I. The last statement under
3 the 84,000 one is "will also be part of the activity of the
4 E&S center core staff."

5 MR. HINKLE: But this 84,000 is to go outside and
6 get the assistance to set it up, and the E&S center has their
7 hand in everything going on up there, and they are also going
8 to help in there. But they don't pinpoint how much of their
9 \$187,000 will supplement the 84,700.

10 DR. MAYER: Well, what that said to me, Bill, was
11 the EMS center was going to carry out an evaluation of that
12 contracted outside evaluation system. Now is that what they
13 are planning on doing?

14 MR. HINKLE: No--

15 DR. MAYER: They are going to do it?

16 MR. HINKLE: They are going to assist in it. They
17 are going outside to get help to do it because their
18 staff, their overworked status up there which they kept
19 referring to, it doesn't have enough people to do it on
20 their own.

21 DR. MAYER: But they are going to keep close tabs
22 on it. They are going to subcontract some part of it.

23 MR. HINKLE: In reading the project anything that
24 has to do with the mission they say E&S center is going to have
25 a hand in it also. There is a survey which they are going

1 to conduct with outside funds, which is another project,
2 and we asked them why can't the E&S center conduct this.
3 There again they said they are overworked with available
4 staff and they don't want to get out and hire additional
5 people.

6 SISTER ANN JOSEPHINE: I got the impression, too,
7 that the E&S center is already -- someone has contracted
8 with the E&S center to provide some of this data collection
9 and evaluation, and are presently engaged in it.

10 MR. HINKLE: This point is another aspect that the
11 site visit kept focusing on, the site visitors wanting to know
12 why the E&S center is doing so much outside evaluation work
13 for other people, why can't they get these people to pay for
14 it. And they finally in the final analysis said they have
15 been thinking along those lines and they plan to do it, have
16 the E&S center contract outside.

17 Now on one hand they say their staff is overworked
18 and they can't do it themselves, and on the other hand they
19 say they are doing work for people outside. This is just
20 one of the ambiguities we kept running into every time we would
21 ask questions.

22 DR. MAYER: Dr. Farrell, one of the questions that
23 has been raised was who's on first in the HMO situation as
24 it related to the Maryland project, and with some lack of
25 clarity of that, and we wondered if you could comment about it.

1 DR. FARRELL: Yes. This is the University of
2 Maryland?

3 DR. MAYER: Right.

4 DR. FARRELL: My reading of that was that it was --
5 what was the word we used -- marathon evaluation project
6 to the extent if an HMO were started in the community
7 what would be its effect upon present provider structure
8 and particularly upon the state run medical school. Most
9 of the planning contracts of the HMO service are to the
10 extent of \$25,000 limit, and this was three years for something
11 in the range of \$187,000 a year, if I remember it..

12 DR. THURMAN: Why was there a difference between the
13 University of Maryland and Johns Hopkins? That was the other
14 question. Johns Hopkins is 146. That's a big difference..

15 DR. FARRELL: Well, they are dealing with an
16 operational HMO, and they are doing a specific quality care
17 project.

18 DR. KRAWLEWSKI: Were you able to determine how
19 many other granting agencies were involved in these HMO activities
20 in these schools and whether this logically fits in with
21 their funding so it makes a pattern?

22 DR. FARRELL: Yes, the only HMO service is from the
23 HMO's now.

24 DR. KRAWLEWSKI: Do they have a grant from an
25 insurance company also?

1 DR. FARRELL: The Columbia project you mean?

2 DR. KRAWLEWSKI: Right.

3 MR. TOOMEY: No, the East Baltimore project. The
4 East Baltimore project has somewhere in the neighborhood of
5 15 to 20 federal programs participating in that. I don't
6 know whether you call it an HMO at the moment, but in actual
7 practice--

8 DR. KRAWLEWSKI: And the national center has some
9 money in that in an evaluation form?

10 DR. FARRELL: There are all the specific aspects, and,
11 of course, it is one of these organizations that's being
12 looked at from about twelve different angles. It is not
13 typical.

14 DR. BESSON: Mr. Chairman, I think we are really
15 talking about something that we will hear many more times
16 before we see the end of HMO's, and it will be well for us
17 to make sure that we have a clear statement from the Council
18 and suggest what RMP's bag is going to be in HMO. I heard
19 Mr. Chambliss say that one of the reasons we are funding
20 project 36 perhaps or why we are giving this 25,000 is to
21 study feasibility, and as I read at least our local guru's
22 interpretation of what HMO's relationship to RMP should be
23 it's not for feasibility. That should be the HMO organizations
24 in HSHMA.

25 I think that this being the bottomless pit that it

1 is, feasibility studies, developmental studies, et cetera,
2 requested from RMP can really get us far afield. Now
3 as I read the abstracts and then go back to the original
4 proposal I am not sure I read the same words that have been
5 reiterated here about why one project is going to be funded
6 and another is not. The entire project summary appears in
7 no greater detail than this yellow sheet does except by a slight
8 amount. And therefore we are left with just a series of
9 cliches, some of which are okay words, and some of which are
10 not.

11 But as I look at project number 36 which we are
12 suggesting may be funded, I see some okay words like routine
13 monitoring of the volume and types of medical services, but
14 I see some non-okay words like providing all necessary
15 financial billing functions and summary revenue statements
16 for accounting purposes, data for meeting the reporting
17 requirements of various external administrative agencies,
18 actuarial useful data for estimating future utilization of co-
19 payment revenues and capitation costs. These are clearly
20 not within RMPS purview.

21 So I am not sure whether there isn't a little bit of
22 misemphasis in using some words that will again push the
23 button that gets the green pellet. And we went through this with
24 cardiopulmonary resuscitation a few years ago and cardiac
25 care unit, and if they said those magic words, bang went the

1 dollars. And I am a little bit afraid that this is what we
2 are beginning to see with HMO's. So maybe at this early
3 stage of the game we should get a very explicit statement
4 from Council as to just what RMP's bag is in relation to
5 HMO's. And I would so move, couched in more elegant language.

6 DR. MAYER: All right.

7 DR. BESSON: We have a motion on the floor, Mr.
8 Chairman. I wonder whether with all this discussion Sister
9 is inclined to modify any of the recommendations or--

10 DR. MAYER: Well, I think, you know, the intent --
11 I gather the intent -- let me try to summarize what I pick
12 up now from what has been said. That what you were saying,
13 Sister, was a deletion of the project component by about
14 \$150,000, the basis of which was really deletion of that from
15 project 37, the University of Maryland HMO, with the
16 provision of about \$25,000 in that project for the effort
17 as it relates to the planning for HMO activity.. Is that
18 correct?

19 SISTER ANN JOSEPHINE: Yes..

20 DR. MAYER: And secondly, you therefore were saying
21 full funding of project 36. And Jeery just raised the
22 question whether items 2 and 3 under the objectives of
23 that project were appropriate. I think we can handle within
24 the motion that was made by saying that we would recommend
25 that level of funding, but would request that Council review

1 both of those two issues vis-a-vis the reduction of that by
2 either 25,000 more, if that's inappropriate, or by reduction
3 of it even further by whatever is represented in dollars
4 by components or objectives 2 and 3 of project 36. And if
5 we red flag that and ask that then I think we have handled
6 both the dollar component as well as those two issues.

7 DR. BESSON: If we also add to that, Dr. Thurman's
8 concern about project 41, and Mr. Toomey's concern about
9 project number 40, is it?

10 SISTER ANN JOSEPHINE: 40.

11 DR. BESSON: 40 for 30,900. These four programs
12 that impinge on the HMO's, we should have a policy decision
13 maybe focused on these four projects.

14 MISS ANDERSON: Do you think we will have a chance
15 to talk about that tomorrow morning maybe?

16 DR. BESSON: Yes, except that even though we are
17 not in executive session I constantly am running against the
18 query that I ask myself as to where policymaking decisions
19 lie. I prefer to ask Council for decisions.

20 SISTER ANN JOSEPHINE: I would like to say that
21 the questions that are being raised here are the questions
22 that continued to disturb the site visitors all during
23 the site viist. And as we had our discussion this morning
24 I just thought to myself Maryland is going to be just a
25 demonstration project for the dilemma in which we found

1 ourselves this morning. We really had no answers. We had
2 no guidelines. And staff was very helpful, but there just
3 were no guidelines to provide us. And we continue to be
4 disturbed, that here was a program that had taken an entirely
5 new turn and was in direct response to the most recent
6 directives from Washington, and that if certain components,
7 major components were deleted there would be no program.

8 MR. TOOMEY: Sister, can I take a crack at that?
9 It would seem to be that Baltimore, Johns Hopkins and the
10 University of Maryland are doing so much in so many areas
11 it doesn't make any difference where they get their support
12 or for what they get their support, they are going to need
13 some support for everything. And if the magic words from
14 Washington were heart disease, cancer, stroke, kidney, and
15 so on, they would go in that direction. If it was health
16 maintenance organization or new forms of delivery of health
17 services they would go in that direction; and if they went
18 in that direction they have got two universities and an RMP
19 and they decide that somewhere along the line they could
20 divide the money up. They are dividing the projects up.

21 DR. KRAWLEWSKI: With applications off the shelf
22 probably.

23 MR. TOOMEY: Well, you know, they are doing all
24 these things and they need money, so where do you want to
25 give it to them, for what, and they don't really care.

1 DR. BESSON: Well, there is one other aspect of
2 this that I think is pertinent to put it historically, at
3 least focusing on Maryland's move in the direction of new
4 mission, and that is that a statement about their involvement
5 in health maintenance organization reflects back to the
6 RMP coordinators meeting in March, 1971 following the
7 president's health message, and after discussion with
8 Secretary Richardson about the new mission for RMP in HMO's,
9 and the words they use is that, following presentation the
10 following month, "promotion of the development of HMO's
11 was featured as a prime activity for RMP's because of their
12 experience and their close relation to the providers of
13 health care."

14 That was before there was an HMO office yet
15 created. Now there is one, and now the turf is being a
16 little more carefully delineated and RMP no longer has this
17 large potential charge, but a more refined charge of
18 assessment of quality of care in HMO's.

19 Now if that's going to be our focus I would like
20 Council to state that explicitly so that we can be sure that
21 our funds aren't lost in the morass of funding development
22 of HMO's.

23 DR. MAYER: Is everyone clear on the questions
24 being raised? The questions are being raised relative to,
25 as I previously stated -- relative to number 36 and number 37

1 in the frame of reference that I raised them, in the dollar
 2 amounts that I raised them, also are being raised in terms
 3 of project 41 and the appropriateness of that. And I assume,
 4 Mr. Toomey, that the question relative to project 40, which
 5 if there wasn't any talk of HMO's in here I don't think
 6 this group would have had any difficulty with, but I think
 7 it is being raised in the framework -- at least let me
 8 try it -- that your thought was that that is additional
 9 information that may be useful to the formulation of an HMO.
 10 Is that the context in which you raised the question on 40?

11 MR. TOOMEY: Well, that's part of it. The other
 12 part is that it is a statistical study, it's part of the
 13 E&S, could be part of an E&S grant. My concern is that they
 14 have overlapped so much in separate projects. This project
 15 40 with project -- one of the earlier projects..

16 DR. THURMAN: Forty relates to 35.

17 MR. TOOMEY: Forty relates to 35, and 36 and 37
 18 are just two parts of the whole. And I think my hang-up
 19 is that they have just divided them up.

20 DR. MAYER: Okay. Further comments?

21 DR. WHITE: Can I ask something that doesn't relate
 22 to HMO's, except peripherally perhaps? Sister, I was
 23 on two previous site visits to Maryland, 1968 I think, and
 24 I have forgotten when the other one was, and both of them
 25 seemed to be sort of in an area of opportunism, and the

1 original one, heart, cancer and stroke was all the word, and
2 we had very elaborate stroke proposals, as I recall,
3 something that had to do with congenital heart disease, and
4 one thing and another. The next time around, I have forgot
5 what the guidelines were at that particular time, but they
6 responded to them also, some kind of elaborate project
7 mechanism which seemed to me it was a system of directors
8 of continuing education or something of that sort. And
9 now perhaps we are seeing the same kind of response at this
10 time.

11 But then there is the theme between here, and that
12 is the epidemiology and statistics function, and on each
13 of those previous visits there was a question of what they were
14 doing, and we were told well, any moment now we are going to
15 have a real basis upon which we can design our own programs,
16 and yet now I hear again that we don't really have anything
17 from that, and that was a very sizeable budget item, as I
18 recall, in earlier years, and even now.

19 And on page 14 of your report at the top under
20 assessment of needs and resources this confuses me again
21 further. There is one statement about the site visitors were
22 concerned that the overall needs assessment had not been
23 carried out. And yet on the last paragraph of page 8 it
24 seems as though the statement there is a little bit
25 contradictory, and I wonder if you can clarify that. I

1 wonder if you can help me get a grasp of the Regional
2 Medical Program general -- separate from whether or not this
3 parceling out of HMO money is appropriate or not.

4 SISTER ANN JOSEPHINE: Well, I have never been to
5 Maryland before, but I was impressed that the guidelines
6 and the program as it was developed was an aspect of an
7 opportunistic response.

8 In discussing and thinking about the Epidemiological
9 and Statistical Center it was my impression that although
10 this center had in the past been funded under core staff
11 it had in truth not really been an integral unit in core staff.
12 And I think that the attempt that is made at the present
13 time with the appointment of a new director, Dr. Leon Gordis,
14 is to achieve the objective of having some of the effort --
15 what percentage I wouldn't be able to determine -- but to
16 have some of the effort of this center provide the evaluation
17 and the planning types of services that they had spoken of as
18 being provided in the past. We could not identify that
19 this was being done at the present time. Everything that
20 was described was described in futuristic terms.

21 And I don't know whether that answers your question.
22 And I don't know, maybe Harold -- would you want to comment
23 on that?

24 MR. O'FLAHERTY: I think basically we went there
25 with the concern that we could not really see the pay-off

1 of the Epidemiology and Statistics Center. At least some of
2 us left there having that suspicion confirmed; that really
3 we were unable to tell, A, was the center an integral part
4 of the program, and B, how had the results of its activities
5 affected the development and implementation and decision-
6 making process of the Maryland Regional Medical Program.

7 In querying the chairman of the Regional Advisory
8 Group with respect to how decisions were made he informed
9 us that priorities, goals and objectives were set vis-a-vis group
10 discussion, and did not really utilize the process as
11 delineated for this center.

12 So we were concerned as a site visit team not only
13 with the effectiveness of the center and its output, but
14 also the Regional Advisory Group did not really appear to have
15 a logical reason d'etre for decisionmaking. So these were
16 some of the reasons we went into questioning really from
17 both ends the role of the center.

18 So to comment just one little bit further, the
19 RAG is so very Baltimore based, and we felt that it was not
20 really reflective of the total geography of the region,
21 and we could not really see how it went about the business of
22 making decisions other than through the process of group
23 dynamics.

24 SISTER ANN JOSEPHINE: I think it's fair to say also
25 that many of the site visit team when they left felt

1 somewhat uncomfortable about these recommendations, but
2 having no guidelines to make decisions about appropriation
3 of funds for health maintenance organizations it's very
4 difficult to deal with these kinds of problems.

5 DR. WHITE: My concern is even if these proposals
6 were precisely relevant to whatever the guidelines might be
7 that I can see them as simply being something they weren't
8 really concerned about, but this was a way of getting some
9 money, and whether this represents the quality of the program
10 rather than the quality of the projects that we should
11 be looking into.

12 SISTER ANN JOSEPHINE: Well, I think wherever there was
13 any discussion it was very difficult to get a review of
14 anything that was being done or had been done. Everything was
15 described in terms of the future and how all these things
16 would fit in, and then Dr. Daven kept coming back to the
17 point that they had the responsibility to form this network
18 of HMO's in the state of Maryland, and it was quite a
19 diversified group.

20 MR. O'FLAHERTY: One of the problems, I think, that
21 we see the HMO bag being fed to the medical schools as much
22 as it is, I think from a historical perspective that there
23 has been kind of a rift over there between the RMP and the
24 two medical schools, particularly with respect to who would
25 receive the tissue typing project since there was only one

1 tissue typing project given out, and it almost caused the
2 Battle of Armagetta. Nevertheless, what they did was
3 HMO's became a very popular mechanism to have everybody involved
4 in, so instead of putting these people on contracts or
5 extension of core -- I'm sorry, on projects or extension of
6 core, they have developed contracts with these two medical
7 schools to be involved in the HMO area.

8 One of the things that we talked about in the
9 report was that we could not see an emerging conceptual
10 strategy for HMO's or the Maryland RMP's role. It was kind
11 of a hit and miss approach to HMO's. So the 172,000 that
12 went to Maryland was really just literally -- and some of
13 you on the team may disagree, but we talked about this --
14 appeared to be a mechanism for appeasing this medical school
15 since it didn't get one of the tissue typing projects.

16 DR. MAYER: Well, what's your pleasure? There is a
17 recommendation on the floor with modification already
18 incorporated in it. I think one of the messages that is coming
19 through to me loud and clear, which I assume is coming through
20 to staff, which I assume would be translated to the Maryland
21 RMP, is that E&S Center has got to become incorporated as
22 a useful device in the decisionmaking process of the Maryland
23 Regional Medical Program or it's going to be out of business
24 at least as far as funding is concerned.

25 Now what beyond that do you want to put as

1 stipulations on the motion other than the ones we already
2 have?

3 DR. WHITE: The motion is for one million two
4 nine something?

5 DR. MAYER: The motion is for one million 294
6 with the potentiality of further reduction as a result of
7 projects 35, 36, and 41, I think it was, and their relationship
8 to are they appropriate as funding under RMP due to
9 RMP's role in HMO's.

10 MR. PARKS: Sister, may I ask you a question?

11 SISTER ANN JOSEPHINE: Yes.

12 MR. PARKS: This concerns a couple of things. Was
13 there any feeling or concern among the site visit group
14 that this program being administered by two rather large,
15 and certainly universities with rather wide reputations, that
16 they were missing or not reaching the rural population of
17 Maryland, and did you see any -- this doesn't come through
18 clear. There is some compromising language in several places
19 in this report. Do you see any manifestation of what is
20 categorized here as regionalization?

21 As I go down this and go down the itemization here
22 I am almost at a point of wondering whether this program
23 really shouldn't be put on notice that some more substantial
24 critical changes be made within a time limitation, that only
25 a conditional funding be given this program, and a short

1 review of the progress. Was that at all considered?

2 DR. MAYER: Well, I think that was what I heard
3 by the intent of the motion to disapprove their triennial
4 request, their developmental component, and to say all right,
5 there are two years in which to meet some of these conditions
6 to come back for a valid triennial request.

7 SISTER ANN JOSEPHINE: We felt that by the time the
8 word got to them really they would have six months to pull
9 something together. Is that right? If we did it just one
10 year. And this could destroy a program. And this was the
11 reason why, and this poll was taken by phone, as we realized
12 the time limit set. Originally when we left Maryland the
13 decision was we would make the recommendation that the
14 triennial application not be accepted, the developmental
15 component not be accepted, and then with the deletions
16 indicated, and also that they be funded for one year and
17 would have to re-apply and would have to justify their
18 program; that by the time they get word and begin writing
19 it up actually they have about six months in which to do
20 this. And so in thinking it over the decision was that
21 possibly by saying two years, which is actually a year and a
22 half to work, that it might be a little more reasonable.

23 Now the concerns that you expressed were expressed by
24 the group, and there were a number in the group who went
25 away very uncomfortable with this. I think there was question

1 about the regionalization effort.

2 In the discussion with the people who were there with
3 whom we could discuss this there was an indication that they
4 were beginning to move in this direction, the movement was
5 slow. And the majority of the members of RAG are still from
6 Baltimore and are still heavily oriented toward the two
7 medical schools. That was a point of concern.

8 There was a young doctor from a minority group who
9 was functioning with one of the programs who was very
10 articulate and very impressive and very involved, but whether
11 this represents a move toward minority group needs was
12 difficult to evaluate.

13 MR. PARKS: The reason I asked about the outreaching
14 to the rural areas is that there is a considerable portion
15 of Maryland that is in fact rural, and that is where I would
16 imagine the vast number of people, aside from those few pockets
17 close in here, Tobbytown and some places like that, where the
18 underserved populations, especially minority populations which
19 are not served -- they are not underserved, they are not
20 served -- St. Mary's County and various other places, where
21 they are not reached. And this is why I asked whether you
22 got a feeling that there would be a kind of movement toward
23 reaching out further.

24 SISTER ANN JOSEPHINE: I personally got the feeling that
25 there was an effort being made to move out in that direction

1 and probably some small successes were being achieved.

2 MR. PARKS: Was this one of the programs, in light
3 of the information we got this morning, that was reduced or
4 affected at all by prior funding reductions? Do we know that?

5 DR. ANCRUM: I think this has been a problem for the
6 last two years, that most of their efforts have been concentrated
7 in the Baltimore area with very little involvement of the
8 rural or the outer areas.

9 MR. PARKS: Right. This morning I heard that a
10 number of areas were affected a year or so ago by reductions
11 in appropriations, and now that there is a surplus that has
12 developed or an increase in appropriation, the application
13 of them administratively would be first to those programs
14 that fell into A, B and C categories automatically in terms
15 of awarding certain kinds of funds. If we are here putting some
16 limitations on the program in this particular review I think
17 also we ought to put an embargo on any added to it
18 administratively.

19 DR. MAYER: Yes, Judy.

20 MRS. SILSBEE: Under the circumstances, Mr. Parks,
21 this region is just being reviewed, so the level that comes
22 out of Council will be what we are bound by.

23 MR. PARKS: This morning Dr. Margulies explained
24 that there was--

25 MRS. SILSBEE: Only up to the approved level of

1 Council--

2 MR. PARKS: I'm sorry?

3 DR. MAYER: Only up to the approved level of
4 Council action was the qualifying statement of the add-on
5 even in the case of those that were reduced.

6 MR. PARKS: Do we know that level?

7 DR. MAYER: Well, this is what we are arriving at,
8 and what we have said as part of the motion was a million 294
9 plus possible further reduction dependent upon interpretation
10 of HMO. And that's a level that is about 300 to 400 thousand
11 below the level that they are currently functioning.

12 DR. KRAWLEWSKI: Add-on notwithstanding.

13 DR. MAYER: Well, further comments on the motion?
14 We will have -- just to remind you, we would have the
15 opportunity, of course, of the anniversary review even if this
16 is passed to get some feel for what kind of progress has been
17 made in this, and another opportunity to put that last six
18 months of shot into them in case they don't hear the message
19 very clearly this time. But I think the message that has
20 come here is pretty clear to me, and I assume it is pretty clear
21 to staff, of some of the real problem areas that are there.

22 MISS ANDERSON: I would like to hear it spelled out
23 more clearly more community involvement should be in regard
24 to these projects rather than a package deal by one person
25 or one organization.

1 DR. MAYER: Okay. Further comments?

2 SISTER ANN JOSEPHINE: I would like to make just
3 one other comment. I think that it applies to maybe a number
4 of Regional Medical Programs, and that is that I think the
5 group needs to be very conscious of programs where there is
6 such a rapid turnover in coordinators, because this precludes
7 any kind of continuity of planning and continuity of effort,
8 and it is really difficult to evaluate the progress made by
9 a program.

10 DR. MAYER: They need to provide a course like I
11 have tried to institute in my faculty on the care and nurture
12 of the dean and how important that is. They need one for
13 coordinators.

14 MISS KERR: You are recommending not funding the
15 developmental component?

16 SISTER ANN JOSEPHINE: That's right.

17 MRS. SILSBEE: Does not the committee have the
18 prerogative to ask to see this application after one year?

19 DR. MAYER: Yes, I would assume that we do, and I had
20 hoped that that was picked up as the intent of my comment.

21 MRS. SILSBEE: It wasn't.

22 DR. MAYER: All right. Do you hear us now?

23 SISTER ANN JOSEPHINE: It seems to me if we could
24 work through some of the problems presented by this particular
25 Regional Medical Program we would have the basis for other

1 decisions that would help us out.

2 MR. PARKS: Sister, may I ask you something else?
3 In terms of continuation of support did you find that there
4 was any involvement, technical assistance or other things
5 from other federal programs that might be supportive in some
6 of the areas in which these programs are weak?

7 SISTER ANN JOSEPHINE: Would you ask that again?

8 MR. PARKS: Yes. Did you find any -- someone
9 mentioned here that the universities programwide are working
10 a number of developmental areas, and that this apparently was
11 one of the areas in which they figured, you know, we would
12 just treat this as a particular thing and let those funds
13 deal with HMO's. I believe that was the suggestion. But
14 in light of this I would assume that there is a plethora
15 of federal involvement in different kinds of funding of
16 medical programs and medical activity, extension services,
17 experimentation, the development of physical and human
18 resources to provide medical services. And I would assume
19 that these two universities are really the heart of it in
20 the state of Maryland.

21 I was wondering whether you found that there was any
22 coordination either at the federal level or in conjunction
23 with the operational level at these universities, that you
24 would tend to find a meshing so that some of the weaknesses
25 that you may have identified here, you might have other

1 resources , either federal or private, tied in to those
2 universities that could be identified to help strengthen.

3 I mention that because I am pretty sure that the
4 federal establishment, and a large part of it in the medical
5 area comes from HEW, should really be involved in this in
6 a way that one program is not saying this is weak, and there's
7 some other technicians that really have a responsibility,
8 primary in some cases, exclusive in others, to do some of
9 jobs that we are canning a program here for being either
10 unable to do or are not doing.

11 SISTER ANN JOSEPHINE: I think that during our visit
12 we were not able to -- we didn't identify things. Now
13 probably we didn't probe deeply enough into it, and in the
14 length of time that we were there it just wasn't possible to
15 clarify these areas. So I would say that I really don't
16 know whether this is true. But I do know this from my
17 experience in other areas where there are a number of federal
18 programs in operation, one of the disturbing features that
19 I continue to encounter is that sometimes federal programs
20 functioning within one institution or a neighboring
21 institution tend by their guidelines and the way they develop
22 to pit one program against another one rather than to
23 compliment programs, and I would be surprised if the
24 situation were any different here. And this is probably one
25 whole area that we talked about needs to be explored.

1 MR. PARKS: Well, if it is possible I think we ought
2 to pass this on for advice because I think this would be a
3 tremendous help, not just from our standpoint, but from the
4 standpoint of many of these programs operationally in
5 terms of strengthening, supporting, reinforcing what they
6 are doing, to make sure that these things do in fact
7 compliment one another rather than being antithetical..

8 DR. MAYER: All right. Jerry.

9 DR. BESSON: I think that's an important enough
10 point that Mr. Parks raises that particularly since the new
11 Deputy Administrator for Development -- is that what
12 Mr. Reeso's title is -- represents a change in the organizationa
13 format of HSHMA, so that HMO's, National Center for Health
14 Services Research and Development, RMPS, Hill-Burton, and
15 Community Health Services are all put into one package
16 for this kind of coordinative effort.

17 However, it may be that the political exigencies
18 of program development and the historical aspects of each
19 program being relatively autonomous, it may be that each
20 program should be encouraged to do the kind of coordinative
21 thing on the federal level that is implicit in Mr. Parks'
22 remarks. I think it would auger well for the periphery if
23 the center can show some leadership in this regard rather
24 than protecting their very parochial interests as they have
25 tended to do in the past, and probably we see evidence of

1 doing now.

2 So I think it might be in order for us as the
3 Review Committee to recommend to Council again that a clear
4 statement of a coornative effort at least as far as HMO's are
5 concerned, area health education centers, manpower
6 utilization -- a clear statement be made by Council as to
7 how RMPS efforts might best be coordinated with other
8 agencies that bear on these questions.

9 DR. MAYER: Got it.

10 Other comments?

11 Yes, Joe.

12 DR. HESS: One further question. If I understand
13 the proposal, it is 1.294, possibly less, which may bring it
14 down to the neighborhood of 1.2. They are currently funded
15 at 1.6, 1.7. Is this cut in funding, which is really
16 substantial over current levels, is this going to do any
17 real damage to the program?

18 DR. MAYER: They have already programmed in the
19 phasing out of about \$800,000 worth of that anyway. As least
20 as I read the--

21 DR. HESS: I would just like to hear from the
22 site visit team that indeed this is not going to do too
23 much violence.

24 SISTER ANN JOSEPHINE: I got the impression -- and
25 I would like some of the others who were there to comment--

1 but I got the impression so far as the project number 36
2 that this is a project -- the things that are outlined here
3 would probably take place anyway, but at a much slower pace.
4 And I don't know how this relates to other projects. I
5 am not sure that this cut in funding would necessarily change
6 what they are planning to do. Maybe they couldn't move as
7 fast. But they are phasing out the projects that I would be
8 really concerned about to provide continuity in the total
9 program, and they are phasing those out themselves.

10 DR. MAYER: Further comments?

11 Everyone understand the motion?

12 All those in favor say "aye."

13 (Chorus of "ayes.")

14 Opposed?

15 (No response.)

16 All right, let me suggest that we take about a
17 five minute break at the outside just to get up and stretch
18 and clear our heads.

19 (A recess was taken.)

20 DR. MAYER: Could we get started, please?

21 Let me suggest that what I would like to try to
22 do, if we possibly can, is to get through Louisiana and
23 Greater Delaware Valley before we quit. That may take us
24 to 5:30, a quarter to 6:00, but I think if we don't do that
25 the pressure tomorrow is going to be too great.

1 DR. THURMAN: Could we do Greater Delaware first?

2 DR. MAYER: I have no objection to that if
3 Dr. White and Mr. Parks do not.

4 DR. WHITE: Doesn't make any difference to me.

5 DR. MAYER: Okay. Joe, you want to give this
6 then on Greater Delaware Valley.

7 DR. HESS: All right. This site visit was made
8 in mid December, and the members of the site visit team you
9 can read. I will not take time to do that.

10 This region is in its third operational year and
11 submitted a triennial application for developmental components
12 requesting renewal of core--

13 DR. MAYER: Would you speak up or use the
14 microphone?

15 DR. HESS: The greater Delaware Valley region
16 includes the area around Philadelphia and portions of
17 Pennsylvania, reaching up in the area of Scranton and
18 Wilkes-Barre, and parts of New Jersey, and all of the
19 state of Delaware.

20 The major educational institution that has been
21 involved in this region are the medical schools in the
22 city of Philadelphia. The grantee organization is the
23 University City Science Center, which is an organization formed
24 by institutions of higher learning in the Philadelphia area,
25 formed to accomplish cooperative scientific project

1 investigations, and because this was a common meeting ground
2 for other purposes it would mean an appropriate grantee
3 agency in order to get the Regional Medical Programs going
4 and provide the grantee type of support. This history has
5 also led to a rather unusual type of arrangement in terms
6 of the overall region's directions, and I would call your
7 attention to the organizational diagram on page 13 of
8 the yellow summary in which on the lefthand side we see the
9 University Science Center as the grantee organization, and the
10 board of directors of this center shown in this diagram
11 in a sort of parallel fashion to the Regional Advisory
12 Group, certain areawide committees which report to both,
13 and then the executive director reports directly to the
14 board of directors of the corporation.

15 All of the board of directors of the corporation
16 are on the Regional Advisory Group, and the chairman of the
17 RAG is on the board of directors. But it was clear to us
18 as we investigated the policy making, decisionmaking mechanism
19 within this region that the real power seems to be in the
20 board of directors, not in the RAG. And the board of
21 directors is rather heavily weighted with medical school,
22 university type representatives, as well as Philadelphia
23 representatives, and this I think highlights at least one
24 of the important problems that we encountered.

25 As far as the goals, objectives and priorities are

1 concerned, the region has identified some broad goals which
2 are in keeping with current national RMP goals, but have
3 not taken the additional steps of factoring these down
4 into ... and having any system on priorities. As we
5 inquired about priorities, decisions are made at the moment
6 primarily on the basis of their narrative of the particular
7 project, and we don't have a yardstick against which to
8 measure projects as they come in.

9 As far as accomplishments and implementation are
10 concerned, the core staff has enjoyed some success with
11 its supported feasibility studies. They have acquired some
12 community profiles which have contributed to the development
13 of a data base, and this data is being used by other
14 agencies concerned with problems of health and health care.
15 This is not occurring on a truly regionwide basis. We
16 found this has been done to some extent in the city of
17 Philadelphia, and a rather good study had been done in the
18 northeast regionwide which had resulted in some good
19 projects which seemed to be addressing themselves to the
20 diminishing supply of health manpower. But it seemed to be
21 very spotty and even nonexistent in some of these other areas.

22 We were favorably impressed with the activities related
23 to peer review, continuing education and manpower problems,
24 at least in some of the areas.

25 The region does not have a formal policy on

1 continued support for projects beyond the approved period,
 2 and their application reflects this because there are
 3 some projects for which support is requested the fourth and
 4 fifth year and there still are no definite plans for phasing
 5 out those that have been funded for that long.

6 On the issue of minority interests, they are
 7 aware of this to some extent, and are directing their
 8 efforts, at least from the medical school basis operation,
 9 to try to assist with improving the health care of some of
 10 the underserved people in the city of Philadelphia. But
 11 as far as representation on the RAG and policymaking,
 12 decisionmaking level, we felt that this region has much room
 13 for improvement.

14 I will not go into great detail as far as the
 15 individual activities of each of the medical schools are
 16 concerned. But I should point out that they have divided
 17 up the city of Philadelphia amongst the medical schools and
 18 one osteopathic school, and they now have responsibility
 19 for defined geographical areas in terms of working to improve
 20 the health care in these specified areas, and this we felt
 21 was a very constructive step in terms of being able to
 22 organize and coordinate their efforts in this area, working and
 23 helping to set up neighborhood health centers and other
 24 type of health care activities. And they have also had some
 25 categorical projects in the areas of medical school

1 responsibility.

2 I might also mention that some of the other areas
3 outside Philadelphia do seem to be giving some attention
4 to this, although again we felt there was room for
5 improvement.

6 The coordinator has been functioning in his position
7 for about four months, and we felt that we had to make some
8 allowance for his relative newness in this position, although
9 he was a deputy coordinator prior to being appointed in this
10 capacity. We do not feel that he has a strong RAG to back him.
11 His major backing direction seems to come from the board of
12 directors.

13 There are several key staff vacancies which
14 exist which go back prior to his appointment and which have
15 not as yet been filled, and these vacancies limit to a
16 considerable degree what he is able to do because of lack of
17 staff support.

18 Regarding the core staff, three of the five senior
19 level positions are presently vacant, and the fourth will
20 become vacant -- or I guess is vacant now, as of January 1.
21 These key vacancies are: the Associate Director for
22 Planning and Evaluation; the Assistant Director for
23 Communications and information; and the Associate Director for
24 Program Development and Operation. The one which is now
25 vacant in addition to those is the Associate Director for

1 Continuing Education and Manpower. There is an acting
 2 Associate Director for Program Development and Operation on
 3 a part time basis, but we do not feel that this is sufficient
 4 for what is needed.

5 We had the feeling that the coordinator is not
 6 pursuing recruitment of people to fill the key vacancies as
 7 vigorously as he should. We were told that he was being very
 8 cautious to make sure he got the right people, and while
 9 we concurred with that, we also felt a sense of urgency to
 10 get these vacancies filled because of the obvious need for
 11 this kind of assistance.

12 We felt that most of the key health interests and
 13 institutions were represented on the RAG. However, there
 14 were notable deficiencies with respect to nursing and allied
 15 health professions; and as I recall, there was no real
 16 direct linkage of organized medicine to the RAG, although
 17 there are a number of physicians on it. Most of the public
 18 representatives were bankers, college presidents, et cetera,
 19 rather than the consumer type, particularly from the lower
 20 level of the socio-economic scale. There are specifically
 21 as far as minority representation is concerned only two
 22 blacks on the 61 member RAG, and we found little evidence that
 23 there was this level of consumer input into the shaping
 24 of policy and program direction.

25 We have already mentioned the relationship between

1 the board of directors of ECS and the RAG. The RAG
2 chairman at least, and the chairman of the board of directors,
3 are fairly comfortable with their relationship, but we
4 question the broader context, whether or not they are as
5 comfortable as they say in this situation.

6 As far as the grantee organization is concerned we
7 found no evidence that the UCSC is not providing adequate
8 administrative and other support. We had members of the team
9 specifically look at some of the budgetary reporting
10 procedures, and so forth, which had been questioned on earlier
11 site visits, and they seemed to be satisfied that that end
12 of it was being taken care of satisfactorily.

13 The region's five medical schools have been deeply
14 involved in developing the RMP from the beginning and still
15 have a dominant influence, and our feeling was that perhaps
16 it is time for the medical schools to become less dominant
17 and other forces become more dominant in giving direction
18 to the RMP in this region.

19 The GDVRMP and CHP seem to be working quite closely
20 together in developing local planning groups. The CHP
21 is less well developed in this region than is RMP, and as a
22 consequence the RMP area coordinator seems to be providing
23 much of the leadership and direction in this area. But we
24 anticipate that CHP will pick up the slack. But as far
25 as RMP's responsibility is concerned they seem to be doing

1 what they can to cooperate. They have established a
2 mechanism for obtaining CHP review and comments on various
3 applications.

4 We found that there has been considerable data
5 gathering in the region by the medical schools. They do have
6 an epidemiologist consultant who has worked with the RMP and
7 has performed some studies, but again this is still a
8 bit spotty, it is not a general thing, and we believe that
9 this is an area that could stand considerable strengthening.

10 As far as management is concerned, we have mentioned
11 the organization as far as the medical school responsibility
12 in Philadelphia. They do have a coordinating committee which
13 is comprised of the RMP coordinators in each of the medical
14 schools, Dr. Wollman, and others on the central core staff
15 who meet weekly and attempt to by this mechanism coordinate
16 activities to this extent.

17 The Associate Director for Community Affairs
18 is the member of core staff who is responsible for working
19 with the area coordinators and providing liaison, and we felt
20 that perhaps there might be some improved strengthening
21 and coordination between what is going on in core and some
22 of the region.

23 The absence of an evaluation person on the staff is
24 perhaps one of the reasons for the rather poor evaluation,
25 and in some instances almost totally lacking, of some of the

1 projects which we reviewed.

2 The region recently formed an evaluation committee
3 which met, and we reviewed the minutes of meetings of this
4 committee, and this committee very quickly identified
5 this deficiency and made some recommendations to the RAG
6 concerning this. But it is doubtful that their recommendations
7 can be implemented until they get the evaluation person on
8 core staff.

9 As far as the program proposal is concerned, while
10 it may have a number of merits we do not feel it has the
11 qualities based on a systematic assessment of their needs
12 and a system of defined priorities, and as a consequence
13 suffers from the deficiencies which are a natural trend of events
14 resulting therefrom.

15 An example, one project in which we felt this was
16 illustrated was a project of pediatric respiratory care
17 in which the project had been replicated in a number of
18 hospitals and they were planning to replicate it several
19 more times, and the people from the project were there and
20 we spoke with them, and we asked them -- they had been in
21 operation for three years, and we asked them what impact they
22 had had, if they had any indices of the effectiveness of their
23 programs and whether or not they really knew whether the
24 hospitals where they wanted to disseminate it really needed
25 the program, etc., and they had really no information, there

1 had been no evaluation. So it really was by dissemination by
2 popularity and salesmanship rather than by any very solid
3 basis of analysis.

4 As far as dissemination of knowledge is concerned,
5 one of the strong points in this RMP is their team education
6 program, part of which is related to peer review and to the
7 model of quality of care assessment developed by Dr. Brown, and
8 which is one of the strong areas in this total program, and
9 medical schools are quite involved in this endeavor. And
10 on this particular score I think they are doing reasonably
11 well.

12 Up until the present time most of the region's
13 efforts have been related to or directed to the medical
14 school complex, and as a consequence some of the outlying
15 areas have not been receiving as much attention and
16 consequent funding as might be appropriate if one looked at
17 this on a regionwide basis.

18 Some of these other areas I think we have already
19 touched on. I will not belabor them.

20 There is some effort at regionalization. They do
21 have area coordinators, and are attempting to strengthen these
22 areas; in this particular category they seem to be moving
23 in the appropriate direction.

24 As far as other funding is concerned, I have already
25 mentioned that they do not have a good record of phasing

1 out and planning new funds to support RMP initiated projects,
2 and they do not have a firm, strong policy in this area.

3 Is Dr. Hinman here?

4 MR. PETERSON: No, he is not. He had to go to
5 another meeting.

6 DR. HESS: There were some renal disease projects
7 which were a matter of particular concern, and Dr. Hinman was
8 a member of our site visit team and paid particular attention
9 to these.

10 There is not a well developed regional kidney
11 disease plan, although there are active transplantation and
12 dialysis efforts going on in the region. But the feeling was th
13 this region as far as developing a well thought out, carefully
14 planned regional approach to management of kidney disease,
15 just had not achieved it yet, and this has consequences for
16 the recommendation that we will get to in a moment..

17 Another particular area that we looked into was
18 action which is being pursued by various people in the state
19 of Delaware to form its own RMP and secede from the Greater
20 Delaware Valley, and this I suppose has had its impetus
21 from a variety of sources, including the Governor, and we
22 understand that he has had some conversations with people
23 here in Washington, and so on, and for various and sundry
24 reasons are thinking about trying to like all health related
25 activities in the state of Delaware into a health services

1 authority. So that there are many broader implications for
2 this.

3 We spoke specifically with Mr. Edgar Hare, the
4 area coordinator, and we asked Dr. Cannon to come down
5 from Wilmington to talk with us to see what the view of the
6 RMP people was in this business and see what light they
7 could shed on this problem from the standpoint of RMP, and
8 we were told that there was a fair amount of dissatisfaction
9 on the part of the RMP group in Delaware, feeling that they
10 perhaps had not gotten a fair shake as far as both funding
11 as well as participation in policy setting, decisionmaking,
12 et cetera; and as a result they were really rather
13 ambivalent about this secession movement, and they could see
14 some things for it and some things against it. Some there
15 contradicted their statement that they hadn't received a
16 fair share of the funding, and felt that they really had. So
17 this was a point which was sort of up for grabs, it was
18 not really clear, but it was evident that this was a bone of
19 contention and was contributing in some way to the
20 secession movement.

21 At the end of our site visit we had a feedback
22 session with Dr. Kellow, who is the chairman of the board
23 of directors, Dr. Wolf, the chairman of RAG, and Dr. Wollman,
24 the RMP coordinator, and expressed there frankly some of the
25 current concerns which the site visit team shared about the

1 program. We raised questions about the relationship between
2 the board of directors and the RAG and the representativeness
3 of the board of directors of the regionwide concerns, and
4 suggested that they re-examine that relationship and this whole
5 question, and see if perhaps they might have some other
6 thoughts about it.

7 The second recommendation which we made to them was
8 that they give high priority to filling the vacancies on
9 core staff, because we just don't see how this region
10 can function very effectively with the shortage of key
11 personnel which they currently have.

12 We called attention to the recommendation of their
13 own evaluation committee made in the summer of '71, and there
14 also was an ad hoc committee appointed to study a special
15 report prepared by the Arthur D. Little Company who
16 came in as consultants to pursue a management study or
17 organizational study of the region and really read back to
18 them the recommendations of this committee that they give
19 attention to setting goals, objectives and priorities of
20 the regional plan, precisely the same ideas that we came up
21 with, and it was interesting that this came as rather news
22 to the people that we had discovered this and were feeding back
23 to them information which was already currently available.
24 And I would judge from the reaction on the faces they were
25 probably going to go back and read those reports a little

1 more carefully to see what was in them.

2 We felt that when attention had been given to the
3 issues of the management from the RAG level, the setting
4 of goals, objectives and priorities, and when they look again
5 at their total regional situation they perhaps can address
6 themselves to this secession movement going on in Delaware.
7 In the view of the site visit team this is not a necessary
8 thing, and from many standpoints would be an undesirable thing
9 to try to carve out a separate RMP for 600,000 people when
10 really Philadelphia has many of the resources and they already
11 have established relationships between Wilmington and some
12 medical schools in Philadelphia, and so on. So that it
13 seemed to us that this was still a repairable breach,
14 assuming that other more overriding considerations at the
15 Governor's level and elsewhere do not come in to intervene.

16 But just looking at it strictly from the RMP
17 standpoint, in our minds this was, of the two options, trying
18 to beef up and more adequately attend to the Delaware problems,
19 it was preferable to secession and the creation of a new
20 region.

21 In conclusion, we felt that there were many
22 positive features of this Regional Medical Program. It was
23 clear that the resources of medical schools and other
24 institutions are actively involved in RMP activity and have
25 contributed much to what is going on there at the present

1 time. Some of the activities are beginning to have a
2 favorable impact on manpower utilization, ambulatory care, and
3 health care delivery problems. Planning in the inner city by
4 the medical schools appears to have real potential for the
5 future, and they are very much involved in this.
6 Subregionalization is under way and has potential for the
7 future as well as important benefits already apparent,
8 especially in the Northeast area. Now that's the plus side
9 of the ledger.

10 On the minus side, in summary, we found the absence
11 of a well thought out regional plan. We have already
12 mentioned the board of directors and the RAG, the lack of
13 minority representation, the high number of central core
14 vacancies, the inadequate evaluation, the under utilization
15 of available data in assessing needs, and the program's poor
16 record for phase out.

17 Now as a consequence the team felt that this region
18 was not ready for triennial status and felt that there is
19 a good deal of work that needed to be done yet, and our
20 recommendation was for one year funding at essentially the
21 current level of 1.9 million.

22 We did not feel that they were ready for a
23 developmental component. They are currently operating something
24 close to \$200,000 under their approved budget, so we felt that
25 there was some flexibility within this figure of 1.9 for a

1 certain number of feasibility studies, so it wouldn't
2 seriously impair them.

3 We felt that whatever report goes back to them
4 should attempt to enforce the points that were made in the
5 feedback session.

6 We were not in favor of the expansion of the
7 renal disease patient support project or the initiation of
8 the demonstration and evaluation of chronic hemodialysis,
9 and the proposal for the school of radiotherapeutic
10 technology was contrary to RMP policy.

11 So in essence it was for one year funding at a level
12 of 1.9.

13 DR. MAYER: Okay. Bill, comments?

14 DR. THURMAN: I'm just less tactful and everything
15 else than Joe, so I will just add a few things..

16 I think there is very little relationship that we
17 could define between the RAG and the grantee agency.. That's
18 a very nebulous thing. Without the board of directors
19 I don't think the RAG would know where the grantee agency was.

20 I would emphasize again how ineffectual the RAG
21 is as far as geographic representation in particular, but
22 also in other areas that Joe has already brought out.

23 Any time you asked somebody on RAG what thier
24 functions were it was like talking to a machine, you got
25 evaluation, project approval and advisory capacity back, but

1 nobody could define what those were. So that that made it a
2 little difficult to see how they were really moving along.

3 Pete Peterson pointed out that 60 percent of their
4 money went to three things, and has over the years --
5 coronary care units, continuing education, and the
6 pediatric pulmonary disease that Joe mentioned. And none of
7 these really have been well thought out regionally, are
8 well planned or anything else.

9 The planning studies in reference to the core staff
10 and the medical school units theoretically are being done by
11 the coordinating committee established between the core staff
12 and the medical units, but those are not broad based, they
13 don't work well together, they don't know what each other
14 are doing, and rather than initiate they respond, and
15 that's very much of a problem.

16 The physician who is vice chairman of the RAG, who
17 happens to be from one of the outlying areas, didn't know
18 half of what was being said. He said that they were really
19 not truly involved. He happened to be from New Jersey, and
20 not Delaware. And he was a little bit upset. He straightened
21 out and supported everything before the day was over, but he
22 initially was kind of upset.

23 The area coordinators have been stretched very
24 thin. But as Joe indicates, that's one of the more
25 positive features of what they have, because if that were to

1 work then their regionalization would really go well.
2 They happen to have one good politician who is a regional
3 coordinator, and he is doing a superb job of getting Mr. Flood
4 into the act and everybody else. But the rest of them are
5 just really getting off the ground.

6 There really doesn't appear, except for the business
7 of splitting up the city, which is idea, as Joe indicates --
8 there doesn't appear to be any understanding between the
9 schools about the fact that they are all working toward an
10 RMP that means something to everybody. They really just
11 don't have priorities. And I can't emphasize any more than
12 Joe has how weak this core staff is, and they really just
13 are -- something has to be done to shape that group up
14 or else it will continue to be five or six little RMP's
15 running all over the place under the framework of one RMP.

16 Despite all those things, I think there are some
17 strengths there, as Joe has indicated. But it would
18 appear to me that it was time to really draw a few lines for
19 them and make those lines reasonably definite. But I have
20 a lot less tact than Joe.

21 One other positive point, they have used a lot of
22 developmental component money by small subgrants to the
23 medical school units primarily to coordinate or to give X
24 amount of dollars, and \$75,000 they are asking to get a
25 project going which has been developmental component money,

1 and they will pick up money here, there, every place else.
2 But that has served a useful purpose as they have begun to put
3 some guts into the core staff which they haven't had in the
4 past.

5 That's all I would add.

6 DR. MAYER: Leonard.

7 DR. SCHERLIS: I guess in view of what they have
8 asked for you aren't being very generous, but at the same
9 time I tried to make some sense out of page 3 of the yellow
10 sheets. Perhaps you can help guide me on that. Column 2,
11 as I read this, a project which they will continue to
12 support would be those which are really outside the initial
13 period, coronary care, and as I turn over the sheet some
14 of the pulmonary, etc. In other words, what will they
15 really be doing with that 1.9 million dollars? Are you
16 making your message to them clear at this point, will they be
17 putting that money into the same old projects, since you
18 have really told them they can't do some of the others they
19 would like to do. What will they be doing with that sum
20 of money that is any different than what they are doing now?

21 I view them as having a couple hundred thousand
22 dollars thrown into the developmental components. If I
23 read it correctly -- well, that's why I need your help in
24 defining how you are suggesting they spend that money.

25 DR. HESS: These projects that you see here are

1 indeed ongoing projects, some of them go longer than we would
2 ordinarily like to see them go. But at the same time I don't
3 think it is fair or reasonable to the people on the other end
4 of the pipeline to suddenly have a cut-off, and they have
5 got to have some time to do some phasing out, preparing, and
6 so forth, in order to not do too much violence to what they
7 have already done. So our rationale was to give them a
8 year to do some re-thinking on the basis of this recommendation.

9 And I might also say that another point that isn't
10 written down here, but Dr. Watkins from the Council raised
11 this point, and I certainly concur with it, that this region
12 should have ongoing RMPS staff contact to help make sure that
13 the message is interpreted to them so that if they choose to
14 come in in another year with a triennial application that they
15 indeed do the homework they need to do in order to be ready
16 for that.

17 But in fairness to the people in the communities who
18 are counting on this funding we just didn't feel it was
19 fair to them to try to cut that back too severely, and they
20 are attempting to move in the "new direction" of RMP. Their
21 ability to do that largely comes out of the core staff and
22 some of the small feasibility studies that they can obtain,
23 and their general approach is consistent with the way they
24 manage things in terms of the RAG, and the way they determine
25 the overall program needs, etc., is not as systematic and

1 clearcut as we would like to see it.

2 DR. SCHERLIS: I guess my problem is instead of
3 seeing just one or two projects going beyond the three year
4 period you see a whole array of them, and I would hope that
5 they might receive very strict and harsh suggestions as far
6 as how to direct some of these funds. In fact, I would
7 be in favor of literally telling them, you know, we can't
8 support X projects for three years, and go on and do something
9 else.

10 The other question I have is for a while written
11 communications were going back to the coordinators indicating
12 the exact specific areas of concern. I understand that has
13 been modified, is that true?

14 DR. MAYER: Can staff help us on that?

15 DR. SCHERLIS: I was caught in one of those
16 programs of ultra detail communications which went back, and I
17 was curious what the present policy is.

18 VOICE: Are you talking about technical aspects of
19 individual projects?

20 DR. SCHERLIS: A very frank discussion of what the
21 site visitors have stated in detail. How much of that is now
22 going back to the coordinator?

23 MR. CHAMBLISS: Principally that goes back now in
24 the form of the post Council advice letter. There have been
25 before, though, some rather frank discussions with Greater

1 Delaware Valley. Dr. Margulies has been there along with
2 other members of the staff, which included Pete Peterson, I
3 was there, and others of us, and there have been some rather
4 frank discussions with them.

5 DR. SCHERLIS: In writing or--

6 MR. CHAMBLISS: I believe they were followed by --
7 the visit was followed by a letter.

8 DR. SCHERLIS: I think this is a vital concern here.

9 DR. PERRY: I am greatly concerned and I am happy
10 you mentioned the lack of allied health representation. If
11 you look at the amount of the projects they have, they do
12 relate to systems, they relate to these areas. That region
13 is not utilizing resources they have. They have really
14 very strong allied health programs in the University of
15 Pennsylvania, one at Hahneman. Here are resources that need some
16 kind of a voice and some kind of relationship to a program
17 that is spending that much money, but they are not involving
18 them. I know in one case Dr. Frank Houston has gone
19 in to RMP asking to be involved, and they said "thank you."

20 MISS ANDERSON: In the recommendation, too, where it
21 says "lack of appropriate representation of allied health,
22 minorities, and true consumers on the board of directors and
23 the Regional Advisory Group," they should also say "and staff."

24 DR. MAYER: Right, and staff. I am trying to --
25 you know, if I were Martin Wollman, who has four or five

1 vacancies already that are there, with a couple more that
2 are going to appear evidently, and I am told that the dollars
3 I have for next year are essentially the same as the dollars
4 I have for this year, and I have got six months to turn the
5 program around and then I am out of any approved funding
6 anywhere, and I had a little bit of difficulty because I am
7 new trying to recruit those people, and now I have got a
8 new message which is there, and the only thing that I have
9 got working for me is the fact that RMP nationally got a
10 30 million dollar increase and at least there is a general
11 feeling that maybe it isn't going to die after all, it is out the
12 in the hustings, but that's all I have got going for me. My
13 program sure looks like it is going to die, and those bright
14 people I am trying to recruit said what, the Greater Delaware
15 Valley RMP -- now I don't know what kind of chances he has
16 got in six months, which is what he really has, to
17 initiate another grant application to come in here that is
18 different than this and to create a program in six months
19 that is different from this.

20 I guess I am caught up on the one year, two year
21 approach issue in terms of the chances to do this job.

22 DR. HESS: I must say I have great personal regret
23 in not being able to recommend more funding because I think
24 this region is underfunded in relationship to what should be
25 done there. And so I am most reluctant to make this

1 essentially a level of funding recommendation, and I really
2 believe they probably should have twice that much, and the
3 needs are there if the system were there to appropriately
4 utilize it.

5 But if the question you are raising is should we
6 make this a two year recommendation instead of one in order
7 to give the region, particularly the coordinator, a little
8 more to bank on in terms of recruitment, I am certainly in
9 favor of that. I think we need to do anything we can in
10 order to strengthen them and give them the assist they need
11 in order to build an effective program which will qualify
12 them for the kind of funding that I really believe they
13 should have.

14 DR. MAYER: To what degree do you think those
15 medical schools understood that whether that BMP is going to
16 survive or not is dependent upon having a strong central
17 core staff, and to what degree are they breaking their necks
18 to try to see that that happens, or are they just glad to
19 keep it nice and weak?

20 DR. HESS: Well, I would be most reluctant to
21 attribute -- Bill can speak from his own point of view,-- any
22 Machiavellian motivation to Dr. Kellow in particular, who
23 is the one we spoke to. The time we spent with him I just
24 didn't get any feelings of this type about him whatever;
25 and whether that's valid or not, I have no way of knowing.

1 It's just gut reaction. But he seemed to understand when we
2 talked with him about the need to shift the emphasis away
3 from such heavy medical school domination. In the feedback
4 we went into this in some detail. We told him we recognized
5 why they were where they were now, that they needed to pull the
6 medical schools together, and those were some of the major
7 resources they had to get started with, but now that
8 it was on its feet and going that it was important for
9 the medical schools to move more in the background and let
10 other interests play a more dominant role. And he seemed
11 to accept this without any real difficulty, but again I
12 can't say how much the message got across. But I, at least,
13 do not have any reason to believe that this has been
14 overtly intentional on the part of the medical schools.

15 One of the problems that they pointed out is that of
16 the difficulty of attracting qualified professionals to
17 essentially what many people see as a SOP operation with
18 regard to RMP. The medical school positions are for all
19 intents and purposes filled, and I think it's more a function
20 of the way people see RMP there versus a university base
21 than it is any conscious effort on the part of the medical
22 schools to keep core staff weak. I just don't think that's
23 there.

24 MISS ANDERSON: Are you suggesting a time schedule
25 or anything for these changes?

1 DR. HESS: No, we just said as quickly as they could
2 do it. We didn't give them any specific time schedule, but we
3 told them we felt it was important and urgent that they address
4 these problems promptly.

5 MISS ANDERSON: These things have been brought up
6 before over and over again.

7 DR. THURMAN: I think Mr. Chambliss has a very
8 important point. They have been talked to by a lot of people.

9 To go back, Bill, to what you said, I would agree
10 one hundred percent with Joe. I don't believe this is
11 Machiavellian at all. It is more a realization that we have
12 five RMP's, and not one, because they are filling all the
13 medical school components, whereas if they devoted that
14 degree of effort to really making the core staff one who had
15 a lot of clout they could do it, because we are in a surplus
16 of people right now, particularly where you have five
17 medical schools generating people who could do this and two
18 very good schools of allied health. If you get two of
19 the faculty of one of those schools they could fill three of
20 the positions that are open if they would just get together
21 and talk about it. But they are operating five little RMP's,
22 is what they are doing, and they are not looking at the core
23 staff. But I don't believe it's by design. It's just by
24 the fact that Temple is not really going to shake the hand
25 of the University of Pennsylvania too hard. They will meet

1 them once a month for dinner, but they are not going to shake
2 their hand too hard. And that's where the weakness really
3 comes up. And that's why I think again, to go back to what
4 Joe said, I would be opposed to going to more than one year
5 because I think they have got everything they need to make
6 this a going operation. They have got the demand, they have
7 the support of the people around them, and everything else.
8 They need to know that they can do it, and I think they can.

9 DR. MAYER: Leonard.

10 DR. SCHERLIS: From a practical point of view I
11 would certainly agree with what the Chairman stated, that you
12 can't go and hire anyone really of any stature if he only
13 thinks he can work for one year. This has been one of the
14 difficulties with not just getting staff, but of keeping
15 staff. And I question whether or not this is the way to
16 strengthen a region by telling them they will get no money
17 whatsoever unless they shape up and at the same time give
18 them no way to do it.

19 And what I was wondering would be the following. I
20 think that if you look at how they are spending their money,
21 one and a half million is core, and they only have of total
22 projects about 400,000 for projects. And if you look at
23 those projects practically every one of them is outdated
24 in terms of it has been over three years, and they are just
25 supporting them for much too long a period of time, and this

1 is how they get the request -- their operating level of 1.9
2 direct. I don't have a specific number, but I guess I could
3 come up with one. I would be more in favor of giving them, say,
4 two years of support, but knocking that 1.9 down and then in
5 the second year giving them a sum that would at least enable
6 their core and some projects to function, because if you
7 gave them, for example, 1.9 for that two years away period
8 they are going to have nothing to support unless they keep
9 going on their projects, and that's an easy way to go for it.

10 My feeling would be something on the order of
11 say they have to shape up and let's cut it down to 1.7 this
12 year and 1.25 the following year, if you can really come up
13 with a program we will accept an application year after year.
14 At least they can hire someone for a two year period of
15 time.

16 I think 1.9 is high, and I think that they won't be
17 able to really shape up if we don't promise them some support
18 after that one year period. I don't see how you can go out to
19 a professional person of some stature if you want him in core
20 and say "well, if we really do well we will hire you the
21 second year, but it looks like it will be a one year period."

22 DR. MAYER: And two years doesn't, you know, bother
23 me. Bob Marston always used to say that, you know, two years
24 is forever. God knows what's going to happen in two years,
25 whereas one year is not quite that, and neither is 18 months.

1 But two years, you know, is a pretty solid time term.

2 DR. SCHERLIS: I'm concerned about that 1.9 because
3 I do have this concern about continuity of ongoing projects,
4 and we are really telling them to continue what they are
5 doing but do it better, whereas if we put some stringency on and
6 say the only reason you are getting that other year is
7 because we feel you have to get some core staff to carry this
8 on. I am not making this as a motion because I want to
9 see what your reaction would be to that, Dr. Hess.

10 DR. HESS: Our thought was they they indeed could
11 begin to tackle the issue of phase out by trying to fund some
12 of the new projects that they would like to by phasing out
13 some of the old ones. This would give us a means of finding
14 out when we review another year whether or not they really
15 had established some goals and priorities that they were
16 making operational, and we felt we needed to give them a
17 little maneuvering room in order to do this..

18 Now your real question is how much, and if we cut
19 them back too much will they be able to fill those core
20 vacancies they want to fill in light of their ongoing obligations
21 to people out in the field that they have to maintain some
22 kind of credibility in terms of funding.

23 DR. SCHERLIS: I really feel more strongly about
24 that second year of support. Do you feel it should be zeroed
25 in view of the discussion?

1 DR. HESS: No, I would be perfectly willing to show
2 support for the second year in order to give them something
3 to bank on. I think that's sound.

4 DR. MAYER: The request for core in the second year,
5 that includes all components of core, central core plus the
6 individual schools, is 1.67.

7 DR. HESS: Incidentally, the major increment in core
8 in their proposal as opposed to where they are now is in
9 the medical school components. We suggested to them that
10 they consider keeping the medical school components at level
11 funding and try and get more out into the field and not
12 put as much in medical schools.

13 MISS KERR: Joe, how long as Dr. Wollman been there?

14 DR. HESS: He has been director since last July.

15 MISS KERR: Which is a very short time. And in
16 view of the fact that so many people have been talking to
17 the director, and so forth, perhaps it was hard to evaluate
18 on the site visit a man who had been there four months, do
19 you think the potential for a more positive leadership was
20 there?

21 DR. HESS: He was deputy director before, so he is
22 not brand new to the program. I just don't know.

23 MR. CHAMBLISS: If the committee would just permit
24 me to act as a volunteer here, may I say that in these
25 complex metropolitan areas where there are multiple medical

1 schools there are very definite problems in getting the
2 RMP going. Whether they need additional time I personally
3 cannot say. Whether it will be additional money I cannot say.
4 I do have this feeling, though, that it centers around the
5 element of leadership -- of leadership of a person having
6 a certain amount of boldness, who is willing to get things
7 moving, and I think we have seen this very candidly expressed
8 already today in the Illinois situation.

9 So what is the element that these complex metro-
10 politan areas need that we can provide, and I think this
11 element of leadership is one of the sine qua nons of which
12 it will not move unless it has.

13 Now you make the point that this coordinator has
14 been there since July, and the point is reinforced by the
15 fact that he was the deputy under the previous coordinator
16 for some time. We need your help here in trying to find what
17 are the elements needed to get this kind of RMP under way,
18 to help us examine what you think ought to be done and make
19 some recommendations in accordance thereto.

20 DR. SCHERLIS: I have a certain allergy at least
21 to working after 5:00, but the problem of seeing a core budget
22 which has inner cores and outer cores and peripheral cores --
23 and this core budget is one which has \$750,000 for the inner
24 core and another \$750,000, \$110,000 plus or minus 20 I guess
25 was the number they agreed upon, which would be centered around

1 the other six medical schools. And I think one way to preserve
2 a weak RMP is to have a good portion of that budget not
3 under his and the RAG's domain. And as I read this my concern
4 would be that one message that should go back would be that
5 the core should really run the RMP in that state, and not
6 be subservient to all the other cores which operate, and I
7 would assume fairly independent. And if they want to
8 set up projects in the other medical schools, in one school
9 where Dr. Pastore is, and if his thing is peer review and
10 continuing education and ambulatory care which he does in
11 exemplary manner, I am sure he can come in with an
12 excellent project which would then be subject to technical
13 review.

14 I don't think you can have a strong RMP where you
15 have a series of cores which operate independently and
16 not subject to the usual type of technical review, and I think
17 that's what we are seeing replicated in a great many urban
18 areas where we have a great many medical school operating.

19 And I would think that one message to get back
20 here -- this is why the system has worked so well in
21 Chicago. Their executive director makes it very clear that
22 he runs that program, and if a medical school wants something
23 they work with him. This hasn't caused any schism, but it
24 has caused an unbelievable amount of support, and I would
25 think this is one message that should get back.

1 As I read core, it is a fractionated, multicentric,
2 multilayered core. I would like a comment of the site
3 visitors on this. Do I misread that?

4 DR. HESS: I think you are essentially correct, and
5 this is the point that I tried to make earlier, that
6 medical school domination at a number of points in the
7 system is having an adverse effect on the region, and it is
8 indeed going to take stronger leadership in terms of the RAG.
9 We can't in a very detailed way evaluate the coordinator
10 and the effectiveness of his function. We do have some
11 serious questions about it, but again we recognize the
12 short period of time which he has been in the full authority
13 position, and therefore we sort of hedged on that particular
14 issue, but fully aware that this may be part of the crux
15 of the whole problem. It is not the whole crux because this
16 whold board of directors, RAG is another part of it, which
17 until that is resolved I don't think you are going to get the
18 kind of coordinator appointed that we would like to see.
19 Now maybe if the center of power shifted that current
20 coordinator would be able to function much more effecgively
21 because he would have a different kind of power base
22 behind him backing him up at a policymaking level.

23 So, you see, there are all these dimensions that
24 are very hard to get a handle on, and they all directly
25 interact.

1 DR. MAYER: Would somebody care to make a motion?

2 DR. HESS: I will make the motion. We have made
3 it for 1.9 for the first year, and I would like to suggest
4 that -- pull a figure out of the air --1.7 for a second year
5 so that that gives them some firm funding to count on,
6 and then I guess -- well, they would have to come in for
7 an annual application, wouldn't they, another year, another
8 site review, and so on. Is that correct?

9 DR. MAYER: No, wouldn't have to be site visited.

10 DR. HESS: All right. I would attach a recommendation
11 of a site visit in one year to that. 1.9 the first year,
12 1.7 the second, with a site visit after one year.

13 DR. MAYER: Is there a second to that motion?

14 MISS ANDERSON: Do you want to reverse those
15 figures? Wasn't that what you suggested earlier, reverse
16 those figures?

17 DR. HESS: No.

18 MISS ANDERSON: I'm sorry.

19 DR. MAYER: Further discussion? With, I assume,
20 a clearcut understanding that not only verbal, but written
21 message needs to get back that incorporates much of what
22 has been said.

23 DR. SCHERLIS: I did not see in the site visit
24 report specific reference to these multiple cores. I
25 would hope that that discussion would be incorporated in the

1 evaluation of the unit, because I expect the Greater
2 Delaware Valley area will not move from where it is now
3 unless these counter cores become subject to their
4 coordinator. I don't see how it can move.

5 Dr. Mayer, do you want to comment on that? Do you
6 think that should be part of the recommendation that goes
7 out?

8 DR. MAYER: (Nods.)

9 Further comment, discussion?

10 All those in favor, "aye"?

11 (Chorus of "ayes.")

12 Opposed?

13 DR. THURMAN: Aye.

14 DR. SCHERLIS: I think I should ask the Chairman
15 to speak up and not move his head because that doesn't go
16 on the tape. You expressed concurrence.

17 DR. MAYER: What's that?

18 DR. SCHERLIS: I don't know if the tape heard you.
19 You agreed, didn't you?

20 DR. MAYER: Yes, I did.

21 Let us move on to Louisiana and then we will call
22 it a day.

23 DR. WHITE: Normally I come to this point in time
24 feeling fairly comfortable about how I feel about the region
25 I visited, and I have adopted a position and I try to persuade

1 you to adopt the same position. At this moment I feel
2 that I probably will be a twig which bends with the winds
3 that blow across this table during the discussion, and I
4 say that because I never really got a very definite kind of
5 feeling about anything specific about the Louisiana Regional
6 Medical Program.

7 This is in part my own fault because I was helped
8 by a superlative team of site visitors, including Mr. Parks
9 and our staff from here, and I guess it's because I tried
10 to mix business and pleasure. As my wife and I viewed the
11 stark, bleak, white winter of Wisconsin ahead of us we
12 decided that perhaps she should go to Louisiana with me.
13 But I find that it's difficult to have a second honeymoon and
14 be an effective site visitor at the same time. Neither one
15 was accomplished to my satisfaction.

16 (Laughter.)

17 I think that to view the Louisiana program one has
18 to recognize some of the encrusted attitudes that exist
19 in that state. They take great pride in their crawfish and
20 oysters, and I think that there are other shells in that
21 area which are difficult to penetrate or to crack open.

22 You may recall that there was some early trouble
23 with the development of the Regional Medical Program of
24 Louisiana, that Dr. Sabatier, even though a past president,
25 I believe, of the Medical Society, was at one time to be

1 expelled because he expressed some interest in the Regional
2 Medical Programs. So he has had a tightrope to walk, and
3 he has had some difficult problems, and only now is he beginning
4 to get some consensus on the part of organized medicine and
5 organized health facilities that maybe the Regional Medical
6 Program has a place to play in the state of Louisiana.

7 Another problem relates to the two systems of health
8 care that exist in that state. There is a system of state
9 hospital around Louisiana, charity hospitals. These have
10 been in existence for some time, they are pretty well
11 established, they are supported by the medical colleges.
12 The medical schools find them essential in their educational
13 programs. But it has created not an iron curtain nor a
14 bamboo curtain, but sort of a gauze curtain between the
15 private and the nonprivate health care systems in the state
16 of Louisiana.

17 Further I think that the Louisiana medical program
18 has suffered, in my view, from the sufferings of the
19 other Regional Medical Programs. Sometimes the signals
20 they have had from those of us who have made site visits
21 or from staff or from the Council have not always been those
22 that served them well over periods of time. By the time
23 they began responding to that signal new ones were coming
24 down the pathway. But I think that this is not the fault
25 of Washington alone or the Fed's alone. I think that the

1 Regional Medical Programs in the context of our earlier
2 discussion today have been hanging around too long waiting
3 for someone to put a hoop through their nose or ring through
4 their nose to lead them down the path. Seems to me the
5 guidelines and messages are broad enough, nonspecific
6 enough that the region should be able to define its own
7 programs within those and not wait for specific types of
8 statements that they can voice back. Louisiana has been
9 guilty of this, and still is guilty of this.

10 But in honesty and in fairness to them I would say
11 that they have gotten into the planning of things to a
12 great extent because this is what they were told to do by
13 previous site visitors. And this is one of the difficulties
14 we see at the moment.

15 They and CHP have blurred images. It is difficult
16 to sort them out. They indeed have become the planning
17 body for the state of Louisiana. They are not an action
18 oriented group.

19 But I don't want to leave you with the impression
20 that there is no quality in this program, because there is
21 quality. I think if they were now approaching the state
22 of asking for an operational grant this would be just dandy.
23 But they are asking for a triennial grant, and this has to
24 be viewed somewhat more critically.

25 They have indeed established goals and objectives.

1 They both say the same thing in different words. They are
2 going to deliver better care to the medically disadvantaged,
3 they are going to increase productivity, they are going
4 to contain costs, they are going to develop the
5 additional kinds of health manpower that are necessary, and
6 so on. These are the same kinds of words that we have
7 heard over and over again. They are laudable, to be sure;
8 but I don't see really any clear view as to how these are
9 going to be implemented in the state of Louisiana. Nor do
10 I see a clear understanding of the priorities for the actions
11 to be taken to implement them.

12 They have indeed a well established data base now
13 for the assessment of the needs. But I don't know that they
14 have undertaken this assessment. They have the data, but
15 I don't see that they have clearly used these data to predict a
16 goal and objective for them.

17 Again, however, I don't want to be negative.. These
18 people have accomplished things. They do have, as I said,
19 these data. They have used them in conjunction with other
20 health agencies in the state well. They have even been
21 requested by the State Medical Society to provide some data,
22 and I think this is a mark of distinction for this Regional
23 Medical Program because they were never even regarded with
24 anything prior to that. They have planned with area health
25 planning councils, New Orleans and State Health Departments;

1 they provide a data base which are helpful to them as well
2 as to RMP.

3 They have developed methods for studying
4 immunization problems which has been helpful in upgrading
5 care in certain areas.

6 They have been able to determine needs for certain
7 types of allied health manpower which may be helpful to
8 Dr. Peterson and some of the others in the future for
9 determining the programs to be undertaken by the respective
10 schools.

11 They have one mark which I think is helpful. They
12 undertook a study of irradiation therapy capacities in the
13 state, and on the basis of their studies the hospitals
14 recognized that there wasn't a need for each of them to
15 develop a facility, there was an adequate base for care at
16 the present time. And I think this was a significant
17 accomplishment.

18 They have broad support from the pathologists
19 in the state because they were helpful to the pathologists
20 in developing a laboratory standards committee and quality
21 controls which were applied to most of the state laboratories
22 and I think this is a mark of distinction, too.

23 So I am presenting a picture that is mixed
24 obviously. There are some accomplishments, there are many
25 weaknesses. But I don't think we should focus just on the

1 weaknesses.

2 Another point in their favor is that they have been
3 able to phase out, even though their evaluation and review
4 mechanisms are rather weak, somehow or other they did manage to
5 identify one particular project at least that was not meeting
6 its objectives and goals and was just wasting money, and they
7 terminated it.

8 They have been able to find certain kinds of support
9 for some of their other activities. The Heart Association
10 is going to continue supporting the cardiopulmonary
11 resuscitation program. The State Department of Health will
12 continue to provide funding for the health information
13 clearinghouse project. The Louisiana Medical Society has
14 indeed subscribed to and supports the dial access program
15 that was created by RMP in that area.

16 Minority interests are not really represented even
17 in a token manner, and certainly not represented, I believe,
18 in the deliberations that are necessary for the plan of
19 action that is required for the state of Louisiana. They
20 expressed an interest in recruiting additional minority and
21 disadvantaged participation with a view that they were going to
22 do this through the CHP B agencies. They were indeed going
23 to use these agencies as their subregionalization or local
24 area councils. And to me at least this seems a dubious way of
25 going about it. I am doubtful that the people involved in

1 CHP creation are likely to be any more concerned about
2 minority interests than has been the RAG of the Regional
3 Medical Program.

4 We saw little to indicate that black physicians were
5 involved, black citizens involved. We saw little in the way
6 of Indians or the Spanish speaking people. And this is
7 certainly an area which needs strengthening.

8 Dr. Sabatier is a good man. He has provided good
9 leadership. He has been able to be persuasive, has been able
10 to meld things together. To me he is not a particularly
11 dynamic individual, and he may not be the kind of guy that
12 can rock the boat that someone talked about here earlier
13 in another program, and perhaps this is a time that this needs
14 to be done in Louisiana, I don't know. But I think he is a
15 talented man, and he is skillful, and he has brought together
16 a good core staff. Surprisingly, their background would lead
17 you to think they are not very capable, but they are. Few of
18 them have had any education in health fields or management
19 fields. One was an airline stewardess who somehow or other
20 got into the Regional Medical Programs, and I think is doing a
21 heck of a good job, as well as being very attractive.

22 They have worked well with other health agencies in
23 the community. I think they have created visibility for the
24 Regional Medical Program. The Regional Medical Program
25 through the efforts of core staff and Dr. Sabatier I think now

1 is regarded as a resource to be called on for help in the
2 Louisiana region, and perhaps this is a right time for having
3 been identified as a resource to begin acting.

4 I won't go into further details about how the core
5 functions. There are strengths, there are weaknesses. They
6 manage things very well. They have fiscal management which is
7 very good. They have been subject to audit without fault.

8 I think their evaluation procedures within core are
9 somewhat weak, but this is not peculiar to Louisiana.

10 The review process for the review of new projects
11 is rather sketchy, and this obviously needs strengthening.
12 But this relates to a problem that we will get to a little
13 later, and not too much later because I see that's on the
14 next page, and that's the Regional Advisory Group.

15 Although fairly representative of key health interests
16 in the state on paper, I think we came away with the feeling
17 they didn't really participate very much. There were allied
18 health people listed, there were hospital administrators
19 listed, there were medical school deans listed, there were
20 medical society representatives listed, and so on. But it
21 was difficult for us to get a grasp of any facts that would
22 lead us to think that they actually participated, particularly
23 in reference to defining the programs for the state, what
24 they should be and what the action plan would be that would
25 be likely to achieve these objectives and goals. They met

1 infrequently, they did not serve on any of the committees.
2 They did not function in reviewing the projects other than
3 to look at what was handed them when it finally came to the
4 time of a Regional Advisory Committee meeting.

5 Surprisingly enough, some of them, I guess, had
6 recognized this same weakness in themselves, and they had
7 undertaken a task force analysis of the Regional Advisory
8 Group roles, and they have indeed identified certain
9 weaknesses and certain faults, but when we asked them what was
10 to be done about this we got no really clear conception.
11 It was sort of an apathetic "gee, I guess we really aren't
12 doing what we should do, fellows. We know that," but hadn't
13 really thought that maybe they should do something about
14 the fact that they weren't doing what they really should be
15 doing.

16 Well, this I think, in my opinion at least -- others
17 may have a different view of Regional Medical Programs in
18 Louisiana -- this is a major weakness. This is not a program
19 in which people participate.

20 The Regional Advisory Group is sort of a window-
21 dressing affair which may or may not be rubberstamp. I
22 don't know whether that's even the appropriate term. They
23 just don't participate. They must be made to participate.
24 And we have some recommendations to make in our overview of
25 the program with Dr. Sabatier when we finish.

1 Related to this is another program, and that is
2 the relationship to the grantee organization. The grantee
3 organization is a nonprofit corporation with a nine member
4 board of trustees defined as needing to incorporate an
5 economist, an engineer, and certain other people, so the
6 flexibility that the Regional Advisory Group has in appointing
7 members to this is very slight. It must include the past
8 chairman of the Regional Advisory Group, the medical center
9 officials, and a member of the State Medical Society.

10 In reality this group has full veto over anything
11 the Regional Advisory Group does. Now they tell us that this
12 has not occurred in the past, that they have not indeed ever
13 vetoed any decision made by the Regional Advisory Group. But
14 I fear in my own mind that the time has come that if the
15 Regional Advisory Group does become active, does find a
16 spark that gets it going, that there may be some conflict
17 which comes about. There is the one trustee structure which
18 likes status quo and don't rock the boat, and another one
19 wants to start doing it, there may be areas of conflict
20 that come about; and this relationship should be straightened
21 out prior to that.

22 Many of the health interests in Louisiana are
23 involved in programs. We don't see that any one of them has
24 co-opted the Regional Advisory Group. No problems really
25 in relating within the health structure at the present time.

1 This has improved, as I said, from the past.

2 The relationships between RMP and CHP, difficult
3 to straighten out, largely because RMP has been doing what
4 CHP would be expected to do, I think, and this is reflected
5 in the attitude of people in the state. They have a blurred
6 image of what RMP should be and what CHP should be. And a
7 Dr. Acory, who was appointed -- and I have forgotten exactly
8 how this came about -- but in any event he was appointed
9 by somebody in authority to try and define what the respective
10 roles of these two organizations is to be, and he confussed
11 to us in open forum that he didn't really know. And I kind
12 of got an idea that he wasn't terribly concerned that it be
13 cleared up. I am not sure that he is the kind of person
14 that should be conducting that study.

15 I mentioned local planning and that we felt that
16 perhaps this was somewhat weak because it was going to be
17 dependent upon CHP B agencies. We saw little involvement by
18 actual citizens of the state. What we saw was not terribly
19 heartening.

20 They did have one project which was called consumer
21 health education programs, and we had others that had to do
22 with helping people to get into the health care system, both
23 apparently grass roots sort of project. But we weren't
24 terribly stimulated by the individual who presented that to
25 us, weren't sure that the concepts were entirely correct,

1 wondered whether this, too, was sort of a window dressing
2 to prove that minority interests or disadvantaged people
3 were actually getting represented.

4 As I mentioned, they have an excellent data base.
5 I won't repeat that further.

6 Their management is adequate. Their evaluation is
7 weak.

8 The action plan there really is not much of an
9 action plan. They have said that they are going to improve
10 certain things. They are going to improve health care for the
11 disadvantaged, but look at what they are going to do. They
12 are going to create a half a million dollar coronary care
13 center in the New Orleans Charity Hospital. They are going
14 to create a half a million dollar pulmonary pediatric center
15 in the New Orleans Charity Hospital, and they are going
16 to create -- I have forgotten -- a renal program within
17 the Charity Hospital system. Now they say this will help health
18 care because all of these guys are trained by the medical
19 schools and the Charity Hospital, therefore they are going
20 to go out to the charity hospitals in the rest of the
21 state and automatically this will bring better care to the
22 people of the state. Well, we know that this may or may not
23 be true. These doctors trained in Louisiana don't necessary
24 stay in Louisiana. If they do stay in Louisiana they will
25 go in private practice in large part, and once they go into

1 private practice the relationship to the charity hospital
2 system becomes quite weak. So it is highly tenuous sort of
3 reasoning that they have used.

4 They have created priorities which I will read
5 to you. The cardiac care unit is the number one priority.
6 This incorporated the spending of several hundred thousand
7 dollars for equipment. Something having to do with shared
8 services, and this is a program which rural hospitals would
9 define what they can do in concert better than they can do
10 separately. A tumor registry is number three.. And I have
11 always had a bias, I never did quite clearly understand
12 how tumor registries related to bringing better care to the
13 rural and disadvantaged people.

14 A regional kidney program is four.. Health data
15 information center is five. Cardiopulmonary resuscitation
16 unit is six. Stroke discharge planning, seven; pediatric
17 pulmonary planning, eight; organ, number nine,, and that has
18 been phased out; and a health consumer education and citizens'
19 advice bureau, the last two in their order.

20 They have been instrumental in developing some kinds
21 of continuing education programs around the state for the
22 nurses, the dial access program for physicians, and so on.

23 I think I shall not go into further detail about
24 this. I think I have covered the points that I think are of
25 concern to me, and I would rather turn to Dr. Parks at this

1 time before we get into telling you what our specific thoughts
2 might be as to funding and other recommendations.

3 MR. PARKS: Well, due to the lateness of the hour
4 and the completeness of that report, I can agree with most
5 of it. There are a couple of things that I think I should
6 probably highlight.

7 There was a lot that I didn't see in that room.
8 I did walk the streets, I took the lunch hour and walked the
9 streets to see something of the population, to see if I
10 found any kind of representation in that population within
11 the confines of the room in which we were conferring. I did
12 not find it there, and I think that has been covered somewhat
13 adequately.

14 I happened quite accidentally to ask the black
15 receptionist that they had about opportunities for
16 advancement, and she mentioned to me that she had just come
17 on board the week before. So I assume from that that the
18 word went out that there probably would be a black on the
19 review thing and they ran out and got a lady.

20 This troubled me a little bit, but I leave that
21 just as an example of the kind of thing that occurs here.

22 There was another black fellow, his name was
23 Bonner. He was a parish agent for the Department of
24 Agriculture. He was very glib, but largely impertinent
25 in terms of the information that he gave us; impertinent not

1 in the insulting sense, but impertinent in terms of what he
2 was addressing.

3 We talked with Mr. Roberts, who is the Assistant
4 Director for Administration. He is a very able man. He
5 mentioned some problems which were fiscal which were
6 occasioned by late funding, and this was being unable to
7 start programs and then getting money in the middle of
8 their fiscal year. But I think there was some suggestions
9 that would deal with that.

10 I did ask him about the question of whether the
11 various programs and activities that they funded at the various
12 medical schools and activities throughout the state; with
13 respect to regionalization I think they probably had
14 somewhere between five and seven outreach projects that were
15 spread in different points in the state. But he did indicate
16 to me beyond receiving a certificate of compliance they
17 did no monitoring to make sure whether the programs were
18 in fact reaching the people that they were designed to,
19 whether there were fair hiring practices that were in fact
20 operational, and various other things like this, which I
21 thought was a weakness, perhaps not by intent, but by virtue
22 of lack of direction in that area.

23 The RAG chairman I thought was a disaster. He was
24 the director of the state health system, something like that.
25 He was a state official. He was introduced as a--

1 DR. WHITE: He was a private practitioner.

2 VOICE: He sits on several boards that have
3 jurisdiction over the state system. I think he sits on the
4 state administration of hospitals.

5 MR. PARKS: This is somehow very closely tied into
6 that operation; and to the ex officio appointees to both
7 the RMP and the RAG, in the composition of those bylaws, there
8 is an interlocking kind of directorate really which makes
9 up the executive committee of both.

10 There were apparently problems of turf and rivalry
11 between the medical schools, and, of course, the peculiar
12 problems, the duality of the medical systems that they
13 have there.

14 Now these were presented to me really as a
15 reconcilable concomitance of the Louisiana situation, and
16 that Dr. Sabatier, whom I think is a very skillful
17 coordinator, and certainly I would assume a skillful politician,
18 seems to have made some passable accomodation with these
19 competing forces to obtain some measure of recognition and
20 some latitude for movement and development in this particular
21 program.

22 I did detect, though, in the statement of these
23 problems that they were almost incapable of resolution, and
24 that they would be boulders behind which they would hide for
25 not making certain kinds of changes that we were looking for in

1 terms of action oriented or delivery oriented kinds of activity.

2 The thing came through very directly to me that
3 Louisiana has some very, very peculiar problems, and I did not
4 detect that they had been not only recognized, but met, and now
5 that they were in a position hopefully to move around them
6 to achieve some other things.

7 I detected two others things. One, that the design,
8 the planning design was sort of an operational device to
9 get around some of the hostility, in addition to having been
10 perhaps an invited error by prior site visitors. The other
11 thing was as a result of that, the heavy emphasis of planning,
12 it did present some imbalance in terms of staffing, and
13 this was with respect to core.

14 There was a coordinator -- not a coordinator --
15 what's the name of--

16 VOICE: Project development officer.

17 MR. PARKS: Project development officer, who worked
18 apparently by himself. And this was really the key man to
19 their outreach and their developmental activity.

20 I would say that there are a number of positives, and I
21 think the fact perhaps that they have survived and done as
22 well as they have is somewhat remarkable, if what I have been
23 told is true.

24 But I would think, though, that they should be put
25 on a basis where some of the recommendations will address

1 themselves to this. They can be watched and encouraged to
2 make certain kinds of programmatic and organizational changes
3 that would bring them more into line with the program
4 statements and mission statements that have come from here.

5 DR. MAYER: Care for a recommendation?

6 DR. WHITE: Well, before I do that I would like to
7 voice my feelings about the renal program in the state of
8 Louisiana, in spite of separate or semi-separate or not
9 separate funding, or whatever it might be.

10 In spite of the fact that the technology is
11 apparently available for saving lives, in spite of the fact
12 that some actions have been undertaken to correct what are
13 viewed as shortcomings in this program, namely that it is going
14 to be phased in gradually rather than all of a sudden, and
15 that it relates appropriately to a center for transplantation,
16 and so on, and that people now on another kidney project
17 won't get paid twice by being on this project, too, and those
18 sort of things, as I view the project it really does not
19 serve the purpose of the Regional Medical Programs. It is
20 going to be a system in the charity hospital system. There
21 is nothing that I see in it which makes it a total system for
22 the state.

23 The fact that we have some documents which indicate
24 there is some disagreement as to whether or not there should
25 be a total system for the state, with the feeling that maybe

1 there should be one renal program for the charity and one
2 renal program for the other people.

3 I think, therefore, that regardless of the funding
4 mechanisms or the categorical nature or what have you, that
5 if this renal program is to survive in the state of Louisiana
6 that it should not be funded at this time, that it should go
7 back through a review process and be looked at by the
8 Regional Advisory Group, and this is a chance that they can
9 either hang themselves or prove themselves as responsible
10 citizens of the state.

11 With that as a preamble, I think the site visitors
12 at the late hour that we met on the second day came up with
13 a round figure of a million dollars. They had asked for
14 a million eight, and they are currently functioning at
15 about seven fifty. We felt that this was enough to help them
16 strengthen their core. It might also be enough to entice
17 them to do something other than to strengthen their core.
18 And this might be a measure again of their maturity and
19 ability to handle their own funds and establish their own
20 priorities, and give us further evidence to base our judgments
21 on in the future as to whether there should not necessarily
22 be a triennial RMP, but one at all in the state of
23 Louisiana.

24 There is a problem in reference to the coronary
25 care units. This was previously approved by this body prior

1 to the time that there was any interdiction on the use of
2 funds for equipment. They feel that it is perfectly
3 legitimate under those circumstances for them to proceed with
4 this. I don't know that we should give them direction along
5 these lines. This again would be a measure of whether or not
6 they are capable of managing their funds and programs
7 appropriately.

8 So I think our recommendation is for a million dollars
9 with a message, and that their fate is in the balance and
10 will be determined by how they manage this million dollars.

11 DR. MAYER: Do you want to comment about the
12 discussion we have now had times two about the two year
13 funding?

14 DR. WHITE: I have no objections to that. That will
15 be all right -- for myself. I don't know how Mr. Parks
16 feels about that.

17 DR. MAYER: The question being do we make a commitment
18 for a second year at some level so at least they are assured
19 of that kind of two year continuity while they spend the
20 year to try to get ready to put something back into the
21 system.

22 MR. PARKS: Well, I have not really consulted with
23 anyone about a second year type of funding. But I would
24 say this, that from one of the discussions here I think it
25 is very true that faced with the coordination or direction of

1 the program, especially charged, say, with a direct
2 immediate responsibility of making certain kinds of programmatic
3 changes, having the people aboard who will be necessary to make
4 creditable changes is a very important part of it. And I
5 would assume that the life expectancy of a program is a very
6 great factor involved in determining whether a person will or will
7 not remain in the program. And I think with some of the
8 recommendations that we have here it might be appropriate for
9 us to consider some figure.

10 I am not prepared at this time to make an estimate
11 of what a figure should be for a second year. I would think,
12 though, that some consideration ought to be given to it
13 so that it would not appear that we are asking them to improve
14 for one year and beyond that there is no light at the end
15 of the tunnel.

16 DR. MAYER: Could you and Dr. White come up with
17 a figure by tomorrow for us?

18 DR. WHITE: Well, I think at the time of the
19 deliberation on the figures at the time of the site visit
20 we were fairly much in agreement that a million dollars was
21 an appropriate figure, and I would see no reason why this
22 wouldn't also be appropriate for the second year.

23 DR. MAYER: Leonard.

24 DR. SCHERLIS: You knew I would have to comment.
25 This is the only time I have had to say heart all day, and

1 it's nice to mention that word in a categorical area. I
2 do have a lot of concern about half a million dollars
3 going into the coronary care training unit. I have concern
4 about the way it is described as including remodeling of
5 present heart station, expanding the cardiac catherization
6 laboratory, remodeling the outpatient cardiac clinic,
7 consultation, computer techniques, continuing coronary care,
8 and also it mentions physicians and nurses.

9 One or two things strike me. One, either the mail is
10 very slow between here and New Orleans, or else the
11 visibility of the smoke signals isn't very good. But I
12 would think that had this been submitted even three or four
13 years ago that I would have had a great deal of reaction
14 to it which was negative. I think that any place in the
15 country could come up with this project regardless of how good
16 their program is. If they have a real need for a
17 coronary care unit that something in the neighborhood of
18 20 or 30 thousand dollars would be appropriate just to
19 get the bare bedrock monitoring equipment in place, and
20 that woule be generous. I am sure they have something going.

21 I think at this time to ask for a catherized adult
22 cardiac clinic and to have particular EKG interpretation
23 computer assistance is something that I would look at with
24 a great deal of question. I would hope that there would be
25 an indication that this will not be supported, but if they

1 come in with something for a continuing education program
 2 on heart disease I think this is more satisfactory, because
 3 this to me is out of line with not only the new directions,
 4 but the old priorities as far as the Regional Medical
 5 Program goes. If you can deduct that, which is a half million
 6 dollars, you still leave them with a good boost for what
 7 they have.

8 I don't think we should say to them we are going
 9 to look at how mature you are by whether or not you build
 10 that. I would first build it, and then after I build it
 11 say I have suddenly become mature and I am not going to do
 12 it again. I would not want them to be supported for that.
 13 And it appalls me in an area with the need of this particular
 14 state, Louisiana, that a million dollars of their request
 15 goes to support basically to support pediatric respiratory
 16 care unit and the rest to refurbish a heart station in a
 17 hospital which should be done through other sources,, however
 18 tight they are in that state for support for health.

19 To end up with, if you are really raising that
 20 \$250,000 over what they requested this year in spite of the
 21 failure to recognize priorities and goals, and so on, I
 22 think I share the confusion one might have with the dual
 23 mission that made you go down there, Dr. White. But I do
 24 have some concern -- perhaps you could react to it -- how do
 25 you feel about that half a million dollars? Don't you think

1 we should put a strict no on it, and say well, maybe a few
2 dollars for training, and the increment of \$250,000 over
3 the present level of funding might be something they can
4 work with if we are very strict about what the guidelines
5 are.

6 DR. WHITE: Well, their present level is seven fifty,
7 and we recommended a million. And I think the message we
8 were trying to get to them, hopefully will get to them, the
9 bulk of that should be used to strengthen their action
10 planning functions, and the core staff and personnel required
11 for that. If there is something left over it is obviously
12 going to be insufficient for spending to the extent that
13 they are planning for either the pulmonary or the coronary
14 care unit. They could then perhaps use 25 or 30 thousand
15 dollars to implement an educational program, but they would
16 not have the resources required to begin to do what they
17 are planning to do for the coronary care..

18 DR. SCHERLIS: I would hope we would go on record as
19 saying these funds should not be used for that particular
20 project. Now if they had come in with a system of coronary
21 care for the state I would have urged strongly that it be
22 supported because I think Dr. Burke and his group have men
23 that could do this. What we are talking about essentially
24 is going into a university hospital resource and totally
25 remodeling all the cardiovascular facilities on a single shot

1 basis, and I don't think this is a proper way of using these
2 funds. If they had asked a half million or million dollars
3 to take that state and set up a total coronary care
4 program in a stratified system I would be all for it and
5 I would urge this group go in that direction. That I think
6 is a proper expenditure of RMP funds, but not to refurbish
7 this sort of a unit.

8 DR. MAYER: Between the coronary care unit and
9 the renal program and the pediatric pulmonary care center
10 there is just a little bit over a million dollars that is
11 involved in that, and I heard Dr. White, I thought, a couple
12 of times comment about his concerns about those two programs
13 as well as the coronary care program.

14 Are we implying that we feel that those three
15 issues are inappropriate directions to be taken?

16 DR. WHITE: I think they are inappropriate,
17 and particularly inappropriate until such time as the
18 Regional Advisory Group can come back and justify their
19 appropriateness, which they haven't done at this time.

20 DR. MAYER: Would we like to put a limit then that
21 no expenditures in those three areas would exceed, let's say,
22 \$25,000 each?

23 DR. WHITE: It's acceptable to me. I indicated in
24 advance that I would bend with the wind, and I so bend.

25 VOICE: I would like clarification. The three

1 areas were pediatric pulmonary, coronary care, and what
2 was the third?

3 DR. MAYER: The renal program.

4 Yes, Dr. Hinman.

5 DR. HINMAN: I would like clarification on the
6 renal, what you were saying, Dr. White. Is that the RAG, if
7 they could meld the two systems that have developed
8 independently into one that you feel it would be appropriate
9 to consider the request before their next anniversary, or
10 would they have to put it off a year? The reason I bring this
11 up is part of the charity system has been supported by
12 some contracts from the kidney disease control program
13 which expire in the next several months, and this would be a
14 year before we could even entertain further applications
15 from them, it would put them somewhere between nine and
16 twelve months without any income to support their kidney
17 activities.

18 DR. WHITE: Can they get a new contract?

19 DR. HINMAN: Well, that's another option that they
20 could go. We would prefer -- the RMPS position would be
21 to try to work it into the grant mechanism rather than the
22 contract mechanism. That's why I brought the question up.

23 If the answer is that you think it should wait for
24 another year for anniversary then we would have to go the
25 contract route to try to salvage some pieces of it if it

1 seems worth salvaging.

2 DR. WHITE: Well, Dr. Hinman, the evidence I
3 have is that the Regional Advisory Group was advised by
4 Dr. Sabatier that there were problems in this project and
5 they chose not to regard the comments that he made, which
6 I think is a reflection of their activity and interest. I
7 think it's critical that this be re-awakened.

8 Secondly, we have letters indicating that there is
9 disagreement between scientists as to the appropriate way
10 of conducting this program. Therefore I think that it
11 requires a strong local review before it can be implemented.

12 DR. HINMAN: Fine.

13 DR. MAYER: All right, do we have a clear
14 understanding of the motion?

15 What we are saying is recommending support of a
16 million dollars for two years consecutively, one million
17 each, with the clear indication that those dollars should
18 not be programmed into such unit development as represented
19 by those three units, and that the maximum amount of that
20 million dollars that might go into each of them might be
21 \$25,000 each.

22 MR. TOOMEY: I will second it.

23 DR. MAYER: All right, any further discussion?

24 All those in favor say "aye."

25 (Chorus of "ayes.")

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Opposed?

(No response.)

Let us plan then on 8:30 in the morning. We will be in executive session at 8:30 in the morning I would assume probably for about an hour for staff -- this is an approximation.

We will in the morning then start in with Western New York. We may have to slip to Metropolitan D. C. before Florida because with Dr. Lewis's absence Dr. Carpenter will be in tomorrow, but he won't be in until about 10:30 or so on the Florida activity. Otherwise our intent would be to go through them sequentially with that one exception.

(Whereupon, at 6:00 p.m., the meeting recessed, to reconvene at 8:30 a.m. the following day.)